

**ST. MARY'S HOSPITAL  
MEDICAL STAFF BYLAWS,  
POLICIES AND RULES AND REGULATIONS**

**CREDENTIALING POLICY  
OF  
ST. MARY'S HOSPITAL**

*Approved by the Medical Staff  
November 16, 2007  
Approved by the Board of Directors  
December 20, 2007*

*Horty, Springer & Mattern, P.C.*

## MEDICAL STAFF CREDENTIALING POLICY

### AMENDMENTS:

<b>ARTICLE</b>	<b>MEDICAL STAFF APPROVAL</b>	<b>BOARD OF DIRECTORS APPROVAL</b>
Article 2.A.1.m	06/01/10	06/10/10
Article 2.A.1.n	02/04/14	02/20/14
Article 2.A.1.o	07/28/09	08/06/09
Article 2.A.3	07/28/09	08/06/09
Article 2.C.1.b.3	07/28/09	08/06/09
Article 4.A.1 (b)(c)	01/22/08	02/07/08
Article 4.A.1.f	07/28/09	08/06/09
Article 4.A.1.k	07/28/09 09/23/10	08/06/09 10/07/10
Article 4.A.4	11/05/13	02/20/14
Article 4.A.6 (a)(c)(e)	07/28/09	08/06/09
Article 4.B.1 (a)	09/20/16	10/27/16
Article 4.D(1)(2)(3)(4)	01/22/08	02/07/08
Article 4.D(1)(2)(3)(4)(5)	06/22/11	06/24/11
Article 4.D(6)	06/19/12	06/21/12
Article 5.A.1	01/17/12	03/08/12
Article 6A.6	07/28/09	08/06/09
Article 6.B.1	07/28/09	08/06/09

Article 6.C (1) (3)

07/28/09

08/06/09

Article 6.D.3

07/28/09

08/06/09

# TABLE OF CONTENTS

	<u>PAGE</u>
<b>1. GENERAL</b> .....	1
1.A. DEFINITIONS .....	1
1.B. TIME LIMITS .....	3
1.C. DELEGATION OF FUNCTIONS .....	3
<b>2. QUALIFICATIONS, CONDITIONS AND RESPONSIBILITIES</b> .....	4
2.A. QUALIFICATIONS .....	4
2.A.1. Eligibility Criteria .....	4
2.A.2. Waiver of Criteria .....	6
2.A.3. Factors for Evaluation .....	7
2.A.4. No Entitlement to Appointment .....	7
2.A.5. Nondiscrimination .....	8
2.A.6. Ethical and Religious Directives .....	8
2.B. GENERAL CONDITIONS OF APPOINTMENT AND REAPPOINTMENT .....	8
2.B.1. Basic Responsibilities and Requirements .....	8
2.B.2. Burden of Providing Information .....	10
2.C. APPLICATION .....	11
2.C.1. Information .....	11
2.C.2. Grant of Immunity and Authorization to Obtain/Release Information .....	12
<b>3. PROCEDURE FOR INITIAL APPOINTMENT</b> .....	15
3.A. PROCEDURE FOR INITIAL APPOINTMENT .....	15
3.A.1. Request for Application .....	15
3.A.2. Initial Review of Application .....	16
	<u>PAGE</u>

3.A.3. Steps to Be Followed for All Initial Applicants.....	16
3.A.4. Department Chairperson Procedure .....	17
3.A.5. Credentials Committee Procedure.....	17
3.A.6. Medical Executive Committee Procedure.....	19
3.A.7. Board Action .....	19
3.A.8. Time Periods for Processing .....	20
3.B. PROVISIONAL STATUS.....	20
3.B.1. Duration of Provisional Period.....	20
3.B.2. Duties of Provisional Members.....	21
<b>4. CLINICAL PRIVILEGES .....</b>	<b>23</b>
4.A. CLINICAL PRIVILEGES.....	23
4.A.1. General .....	23
4.A.2. Voluntary Relinquishment of Privileges .....	25
4.A.3. Clinical Privileges for New Procedures .....	26
4.A.4. Clinical Privileges That Cross Specialty Lines .....	28
4.A.5. Clinical Privileges After Age 70 .....	29
4.A.6. Physicians in Training.....	29
4.A.7. Telemedicine Privileges .....	31
4.B. TEMPORARY CLINICAL PRIVILEGES .....	33
4.B.1. Eligibility to Request Temporary Clinical Privileges .....	33
4.B.2. Supervision Requirements.....	34
4.B.3. Termination of Temporary Clinical Privileges .....	34
4.C. EMERGENCY SITUATIONS.....	35
4.D. DISASTER PRIVILEGES .....	35
4.E. CONTRACTS FOR SERVICES .....	37

	<u>PAGE</u>
<b>5. PROCEDURE FOR REAPPOINTMENT</b> .....	39
5.A. PROCEDURE FOR REAPPOINTMENT .....	39
5.A.1. Eligibility for Reappointment .....	39
5.A.2. Factors for Evaluation .....	40
5.A.3. Reappointment Application.....	41
5.A.4. Processing Applications for Reappointment .....	42
5.A.5. Time Periods for Processing .....	43
<b>6. PEER REVIEW PROCEDURES FOR QUESTIONS INVOLVING MEDICAL STAFF MEMBERS</b> .....	44
6.A. COLLEGIAL INTERVENTION .....	44
6.B. INVESTIGATIONS .....	45
6.B.1. Initial Review .....	45
6.B.2. Initiation of Investigation .....	46
6.B.3. Investigative Procedure .....	47
6.B.4. Recommendation.....	49
6.C. PRECAUTIONARY SUSPENSION OR RESTRICTION OF CLINICAL PRIVILEGES.....	51
6.C.1. Grounds for Precautionary Suspension or Restriction .....	51
6.C.2. Medical Executive Committee Procedure.....	52
6.C.3. Care of Patients .....	53
6.D. AUTOMATIC RELINQUISHMENT .....	53
6.D.1. Failure to Complete Medical Records.....	53
6.D.2. Action by Government Agency or Insurer .....	54
6.D.3. Failure to Provide Requested Information .....	55
6.D.4. Failure to Attend Special Conference .....	55
6.D.5. Failure to Abide by Utilization Standards .....	56
6.E. LEAVES OF ABSENCE.....	56

	<u>PAGE</u>
<b>7. HEARING AND APPEAL PROCEDURES</b> .....	59
7.A. INITIATION OF HEARING .....	59
7.A.1. Grounds for Hearing .....	59
7.A.2. Actions Not Grounds for Hearing .....	60
7.B. THE HEARING.....	61
7.B.1. Notice of Recommendation.....	61
7.B.2. Request for Hearing .....	61
7.B.3. Notice of Hearing and Statement of Reasons .....	61
7.B.4. Witness List .....	62
7.B.5. Hearing Panel, Presiding Officer, and Hearing Officer .....	62
7.C. PRE-HEARING AND HEARING PROCEDURE .....	65
7.C.1. Provision of Relevant Information.....	65
7.C.2. Pre-Hearing Conference .....	66
7.C.3. Failure to Appear.....	67
7.C.4. Record of Hearing .....	67
7.C.5. Rights of Both Sides and the Hearing Panel at the Hearing.....	67
7.C.6. Admissibility of Evidence .....	68
7.C.7. Post-Hearing Statement.....	68
7.C.8. Persons to be Present.....	69
7.C.9. Postponements and Extensions .....	69
7.C.10. Presence of Hearing Panel Members.....	69
7.D. HEARING CONCLUSION, DELIBERATIONS, AND RECOMMENDATIONS .....	69
7.D.1. Order of Presentation .....	69
7.D.2. Basis of Hearing Panel Recommendation .....	69
7.D.3. Deliberations and Recommendation of the Hearing Panel .....	70
7.D.4. Disposition of Hearing Panel Report.....	70
7.E. APPEAL PROCEDURE .....	71
7.E.1. Time for Appeal .....	71
7.E.2. Grounds for Appeal.....	71
7.E.3. Time, Place and Notice .....	71

	<b><u>PAGE</u></b>
7.E.4. Nature of Appellate Review .....	72
7.E.5. Final Decision of the Board.....	72
7.E.6. Further Review .....	73
7.E.7. Right to One Hearing and One Appeal Only .....	73
<b>8. CONFIDENTIALITY AND PEER REVIEW PROTECTION .....</b>	<b>74</b>
8.A. CONFIDENTIALITY .....	74
8.B. PEER REVIEW PROTECTION .....	74
<b>9. AMENDMENTS.....</b>	<b>77</b>
<b>10. ADOPTION .....</b>	<b>78</b>
<b>ADDENDA:</b>	
<b>I TEMPORARY PRIVILEGES, EXPEDITED CREDENTIALING POLICY.....</b>	<b>79</b>
<b>I FOCUSED PROFESSIONAL PRACTICE EVALUATION.....</b>	<b>80</b>
<b>II ONGOING PROFESSIONAL PRACTICE EVALUATION.....</b>	<b>84</b>



## ARTICLE 1

### GENERAL

#### 1.A. DEFINITIONS

The following definitions apply to terms used in this Policy:

- (1) "BOARD" means the Board of Directors of the Hospital, which has the overall responsibility for the Hospital or its designated committee.
- (2) "BOARD CERTIFICATION" is the designation conferred by one of the affiliated specialties of the American Board of Medical Specialties, the American Osteopathic Association, the Commission on Dental Accreditation of the American Dental Association, or the American Board of Podiatric Surgery or, as applicable, upon a physician, dentist or podiatrist who has successfully completed an approved educational training program and an evaluation process, including passing an examination, in the applicant's area of clinical practice.
- (3) "CHIEF EXECUTIVE OFFICER" means the individual appointed by the Board to act on its behalf in the overall management of the Hospital.
- (4) "CLINICAL PRIVILEGES" means the authorization granted by the Board to render specific patient care services.
- (5) "CREDENTIALING POLICY" means the Hospital's Medical Staff Credentialing Policy.
- (6) "DAYS" means calendar days.
- (7) "DENTIST" means a doctor of dental surgery ("D.D.S.") or doctor of dental medicine ("D.M.D.").
- (8) "HOSPITAL" means St. Mary's Hospital.
- (9) "MEDICAL EXECUTIVE COMMITTEE" means the Executive Committee of the Medical Staff.

- (10) "MEDICAL STAFF" means all physicians, dentists and podiatrists who have been appointed to the Medical Staff by the Board.
- (11) "ORGANIZED MEDICAL STAFF" means a group of licensed independent practitioners responsible for oversight of care, treatment, and services provided by the practitioners with privileges, provides for a uniform quality of patient care, treatment, and services, and for approval and amendment of Medical Staff Bylaws, and reports to and is accountable to the governing body.
- (12) "MEMBER" means any physicians, dentists, and podiatrists who have been granted Medical Staff appointment and clinical privileges by the Board to practice at the Hospital.
- (13) "NOTICE" means written communication by regular U.S. mail, e-mail, facsimile, or Hospital mail, or hand delivery.
- (14) "ORGANIZED HEALTH CARE ARRANGEMENT" means the term used by the HIPAA Privacy Rule to describe a clinically integrated care setting in which patients typically receive health care from more than one provider (such as a hospital and its Medical Staff) and which benefits from regulatory provisions designed to facilitate compliance with the HIPAA Privacy Rule.
- (15) "PHYSICIAN" includes both doctors of medicine ("M.D.s") and doctors of osteopathy ("D.O.s").
- (16) "PODIATRIST" means a doctor of podiatric medicine ("D.P.M.").
- (17) "SPECIAL NOTICE" means hand delivery, certified mail, return receipt requested or overnight delivery service providing receipt.

#### 1.B. TIME LIMITS

Time limits referred to in this Policy are advisory only and are not mandatory, unless it is expressly stated that a particular right is waived by failing to take action within a specified period.

#### 1.C. DELEGATION OF FUNCTIONS

When a function is to be carried out by a person or committee, the person, or the committee through its chairperson, may delegate performance of the function to one or more qualified designees.

