UNION HOSPITAL

MEDICAL STAFF CREDENTIALS MANUAL

TABLE OF CONTENTS

PAGE

1.001. Appointment to the Medical Staff 1

1. General 1
2. Specific Qualifications 2
3. No Entitlement to Appointment 3
4. Non-discrimination Policy 3
5. Duration of Provisional Period 4
6. Application for Initial Appointment/Reappointment/Clinical Privileges 6
7. Undertakings 8
8. Burden of Providing Information 10
9. Authorization to Obtain Information 10

2.001. Clinical Privileges 14

1. General Information Regarding Clinical Privileges 14
2. Privileges for Individuals with Hospital Contracts 17
3. Interns, Residents, Students and Fellows 18
4. Physicians Not Privileged at Union Hospital 18
5. Telemedicine Privileges 18

3.001. Procedure for Initial Appointment 20

1. Submission of Application 20
2. Initial Credentials Committee Procedure 20
3. Department Chief Procedure 20
4. Credentials Committee Procedure 21
5. Credentials Committee Report 22

PAGE

4.001. Procedure for Reappointment 23

1. Reappointment Application 23
2. Factors to be Considered 24
3. Department Chief Procedure 25
4. Credentials Committee Procedure 26
5. Meeting With Affected Individual 27
6. Conditional Reappointments 28
7. Procedure Thereafter 28

5.001. Increased Clinical Privileges 29

1. Application for Increased Clinical Privileges 29
2. Factors to be Considered 29

5.002. Clinical Privileges for New Procedures 30

5.003. Clinical Privileges That Cross Specialty Lines 31

6.001. Temporary Privileges 32

Eligibility to Request Temporary Clinical Privileges 32

7.001. Emergency Clinical Privileges 34

7.002. Disaster Clinical Privileges 34

8.001. Procedure for Other Questions Involving Medical Staff Appointees 36

1. Collegial Intervention 36
2. Initial Review 37
3. Initiation of Investigation 37
4. Investigative Procedure 38
5. Recommendation 40
6. Grounds for Precautionary Suspension or Restriction 41
7. Credentials Committee Procedure 42

PAGE

8. Care of Patients 43
9. Automatic Relinquishment of Privileges 43
10. Mandatory Reporting of Final Actions 46
11. Non-Reportable Action 47
12. Miscellaneous 47

8.002. Procedure for Leave of Absence 48

9.001. Advanced Practice Professionals 51

1. Advanced Practice Professionals 51
2. Hearing and Appeals for Advanced Practice Professionals 75
3. Medical Assistants 78

CREDENTIALS MANUAL

CR 1.001

Appointment to the Medical Staff

1. General

Appointment to the Medical Staff is a privilege which shall be extended only to professionally competent individuals who continuously meet the qualifications, standards and requirements set forth in this Credentialing Manual and in such policies as are adopted from time to time by the Board. All individuals practicing medicine, podiatry, oral surgery, and dentistry in this Hospital, unless excepted by specific provisions of this Credentials Manual, must first have been appointed to the Medical Staff.

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 evaluated as part of the appointment and reappointment processes:

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

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

(c) good reputation and character;

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

(e) ability to safely and competently perform the clinical privileges requested; and

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

2. Specific Qualifications

Only physicians, dentists, and podiatrists who:

A. possess at all times a current, unrestricted license to practice medicine, surgery, podiatry or dentistry in this state;

B. are located within the geographic service area of the Hospital as defined by the Board, close enough to provide timely care for their patients;

C. possess current, valid professional liability insurance coverage in such amounts, containing such coverage and underwritten by such insurers as shall be required by the Board from time to time;

D. Are board certified in his or her primary area of practice by a board approved by the ABMS, AOA, American Board of Oral & Maxillofacial Surgery or the American Board of Podiatric Surgery.

Board certification or board eligibility for board certification in a practitioner's area of requested privileges is required at the time of application for medical staff appointment and reappointment. Active candidates who do not become board certified within five (5) years following the successful completion of accredited training, or a shorter time as required by their specialty, from the date they become eligible to take the examination, will be deemed to have voluntarily relinquished staff appointment and privileges; and

E. can demonstrate their ability to work cooperatively and professionally with the Hospital, its professional and Medical Staff, and refrain from disruptive behavior, which has or could interfere with patient care or the operation of the Hospital and its Medical Staff.

F. Waiver of Criteria

1. Any individual who does not satisfy a criterion may request that it be waived. The individual requesting the waiver bears the burden of

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demonstrating that his or her qualifications are equivalent to, or exceed, the criterion in question.

2. The Board may grant waivers in exceptional cases after considering the findings of the Credentials Committee, 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.

3. No individual is entitled to a waiver or to a hearing if the Board determines not to grant a waiver.

4. A determination that an individual is not entitled to a waiver is not a "denial" of appointment or clinical privileges.

3. No Entitlement to Appointment

No individual shall be entitled to appointment to the Medical Staff or to the exercise of particular clinical privileges in the Hospital merely by virtue of the fact that the individual:

A. is licensed to practice any profession in this or any other state;

B. is a member of any particular professional organization; or

C. had in the past, or currently has, Medical Staff appointment or privileges in this or another hospital;

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.

4. Non-discrimination Policy

No individual shall be denied appointment on the basis of sex, race, creed, color or national origin.

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5. Duration of Provisional Period

A. <u>General</u>

All initial appointments and clinical privileges to the Medical Staff regardless of the staff category shall be provisional for a period of 12 months from the date of the appointment or longer if recommended by the Credentials Committee. During the provisional period, clinical privileges will be subject to focused professional practice evaluation. During the term of this provisional appointment, the person receiving the provisional appointment shall be evaluated by the chief of the clinical department or departments in which the individual has clinical privileges, and any Medical Staff or Hospital committees relative to the individual's clinical competence, general behavior, and conduct. The evaluation may include chart review, monitoring of the individual's practice patterns, proctoring, external review and information obtained from other physicians.

During the provisional period, the physician will be continuously evaluated in the six areas of "General Competencies" as developed by the Accreditation Council for Graduate Medical Education and the American Board of Medical Specialties joint initiative. The areas of general competency include the following:

- Patient care
- Medical/clinical knowledge
- Practice-based learning and improvement
- Interpersonal and communication skills
- Professionalism
- Systems-based practice

Provisional clinical privileges shall be adjusted to reflect clinical competence at the end of the provisional year or sooner if warranted. Continued appointment after the provisional period shall be conditioned to an evaluation of the factors to be considered for reappointment.