## ARTICLE 2

### QUALIFICATIONS, CONDITIONS AND RESPONSIBILITIES

#### 2.A. QUALIFICATIONS

##### 2.A.1. Eligibility Criteria:

To be eligible to apply for initial appointment or reappointment to the Medical Staff, physicians, dentists, and podiatrists must:

- (a) have a current unrestricted license to practice in this state and have never had a license to practice revoked or suspended by any state licensing agency;
- (b) where applicable to their practice, have a current, unrestricted DEA registration and state controlled substance license;
- (c) be located (office and residence) within the geographic service area of the Hospital, as defined by the Board, close enough to fulfill their Medical Staff responsibilities and to provide timely and continuous care for their patients in the Hospital;
- (d) have current, valid professional liability insurance coverage in a form and in amounts satisfactory to the Hospital;
- (e) 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;
- (f) are not currently excluded or precluded from participation in Medicare, Medicaid or other federal or state governmental health care program;
- (g) have never had Medical Staff appointment or clinical privileges denied, revoked, resigned, relinquished, or terminated by any health care facility or health plan for reasons related to clinical competence or professional conduct;

- (h) have never been convicted of, or entered a plea of guilty or no contest to, any felony, or any misdemeanor relating to controlled substances, illegal drugs, insurance or health care fraud or abuse or violence;
- (i) may be requested to respond to reasonable requests to perform Medical Staff functions, as may be required and
- (j) have or agree to make coverage arrangements with other member of the Medical Staff for those times when the individual will be unavailable;
- (k) have successfully completed a residency training program approved by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association in a specialty in which the applicant seeks clinical privileges, or an oral and maxillofacial surgery training program accredited by the Commission on Dental Accreditation of the American Dental Association, or a podiatric surgical residency program accredited by the Council on Podiatric Medical Education of the American Podiatric Medical Association (This requirement is applicable only to those individuals who apply for initial staff appointment on or after the date of adoption of this Policy.);
- (l) be certified by the appropriate specialty board, as applicable. Those applicants who are not board certified at the time of application but who have completed their residency training within the last five years shall be eligible for Medical Staff appointment. However, in order to remain eligible, those applicants must achieve board certification within five (5) years from the date of completion of their residency training. (This requirement is applicable only to those individuals who apply for initial staff appointment after the date of adoption of this Policy. All individuals appointed previously shall be governed by the board

- certification requirements in effect at the time of their appointments);  
and
- (m) maintain certification and, to the extent required by the applicable specialty/subspecialty board, satisfy recertification requirements. Recertification will be assessed at reappointment. Failure to recertify will result in a one year reappointment. Failure to recertify during that year will result in loss of Medical Staff Appointment.
  - (n) The organized medical staff initially appoints members of the medical staff for a period not to exceed two years.

2.A.2. Waiver of Criteria:

- (a) Any individual who does not satisfy a criterion may request that it be waived. The individual requesting the waiver bears the burden of demonstrating that his or her qualifications are equivalent to, or exceed, the criterion in question.
- (b) The Board may grant waivers in exceptional cases after considering the findings of the Credentials Committee, Medical Executive Committee, or other committee designated by the Board, the specific qualifications of the individual in question, and the best interests of the Hospital and the community it serves. The granting of a waiver in a particular case is not intended to set a precedent for any other individual or group of individuals.
- (c) No individual is entitled to a waiver or to a hearing if the Board determines not to grant a waiver.
- (d) A determination that an individual is not entitled to a waiver is not a "denial" of appointment or clinical privileges.

2.A.3. Factors for Evaluation:

Only those individuals who can document that they are highly qualified in all regards will be appointed to the Medical Staff. The following factors will be consistently evaluated as part of the appointment and reappointment processes:

- (a) relevant training, experience, demonstrated current competence and judgment;
- (b) adherence to the ethics of their profession;
- (c) good reputation and character;
- (d) ability to perform, safely and competently, the clinical privileges requested; and
- (e) ability to work harmoniously with others sufficiently to convince the Hospital that all patients treated by them will receive quality care and that the Hospital and its Medical Staff will be able to operate in an orderly manner.

2.A.4. No Entitlement to Appointment:

No individual is entitled to receive an application or to be appointed or reappointed to the Medical Staff or to be granted particular clinical privileges merely because he or she:

- (a) is licensed to practice a profession in this or any other state;
- (b) is a member of any particular professional organization;
- (c) has had in the past, or currently has, Medical Staff appointment or privileges at any hospital or health care facility;
- (d) resides in the geographic service area of the Hospital; or
- (e) is affiliated with, or under contract to, any managed care plan, insurance plan, HMO, PPO, or other entity.

2.A.5. Nondiscrimination:

No individual shall be denied appointment on the basis of gender, age, ancestry, race, color, creed, sex, marital status, or national origin.

2.A.6. Ethical and Religious Directives:

All members shall abide by the terms of the Ethical and Religious Directives for Catholic Health Care Services promulgated by the National Conference of Catholic Bishops with respect to their practice at the Hospital. No activity prohibited by said directives shall be engaged in at the Hospital by any member.

2.B. GENERAL CONDITIONS OF APPOINTMENT AND REAPPOINTMENT

2.B.1. Basic Responsibilities and Requirements:

As a condition of consideration for appointment or reappointment, and as a condition of continued appointment, every applicant and member specifically agree to the following:

- (a) to provide continuous and timely care to all patients for whom the individual has responsibility;
- (b) to abide by all Bylaws, policies, and Rules and Regulations of the Hospital and Medical Staff in force during the time the individual is appointed;
- (c) to complete in a timely manner all medical and other required records, containing all information required by the Hospital;
- (d) to satisfy continuing medical education requirements;
- (e) to accept committee assignments, may be requested to respond to reasonable requests to perform Medical Staff Functions as may be required and such other reasonable duties and responsibilities as assigned;



- (f) to provide immediately, with or without request, new or updated information to the Chief Executive Officer as it occurs, pertinent to any question on the application form;
- (g) to acknowledge that the individual has had an opportunity to read a copy of this Policy and any other applicable Bylaws, Rules and Regulations and agrees to be bound by them;
- (h) to appear for personal interviews in regard to an application for initial appointment;
- (i) to use the Hospital sufficiently to allow continuing assessment of current competence or to provide information to demonstrate current competence.
- (j) to refrain from illegal fee splitting or other illegal inducements relating to patient referral;
- (k) to refrain from delegating responsibility for hospitalized patients to any individual who is not qualified or adequately supervised;
- (l) to refrain from deceiving patients as to the identity of any individual providing treatment or services;
- (m) to seek consultation whenever necessary;
- (n) to participate in monitoring and evaluation activities;
- (o) to participate in an Organized Health Care Arrangement with the Hospital, to abide by the terms of the Hospital's Notice of Privacy Practices with respect to health care delivered in the Hospital, and to provide patients with a Notice of Organized Health Care Arrangement as a supplement to their own Notice of Privacy Practices;
- (p) to perform all services and conduct himself/herself at all times in a cooperative and professional manner;
- (q) to promptly pay any applicable dues and assessments; and

- (r) that, if there is any misstatement in, or omission from, the application, the Hospital may stop processing the application (or, if appointment has been granted prior to the discovery of a misstatement or omission, appointment and privileges may be deemed to be automatically relinquished). In either situation, there shall be no entitlement to a hearing or appeal.

#### 2.B.2. Burden of Providing Information:

- (a) The individual seeking appointment or reappointment is responsible for providing a complete application, including adequate responses from references. An incomplete application will not be processed.
- (b) Individuals seeking appointment and reappointment have the burden of producing information deemed necessary by the Hospital for a proper evaluation of current competence, character, ethics, and other qualifications and for resolving any doubts.
- (c) Individuals seeking appointment and reappointment have the burden of providing evidence that all the statements made and information given on the application are accurate.
- (d) An application shall be complete when all questions on the application form have been answered, all supporting documentation has been supplied, and all information has been verified from primary sources. An application shall become incomplete if the need arises for new, additional, or clarifying information at any time. Any application that continues to be incomplete 30 days after the individual has been notified of the additional information required shall be deemed to be withdrawn.

#### 2.C. APPLICATION

2.C.1. Information:

- (a) Applications for appointment/ reappointment shall contain a request for clinical privileges and shall require detailed information concerning the individual's professional qualifications. The applications for initial appointment and reappointment existing now and as may be revised are incorporated by reference and made a part of this Policy.
- (b) In addition to other information, the applications shall seek the following:
  - (1) information as to whether the applicant's medical staff appointment or 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 hospital or health care facility or are currently being investigated or challenged;
  - (2) information as to whether the applicant's license to practice any relevant profession in any state, DEA registration, or any state's controlled substance license has been voluntarily or involuntarily suspended, modified, terminated, restricted, or relinquished or is currently being investigated or challenged;
  - (3) information concerning the applicant's professional liability litigation experience, including past and pending claims, final judgments, or settlements; the substance of the allegations as well as the findings and the ultimate disposition, query the National Practitioner Data Bank (NPDB); and any additional information concerning such proceedings or actions as the

Credentials Committee, the Medical Executive Committee, or the Board may request; and

(4) current information regarding the applicant's ability to safely and competently exercise the clinical privileges requested.

(5) the applicant has satisfied the six areas of General Competencies

Patient Care

Medical/Clinical Knowledge

Practice-based Learning and Improvement

Interpersonal and Communication Skills

Professionalism

Systems-based Practice.

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

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

By requesting an application and/or applying for appointment, reappointment, or clinical privileges, the individual expressly accepts the following conditions, whether or not appointment or clinical privileges are granted, and throughout the term of any appointment or reappointment. Appointment to membership is not synonymous with clinical privileges.

(a) Immunity:

To the fullest extent permitted by law, the individual releases from any and all liability, extends absolute immunity to, and agrees not to sue the Hospital, any member of the Medical Staff, their authorized representatives, and appropriate third parties for any matter relating to

appointment, reappointment, clinical privileges, or the individual's qualifications for the same. This includes any actions, recommendations, reports, statements, communications, or disclosures involving the individual which are made, taken, or received by the Hospital, its authorized agents, or appropriate third parties.

(b) Authorization to Obtain Information from Third Parties:

The individual specifically authorizes the Hospital, Medical Staff leaders, and their authorized representatives (1) to consult with any third party who may have information bearing on the individual's professional qualifications, credentials, clinical competence, character, ability to perform safely and competently, ethics, behavior, or any other matter reasonably having a bearing on his or her qualifications for initial and continued appointment to the Medical Staff, and (2) to obtain any and all communications, reports, records, statements, documents, recommendations or disclosures of third parties that may be relevant to such questions. The individual also specifically authorizes third parties to release this information to the Hospital and its authorized representatives upon request.

(c) Authorization to Release Information to Third Parties:

The individual also authorizes Hospital representatives to release information to other hospitals, health care facilities, managed care organizations, and their agents when information is requested in order to evaluate his or her professional qualifications for appointment, privileges, and/or participation at the requesting organization/facility.

(d) Hearing and Appeal Procedures:

The individual agrees that the hearing and appeal procedures set forth in this Policy shall be the sole and exclusive remedy with respect to any professional review action taken by the Hospital.

(e) Legal Actions:

If, notwithstanding the provisions in this Section, an individual institutes legal action and does not prevail, he or she shall reimburse the Hospital and any member of the Medical Staff named in the action for all costs incurred in defending such legal action, including reasonable attorney's fees.

ARTICLE 3  
PROCEDURE FOR INITIAL APPOINTMENT

3.A. PROCEDURE FOR INITIAL APPOINTMENT

3.A.1. Request for Application:

- (a) Applications for appointment shall be in writing and shall be on forms approved by the Board upon recommendation by the Medical Executive Committee.
- (b) Any individual requesting an application for initial appointment shall be sent (1) a letter that outlines the eligibility criteria for appointment as well as clinical privileges, and (2) a Pre-Application form which requests proof that the individual meets the eligibility criteria for appointment . A completed Pre-Application form with copies of all required documents must be returned to the Medical Staff Office within 30 days after receipt, if the individual desires further consideration. Individuals who meet these criteria shall be given an application. Individuals who fail to meet these criteria shall not be given an application and shall be notified that they are ineligible to apply. There is no right to a hearing on a determination of ineligibility.
- (c) Applications may be provided to residents who are in the final six months of their training. Final action will not be taken until all applicable eligibility criteria are satisfied.

### 3.A.2. Initial Review of Application:

- (a) A completed application form with copies of all required documents must be returned to the Chair, Credentials Committee within 30 days after receipt. The application must be accompanied by the application fee.
- (b) As a preliminary step, the application will be reviewed by the Chair, Credentials Committee to determine that all questions have been answered and that the individual satisfies all threshold criteria. Incomplete applications will not be processed. Individuals who fail to return completed applications or fail to meet the threshold criteria will be notified that their application will not be processed.
- (c) The Chair, Credentials Committee shall oversee the process of gathering and verifying relevant information, and confirming that all references and other information or materials deemed pertinent have been received.
- (d) The names of applicants may be posted so that members of the Medical Staff may submit, in writing, information bearing on the applicant's qualifications for appointment or clinical privileges.

### 3.A.3. Steps to Be Followed for All Initial Applicants:

- (a) Evidence of the applicant's character, professional competence, qualifications, behavior, and ethical standing shall be examined. This information may be contained in the application, and obtained from references and other available sources, including the applicant's past or current department chiefs at other health care entities, residency training director, and others who may have knowledge about the applicant's education, training, experience, and ability to work with others.



- (b) An interview with the applicant is required before final action is taken on an application. The purpose of the interview is to discuss and review any aspect of the applicant's application, qualifications, and requested clinical privileges. Preferably, this interview will be conducted by the department chairperson or a designee. In the event that the department chairperson is unavailable, the interview may be conducted by the Credentials Committee, the Medical Executive Committee and/or the Chief of Staff.

3.A.4. Department Chairperson Procedure:

- (a) The Credentials Committee shall transmit the complete application and all supporting materials to the chairperson of each department in which the applicant seeks clinical privileges. Each chairperson shall prepare a written report regarding whether the applicant has satisfied all of the qualifications for appointment and the clinical privileges requested.
- (b) The department chairperson may also recommend that an application raises no questions and should be considered for expedited processing.
- (c) The department chairperson shall be available to the Credentials Committee, Medical Executive Committee or the Board to answer any questions that may be raised with respect to that chairperson's report and findings.

3.A.5. Credentials Committee Procedure:

- (a) For all other applications, the Credentials Committee shall review and consider the report prepared by the relevant department chairperson and shall make a recommendation.

- (b) The Credentials Committee may use the expertise of the department chairperson, or any member of the department, or an outside consultant, if additional information is required regarding the applicant's qualifications.
- (c) The Credentials Committee may require the applicant to undergo a physical and/or psychiatric examination by a physician(s) satisfactory to the Credentials Committee. The results of this examination shall be made available to the Committee for its consideration. Failure of an applicant to undergo an examination within a reasonable time after being requested to do so in writing by the Credentials Committee shall be considered a voluntary withdrawal of the application and all processing of the application shall cease.
- (d) The Credentials Committee may recommend the imposition of specific conditions. These conditions may relate to behavior (e.g., code of conduct) or to clinical issues (e.g., general consultation requirements, proctoring). The Credentials Committee may also recommend that appointment be granted for a period of less than two years in order to permit closer monitoring of an individual's compliance with any conditions.
- (e) If the recommendation of the Credentials Committee is delayed longer than 60 days, the Chairperson of the Credentials Committee shall send a letter to the applicant, with a copy to the Medical Executive Committee and the Chief Executive Officer, explaining the reasons for the delay.

3.A.6. Medical Executive Committee Procedure:

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

3.A.7. Board Action:

- (a) Upon receipt of a recommendation that the applicant be granted appointment and clinical privileges, the Board may:

- (1) appoint the applicant and grant clinical privileges as recommended; or
  - (2) refer the matter back to the Credentials Committee or Medical Executive Committee or to another source inside or outside the Hospital for additional research or information; or
  - (3) reject or modify the recommendation.
- (b) If the Board determines to reject a favorable recommendation, it should first discuss the matter with the Chief of Staff. If the Board's determination remains unfavorable to the applicant, the Chief Executive Officer shall promptly send special notice to the applicant that the applicant is entitled to request a hearing.

#### 3.A.8. Time Periods for Processing:

Once an application is deemed complete, it is expected to be processed within 120 days, unless it becomes incomplete. This time period is intended to be a guideline only and shall not create any right for the applicant to have the application processed within this precise time period.

### 3.B. PROVISIONAL STATUS

#### 3.B.1. Duration of Provisional Period:

- (a) All initial appointments to the Medical Staff (regardless of the category of the staff) and all initial clinical privileges shall be provisional for a period of 6 months or longer, and may be renewed if recommended by the Credentials Committee.

- (b) All grants of increased clinical privileges are also provisional. The duration and/or terms of this provisional period will be recommended by the Credentials Committee, after consulting with the department chairperson, and approved by the Board.
- (c) During the provisional period, the individual shall be evaluated by the chairperson of the department in which the individual has clinical privileges and by the relevant committees as to the individual's clinical competence and general behavior and conduct in the Hospital.

The organized medical staff does the following:

- ◆ Evaluates practitioners without current performance documentation at the organization.
- ◆ Evaluates practitioners in response to concerns regarding the provision of safe, high quality patient care
- ◆ Develops criteria for extending the evaluation period
- ◆ Communicates to the appropriate parties the evaluation results and recommendations based on results
- ◆ Implements changes to improve performance.

### 3.B.2. Duties of Provisional Members:

- (a) The provisional member must arrange, or cooperate in the arrangement of, the required numbers and types of cases to be reviewed/observed by the department chairperson and/or designated observers.
- (b) This process may include an assessment for proficiency in the following six areas of “General Competencies”:
  - ◆ Patient Care
  - ◆ Medical/Clinical Knowledge
  - ◆ Practice-Based Learning and Improvement

- ◆ Interpersonal and Communication Skills
- ◆ Professionalism
- ◆ System-Based practice.

(c) If the provisional member fails to: (1) admit or treat the number of patients established by the Credentials Committee (sufficient to permit observation and assessment), or (2) fulfill all requirements of appointment relating to meeting attendance, completion of medical records, and/or cooperation with monitoring or observation conditions, at the expiration of provisional appointment, all clinical privileges shall be automatically relinquished. The individual may reapply for initial appointment in the future. Whenever provisional appointment or provisional clinical privileges are terminated, revoked, or restricted for other reasons, the individual shall be entitled to a hearing and appeal.

ARTICLE 4  
CLINICAL PRIVILEGES

4.A. CLINICAL PRIVILEGES

4.A.1. General:

- (a) Appointment or reappointment shall not confer any clinical privileges or right to practice at the Hospital.
- (b) Each individual who has been appointed to the Medical Staff is entitled to exercise only those clinical privileges specifically granted by the Board, which is the final authority in the granting, denying or renewal of all privileges. The privileges requested by the applicant and recommended to the Board shall have been evaluated for privilege specific competence utilizing a process that may use, but is not limited to, prospective, current or retrospective review (e.g. chart review, practice patterns, use of EBM and compliance with the six core competencies (see 2.C.1 (b) 5).
- (c) The granting of clinical privileges includes responsibility to respond to reasonable requests to perform necessary Medical Staff functions, as may be required.
- (d) In order for a request for privileges to be processed, the applicant must satisfy any applicable eligibility criteria.
- (e) Requests for clinical privileges that are subject to an exclusive contract will not be processed except as consistent with applicable contracts.
- (f) The clinical privileges recommended to the Board shall be based on consistent evaluation of the following considerations:

- (1) the applicant's education, training, experience, demonstrated current competence and judgment, references, utilization patterns, and ability to perform the privileges requested competently and safely;
  - (2) availability of qualified staff members to provide coverage in case of the applicant's illness or unavailability;
  - (3) adequate professional liability insurance coverage for the clinical privileges requested;
  - (4) the Hospital's available resources and personnel;
  - (5) any previously successful or currently pending challenges to any licensure or registration, or the voluntary or involuntary relinquishment of such licensure or registration;
  - (6) any information concerning professional review actions or voluntary or involuntary termination, limitation, reduction, or loss of appointment or clinical privileges at another hospital; and
  - (7) other relevant information, including a written report and findings by the chairperson of each of the clinical departments in which privileges are sought.
- (g) The applicant has the burden of establishing qualifications and current competence for all clinical privileges requested.
- (h) The report of the chairperson of the clinical department in which privileges are sought shall be forwarded to the Credentials Committee and processed as a part of the initial application for staff appointment.
- (i) During the term of appointment, a member may request increased privileges by applying in writing. The request shall state the specific additional clinical privileges requested and information sufficient to



establish eligibility, as specified in applicable criteria. If the individual is eligible and the application is complete, it shall be processed in the same manner as an application for initial clinical privileges.

- (j) In order to facilitate the clinical privilege delineation process, all departments, through their chairperson, should strive to define core privileges.
- (k) The decision to grant, deny, revise, or revoke privilege(s) is determined by the board, on recommendation from the Medical Executive Committee, and disseminated back to the MEC, Medical Staff Office and Department Chair for further dissemination as necessary or at the request of the practitioner.

No individual shall be denied clinical privileges on the basis of gender, age, ancestry, race, color, creed, sex, marital status, or national origin.

#### 4.A.2. Voluntary Relinquishment of Privileges:

- (a) A Medical Staff member may request voluntary relinquishment of clinical privileges by submitting a written request to the Department Chairperson specifying the clinical privilege(s) to be relinquished and the reasons for the request. The Department Chairperson shall make a recommendation to the Medical Executive Committee.
- (b) The Medical Executive Committee shall evaluate whether the relinquishment of the privilege(s) would create an unreasonable burden on the on-call rotation. The Medical Executive Committee may request a meeting with the member involved. The Medical Executive Committee shall make a recommendation to the Board.
- (c) The Board shall make a final decision on the request, based upon, among other factors, how the request will affect the Hospital's ability to comply

with applicable regulatory requirements, including the Emergency Medical Treatment and Active Labor Act. The Board's decision shall be reported in writing by the Chief Executive Officer to the member, the Medical Executive Committee, and the applicable Department Chairperson. If the Board permits the relinquishment of privileges, it shall specify the effective date of the relinquishment.

- (d) Failure of a member to request relinquishment of clinical privileges as set forth above shall result in the member being maintained on the call schedule without any change to his or her call responsibilities.
- (e) Members who have voluntarily limited their practice to include less than core privileges typically associated with their speciality may be required to participate in a general on-call schedule and to maintain sufficient competence to fulfill this responsibility or arrange for appropriate coverage.

#### 4.A.3. Clinical Privileges for New Procedures:

- (a) Requests for clinical privileges to perform a significant procedure or service not currently being performed at the Hospital (or a significant new technique to perform an existing procedure ("new procedure")) will not be processed until (1) a determination has been made that the procedure will be offered by the Hospital and until (2) criteria to be eligible to request those clinical privileges have been established. If the increase in privileges involves a procedure new to the institution there is a process to determine
  - (1) sufficient space
  - (2) equipment
  - (3) staffing, and

- (4) financial resources are in place within a specified time frame to support each requested privilege.

The organization consistently determines the resources needed for each requested privilege.

- (b) The Department Chair, the Credentials Committee and the Medical Executive Committee shall make a preliminary recommendation as to whether the new procedure should be offered, considering whether the Hospital has the capabilities, including support services, to perform the new procedure.
- (c) If it is recommended that the new procedure be offered, the Credentials Committee shall conduct research and consult with the Department Chair and experts, including those on the Medical Staff and those outside the Hospital, and develop recommendations regarding (1) the minimum education, training, and experience necessary to perform the new procedure, and (2) the extent of monitoring and supervision that should occur if the privileges are granted. The Credentials Committee may also develop criteria and/or indications for when the new procedure is appropriate. The Credentials Committee shall forward its recommendations to the Medical Executive Committee, which shall review the matter and forward its recommendations to the Board for final action.

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

- (a) Requests for clinical privileges that traditionally at the Hospital have been exercised only by individuals from another specialty will not be processed until the steps outlined in this Section have been completed and a determination has been made regarding the individual's eligibility to request the clinical privileges in question.
- (b) The Chairperson of the Department for the individual requesting the privilege and the Chairperson of the Department for which the privilege is delineated as part of the core or specialty shall conduct research and consult with experts, including those on the Medical Staff (e.g., department chairpersons, individuals on the Medical Staff with special interest and/or expertise) and those outside the Hospital (e.g., other hospitals, residency training programs, specialty societies).
- (c) The Department Chairs shall develop recommendations regarding (1) the minimum education, training, and experience necessary to perform the clinical privileges in question, and (2) the extent of monitoring and supervision that should occur. These recommendations may or may not permit individuals from different specialties to request the privileges at issue. The Credentials Committee shall forward its recommendations to the Medical Executive Committee, which shall review the matter and forward its recommendations to the Board for final action.
- (d) The Credentials Committee shall review and act on the recommendations of the Department Chairs and forward its recommendations to the Medical Executive Committee, which shall review the matter and forward its recommendations to the Board for final action.