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B. Duties During Provisional Period

During the provisional period, a physician must arrange for, or cooperate in the arrangement of, the required numbers and types of cases to be reviewed/observed by the department chief and/or designated observers. If a physician fails, within the designated time period, to admit or treat the number of patients that the Credentials Committee determined was required to permit an evaluation of the physician's competence to exercise the newly granted privilege(s), the relevant clinical privileges will be automatically relinquished.

If a physician fails, during the provisional period, to fulfill all requirements relating to emergency service call responsibilities and/or cooperation with monitoring or observation conditions, at the expiration of the provisional period, all relevant clinical privileges will be relinquished.

When, based on the evaluation performed during the provisional period, clinical privileges are terminated, revoked, or restricted for reasons related to clinical competence and/or professional conduct, the individual will be entitled to a hearing and appeal.

If a new physician fails, during the provisional period, to fulfill all requirements of appointment relating to meeting attendance and completion of medical records, at the expiration of the provisional period, appointment to the Medical Staff shall be relinquished.

C. Rights and Duties of Appointees

Appointment to the Medical Staff shall require that each appointee assume such reasonable duties and responsibilities as the Board or the Medical Staff shall require and adhere to the Professional Conduct as defined in the Medical Staff Peer Review Manual 7.001.

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6. Application for Initial Appointment/Reappointment/ Clinical Privileges

A. Information

Applications for appointments and/or reappointments to the Medical Staff shall be in writing. The application shall contain a request for specific clinical privileges desired by the applicant and shall require detailed information concerning the applicant's professional qualifications. A completed application shall include, at a minimum, the following information:

1. evaluations from at least two physicians, dentists or other practitioners, as appropriate, who have had recent extensive experience in observing and working with the applicant and who can provide adequate information pertaining to the applicant's present professional competence and character, to include the practitioner's current:
   - Medical/clinical knowledge
   - Technical and clinical skills
   - Clinical judgment
   - Interpersonal skills
   - Communication skills
   - Professionalism;
2. the names and complete addresses of the chairperson(s) of the clinical service(s) of any and all hospitals or other institutions at which the applicant has worked or trained;
3. information as to whether the applicant's Medical Staff appointment or clinical privileges have ever been resigned, revoked, relinquished, denied, subject to probationary or other conditions, limited, terminated, suspended, reduced or not renewed, whether voluntarily or involuntarily, at any other hospital or health care facility, or are currently being investigated or challenged;
4. information as to whether the applicant has ever withdrawn his application for appointment, reappointment or clinical privileges, whether voluntarily

or involuntarily, before final decision by a hospital's or health care facility's governing board;

5. information as to whether the applicant's membership in local, state or national professional societies or his license to practice any profession in any state, or his Drug Enforcement Administration license has ever been suspended, modified, restricted, relinquished, or terminated whether voluntarily or involuntarily, or is currently being investigated or challenged;
6. copies of all the applicant's current unrestricted license to practice, Drug Enforcement Administration license, medical or dental school diploma, and certificates from all post graduate training programs completed;
7. satisfactory evidence that the applicant has currently in force professional liability insurance coverage, the name of the insurance company and the amount and classification of such coverage;
8. information concerning applicant's malpractice 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; and any additional information concerning such proceedings or actions as the Credentials Committee, the Medical Executive Committee, or the Board may request;
9. a consent to the release of information from the applicant's present and past professional liability insurance carriers;
10. information concerning the suspension, termination, or exclusion by government action for any period of time of participation in Medicare, Medicaid, any other government sponsored program, or any private of public medical insurance program, and information as to whether the applicant is currently under investigation;
11. information as to whether the applicant has ever been named as a defendant in a criminal action and details about any such instance;
12. information on the citizenship and visa status of the applicant;

13. any other information that the Board may require.

B. Signature

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

C. Misstatements and Omissions

1. Any misstatement in, or omission from, the application is grounds to stop processing the application. The applicant will be informed in writing of the nature of the misstatement or omission and permitted to provide a written response. The Chair of the Credentials Committee, Vice President of Medical Affairs, and Chief Executive Officer will review the response and determine whether the application should be processed further.
2. If appointment has been granted prior to the discovery of a misstatement or omission, appointment and privileges may be deemed to be automatically relinquished pursuant to Section 8.001(8).
3. No action taken pursuant to this section will entitle the individual to a hearing or appeal.

7. Undertakings

The following undertakings shall be applicable to every Medical Staff appointee and applicant for staff appointment or reappointment as a condition of consideration of such application and as a condition of continued Medical Staff appointment if granted:

A. an obligation upon appointment to the Medical Staff to provide continuous care and supervision to all patients for whom the individual has responsibility;

B. an agreement to abide by all Bylaws and policies of the Hospital, including all Medical Staff Bylaws, the Operations and Procedure Manual, the Rules and Regulation Manual, the Peer Review Manual, the Hearing and Appeals Manual and this Manual as shall be in force from time to time during the time the individual is appointed to the Medical Staff;

C. an agreement to accept committee assignments and such other reasonable duties and responsibilities as assigned by the Board or the Medical Staff;

D. an obligation to provide the Hospital with current, new or updated information that is pertinent to any question on the application form;

E. a statement that the applicant has received and had an opportunity to read the Medical Staff Bylaws, the Operations and Procedure Manual, the Rules and Regulation Manual, the Peer Review Manual, the Hearing and Appeals Manual and this Manual and that applicant agrees to be bound by these terms;

F. applicant's willingness to appear for personal interviews in regard to his application;

G. applicant will:

1. refrain from fee splitting or other inducements relating to patient referral;
2. refrain from delegating responsibility for diagnoses or care of hospitalized patients to an individual who is not qualified to undertake this responsibility or who is not adequately supervised;
3. refrain from deceiving patients as to the identity of an operating surgeon or any other individual providing treatment or services;
4. seek consultation whenever necessary;
5. abide by generally recognized ethical principles applicable to the profession; and
6. provide continuous care for assigned patients in the Hospital.

I. Appointee/applicant shall promptly notify the Credentials Committee of any change in staff status or reduction in clinical privileges at any other hospital or healthcare institution.