#### 4.A.5. Clinical Privileges After Age 70:

- (a) Individuals who desire to exercise clinical privileges after the age of 70 must apply for reappointment on a yearly basis.
- (b) As part of the annual reappointment process, these members may be required to have a physical and/or psychiatric assessment performed by a physician who is acceptable to the Credentials Committee. The examining physician shall provide a written report, addressing whether the individual has any physical or psychiatric condition that may affect his/her ability to safely and competently exercise the clinical privileges requested, discharge the responsibilities of medical staff membership, or work cooperatively in a hospital setting. The examining physician shall provide this report directly to the Committee and shall be available to discuss any questions or concerns that the Committee may have.
- (c) Upon attaining the age of 75, members of the Medical Staff shall assume Emeritus Staff status and shall no longer have clinical privileges to admit or care for patients at the Hospital (unless an exception for continued privileges is recommended by the Credentials Committee and Medical Executive Committee and approved by the Board. No individual is entitled to an exception or to a hearing if the Board determines not to grant an exception, but the individual may meet with the Medical Executive Committee upon request).

#### 4.A.6. Physicians in Training:

- (a) Participants registered in professional graduate medical education programs at St. Mary's Hospital, with the exception of a chief resident who has completed his or her training, shall not hold appointments to the Medical Staff and shall not be granted specific privileges. The program

director, clinical faculty and/or attending staff members shall be responsible for the direction and supervision of the on-site and/or day-to-day patient care activities of each participant, who shall be permitted to perform only those clinical functions set out in curriculum requirements, affiliation agreements and/or training protocols approved by the Medical Executive Committee, the Graduate Medical Education Committee and the Chief Medical Officer.

- (b) The scope of clinical activities granted to participants in professional graduate medical education programs shall be limited to the specialty and duration of the individual's training program and shall be subject to supervision at all times as specified by residency manuals and policies and the Accreditation Council for Graduate Medical Education, American Osteopathic Association, Commission on Dental Accreditation of the American Dental Association, and Council on Podiatric Medical Education guidelines.
- (c) The applicable program director shall be responsible for verifying and evaluating the qualifications of each participant in training. Any individual from the board, medical/hospital staff or community who has an issue with quality of care, treatment, and services provided by the participants in the GME programs should be directed to the program directors or Designated Institutional Officer.
- (d) Members of the Medical Staff who supervise or oversee the training of these participants shall be provided with written description of the role, responsibilities and patient care activities of the participants in the training programs. These descriptions shall include identification of the mechanisms by which the supervising staff member and training

Program Director make decisions about each participant's progressive involvement and independence in specific patient care activities.

- (e) The Graduate Medical Education Committee shall report to the Medical Executive Committee and the Board of Directors at least yearly concerning:
  - (1) the educational programs being offered at the Hospital;
  - (2) written descriptions of the role, responsibilities and patient care activities of the participants in the program;
  - (3) the safety and quality of patient care provided by the program participants;
  - (4) the related educational and supervisory needs of the participants in the professional graduate medical education programs; and
  - (5) the delineation of who may write patient care orders, the circumstances under which they may do so and what entries, if any, must be counter-signed by a faculty member, the patient's attending staff physician or another appropriate licensed independent practitioner who is a member of the Medical Staff at the Hospital.

#### 4.A.7. Telemedicine Privileges:

- (a) Telemedicine is the exchange of medical information from one site to another via electronic communications for the purpose of improving patient care, treatment, and services. The Board shall determine the clinical services to be provided through telemedicine after considering the recommendations of the appropriate Department Chairperson(s), the Credentials Committee, and the Medical Executive Committee.

- (b) Individuals providing telemedicine services shall be credentialed in accordance with this section, but shall not be appointed to the Organized Medical Staff. In addition, the contractual arrangement that authorizes them to provide services at the Hospital shall address quality review and assessment mechanisms that are designed to promote the provision of safe and competent services.
- (c) In processing a request for telemedicine privileges pursuant to this section, the Hospital may:
  - (1) credential and grant privileges to the practitioner in accordance with the provisions of this Policy in the same manner as any other applicant; or
  - (2) credential and grant privileges to the practitioner in accordance with the provisions of this Policy, but utilize the credentialing information from the practitioner's primary hospital, provided that hospital is accredited by the Joint Commission on Accreditation of Healthcare Organizations; or
  - (3) credential and grant privileges to the practitioner based on the credentialing information and privileging decision from the practitioner's primary hospital, if the following conditions are met:
    - (i) the primary hospital is accredited by the Joint Commission on Accreditation of Healthcare Organizations;
    - (ii) the practitioner has clinical privileges at the primary hospital to perform the same service or procedure being requested at the Hospital; and



- (iii) the Hospital reviews the practitioner's performance of the privileges being requested and provides information resulting from that review to the primary hospital.

#### 4.B. TEMPORARY CLINICAL PRIVILEGES

##### 4.B.1. Eligibility to Request Temporary Clinical Privileges:

- (a) Temporary privileges may be granted by the Chief Executive Officer or delegate to include Chief Medical Officer, Chief of Staff, Associate Chief of Staff, Department Chair, Chief Operating Officer, or Chief Nursing Officer, when there is an important patient care, treatment or service need. Specifically, temporary privileges may be granted for: (i) the care of a specific patient; (ii) an individual serving as a locum tenens for a member of the medical staff; or (iii) the purpose of proctoring or teaching. Prior to granting temporary privileges in these situations, the Chief Executive Officer shall verify current licensure and current competence.
- (b) Temporary privileges may be granted by the Chief Executive Officer, upon recommendation of the Chief of Staff, when an applicant for initial appointment has submitted a completed application and the application is pending review by the Medical Executive Committee and Board, following a favorable recommendation of the Credentials Committee. Prior to being granted temporary privileges in this situation, the credentialing process must be complete, including verification of current licensure, relevant training or experience, current competence, ability to exercise the privileges requested; compliance with privileges criteria; and consideration of information from the Data Bank. In order to be eligible for temporary privileges, an individual must demonstrate that

there are no current or previously successful challenges to his or her licensure or registration and has not been subject to involuntary termination of Medical Staff membership, or involuntary limitation, reduction, denial, or loss of clinical privileges, at another health care facility.

- (c) Prior to temporary privileges being granted, the individual must agree in writing to be bound by the Bylaws, Rules and Regulations, policies, procedures and protocols of the Medical Staff and the Hospital.
- (d) Temporary privileges shall be granted for a specific period of time, as warranted by the situation. In no situation should the initial grant of temporary privileges be for a period exceeding 120 days.
- (e) Temporary privileges shall expire at the end of the time period for which they are granted.

#### 4.B.2. Supervision Requirements:

In exercising temporary privileges, the individual shall act under the supervision of the department chairperson. Special requirements of supervision and reporting may be imposed on any individual granted temporary clinical privileges.

#### 4.B.3. Termination of Temporary Clinical Privileges:

- (a) The Chief Executive Officer may, at any time after consulting with the Chief of Staff, the Chairperson of the Credentials Committee, or the department chairperson, terminate temporary admitting privileges. Clinical privileges shall be terminated when the individual's inpatients are discharged.

- (b) If the care or safety of patients might be endangered by continued treatment by the individual granted temporary privileges, the Chief Executive Officer, the department chairperson, or the Chief of Staff may immediately terminate all temporary privileges. The department chairperson or the Chief of Staff shall assign to another member of the Medical Staff responsibility for the care of such individual's patients until they are discharged. Whenever possible, consideration shall be given to the wishes of the patient in the selection of a substitute physician.
- (c) The granting of temporary privileges is a courtesy and may be terminated for any reason.
- (d) Neither the denial nor termination of temporary privileges shall entitle the individual to a hearing or appeal.

#### 4.C. EMERGENCY SITUATIONS

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

#### 4.D. DISASTER PRIVILEGES

- (1) In the event of a mass disaster, when the emergency management plan has been activated, Medical Staff members and employees may not be able to provide all the care required by individuals seeking treatment at this Hospital's facilities.
- (2) Under such circumstances, the Chief Medical Officer or the Chief of Staff is authorized to grant disaster privileges or permission to treat patients to volunteer physicians, nurses, and other professionals upon receipt of satisfactory evidence that such individuals are currently licensed in some state or otherwise capable of providing services to patients. Before a volunteer practitioner is considered eligible to function as a volunteer licensed independent practitioner, the hospital obtains his or her valid government-issued photo identification (for example, a driver's license or passport and at least one of the following:
  - ◆ A current picture identification card from a health care organization that clearly identifies professional designation.
  - ◆ A current license to practice (any state)
  - ◆ Primary source verification of license
  - ◆ Identification indicating the individual is a member of a Disaster Medical Assistant Team (DMAT), or other recognized state or federal response organization or group.
  - ◆ Identification indicating that the individual has been granted authority by a government entity to provide patient care, treatment, or services in disaster circumstances.
  - ◆ Confirmation by a licensed independent practitioner currently privileges by the hospital or by a staff member with personal knowledge of the volunteer practitioner's ability to act as a licensed independent practitioner during a disaster.

Temporary ID badges identifying them as having Saint Mary's Hospital Temporary Disaster Privileges will be worn at all times.

- (3) Each Department Chair and/or Section Chief will be responsible for employing some form of Focused Professional Practice Evaluation for all practitioners with Disaster Privileges, as time and conditions allow.
- (4) Furthermore, notwithstanding any existing delineation of privileges or scope of authority, during a mass disaster current Medical Staff members, employees and volunteers are authorized to take whatever steps they reasonably believe are necessary to save or preserve the life or health of patients or to protect the public health.
- (5) Within 72 hours of the initial granting of privileges, the medical staff determines if a practitioner's disaster privileges will be continued. That decision is based on need and the results of the professional practice oversight process. A decision to terminate disaster privileges cannot be appealed.
- (6) Primary source verification of licensure occurs as soon as the disaster is under control or within 72 hours from the time the volunteer licensed independent practitioner presents him- or herself to the hospital, whichever comes first. If primary source verification of a volunteer licensed independent practitioner's licensure cannot be completed within 72 hours of the practitioner's arrival due to extraordinary circumstances, the hospital documents all of the following
  - ◆ Reason(s) it could not be performed within 72 hours of the practitioner's arrival
  - ◆ Evidence of the licensed independent practitioner's demonstrated ability to continue to provide adequate care, treatment, and services

- ◆ Evidence of the hospital's attempt to perform primary source verification as soon as possible.
- (7) If, due to extraordinary circumstances, primary source verification of licensure of the volunteer licensed independent practitioner cannot be completed within 72 hours of the practitioner's arrival, it is performed as soon as possible.

Note: Primary source verification of licensure is not required if the volunteer licensed independent practitioner has not provided care, treatment, or services under the disaster privileges.

#### 4.E. CONTRACTS FOR SERVICES

- (1) From time to time, the Hospital may enter into contracts with physicians and/or groups of physicians for the performance of clinical and/or administrative services at the Hospital. All individuals functioning pursuant to such contracts shall obtain and maintain, as necessary, Medical Staff appointment and/or clinical privileges at the Hospital, in accordance with the terms of this Policy.
- (2) To the extent that any such contract confers the exclusive right to perform specified services at the Hospital on the other party to the contract, no other person may exercise clinical privileges to perform the specified services while the contract is in effect.
- (3) If any such exclusive contract would have the effect of preventing an existing medical staff member from exercising clinical privileges that had previously been granted, the affected member shall be given notice of the exclusive contract and have the right to meet with the Board or a committee designated by the Board to discuss the matter prior to the effective date of the contract in question. At the meeting, the affected

member shall be entitled to present any information relevant to the decision to enter into the exclusive contract. That individual shall not be entitled to any other procedural 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 inability of a physician to exercise clinical privileges because of an exclusive contract is not a matter that requires a report to the state licensure board or to the National Practitioner Data Bank.

- (4) In the event of any conflict between this Policy or the Medical Staff Bylaws and the terms of any contract, the terms of the contract shall control.

ARTICLE 5  
PROCEDURE FOR REAPPOINTMENT

5.A. PROCEDURE FOR REAPPOINTMENT

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

5.A.1. Eligibility for Reappointment:

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

- (a) completed all medical records;
- (b) completed all continuing medical education requirements; in accordance with State of Connecticut licensure standards. Programs in quality and patient safety are highly encouraged.
- (c) satisfied all Medical Staff responsibilities, including payment of dues and assessments;
- (d) continued to meet all qualifications and criteria for appointment and the clinical privileges requested; and
- (e) had sufficient patient contacts, as determined by the department chairperson, to enable the assessment of current clinical judgment and competence for the privileges requested. and meet the six core competencies. Any individual seeking reappointment who has minimal activity at the Hospital must submit such information as may be requested (such as a copy of his/her confidential quality profile from his/her primary hospital, clinical information from the individual's



private office practice and/or a quality profile from a managed care organization), before the application will be considered complete and processed further.

5.A.2. Factors for Evaluation:

The following factors will be evaluated as part of the reappointment process:

- (a) current clinical competence, judgment and technical skill in the treatment of patients as evidenced by the six core competencies;
- (b) compliance with the Bylaws, Rules and Regulations, and policies of the Medical Staff and the Hospital;
- (c) participation in Medical Staff duties, including committee assignments, emergency call, and attendance at medical staff, department, and committee meetings and educational conferences.
- (d) behavior at the Hospital, including cooperation with Medical Staff and Hospital personnel as it relates to patient care, the orderly operation of the Hospital, and ability to work with others;
- (e) use of the Hospital's facilities for patients, taking into consideration practitioner-specific information compared to aggregate information concerning other individuals in the same or similar specialty; provided that, other practitioners shall not be identified;
- (f) current ability to safely and competently exercise the clinical privileges requested and perform the responsibilities of staff appointment;
- (g) capacity to satisfactorily treat patients as indicated by the results of the Hospital's performance improvement and peer review activities, including utilization;
- (h) appropriate resolution of any verified complaints received from patients and/or staff; and
- (i) other reasonable indicators of continuing qualifications.

5.A.3. Reappointment Application:

- (a) An application for reappointment shall be furnished to members in a timely fashion, prior to the expiration of their current appointment term. A completed reappointment application must be returned to the Medical Staff Office within 30 days.
- (b) Failure to submit a complete application at least two months prior to the expiration of the member's current term shall result in automatic expiration of appointment and clinical privileges at the end of the then current term of appointment.
- (c) Reappointment shall be for a period of not more than two years.
- (d) Except as provided below, if an application for reappointment is submitted timely, but the Board has not acted on it prior to the end of the current term, the individual's appointment and clinical privileges shall expire at the end of the then current term of appointment. Subsequent Board action may be to grant reappointment and renewal of clinical privileges.
- (e) In those situations where the Board has not acted on a pending application for reappointment and there is an important patient care need that mandates an immediate authorization to practice, including but not limited to an inability to meet on-call coverage requirements, or denying the community access to needed medical services, the Chief Executive Officer shall have the authority to grant the individual temporary clinical privileges until such time as the Board can act on the application. Prior to granting temporary privileges the Chief Executive Officer shall consult with the chairperson of the applicable department, the Chairperson of the Credentials Committee or the Chief of Staff. The

temporary clinical privileges shall be only for a period not to exceed 120 days.

- (f) In the event the applicant for reappointment is the subject of an investigation or hearing at the time reappointment is being considered, or if questions have been raised but not resolved, a conditional reappointment for a period of less than two years may be granted pending the completion of the hearing or appeals process or resolution of the question.
- (g) The application will be reviewed by the Medical Staff Office to determine that all questions have been answered and that the individual satisfies all eligibility criteria for reappointment and for the clinical privileges requested.
- (h) The Chief Executive Officer shall oversee the process of gathering and verifying relevant information. The Chief Executive Officer shall also be responsible for confirming that all relevant information has been received.

5.A.4. Processing Applications for Reappointment:

- (a) The Chief Executive Officer shall forward the application to the relevant department chairperson and the application for reappointment shall be processed in a manner consistent with applications for initial appointment.
- (b) Given the additional expenses incurred in credentialing members of the Medical Staff who have little or no patient activity, the Hospital may impose a reappointment application fee on members of the Affiliate, Associate, and Courtesy Staff.

- (c) If it becomes apparent to the Credentials Committee or the Medical Executive Committee that it is considering a recommendation to deny reappointment or a requested change in staff category, or to reduce clinical privileges, the chairperson of the committee may notify the individual of the general tenor of the possible recommendation and invite the individual to meet prior to any final recommendation being made. At the meeting, the individual should be informed of the general nature of the information supporting the recommendation contemplated and shall be invited to discuss, explain or refute it. This meeting is not a hearing, and none of the procedural rules for hearings shall apply. The committee shall indicate as part of its report whether such a meeting occurred and shall include a summary of the meeting with its minutes.

5.A.5. Time Periods for Processing:

Once an application is deemed complete, it is expected to be processed within 120 days, unless it becomes incomplete. This time period is intended to be a guideline only and shall not create any right for the applicant to have the application processed within this precise time period.

ARTICLE 6  
PEER REVIEW PROCEDURES FOR QUESTIONS INVOLVING  
MEDICAL STAFF MEMBERS

6.A. COLLEGIAL INTERVENTION

- (1) This Policy encourages the use of progressive steps by Medical Staff leaders and Hospital administration, beginning with collegial and educational efforts, to address questions relating to an individual's clinical practice and/or professional conduct, including conduct that might constitute sexual harassment. The goal of these efforts is to arrive at voluntary, responsive actions by the individual to resolve questions that have been raised.
- (2) Collegial efforts may include, but are not limited to, counseling, sharing of comparative data, monitoring, and additional training or education.
- (3) All collegial intervention efforts by Medical Staff leaders and Hospital administration are part of the Hospital's performance improvement and professional and peer review activities.
- (4) The relevant Medical Staff leader shall determine whether it is appropriate to include documentation of collegial intervention efforts in an individual's confidential file. If documentation of collegial efforts is included in an individual's file, the individual will have an opportunity to review it and respond in writing. The response shall be maintained in that individual's file along with the original documentation.
- (5) Collegial intervention efforts are encouraged, but are not mandatory, and shall be within the discretion of the appropriate Medical Staff leaders.

- (6) The relevant department chairperson or the Chief of Staff may confer with each other and/or the Chief Executive Officer to determine whether a matter can be handled through collegial intervention (the Code of Conduct Policy outlines the collegial intervention process in more detail), to direct that a matter be handled in accordance with another Policy, such as the Policy on Physician Health, or to direct it to the Medical Executive Committee for further determination.

## 6.B. INVESTIGATIONS

### 6.B.1. Initial Review:

- (a) Whenever a serious question has been raised, or where collegial efforts have not resolved an issue, regarding:
  - (1) the clinical competence or clinical practice of any member of the Medical Staff, including the care, treatment or management of a patient or patients;
  - (2) the known or suspected violation by any member of the Medical Staff of applicable ethical standards or the Bylaws, policies, Rules and Regulations of the Hospital or the Medical Staff; and/or
  - (3) conduct by any member of the Medical Staff that is considered lower than the standards of the Hospital or disruptive to the orderly operation of the Hospital or its Medical Staff, including the inability of the member to work harmoniously with others,the matter may be referred to the Chief of Staff, the chairperson of the department, the chairperson of a standing committee, the Chief Medical Officer, the Chief Executive Officer, or the Chairperson of the Board.

- (b) The person to whom the matter is referred shall confer with the chairperson of the department and together they shall review the matter and determine whether there might be a need for an investigation. If such a determination is made, the matter will be referred, in writing, to the Medical Executive Committee.
- (c) No action taken pursuant to this Section shall constitute an investigation.

6.B.2. Initiation of Investigation:

- (a) When a question involving clinical competence or professional conduct is referred to, or raised by, the Medical Executive Committee, the Medical Executive Committee shall review the matter and determine whether to conduct an investigation or to direct the matter to be handled pursuant to the Policy on Physician Health Issues or the Code of Conduct Policy. In making this determination, the Medical Executive Committee may discuss the matter with the individual. An investigation shall begin only after a formal determination by the Medical Executive Committee to do so.
- (b) The Medical Executive Committee shall inform the individual that an investigation has begun. Notification may be delayed if, in the Medical Executive Committee's judgment, informing the individual immediately would compromise the investigation or disrupt the operation of the Hospital or Medical Staff.
- (c) The Board may also determine to commence an investigation and may delegate the investigation to the Medical Executive Committee, a subcommittee of the Board, or an ad hoc committee.
- (d) The Chief of Staff shall keep the Chief Medical Officer fully informed of all action taken in connection with an investigation.

6.B.3. Investigative Procedure:

- (a) Once a determination has been made to begin an investigation, the Medical Executive Committee shall either investigate the matter itself, request that the Credentials Committee conduct the investigation, or appoint an individual or ad hoc committee to conduct the investigation. Any ad hoc committee shall not include partners, associates, or relatives of the individual being investigated, but may include individuals not on the Medical Staff. Whenever the questions raised concern the clinical competence of the individual under review, the ad hoc committee shall include a peer of the individual (e.g., physician, dentist, or podiatrist).
- (b) The committee conducting the investigation ("investigating committee") shall have the authority to review relevant documents and interview individuals. It shall also have available to it the full resources of the Medical Staff and the Hospital, as well as the authority to use outside consultants, if needed. An outside consultant or agency may be used whenever a determination is made by the Hospital and investigating committee that:
  - (1) the clinical expertise needed to conduct the review is not available on the Medical Staff; or
  - (2) the individual under review is likely to raise, or has raised, questions about the objectivity of other practitioners on the Medical Staff; or
  - (3) the individuals with the necessary clinical expertise on the Medical Staff would not be able to conduct a review without risk of allegations of bias, even if such allegations are unfounded.



- (c) The investigating committee may require a physical and/or psychiatric examination of the individual by health care professional(s) acceptable to it. The individual being investigated shall execute a release allowing (i) the investigating committee (or its representative) to discuss with the health care professional(s) conducting the examination the reasons for the examination; and (ii) the health care professional(s) conducting the examination to discuss and provide documentation of the results of such examination directly to the investigating committee.
- (d) The individual shall have an opportunity to meet with the investigating committee before it makes its report. Prior to this meeting, the individual shall be informed of the general questions being investigated. At the meeting, the individual shall be invited to discuss, explain, or refute the questions that gave rise to the investigation. A summary of the interview shall be made by the investigating committee and included with its report. This meeting is not a hearing, and none of the procedural rules for hearings shall apply. The individual being investigated shall not have the right to be represented by legal counsel at this meeting.
- (e) The investigating committee shall make a reasonable effort to complete the investigation and issue its report within 30 days of the commencement of the investigation, provided that an outside review is not necessary. When an outside review is necessary, the investigating committee shall make a reasonable effort to complete the investigation and issue its report within 30 days of receiving the results of the outside review, and within a total of 90-120 days of the commencement of the investigation. These time frames are intended to serve as guidelines and, as such, shall not be deemed to create any right for an individual to have an investigation completed within such time periods. In the event the

investigating committee is unable to complete the investigation and issue its report within these time frames, it shall inform the individual of the reasons for the delay and the approximate date on which it expects to complete the investigation.

- (f) At the conclusion of the investigation, the investigating committee shall prepare a report with its findings, conclusions and recommendations.
- (g) In making its recommendations, the investigating committee shall strive to achieve a consensus as to what is in the best interests of patient care and the smooth operation of the Hospital. Specifically, the committees may consider:
  - (1) relevant literature and clinical practice guidelines, as appropriate;
  - (2) all of the opinions and views that were expressed throughout the review, including report(s) from any outside review(s);
  - (3) any information or explanations provided by the individual under review.