J. All members of the medical staff are required to abide by the terms of the Notice of Privacy Practices prepared and distributed to patients as required by the federal patient privacy regulations.

K. A statement that, if appointed, the individual shall cooperate fully with the Corporate Compliance Policy of the Hospital and adhere to all laws, regulations and standards of conduct applicable to their activities at the Hospital to the

practice of the applicable profession, and to their participation in any Federal health program, as a condition of their continued appointment to the Medical Staff. In the event that any Medical Staff appointee knows or suspects that he or she or any director, officer, employee or other appointee has violated applicable laws or regulations, he or she shall immediately report the same to the Chief Executive Officer, the Vice President of Medical Affairs, or the Corporate Compliance Officer.

Each applicant for Medical Staff appointment and reappointment shall specifically agree to these undertakings as part of the application.

8. Burden of Providing Information

The applicant shall have the burden of producing adequate information for a proper evaluation of competence, character, ethics and other qualifications, and of resolving any doubts about such qualifications. Applicant shall have the burden of providing evidence that all the statements made and information given on the application are factual and true. Until the applicant has provided all information required, the application will be deemed incomplete and will not be processed. An application shall become incomplete if the need arises for new, additional, or clarifying information any time. Any application that continues to be incomplete sixty (60) days after the applicant has been notified of the additional information required shall be deemed to be withdrawn. The applicant is responsible for providing a complete application, including adequate responses from references. The applicant shall have the obligation to continuously update one's application with the most current information available. Failure to so update shall constitute grounds for denial of the application.

9. Authorization to Obtain Information

The following statements, which shall be included on the application form and which form a part of this Manual, are express conditions applicable to any Medical Staff applicant, any appointee to the Medical Staff and to all others having or seeking clinical privileges in the Hospital. By applying for appointment, reappointment or clinical

privileges, the applicant expressly accepts these conditions during the processing and consideration of the application, whether or not applicant is granted appointment or clinical privileges. This acceptance also applies during the time of any appointment or reappointment.

A. Immunity

To the fullest extent permitted by law, the applicant releases from any and all liability, and extends absolute immunity to the Hospital, its authorized representatives and any third parties as defined in paragraph D below, with respect to any acts, communications or documents, recommendations or disclosures involving the individual, concerning the following:

1. applications for appointment or clinical privileges, including temporary clinical privileges;
2. evaluations concerning reappointment or changes in clinical privileges;
3. proceedings for suspension or reduction of clinical privileges or for revocation of Medical Staff appointment, or any other disciplinary sanction;
4. suspension;
5. hearings and appellate reviews;
6. medical care evaluations;
7. utilization reviews;
8. other activities relating to the quality of patient care or professional conduct;
9. matters or inquiries concerning the individual's professional qualifications, credentials, clinical competence, character, mental or emotional stability, physical condition, ethics or behavior; or
10. any other matter that might directly or indirectly have an effect on the individual's competence, on patient care or on the orderly operation of this or any other Hospital or health care facility.

The foregoing shall be privileged to the fullest extent permitted by law. Such privileges shall extend to the Hospital and its authorized representatives, and to any third parties.

B. Authorization to Obtain Information

The applicant specifically authorizes the Hospital and its authorized representatives to consult with any third party who may have information bearing on the individual's professional qualifications, credentials, clinical competence, character, mental or emotional stability, physical condition, ethics, behavior or any other matter reasonably having a bearing on the individual's satisfaction of the criteria for initial and continued appointment to the Medical Staff. This authorization also covers the right to inspect or obtain any and all communications, reports, records, statements, documents, recommendations or disclosures of said third parties that may be relevant to such questions.

The applicant also specifically authorizes said third parties to release said information to the Hospital and its authorized representatives upon request.

C. Authorization to Release Information

Similarly, the applicant specifically authorizes the Hospital and its authorized representatives to release such information to other hospitals, health care facilities and their agents, who solicit such information for the purpose of evaluating the applicant's professional qualifications pursuant to the applicant's request for appointment or clinical privileges.

D. Definitions

1. As used in this Section, the term "Hospital and its authorized representatives" means the Hospital corporation and any of the following individuals who have any responsibility for obtaining or evaluating the individual's credentials, or acting upon his application or conduct in the Hospital.

2. As used in this Section, the term “third parties” means all individuals, including appointees to the Hospital’s Medical Staff, and appointees to the medical staffs of other hospitals or other physicians or health practitioners, nurses or other organizations, associations, partnerships and corporations or government agencies, whether hospitals, health care facilities or not, from whom information has been requested by the Hospital or its authorized representatives.

CR 2.001

Clinical Privileges

1. General Information Regarding Clinical Privileges

Medical Staff appointment or reappointment shall not confer any clinical privileges or right to practice in the Hospital. Each individual who has been given an appointment to the Medical Staff of the Hospital shall be entitled to exercise only those clinical privileges specifically granted by the Board.

The clinical privileges recommended to the Board will be based upon consideration of the following:

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

(2) utilization patterns;

(3) ability to perform the privileges requested competently and safely;

(4) information resulting from ongoing and focused professional practice evaluation, performance improvement and other peer review activities, if applicable;

(5) availability of qualified staff members to provide coverage in case of the applicant's illness or unavailability;

(6) adequate professional liability insurance coverage for the clinical privileges requested;

(7) the Hospital's available resources and personnel;

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

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(9) any information concerning professional review actions or voluntary or involuntary termination, limitation, reduction, or loss of appointment or clinical privileges at another hospital;

(10) practitioner-specific data as compared to aggregate data, when available;

(11) morbidity and mortality data, when available; and

(12) professional liability actions, especially any such actions that reflect an unusual pattern or excessive number of actions.

(13) in conjunction with their biennial reappointment, at the age of 65, practitioners holding clinical privileges shall complete an examination that addresses both the physical and mental capacity for the privileges requested. The physical and mental exam will be conducted by a physician approved by the Credentials Committee and acceptable to the physician. The outcome must be evaluated on the approved form and submitted by the date requested by the Credentials Committee. At the age of 70, practitioners shall complete an annual examination that addresses both the physical and mental capacity for the privileges requested. The annual physical and mental exam will be conducted by a physician approved by the Credentials Committee and acceptable to the physician. The outcome must be evaluated on the approved form and submitted by the date requested by the Credentials Committee. In addition to the physical examination, a practitioner may be required to undergo proctoring of their clinical performance as part of the assessment of their capacity to perform requested privileges if there are reasonable questions related to patient safety. The scope and duration of the proctoring shall be determined by the Credentials Committee with input from the department chief.