6.B.4. Recommendation:

- (a) The Medical Executive Committee may accept, modify, or reject any recommendation it receives from an investigating committee. Specifically, the Medical Executive Committee may:
  - (1) determine that no action is justified;
  - (2) issue a letter of guidance, warning, or reprimand;
  - (3) impose conditions for continued appointment;
  - (4) impose a requirement for monitoring or consultation;
  - (5) recommend additional training or education;
  - (6) recommend reduction of clinical privileges;

- (7) recommend suspension of clinical privileges for a term;
  - (8) recommend revocation of appointment and/or clinical privileges; or
  - (9) make any other recommendation that it deems necessary or appropriate.
- (b) A recommendation by the Medical Executive Committee that would entitle the individual to request a hearing shall be forwarded to the Chief Executive Officer, who shall promptly inform the individual by special notice. The Chief Executive Officer shall hold the recommendation until after the individual has completed or waived a hearing and appeal.
- (c) If the Medical Executive Committee makes a recommendation that does not entitle the individual to request a hearing, it shall take effect immediately and shall remain in effect unless modified by the Board.
- (d) In the event the Board considers a modification to the recommendation of the Medical Executive Committee that would entitle the individual to request a hearing, the Chief Executive Officer shall inform the individual by special notice. No final action shall occur until the individual has completed or waived a hearing and appeal.
- (e) When applicable, any recommendations or actions that are the result of an investigation or hearing and appeal shall be monitored by Medical Staff leaders on an ongoing basis through the Hospital's performance improvement activities or pursuant to the applicable policies regarding conduct, as appropriate.

6.C. PRECAUTIONARY SUSPENSION OR RESTRICTION OF  
CLINICAL PRIVILEGES

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

- (a) The Chief of Staff or designee, the chairperson of a clinical department, the Chief Executive Officer or the Board Chairperson shall each have the authority to suspend or restrict all or any portion of an individual's clinical privileges whenever failure to take such action may result in imminent danger to the health and/or safety of any individual or may interfere with the orderly operation of the Hospital. The individual may be given an opportunity to refrain voluntarily from exercising privileges pending an investigation.
- (b) Precautionary suspension or restriction is an interim step in the professional review activity, but it is not a complete professional review action in and of itself. It shall not imply any final finding of responsibility for the situation that caused the suspension or restriction.
- (c) A precautionary suspension or restriction shall become effective immediately upon imposition, shall immediately be reported in writing to the Chief Executive Officer, the Chief Medical Officer and the Chief of Staff, and shall remain in effect unless it is modified by the Chief Executive Officer or Medical Executive Committee.

6.C.2. Medical Executive Committee Procedure:

- (a) The Medical Executive Committee shall review the matter resulting in a precautionary suspension or restriction within a reasonable time under the circumstances, not to exceed 14 days. Prior to, or as part of, this review, the individual will be given an opportunity to meet with the Medical Executive Committee. The individual may propose ways other than precautionary suspension or restriction to protect patients, employees and/or the smooth operation of the Hospital, depending on the circumstances. The individual shall not have the right to be represented by legal counsel at this meeting.
- (b) After considering the matters resulting in the suspension or restriction and the individual's response, if any, the Medical Executive Committee shall determine whether there is sufficient information to warrant a final recommendation, or whether it is necessary to commence an investigation. The Medical Executive Committee shall also determine whether the precautionary suspension or restriction should be continued, modified, or terminated pending the completion of the investigation (and hearing, if applicable).
- (c) There is no right to a hearing based on the imposition or continuation of a precautionary suspension or restriction.

6.C.3. Care of Patients:

- (a) Immediately upon the imposition of a precautionary suspension or restriction, the Chief of Staff shall assign to another individual with appropriate clinical privileges responsibility for care of the suspended individual's hospitalized patients, or to aid in implementing the precautionary restriction, as appropriate. The assignment shall be effective until the patients are discharged. The wishes of the patient shall be considered in the selection of a covering physician.
- (b) All members of the Medical Staff have a duty to cooperate with the Chief of Staff, the department chairperson, the Medical Executive Committee, the Chief Medical Officer and the Chief Executive Officer in enforcing precautionary suspensions or restrictions.

6.D. AUTOMATIC RELINQUISHMENT

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

Failure to complete medical records shall result in automatic relinquishment of all clinical privileges, after notification by the medical records department of delinquency. Relinquishment shall continue until all delinquent records are completed and reinstatement accomplished in accordance with applicable Rules and Regulations. Failure to complete the medical records that caused relinquishment within the time required by applicable Rules and Regulations shall result in automatic resignation from the Medical Staff.

6.D.2. Action by Government Agency or Insurer:

- (a) Any action taken by any licensing board, professional liability insurance company, court or government agency regarding any of the matters set forth below must be promptly reported to the Chief Executive Officer.

- (b) An individual's appointment and clinical privileges shall be automatically relinquished if any of the following occur:
- (1) Licensure: Revocation, expiration, suspension or the placement of conditions or restrictions on an individual's license.
  - (2) Controlled Substance Authorization: Revocation, expiration, suspension or the placement of conditions or restrictions on an individual's DEA or state controlled substance authorization.
  - (3) Insurance Coverage: Termination or lapse of an individual's professional liability insurance coverage in a form and in amounts satisfactory to the Hospital, or other action causing the coverage to fall below the minimum required by the Hospital or cease to be in effect, in whole or in part.
  - (4) Medicare and Medicaid Participation: Termination, exclusion, or preclusion by government action from participation in the Medicare/Medicaid or other federal or state health care programs.
  - (5) Criminal Activity: Indictment, conviction, or a plea of guilty or no contest pertaining to any felony, or any misdemeanor involving (i) controlled substances; (ii) illegal drugs; (iii) Medicare, Medicaid, or insurance or health care fraud or abuse; or (iv) violence against another.
- (c) Automatic relinquishment shall take effect immediately and continue until the matter is resolved, if applicable, and a request for reinstatement of appointment and privileges has been acted upon by the Credentials Committee, the Medical Executive Committee, and the Board.

6.D.3. Failure to Provide Requested Information:

Failure to provide information pertaining to an individual's qualifications for appointment or clinical privileges, in response to a written request from the Credentials Committee, the Medical Executive Committee, the Chief Medical Officer, the Chief Executive Officer, or any other committee authorized to request such information, shall result in automatic relinquishment of all clinical privileges until the information is provided.

6.D.4. Failure to Attend Special Conference:

- (a) Whenever there is an apparent or suspected deviation from standard clinical practice involving any individual, the department chairperson or the Chief of Staff may require the individual to attend a special conference with Medical Staff leaders and/or with a standing or ad hoc committee of the Medical Staff.
- (b) The notice to the individual regarding this conference shall be given by special notice at least three days prior to the conference and shall inform the individual that attendance at the conference is mandatory.
- (c) Failure of the individual to attend the conference shall be reported to the Medical Executive Committee. Unless excused by the Medical Executive Committee upon a showing of good cause, such failure shall result in automatic relinquishment of all or such portion of the individual's clinical privileges as the Medical Executive Committee may direct. Such relinquishment shall remain in effect until the matter is resolved.

6.D.5. Failure to Abide by Utilization Standards:



Failure to abide by utilization standards as defined in the Medical Staff Rules and Regulations or other applicable Hospital or Medical Staff Policy shall result in automatic relinquishment of all clinical privileges.

#### 6.E. LEAVES OF ABSENCE

- (1) An individual appointed to the Medical Staff may request a leave of absence by submitting a written request to the Chief of Staff. The request must state the beginning and ending dates of the leave, which shall not exceed one year, renewable for one year, and the reasons for the leave. Any absence from Medical Staff and/or from patient care responsibilities for longer than 60 days shall require an individual to request a leave of absence.
- (2) The request for a leave of absence shall be reviewed by the Medical Executive Committee with a recommendation to the Board for final action.
- (3) During the leave of absence, the individual shall not exercise any clinical privileges. In addition, the individual shall be excused from all Medical Staff responsibilities (e.g., meeting attendance, committee service, emergency service call obligations) during this period.
- (4) No later than 30 days prior to the conclusion of the leave of absence, the individual shall request reinstatement by providing to the Chief of Staff a written summary of professional activities during the leave of absence. The Chief Executive Officer shall refer the matter to the Medical Executive Committee for a recommendation. The individual bears the burden of providing information sufficient to demonstrate current competence and all other applicable qualifications.

- (5) If the leave of absence was for health reasons, the request for reinstatement must be accompanied by a report from the individual's physician indicating that the individual is physically and/or mentally capable of resuming a hospital practice and safely exercising the clinical privileges requested.
- (6) The Board of Directors shall consider the recommendations of the Medical Executive Committee and may approve reinstatement to the same or a different staff category and may limit or modify the individual's clinical privileges. In the event the Chief Executive Officer determines to take action that would entitle the individual to request a hearing, the individual shall be given special notice.
- (7) Absence for longer than the period granted, including any extension, shall result in automatic relinquishment of Medical Staff appointment and clinical privileges unless an extension is granted by the Medical Executive Committee and approved by the Board of Directors. Extensions will be considered only in extraordinary cases where the extension of a leave is in the best interest of the Hospital.
- (8) If an individual's current appointment is due to expire during the leave, the individual must apply for reappointment, or appointment and clinical privileges shall lapse at the end of the appointment period.
- (9) Leaves of absence are matters of courtesy, not of right. In the event that it is determined that an individual has not demonstrated good cause for a leave, or where a request for extension is not granted, the determination shall be final, with no recourse to a hearing and appeal.

ARTICLE 7  
HEARING AND APPEAL PROCEDURES

7.A. INITIATION OF HEARING

7.A.1. Grounds for Hearing:

- (a) An individual is entitled to request a hearing whenever the Medical Executive Committee makes one of the following recommendations:
  - (1) denial of initial appointment to the Medical Staff;
  - (2) denial of reappointment to the Medical Staff;
  - (3) revocation of appointment to the Medical Staff;
  - (4) denial of requested clinical privileges;
  - (5) revocation of clinical privileges;
  - (6) suspension of clinical privileges for more than 30 days; or
  - (7) mandatory concurring consultation requirement (i.e., the consultant must approve the course of treatment in advance).
- (b) No other recommendations shall entitle the individual to a hearing.
- (c) The hearing shall be conducted in as informal a manner as possible.
- (d) The individual may request a hearing before the Board takes final action, if the Board makes any of these recommendations without a prior Medical Executive Committee recommendation. In this instance all references in this Article to the Medical Executive Committee shall mean the Board.

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

None of the following actions shall constitute grounds for a hearing, and they shall take effect without hearing or appeal, provided that the individual shall be entitled to submit a written explanation to be placed into his or her file:

- (a) issuance of a letter of guidance, warning, or reprimand;
- (b) imposition of conditions, monitoring, or a general consultation requirement (i.e., the individual must obtain a consult but need not get prior approval for the treatment);
- (c) termination of temporary privileges;
- (d) automatic relinquishment of appointment or privileges;
- (e) imposition of a requirement for additional training or continuing education;
- (f) precautionary suspension;
- (g) denial of a request for leave of absence, or for an extension of a leave;
- (h) determination that an application is incomplete;
- (i) determination that an application will not be processed due to a misstatement or omission; or
- (j) determination of ineligibility based on a failure to meet threshold criteria, a lack of need or resources or because of an exclusive contract.

## 7.B. THE HEARING

### 7.B.1. Notice of Recommendation:

The Chief Executive Officer shall promptly give special notice of a recommendation which entitles an individual to request a hearing. This notice shall contain:

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

### 7.B.2. Request for Hearing:

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

### 7.B.3. Notice of Hearing and Statement of Reasons:

- (a) The Chief Executive Officer shall schedule the hearing and provide, by special notice, the following:
  - (1) the time, place, and date of the hearing;
  - (2) a proposed list of witnesses who will give testimony at the hearing and a brief summary of the anticipated testimony;
  - (3) the names of the Hearing Panel members and Presiding Officer (or Hearing Officer) if known; and

- (4) a statement of the specific reasons for the recommendation, including a list of patient records (if applicable), and information supporting the recommendation. This statement may be revised or amended at any time, even during the hearing, so long as the additional material is relevant to the recommendation or the individual's qualifications and the individual has had a sufficient opportunity, up to 30 days, to review and rebut the additional information.
- (b) The hearing shall begin as soon as practicable, but no sooner than 30 days after the notice of the hearing, unless an earlier hearing date has been specifically agreed to in writing by the parties.

7.B.4. Witness List:

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

7.B.5. Hearing Panel, Presiding Officer, and Hearing Officer:

- (a) Hearing Panel:
  - (1) The Chief Executive Officer, after consulting with the Chief of Staff, shall appoint a Hearing Panel composed of not less than three members, one of whom shall be designated as

chairperson. The Hearing Panel shall be composed of members of the Medical Staff who did not actively participate in the matter at any previous level, physicians or laypersons not connected with the Hospital or a combination thereof. Knowledge of the matter involved shall not preclude any individual from serving as a member of the Hearing Panel. Employment by, or a contract with, the Hospital or an affiliate shall not preclude any individual from serving on the Hearing Panel, provided, however, that the Hearing Panel shall not have more than one physician who is employed by the Hospital.

- (2) The Hearing Panel shall not include anyone who is in direct economic competition with, professionally associated with or related to, or involved in a referral relationship with, the individual requesting the hearing.

(b) Presiding Officer:

- (1) In lieu of a Hearing Panel Chairperson, the Chief Executive Officer may appoint a Presiding Officer who may be an attorney. The Presiding Officer shall not act as an advocate for either side at the hearing.
- (2) If no Presiding Officer has been appointed, the Chairperson of the Hearing Panel shall serve as the Presiding Officer and shall be entitled to one vote.
- (3) The Presiding Officer shall:
  - (i) allow the participants in the hearing to have a reasonable opportunity to be heard and to present evidence, subject to reasonable limits on the number of witnesses and duration of direct and cross-examination;

- (ii) prohibit conduct or presentation of evidence that is cumulative, excessive, irrelevant or abusive or that causes undue delay;
  - (iii) maintain decorum throughout the hearing;
  - (iv) determine the order of procedure;
  - (v) rule on all matters of procedure and the admissibility of evidence;
  - (vi) conduct argument by counsel on procedural points outside the presence of the Hearing Panel unless the Panel wishes to be present.
- (4) The Presiding Officer may be advised by legal counsel to the Hospital with regard to the hearing procedure.
  - (5) The Presiding Officer may participate in the private deliberations of the Hearing Panel and be a legal advisor to it, but shall not be entitled to vote on its recommendations.
- (c) Hearing Officer:
- (1) As an alternative to a Hearing Panel, the Chief Executive Officer, after consulting with the Chief of Staff, may appoint a Hearing Officer, preferably an attorney, to perform the functions of a Hearing Panel. The Hearing Officer may not be, or represent clients, in direct economic competition with the individual requesting the hearing.
  - (2) If a Hearing Officer is appointed instead of a Hearing Panel, all references in this Article to the "Hearing Panel" or "Presiding Officer" shall be deemed to refer to the Hearing Officer.
- (d) Objections:



Any objection to any member of the Hearing Panel, or the Hearing Officer or Presiding Officer, shall be made in writing within 10 days of receipt of notice to the Chief Executive Officer, who shall resolve the objection.

## 7.C. PRE-HEARING AND HEARING PROCEDURE

### 7.C.1. Provision of Relevant Information:

- (a) The individual requesting the hearing is entitled to the following, subject to the condition that all documents and information be maintained as confidential and not disclosed or used for any purpose outside of the hearing:
  - (1) copies of, or reasonable access to, all patient medical records referred to in the statement of reasons, at the individual's expense;
  - (2) reports of experts relied upon by the Medical Executive Committee;
  - (3) copies of relevant minutes (with portions regarding other physicians and unrelated matters deleted); and
  - (4) copies of any other documents relied upon by the Medical Executive Committee.

The provision of this information is not intended to waive any privilege under the state peer review protection statute.

- (b) The individual shall have no right to discovery beyond the above information. No information shall be provided regarding other practitioners.
- (c) Prior to the hearing, on dates set by the Presiding Officer or agreed upon by both sides, each party shall provide the other party with its proposed exhibits. All objections to documents or witnesses, to the extent then

reasonably known, shall be submitted in writing in advance of the pre-hearing conference. The Presiding Officer shall not entertain subsequent objections unless the party offering the objection demonstrates good cause.

- (d) Evidence unrelated to the reasons for the recommendation or to the individual's qualifications for appointment or the relevant clinical privileges shall be excluded.
- (e) Neither the individual, nor his or her attorney, nor any other person acting on behalf of the individual shall contact Hospital employees appearing on the Medical Executive Committee's witness list concerning the subject matter of the hearing, unless specifically agreed upon by counsel.

7.C.2. Pre-Hearing Conference:

The Presiding Officer shall require a representative (who may be counsel) for the individual and for the Medical Executive Committee to participate in a pre-hearing conference. At the pre-hearing conference the Presiding Officer shall resolve all procedural questions, including any objections to exhibits or witnesses, and the time to be allotted to each witness's testimony and cross-examination.

7.C.3. Failure to Appear:

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

7.C.4. Record of Hearing:

A stenographic reporter shall be present to make a record of the hearing. The cost of the reporter shall be borne by the Hospital. Copies of the transcript shall be available at the individual's expense. Oral evidence shall be taken only on oath or affirmation administered by any person entitled to notarize documents in this state.

7.C.5. Rights of Both Sides and the Hearing Panel at the Hearing:

- (a) At a hearing, both sides shall have the following rights, subject to reasonable limits determined by the Presiding Officer:
- (1) to call and examine witnesses, to the extent they are available and willing to testify;
  - (2) to introduce exhibits;
  - (3) to cross-examine any witness on any matter relevant to the issues;
  - (4) to have representation by counsel who may be present but who may not call, examine, and cross-examine witnesses and present the case; and
  - (5) to submit a written statement at the close of the hearing.
- (b) If the individual who requested the hearing does not testify, he or she may be called and questioned.
- (c) If neither side has representation by counsel, the individual who requested the hearing may nevertheless be represented at the hearing by a colleague on the Medical Staff, who is also not a lawyer.
- (d) The Hearing Panel may question witnesses, request the presence of additional witnesses, and/or request documentary evidence.

- (e) It is expected that the hearing will last no more than 15 hours, with each side being afforded approximately seven and a half hours to present its case, in terms of both direct and cross-examination of witnesses. Both sides are required to prepare their case so that a hearing shall be concluded after a maximum of 15 hours.

7.C.6. Admissibility of Evidence:

The hearing shall not be conducted according to rules of evidence. Evidence shall not be excluded merely because it is hearsay. Any relevant evidence shall be admitted if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law. The guiding principle shall be that the record contain information sufficient to allow the Board to decide whether the individual is qualified for appointment and clinical privileges.

7.C.7. Post-Hearing Statement:

Each party shall have the right to submit a written statement, and the Hearing Panel may request that statements be filed, following the close of the hearing.

7.C.8. Persons to be Present:

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

7.C.9. Postponements and Extensions:

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

7.C.10. Presence of Hearing Panel Members:

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

7.D. HEARING CONCLUSION, DELIBERATIONS, AND RECOMMENDATIONS

7.D.1. Order of Presentation:

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

7.D.2. Basis of Hearing Panel Recommendation:

Consistent with the burden on the individual to demonstrate that he or she satisfies, on a continuing basis, all criteria for initial appointment, reappointment and clinical privileges, the Hearing Panel shall recommend in favor of the Medical Executive Committee unless it finds that the individual who requested the hearing has proved, by clear and convincing evidence, that the recommendation that prompted the hearing was arbitrary, capricious, or not supported by credible evidence.

7.D.3. Deliberations and Recommendation of the Hearing Panel:

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

7.D.4. Disposition of Hearing Panel Report:

The Hearing Panel shall deliver its report to the Chief Executive Officer. The Chief Executive Officer shall send by special notice a copy of the report to the individual who requested the hearing. The Chief Executive Officer shall also provide a copy of the report to the Medical Executive Committee.

7.E. APPEAL PROCEDURE

7.E.1. Time for Appeal:

Within 10 days after notice of the Hearing Panel's recommendation, either party may request an appeal. The request shall be in writing, delivered to the Chief Executive Officer either in person or by certified mail, return receipt requested, and shall include a statement of the reasons for appeal and the specific facts or circumstances which justify further review. If an appeal is not requested within 10 days, an appeal is deemed to be waived and the Hearing Panel's report and recommendation shall be forwarded to the Board for final action.

7.E.2. Grounds for Appeal:

The grounds for appeal shall be limited to the following:

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

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

Whenever an appeal is requested as set forth in the preceding Sections, the Chairperson of the Board shall schedule and arrange for an appeal. The individual shall be given special notice of the time, place, and date of the appeal.

The appeal shall be held as soon as arrangements can reasonably be made, taking into account the schedules of all the individuals involved.

7.E.4. Nature of Appellate Review:

- (a) The Chairperson of the Board shall appoint a Review Panel composed of not less than three persons, either members of the Board or others, including but not limited to reputable persons outside the Hospital, to consider the record upon which the recommendation before it was made, or the Board may consider the appeal as a whole body.
- (b) Each party shall have the right to present a written statement in support of its position on appeal. The party requesting the appeal shall submit a statement first and the other party shall then have ten days to respond. In its sole discretion, the Review Panel (or Board) may allow each party or its representative to appear personally and make oral argument not to exceed 30 minutes.
- (c) The Review Panel (or Board) may, in its discretion, accept additional oral or written evidence subject to the same rights of cross-examination or confrontation provided at the Hearing Panel proceedings. Such additional evidence shall be accepted only if the party seeking to admit it can demonstrate that it is new, relevant evidence or that any opportunity to admit it at the hearing was improperly denied, and then only at the discretion of the Review Panel (or Board).
- (d) The Review Panel shall recommend final action to the Board.

7.E.5. Final Decision of the Board:

Within 30 days after receipt of the Review Panel's recommendation, the Board shall render a final decision in writing, including specific reasons, and shall send special notice thereof to the individual. The Board may affirm, modify, or reverse the recommendation of the Review Panel or, in its discretion, refer the



matter for further review and recommendation, or make its own decision based upon the Board's ultimate legal responsibility to grant appointment and clinical privileges. A copy shall also be provided to the Medical Executive Committee for its information.

7.E.6. Further Review:

Except where the matter is referred for further action and recommendation, the final decision of the Board following the appeal shall be effective immediately and shall not be subject to further review. If the matter is referred for further action and recommendation, such recommendation shall be promptly made to the Board in accordance with the instructions given by the Board.

7.E.7. Right to One Hearing and One Appeal Only:

No applicant or member of the Medical Staff shall be entitled to more than one hearing and one appellate review on any matter. If the Board denies initial appointment to the Medical Staff or reappointment or revokes the appointment and/or clinical privileges of a current member of the Medical Staff, that individual may not apply for staff appointment or for those clinical privileges for a period of five years unless the Board provides otherwise.

## ARTICLE 8

### CONFIDENTIALITY AND PEER REVIEW PROTECTION

#### 8.A. CONFIDENTIALITY

Actions taken and recommendations made pursuant to this Policy shall be strictly confidential. Individuals participating in peer review activities shall make no disclosures of any such information (discussions or documentation) outside of peer review committee meetings, except:

- (1) when the disclosures are to another authorized member of the Medical Staff or authorized Hospital employee and are for the purpose of conducting legitimate peer review activities; or
- (2) when the disclosures are authorized, in writing, by the Chief Executive Officer or by legal counsel to the Hospital.

Any breach of confidentiality may result in a professional review action and/or appropriate legal action.

#### 8.B. PEER REVIEW PROTECTION

- (1) All peer review activities pursuant to this Policy and related Medical Staff documents shall be performed by medical review committees in accordance with Chapter 368a of the Connecticut General Statutes. Medical review committees include, but are not limited to, the following:
  - (a) Medical Executive Committee, Credentials Committee, Allied Health Review Committee, Cancer Committee, Joint Conference Committee, Peer Review Oversight Committee, and Quality Coordinating Council;

- (b) all other standing and ad hoc Medical Staff and Hospital committees;
  - (c) any hearing panels;
  - (d) the Board and its committees;
  - (e) any individual acting for or on behalf of any such entity, including but not limited to department chairpersons, services chairpersons, committee chairpersons and members, officers of the Medical Staff, the Chief Executive Officer and experts or consultants retained to assist in peer review activities; and
  - (f) all departments and services.
- (2) These committees, groups and individuals are established as medical peer review committees for the purpose of conducting peer review activities in accordance with Chapter 368a, which shall include evaluating the quality and efficiency of services ordered or performed in the Hospital, performing practice analyses, conducting inpatient, outpatient and extended care utilization reviews, and conducting medical audits and other reviews. It is intended and understood that when performing these activities, these medical review committees will, among other things, gather and review information relating to the care and treatment of patients for the purposes of evaluating and improving the quality of health care rendered, reducing morbidity or mortality, or establishing guidelines to keep within reasonable bounds the cost of health care.
- (3) The proceedings of all medical review committees, including all reports, recommendations, actions, minutes, data and information-gathering and analysis by authorized individuals for peer review activities, shall be

covered by the provisions of applicable state law and be strictly confidential.