The granting of clinical privileges includes responsibility for emergency service call established to fulfill the Hospital's responsibilities under the Emergency Medical Treatment and Active Labor Act and/or other applicable requirements or standards. In order for a request for privileges to be processed, the applicant must satisfy any applicable eligibility criteria. Requests for clinical privileges that are subject to an exclusive

contract will not be processed, except as consistent with applicable contracts (See Article 2.001 (5) of this Manual.) Each applicant shall complete a delineation of privileges form corresponding to the appropriate specialty. In instances where there is a doubt about an applicant's ability to perform privileges requested, an evaluation by an external and internal source may be required to insure that the applicant's health would not interfere with their ability to perform her/her duties. The clinical privileges recommended to the Board shall be based upon the applicant's education, training, experience, demonstrated competence and judgment, references utilization patterns ability to perform the privileges requested competently and safely, and other relevant information, including the written report and findings recommendations by the appropriate clinical department chief; availability of qualified staff members to provide coverage in case of the applicant's illness or unavailability; adequate professional liability insurance coverage for the clinical privileges requested; the Hospital's available resources and personnel; any previously successful or currently pending challenges to any licensure or registration, or the voluntary or involuntary relinquishment of such licensure or registration; any information concerning professional review actions or voluntary or involuntary termination, limitation, reduction, or loss of appointment or clinical privileges at another hospital; and other relevant information.

The applicant shall have the burden of establishing his qualifications for and competence to exercise the clinical privileges he/she requests. The report of the clinical department in which privileges are sought shall be forwarded to the Credentials Committee and thereafter processed as a part of the initial application for Medical Staff appointment. During the time 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. In order to facilitate the clinical privileges delineation process, all departments, through their chief should strive to define core privileges.

2. Privileges for Individuals with Hospital Contracts

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 Manual. 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. Clinical privileges or Medical Staff appointment that results from a contract or employment shall be valid only during the term of the contract. In the event that the contract or employment expires or is terminated, the clinical privileges and Medical Staff appointment resulting from the contract or employment shall automatically expire at the time the contract or employment expires or terminates unless there is a specific provision to the contrary in the contract. This expiration of clinical privileges and Medical Staff appointment or the termination or expiration of the contract itself, shall not entitle the physician to any hearing or appeal, unless there is a specific provision to the contrary in the contract. In the event that only a portion of the physician's clinical privileges is covered by the contract or employment, only that portion shall be affected by the expiration or termination of the contract or employment. 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 Manual. 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. Specific contractual or employment terms shall in all cases be controlling in the event that they conflict with provisions of Hospital Bylaws, Medical Staff Bylaws, the Operations and Procedure Manual, the Rules and Regulation Manual, the Peer Review Manual, the Hearing and Appeals Manual and this Manual.

5. Interns, Residents, Students and Fellows

Interns, residents, students and fellows in training in the Hospital shall not hold appointments to the Medical Staff and shall not be granted specific clinical privileges. Rather, they shall be permitted to exercise only those activities and functions set out in training protocols approved by the Executive Committee.

6. Physicians Not Privileged at Union Hospital

Physicians not requesting or granted clinical privileges at Union Hospital but who refer their patients to the out-patient departments for testing and procedures shall have their licensure validated by querying the appropriate state medical board for verification of licensure.

7. Telemedicine Privileges

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 will approve the clinical services that will be provided through telemedicine upon the recommendations of the Medical Executive Committee.

Each appointee to the Telemedicine Staff shall be credentialed and granted privileges in accordance with the provisions of this policy in the same manner as any other applicant. Exception may be made if the following criteria are met:

1. Union Hospital, in providing telemedicine services to patients, has an agreement with the distant site hospital or distant site telemedicine entity and requires that the distant site meet the existing Medicare conditions of participation for credentialing and privileging decisions.
2. Union Hospital must ensure that:

a. The distant site entity is either a Medicare participating hospital, or its credentialing and privileging process and standards meet those in the Medicare conditions of participation;

b. The physician or practitioner is privileged at the distant site hospital or entity;

c. The physician or practitioner holds a license issued by the State Medical Board of Ohio, the state in which Union Hospital's patients are receiving the telemedicine services; and

d. It reviews the exercise of telemedicine privileges at Union Hospital and provides this quality assurance/performance improvement information to the distant site hospital or entity for use in its periodic appraisal of the physician or practitioner;

e. The physician or practitioner must possess current, valid professional liability insurance coverage in such amounts, containing such coverage and underwritten by such insurers as shall be required by the Union Hospital Board of Trustees from time to time;

f. Membership and privileges at Union Hospital shall be contingent upon the practitioner maintaining privileges at the distant site hospital or entity with the existing contractual arrangement.

Telemedicine privileges, if granted, shall be for a period of not more than two years.

Telemedicine privileges do not include any onsite inpatient or outpatient procedural privileges.

Individuals granted telemedicine privileges shall be subject to Union Hospital's performance improvement and peer review activities.

CR 3.001

Procedure for Initial Appointment

1. Submission of Application

The applicant shall submit an application for Medical Staff appointment to the Hospital's Chief Executive Officer or designee. The applicant shall have the burden of producing adequate information for proper evaluation of experience, professional ethics, background, training, demonstrated ability, and physical and mental status, and of resolving any doubts about these or any other basic qualifications specified in the Credentials Manual. The application process formally begins when the applicant furnishes the Hospital with a complete application containing all the information and supportive documentation requested thereon, subject to Section 1.001(8). An incomplete application will not be processed. After receiving a complete application, the Chief Executive Officer or designee shall transmit the application and all supporting materials to the Credentials Committee for evaluation.

2. Initial Credentials Committee Procedure

Upon determination that an application is complete, the Credentials Committee will:

A. request the appropriate clinical department chief of each department in which the applicant seeks clinical privileges to review the pending application and provide recommendations; and

B. provide any current Medical Staff appointee the right to appear in person before the Credentials Committee to discuss in private and in confidence any concerns about the applicant.