- (4) All medical review committees shall also be deemed to be "professional review bodies" as that term is defined in the Health Care Quality Improvement Act of 1986, 42 U.S.C. ' 11101 *et seq.*

ARTICLE 9  
AMENDMENTS

- (1) This Policy may be amended by a majority vote of the members of the Medical Executive Committee present and voting at any meeting of that committee where a quorum exists, provided that the written recommendations of the Credentials Committee concerning the proposed amendments shall have first been received and reviewed by the Medical Executive Committee.
- (2) At least 14 days prior to the Medical Executive Committee meeting, members of the Medical Staff shall be notified that copies of all proposed amendments are available in the Medical Staff Office. Any member of the Medical Staff may submit written comments to the Medical Executive Committee.
- (3) No amendment shall be effective unless and until it has been approved by the Board.

ARTICLE 10

ADOPTION

This Policy is adopted and made effective upon approval of the Board, superseding and replacing any and all other Bylaws, Rules and Regulations of the Medical Staff or Hospital policies pertaining to the subject matter thereof.

Adopted by the Medical Staff: November 1, 2005

---

Chief of Staff

Approved by the Board: December 8, 2005

---

Secretary, Board of Directors

## ST. MARY'S HOSPITAL TEMPORARY PRIVILEGES AND EXPEDITED CREDENTIALING POLICY

### TEMPORARY PRIVILEGES-

Purpose: To grant privileges to an individual after Credentials Committee has approved the application, but before MEC and/or the Board has met.

Elements Required:

- 1) Important patient care, treatment and service need.
- 2) A completed application file approved by the Credentials Committee *without concern*.
- 3) Review and approval by Chief of Staff.
- 4) Review and temporary approval by CEO.
- 5) MEC and Board review occurs along normal timeframe.

Temporary privileges are time limited and cannot be granted for more than 120 days according to our Credentialing Policy and will usually be granted until the next meeting of the hospital board.

### EXPEDITED CREDENTIALING-

Purpose: To allow an expedited board approval process to be used for an initial appointment and reappointment to the medical staff and when granting privileges.

Elements Required: The application must be complete as defined by the application process **and** the Medical Executive Committee approves the application "without concern".

The following situations are evaluated on a case-by-case basis and usually result in ineligibility for the expedited process:

- ◆ There is a current challenge or a previously successful challenge to licensure or registration.
- ◆ The applicant has received an involuntary termination of medical staff membership at another organization.
- ◆ The applicant has received involuntary limitation, reduction, denial, or loss of clinical privileges.
- ◆ The hospital determines that there has been either an unusual pattern of, or an excessive number of, professional liability actions resulting in a final judgment against the applicant.
- ◆ The organized medical staff uses the criteria developed for the expedited process when recommending privileges.

Amendment approved by the Medical Executive Committee 01/22/08

Approved by the Board of Directors 02/07/08

## **OPPE/FPPE Peer Review Process at Saint Mary's Hospital**

### **General Principles and Objectives:**

1. The primary objectives of the peer review process of Saint Mary's Hospital are to:
  - a. define prospectively, to the extent possible, the expectations for patient care and safety through patient care protocols;
  - b. establish and continually update triggers for focused professional practice evaluation and for ongoing professional practice evaluation that will facilitate a meaningful review of the care provided;
  - c. effectively, efficiently, fairly, and reasonably evaluate the care being provided by practitioners, comparing it to established patient care protocols and benchmarks whenever possible; and
  - d. provide constructive feedback, education, and performance improvement assistance to practitioners regarding the quality, appropriateness, and safety of the care they provide.
2. This Policy applies to members of the Medical Staff who have been granted clinical privileges. Members of the Medical Staff who have not been granted clinical privileges (e.g., Community Staff and Emeritus Staff) are not generally covered by this Policy.
3. In all stages of the peer review process, the use of collegial efforts and progressive steps to address issues that may be identified is encouraged. The goal of those efforts is to arrive at voluntary, responsive actions by the practitioner. Collegial efforts and progressive steps may include, but are not limited to, counseling, education, mentoring, letters of counsel, education or guidance, sharing of comparative data, and performance improvement plans. These efforts are encouraged, but are not mandatory, and will be within the discretion of the Department Chair or Medical Staff Quality and Safety Committee.
4. In order to be effective, peer review must be timely. With respect to the focused professional practice evaluations, when questions or concerns have been raised, the goal is to complete reviews, from initial identification to final disposition, within 90 days.
5. The Quality Department will track the processing and disposition of matters reviewed pursuant to this Policy.



## **OPPE (Ongoing Professional Practice Evaluation):**

1. OPPE reports must be reviewed by each Department Chair (DC) or Section Chief (SC) for every member of the Medical Staff in their department/section every 6 months. Since members of the Community Staff and the Emeritus Staff have not been granted clinical privileges, this process does not apply to them. Also, Consulting Staff will not be required to undergo this process given their expertise and the requirement for them to work in conjunction with another member of the Active Staff.
  - a. DC/SC must select 3-4 discrete aspects of clinical practice which share the following characteristics:
    - i. are measurable
    - ii. have an acceptable normative level
    - iii. are clinically relevant
2. Examples:
  - a. For Medicine –
    - i. 30 day pneumonia readmission rate
    - ii. Appropriate use of DVT prophylaxis
  - b. For Surgery –
    - i. Surgical Site Infection rate
    - ii. Rate of unplanned returns to the OR during an admission
3. The Quality Department will prepare a report of OPPE performance on these measures semiannually and provide the appropriate DC or SC with a copy of the report. Practitioners will be provided with a copy of or have access to their own OPPE reports.
4. The DC or SC will review the OPPE reports for practitioners in the department or section. Those practitioners who meet the threshold normative rate or number require no further review. Those practitioners who fail to meet normative rate require other steps as follows:
  - a. Quality Department staff will pull a sample of records, at the direction of DC/SC, of cases not meeting the threshold. These cases will be reviewed

- by the DC/SC and Quality Staff person to monitor for performance problems.
- b. If there are NO performance problems the process is complete requiring no further review.
  - c. If there ARE performance problems, the DC/SC may recommend some collegial intervention including an FPPE plan and implement it either alone or in conjunction with a Department/Section Peer Review Committee.
5. In addition to the 3-4 clinical aspects of care that are monitored every 6 months, all reports of disruptive behavior, poor citizenship such as medical records based suspensions, etc. should be part of the 6 month OPPE reports.
  6. The Quality Department will provide reports of volume of procedures performed by physicians upon request of DC/SC to assist in determining whether a physician has performed adequate numbers of procedures to warrant reapproval of the procedural privileges. It will be at the discretion of the DC/SC to determine an adequate number for thresholds for procedures unless there are specific professional required guidelines established by recognized specialty based organizations.
  7. Each DC/SC will submit a report semiannually to the Medical Staff Quality and Safety Committee outlining all physicians whose reports are within normal range and giving details of those which are not, along with performance plans/actions for each.
  8. OPPE reports will be available for the reappointment process.

### **FPPE (Focused Professional Practice Evaluation):**

1. There are three types of FPPE:
  - a. FPPE for a new member of the Medical Staff who has been granted clinical privileges;<sup>1</sup>
  - b. FPPE for a current member of the Medical Staff who has been granted a NEW clinical privilege;
  - c. FPPE for a current member of the Medical Staff, because a question or concern has been raised, including, but not limited to, an actual or potential adverse patient outcome or a pattern or trend of concerns.

---

<sup>1</sup>Members of the Community Staff and Emeritus Staff are not granted clinical privileges and are not generally subject to peer review. Members of the Consulting Staff will not require a new member FPPE given their expertise and the requirement for them to work in conjunction with another Active member of the Medical Staff.

- d. The following tools can be used during any part of the FPPE process:
    - i. retrospective or prospective chart review by internal or external reviewers;
    - ii. concurrent proctoring or direct observation of procedures or patient care practices;
    - iii. discussion with other individuals also involved in the care of the practitioner's patients; and
    - iv. review of available quality data.
2. FPPE for a New Member of the Medical Staff
- a. The standard evaluation period includes 6 months of "close review of outcomes." The evaluation period may be refined by DC/SC.
  - b. The DC/SC will recommend the number and types of procedures or cases that will be subject to review to confirm a practitioner's competence to exercise the core and special privileges granted, subject to approval by the Credentials Committee and Medical Executive Committee.
  - c. If there is inadequate data after the first 6 months of evaluation, FPPE should be continued and should be so reported to the Credentials Committee.
3. FPPE for Current Member with New Privilege
- a. The DC/SC must determine the type and volume of FPPE.
  - b. Examples of Type –
    - i. Direct proctoring such as a surgeon with a privilege scrubbing in with one requesting the privilege;
    - ii. Intensive case review by DC/SC or designee of a series of cases monitoring for adverse outcomes; and
    - iii. Other types of review at the discretion of the DC/SC with the approval of the Credentials Committee.
  - c. Volume may be a specific amount of time of monitoring, number of cases, etc. depending on the specialty and the privilege in question.

4. FPPE for Current Member of the Medical Staff when Concern is Raised
  - a. An FPPE will be undertaken when a question or concern has been raised, including but not limited to an actual or potential adverse patient outcome or a pattern or trend of concerns. The DC will review the question or concern for the purpose of confirming its validity and assessing the severity of the question or concern.
  - b. The DC or SC will involve Medical Staff Member in reviewing the question or concern.
  - c. The DC, SC (if applicable) may propose and the Medical Staff Quality and Safety Committee will approve, any collegial intervention or Plan of Correction. Results should also be reported to MEC.
  - d. Collegial intervention and Plan of Correction may include:
    - i. Letters of information or education;
    - ii. Intensive review of cases, concurrently or selectively until the DC is satisfied that outcomes are acceptable;
    - iii. Direct supervisory oversight (proctoring);
    - iv. Requirement for a training or educational course;
    - v. Second opinions/consultations;
    - vi. Participation in a formal evaluation/assessment program; and
    - vii. Other, as determined by DC (with SC if applicable) and approval by the Medical Staff Quality and Safety Committee.

### **Role of The Medical Staff Quality and Safety (MSQS) Committee:**

1. The Medical Staff Quality and Safety Committee will receive and review OPPE reports from Department Chairs and/or Section Chiefs every 6 months for each member of the Medical Staff who have been granted clinical privileges.
2. The reports will be acted upon as follows:
  - a. For Medical Staff members who meet all OPPE thresholds, have no FPPE issues or requirements, and have no “citizenship issues,” these would be approved as a block.

- b. If there are OPPE outliers, requirements for FPPE, or citizenship issues, the MSQS Committee would be made aware of the relevant details of the issue and the proposed remediation plan by the relevant Department.
    - c. The MSQS Committee could then endorse the Department's assessment and plan or recommend changes in it.
  3. If there is disagreement between the MSQS Committee and the Department Chair/Section Chief, the Committee would forward the issue to the MEC for resolution of the disagreement and implementation of the appropriate plan.
  4. MSQS Committee may also recommend that an external review be used. An external review may be appropriate if:
    - a. there are ambiguous or conflicting findings by internal reviewers;
    - b. the clinical expertise needed to conduct a review is not available on the Medical Staff; or
    - c. an outside review is advisable to prevent allegations of bias, even if unfounded.
  5. If a decision is made to seek an external review, the practitioner involved will be notified of that decision and the nature of the external review.
  6. All records of OPPE, FPPE, informational and educational letters, peer review recommendations, and other records relating to physician evaluation will be kept in files maintained in and by the Medical Staff Office.