3. Department Chief Procedure

The department chief in which the applicant seeks clinical privileges shall provide the Credentials Committee with specific written recommendations for approving or

disapproving the application and for delineating the applicant's clinical privileges. These recommendations shall be made a part of the Credentials Committee's report. The applicant will be scheduled an interview to meet with the Chief Executive Officer and the clinical department chief.

4. Credentials Committee Procedure

A. The Credentials Committee shall examine the evidence of the character, professional competence, qualifications, prior behavior and ethical standing of the applicant and shall determine, through information contained in references given by the applicant and from other sources available to the committee, including the chief of the department in which privileges are sought, whether the applicant has established and meets all of the necessary qualifications for the staff category and clinical privileges requested.

B. If, after considering the recommendations of the chiefs of the clinical departments concerned, the Credentials Committee's recommendation for appointment is favorable, the Credentials Committee shall recommend provisional department assignment and provisional clinical privileges.

C. After determining that the applicant is qualified for appointment and privileges, the Credentials Committee may require the applicant to undergo a physical and/or mental examination by a physician or physicians satisfactory to the Credentials Committee if there is any question about the applicant's ability to perform the privileges requested and the responsibilities of appointment and shall require that the results be made available for the committee's consideration. Failure of an applicant to undergo such an examination within a reasonable time after being requested to do so in writing by the Credentials Committee shall constitute a voluntary withdrawal of the application for appointment and clinical privileges, and all processing of the application shall cease.

5. Credentials Committee Report

A. The Credentials Committee shall prepare a written report and recommendation with respect to the applicant for the Executive Committee and the Board. The Medical Executive Committee shall approve the recommendations of the Credentials Committee and transmit it to the Board of Trustees. If the Medical Executive Committee denies the report it will be returned to the Credentials Committee for further review.

B. If the recommendation of the Credentials Committee is delayed longer than 90 days, the Chairperson of the Credentials Committee shall send a letter to the applicant, with a copy to the Executive Committee and Chief Executive Officer explaining the delay.

C. If the Credentials Committee's recommendation for appointment is favorable, the Credentials Committee shall include in the report, recommended provisional assignment and provisional privileges.

D. If the Credentials Committee's recommendation is adverse to the applicant with respect to appointment or clinical privileges, the Credentials Committee shall notify the applicant by certified mail, return receipt requested. The Credentials Committee shall then hold the application until after the applicant has exercised or has deemed to have waived his rights to a hearing as provided in the Hearing and Appeal Procedure Policy.

E. The Credentials Committee's report shall be transmitted to the Board through the President of the Medical Staff, Chairman of the Medical Executive Committee. If the Committees recommendation is favorable, the report shall be transmitted upon completion. If the Committee's recommendation is adverse to the applicant with respect to appointment or clinical privileges, the report shall be transmitted after exhaustion of waiver of the Hearing and Appeal Procedure. The Chairman of the Credentials Committee or designee shall be available to the Board to answer any questions that may be raised with respect to the recommendation.

CR 4.001

Procedure for Reappointment

1. Reappointment Application

(a) An application for reappointment shall be furnished to Medical Staff appointees at least four months 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 return a completed application within this time frame will result in the assessment of a reappointment processing fee. In addition, failure to submit a complete application at last two months prior to the expiration of the Medical Staff appointee'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) If an application for reappointment is submitted timely, but the Board has not acted on it prior to the expiration of the current term, the individual's appointment and privileges shall expire at the end of the current term. Temporary privileges may be granted by the Chief Executive Officer until such time as the Board acts on the application only if the Chief Executive Officer determines, after consulting with the chief of the applicable department, the Chair of the Credentials Committee and the President of the Medical Staff, that there is an important patient care need that mandates an immediate authorization to practice. An "important patient care need" shall include, but not be limited to, an inability to meet on-call coverage requirements or denying the community access to needed medical services. The temporary clinical privileges shall be only for a period not to exceed 30 days, while the full credentials information is verified and approved.

(e) In the event the applicant for reappointment is the subject of an investigation or hearing at the time reappointment is being considered, a conditional

reappointment for a period of less than two years may be granted pending the completion of that process.

2. Factors to be Considered

Each recommendation concerning reappointment of a person currently appointed to the Medical Staff or a change in staff category, where applicable, shall be based upon such appointee's:

1. ethical behavior, clinical competence and clinical judgment in the treatment of patients;
2. attendance at Medical Staff meetings and participation in staff duties, including committee assignments and emergency call;
3. compliance with Hospital bylaws and policies and with Medical Staff Bylaws, the Operations and Procedure Manual, Peer Review Manual, Rules and Regulations Manual and this Manual;
4. behavior in the Hospital, cooperation with medical and Hospital personnel as it relates to patient care or the orderly operation of this Hospital, and general attitude toward patients, the Hospital and its personnel;
5. the results of the Hospital's performance improvement, ongoing professional practice evaluations, and other peer review activities;
6. use of the Hospital's facilities for one's 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;
7. any focused professional practice evaluations;
8. verified complaints received from patients and/or staff;
9. current information regarding the applicant's ability to exercise the privileges requested competently and safely and to perform the duties and responsibilities of appointment;

10. capacity to satisfactorily treat patients as indicated by the results of the Hospital's quality assessment and improvement activities or other reasonable indicators of continuing qualifications;

11. satisfactory completion of such continuing education requirements as may be imposed by law, this Hospital or applicable accreditation agencies; and

12. other relevant findings from the Medical Staff's peer review activities and other reasonable indicators of continuing qualifications.

Individuals appointed to the Medical Staff prior to December 1987 shall not be required to be board certified as a condition of reappointment.

3. Department Chief Procedure

A. No later than three months prior to the end of each appointee's current appointment period, the Chief Executive Officer shall send the application to the appropriate department chief. Each application for reappointment shall be accompanied by a statement of clinical privileges requested.

B. No later than 15 days after review of the application, the chief of each department shall transmit to the Credentials Committee the recommendations, and the reasons therefore, for reappointment and continued clinical privileges, any changes recommended in staff category, in clinical privileges, or for non-reappointment.

C. Recommendations for continued privileges, and increase or decrease of clinical privileges shall be based on:

1. relevant recent training;
2. observation of patient care provided;
3. review of the records of patients treated in this or other Hospitals;
4. results of the Hospital's quality assessment/risk management activities; and
5. other reasonable indicators of the individual's continuing qualifications for the privileges in question.

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4. Credentials Committee Procedure

1. The Credentials Committee, after receiving recommendations from the clinical department chief shall review all pertinent information available including all information provided from other committees of the Medical Staff and from Hospital management for the purpose of determining its recommendation for staff reappointment, for change in staff category, and for the granting of clinical privileges for the ensuing appointment period.
2. The Credentials Committee may require that a person currently seeking reappointment procure a physical and/or mental examination by a physician or physicians satisfactory to the Credentials Committee either as part of the reapplication process or during the appointment period to aid it in determining whether clinical privileges should be granted or continued and make results available for the Credentials Committee consideration. Failure of the person seeking reappointment to procure such an examination within a reasonable time after being requested to do so in writing by the Credentials Committee shall constitute a voluntary relinquishment of all Medical Staff and clinical privileges until such time as the Credentials Committee has received the examination results and has had a reasonable opportunity to evaluate them and make a recommendation thereon.
3. The Credentials Committee shall prepare its recommendation for reappointment without change in staff category and clinical privileges, or for non-reappointment and for changes in category or privileges, with supporting data and reasons attached.
4. The Credentials Committee shall transmit its report and recommendations to the Board through the Chief Executive Officer, providing a copy to the Executive Committee. The Chairperson of the Credentials Committee or his designee shall be available to the Board or its appropriate committee to answer any questions that may be raised with respect to the recommendation. Where non-reappointment or reduction in clinical privileges or denial of requested additional privileges is recommended, the reasons for such recommendation shall

be stated and documented and included in the report. The report shall not be transmitted to the Board until the affected appointee has exercised or has been deemed to have waived his right to a hearing as provided in the Hearing and Appeal Procedures Policy.

At its next regular meeting after receipt of the written findings and recommendation of the Credentials Committee, the 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 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.

5. Meeting with Affected Individual

If, during the processing of a particular individual's reappointment, it becomes apparent to the Credentials Committee or its Chairperson that the committee is considering a recommendation that would deny reappointment, deny clinical privileges, or reduce clinical privileges, the Chairperson of the Credentials Committee shall notify the individual of the general tenor of the possible recommendation and ask him if he desires to meet with the committee prior to any final recommendation by the committee. At such meeting, the affected individual shall be informed of the general nature of the evidence supporting the action contemplated and shall be invited to discuss, explain or refute it. This interview shall not constitute a hearing and none of the procedural rules provided in this Manual with respect to hearings shall apply nor shall minutes of the discussion in the meeting be kept. However, the committee shall indicate as part of its report to the Board whether such a meeting occurred.

6. Conditional Reappointments

Recommendations for reappointment may be subject to an applicant's compliance with specific conditions. These conditions may relate to behavior (e.g., personal code of conduct) or to clinical issues (e.g., performance improvement steps such as general consultation requirements, proctoring, completion of CME requirements). Reappointments may be recommended for periods of less than two years in order to permit closer monitoring of a Member's compliance with any conditions that may be imposed. A recommendation of a conditional reappointment or for reappointment for a period of less than two years does not, in and of itself, entitle an individual to request a hearing or appeal.

7. Procedure Thereafter

Any recommendation by the Credentials Committee denying appointment or clinical privileges shall entitle the affected individual to the procedural rights provided in the Hearing and Appeal Procedures Policy. The Chief Executive Officer shall than promptly notify the individual of the recommendation by certified mail, return receipt requested. The recommendation shall not be forwarded to the Board until the individual has exercised or has been deemed to have waived his right to a hearing as provided in the Hearing and Appeal Procedures Policy, after which the Board shall be given the committee's final recommendation and shall act on it.

CR 5.001

Increased Clinical Privileges

1. Application for Increased Clinical Privileges

All requests for an increase in clinical privileges must be submitted in writing to the Medical Staff Office. The request shall state in detail the specific additional clinical privileges desired and the applicant's relevant recent training and experience which justify increased privileges. This application will be transmitted by the Chief Executive Officer to the Credentials Committee and by it to the appropriate department. Thereafter, it will be processed in the same manner as an application for initial clinical privileges if the request is made during the term of appointment, or as a part of the reappointment application if the request is made at that time.

2. Factors to be Considered

Recommendation for an increase in clinical privileges made to the Board shall be based upon:

A. verification of relevant recent training;

B. observation of patient care provided;

C. review of the records of patients treated in this or other hospitals;

D. results of the Hospital's quality assessment and improvement activities; and

E. other reasonable indicators of the individual's continuing qualifications for the privileges in question.

The recommendation for such increased privileges may carry with it such requirements for supervision, proctoring or consultation for such period of time as are thought necessary.

Clinical Privileges for New Procedures

Whenever a Medical Staff appointee requests 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), the appointee shall first be informed by the Chief Executive Officer (or designee) that his/her request will not be processed until (1. A determination has been made regarding whether the procedure /service/technique will be offered by the Hospital and, if so, until (2. Minimum threshold criteria to be eligible to request clinical privileges in question have been established.

A. The Credentials Committee and the Executive Committee shall make a preliminary recommendation as to whether the procedure / service/technique should be offered, considering whether the Hospital has the capabilities, including support services, to perform the procedure/service/technique. After receiving the recommendations from the Executive Committee and the Credentials Committee, the Board (or its designated committee) shall determine whether the new procedure/service/technique will be offered.

B. If the procedure/service/technique will be offered, the Credentials Committee shall conduct research and consult with experts, including those on the Hospital's Medical Staff and those outside the Hospital, and develop recommendations regarding (1. The minimum education, training, and experience necessary to perform the procedure/service/technique, and (2. The extent of monitoring and supervision that should occur if the privileges are granted. The Credentials Committee or its designee may also develop criteria and/or indications for when the procedure/service/technique is appropriate. The Credentials Committee shall forward its recommendations to the Executive Committee, which shall review the matter and forward its recommendations to the Board (or its designated committee) for final action.

C. Once the minimum threshold qualifications that an individual must demonstrate in order to be eligible to request the clinical privileges in question are approved by

the Board, specific requests from eligible Medical Staff members may be processed.

CR 5.003

Clinical Privileges That Cross Specialty Lines

Whenever a Medical Staff appointee requests clinical privileges that traditionally at this Hospital have been exercised only by individuals from another specialty, the individual shall first be informed by the Chief Executive Officer (or designee) that his/her request 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.

A. The Credentials Committee shall conduct research and consult with experts, including those on the Hospital's Medical Staff (e.g., appropriate department Chiefs, individuals on the Medical Staff with special interest and/or expertise) and those outside the Hospital (e.g., other hospitals, residency training programs, specialty societies).

B. The Credentials Committee shall then 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 Executive Committee, which shall review the matter and forward its recommendations to the Board (or its designated committee) for final action.

C. Once the Board (or its designated committee) has adopted minimum threshold qualifications that an individual must demonstrate in order to be eligible to request the clinical privileges in question, specific requests from eligible Medical Staff members may be processed.

Temporary Privileges

<u>Eligibility to Request Temporary Clinical Privileges</u>:

(a) Temporary privileges may be granted by the Chief Executive 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 an appointee 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 President of the Medical 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 appointment, 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 period of time not to exceed 120 days.

(e) Temporary privileges shall expire at the end of the time period for which they are granted.

Supervision Requirements:

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

Termination of Temporary Clinical Privileges:

(a) The Chief Executive Officer may, at any time after consulting with the President of the Medical Staff, the Chairperson of the Credentials Committee, or the department chief, 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 chief, or the Chief of Staff may immediately terminate all temporary privileges. The department chief or the President of the Medical 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.

CR 7.001

Emergency Clinical Privileges

A. In an emergency involving a particular patient, a physician who is not currently appointed to the Medical Staff may be permitted by the Hospital to exercise clinical privileges to act in such emergency using all necessary facilities of the Hospital, including calling for any consultation necessary or desirable.

B. Similarly, in an emergency involving a particular patient, a physician currently appointed to the Medical Staff may be permitted by the Hospital to act in such emergency by exercising clinical privileges not specifically assigned to him.

C. When the emergency situation no longer exists, such physician must request the temporary privileges necessary to continue to treat the patient. In the event such temporary privileges are denied or he does not request such privileges, the department chief shall assign the patient or President of the Medical Staff or their designee to an appropriate person currently appointed to the Medical Staff. The wishes of the patient shall be considered in the selection of a substitute physician.

D. For the purpose of this section, an "emergency" is defined as a condition which could result in serious or permanent harm to a patient or in which the life of a patient is in immediate danger and any delay in administering treatment could add to that harm or danger.

CR 7.002

Disaster Clinical Privileges

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 our facilities.

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Under such circumstances, The CEO or the President of the Medical Staff is authorized to grant disaster clinical 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. If possible, verification of the volunteer's identity by a current medical staff member or Hospital employee shall be obtained. Government-issued photo identification, current photo identification from another hospital and/or identification shall be presented to the command center, indicating the individual is a member of a Disaster Medical Assistance Team, if possible.

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.

When the Emergency Management Plan has been deactivated, these privileges will expire.

CR 8.001

Procedure for Other Questions Involving Medical Staff Appointees

1. Collegial Intervention

A. This Manual encourages the use of progressive steps by Medical Staff leaders and Hospital management, beginning with collegial and educational efforts, to address issues pertaining to clinical competence or professional conduct. The goal of these efforts is to arrive at voluntary actions by the individual to resolve an issue that has been raised. Collegial intervention may be carried out, within the discretion of Medical Staff leaders and Hospital management, but is not mandatory.

B. Collegial intervention is a part of the Hospital's professional review activities and may include counseling, education, and related steps, such as the following:

1. advising colleagues of applicable policies, such as policies regarding appropriate behavior, emergency call obligations, and the timely and adequate completion of medical records;
2. proctoring, monitoring, consultation, and letters of guidance; and
3. sharing comparative quality, utilization, and other relevant information, including any variations from clinical protocols or guidelines, in order to assist individuals to conform their practices to appropriate norms.

C. The relevant Medical Staff leader(s), in conjunction with the Chief Executive Officer, may determine whether a matter should be handled in accordance with another policy (e.g., Code of Conduct Policy, Practitioner Health Policy, Peer Review Manual) or should be referred to the Executive Committee for further action.

D. The relevant Medical Staff leader(s) will determine whether to document a collegial intervention effort. Any documentation that is prepared will be placed in an individual's confidential file. The individual will have an opportunity to

review the documentation and respond to it. The response will be maintained in the individual's file along with the original documentation.

E. All ongoing and focused professional practice evaluations will be conducted in accordance with the peer review policy. Matters that cannot be appropriately resolved through collegial intervention or through the peer review policy will be referred to the Credentials Committee.

2. 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 members to work harmoniously with others,

the matter may be referred to the President of the Medical Staff, the chief of the clinical department, the chairperson of a standing committee, the CEO, or the Chairperson of the Board.

(b) The person to whom the matter is referred shall make sufficient inquiry to satisfy himself or herself that the question raised is credible and, if so, shall forward it in writing to the Credentials Committee.

(c) No action taken pursuant to this Section shall constitute an investigation.

3. Initiation of Investigation

(a) When a question involving clinical competence or professional conduct is referred to, or raised by, the Credentials Committee, the Credentials Committee shall

review the matter and determine whether to conduct an investigation or to direct the matter to be handled pursuant to another policy, such as the physician health policy or peer review policy, or to proceed in another manner. In making this determination, the Credentials Committee may discuss the matter with the individual. An investigation shall begin only after a formal determination by the Credentials Committee to do so.

(b) The Credentials Committee shall inform the individual that an investigation has begun. Notification may be delayed if, in the Credentials 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 Credentials Committee, a subcommittee of the Board, or an ad hoc committee.

(d) The President of the Medical Staff shall keep the CEO and Executive Committee fully informed of all action taken in connection with an investigation.

4. Investigative Procedure

(a) Once a determination has been made to begin an investigation, the Credentials Committee shall either investigate the matter itself, request that the Executive 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

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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 mental 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. 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, while balancing fairness to the individual, recognizing that fairness does not require that the individual agree with the recommendation. 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.

5. Recommendation

(a) The Credentials Committee may accept, modify, or reject any recommendation it receives from an investigating committee. Specifically, the Credentials Committee may:

(1) determine that no action is justified;

(2) issue a letter of guidance, counsel, warning, or reprimand;

(3) impose conditions for continued appointment;

(4) 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 Credentials Committee that would entitle the individual to request a hearing shall be forwarded to the CEO, who shall promptly inform the individual by special notice. The CEO shall hold the recommendation until after the individual has completed or waived a hearing and appeal.

(c) If the Credentials 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 Credentials Committee that would entitle the individual to request a hearing, the CEO 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. Grounds for Precautionary Suspension or Restriction

(a) Whenever, in their sole discretion, failure to take such action may result in imminent danger to the health and/or safety of any individual, the President of the Medical Staff, the chief of the clinical department, the Chief Executive Officer, or the Board Chairman, will each have the authority to (1) suspend or restrict all or any portion of an individual's clinical privileges; and (2) afford the individual an opportunity to voluntarily refrain from exercising privileges pending an investigation.

(b) A precautionary suspension or restriction can be imposed at any time including, but not limited to, immediately after the occurrence of an event that causes concern, following a pattern of occurrences that raises concern, or following a recommendation of the Executive Committee that would entitle the individual to request a hearing.

(c) Precautionary suspension or restriction is an interim step in the professional review activity, but it will not imply any final finding of responsibility for the situation that caused the suspension or restriction.

(d) A precautionary suspension or restriction shall become effective immediately upon imposition, shall immediately be reported in writing to the CEO and the President of the Medical Staff, and shall remain in effect unless it is modified by the CEO or Executive Committee.

(e) Within three days of a suspension, a brief written description of the reason(s), including the names and medical record numbers of patients involved, if any, will be provided to the individual.

7. Credentials Committee Procedure

(a) The Credentials 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 Credentials 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.

(b) After considering the matters resulting in the suspension or restriction and the individual's response, if any, the Credentials Committee shall determine whether there is sufficient information to warrant a final recommendation, or whether it is necessary to commence an investigation. The Credentials 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.

8. Care of Patients

(a) Immediately upon the imposition of a precautionary suspension or restriction, the President of the Medical 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 President of the Medical Staff, the department chief**,** the Credentials Committee, and the CEO in enforcing precautionary suspensions or restrictions.

9. Automatic Relinquishment of Privileges

The clinical privileges of any individual shall be automatically relinquished for the following:

A. Failure to Complete Medical Records:

1. The admitting and clinical privileges (elective and emergency) of any individual shall be deemed to be automatically relinquished for failure to complete medical records in accordance with applicable regulations governing the same, effective seven (7) days after notification by the medical records department of such delinquency. Such relinquishment shall continue until all the records of the individual's patients are no longer delinquent.

2. Failure to complete the medical records that caused relinquishment of clinical privileges within sixty (60) days from the relinquishment of such privileges shall constitute an automatic relinquishment of all clinical privileges and resignation from the Medical Staff.

3. In addition, should any physician relinquish clinical privileges because of medical record delinquency four (4) times during any one year of staff appointment, the physician shall automatically resign from the Medical

Staff. The physician may subsequently reapply to the Medical Staff as an initial applicant, but may not be granted temporary privileges during the processing of the application.

B. Action by Government Agency or Professional Liability Insurer:

Any action taken by any licensing board, professional liability insurer, court, or government agency regarding any of the matters set forth below must be promptly reported to the Chief Executive Officer and the President of the Medical Staff. Automatic relinquishment or restriction of privileges shall take effect immediately and continue until the matter is resolved and a request for reinstatement of privileges has been acted upon by the Credentials Committee and the Executive Committee and approved by the Board (or its designated committee). If the automatic relinquishment extends for more than 90 days, the individual shall be deemed to have resigned from the Medical Staff.

1. Licensure. Action by the state licensing board or agency revoking or suspending an individual's professional license, or loss or lapse of a state license to practice for any reason, shall result in automatic relinquishment of all Hospital clinical privileges. In the event the individual's license is only partially restricted or placed on probation, the clinical privileges that would be affected by the license restriction shall automatically be similarly restricted.
2. Controlled Substance Authorization. Revocation, limitation, or suspension of an individual's federal or state-controlled substance certificate shall result in automatic relinquishment of the right to prescribe medications covered by the certificate. Whenever an individual's state or federal controlled substance certificate is subject to probation, the individual's right to prescribe such medications shall automatically become subject to the same terms of the probation.
3. Insurance Coverage. Termination or lapse of an individual's professional liability insurance coverage or other action causing the coverage to fall

below the required minimum or cease to be in effect, in whole or in part, shall result in the automatic relinquishment or restriction of privileges as applicable.

4. Medicare and Medicaid Participation. Termination, exclusion, or preclusion by government action from participation in the Medicare or Medicaid programs shall result in automatic relinquishment of all clinical privileges. In the event the individual's participation is not fully reinstated by the expiration of the current appointment term, the individual will be deemed to have resigned from the Medical Staff at that time.

5. Criminal Activity. Conviction of any felony or of any misdemeanor involving violations of law pertaining to controlled substances, illegal drugs, Medicare, Medicaid, or medical or health insurance fraud or abuse, or violence, or a plea of guilty or nolo contendere to charges pertaining to the same, shall result in automatic relinquishment of Medical Staff appointment and all clinical privileges.

C. Failure to Provide Requested Information:

Failure to provide required information in response to a written request by the Credentials Committee, Executive Committee, or the Chief Executive Officer shall result in automatic relinquishment of all clinical privileges until the required information is provided to the satisfaction of the requesting person. For purposes of this section, "required information" shall mean:

1. Physical or mental examination reports such as specified elsewhere in this policy;

2. Information necessary to explain any action covered by Section 8 B above or any investigation or action by, or resignation from another health care facility, third party payer, or government agency;

3. Information from an individual's private office that is necessary to address and/or resolve questions that have arisen during the credentialing and/or peer review processes; or

4. Information pertaining to professional liability actions.

D. Failure to Attend Special Conference:

The Peer Review Committee may notify an individual that he/she is required to attend a special conference to consider the matter. The conference may be held with individual Medical Staff leaders and/or with a committee of the Medical Staff. The notice to the appointee regarding this conference shall be given by certified mail, return receipt requested, at least five (5) days prior to the conference and shall state whether attendance at the conference is mandatory. Failure of the individual to attend the conference shall be reported to the Executive Committee. Unless excused by the Executive Committee upon showing of good cause, such failure shall constitute automatic relinquishment of all or such portion of the individual's clinical privileges as the Executive Committee may direct. Such relinquishment shall remain in effect until the matter is resolved.

10. Mandatory Reporting of Final Actions

Within fifteen (15) days of final action by the Board, the President of the Medical Staff (or his designee) shall report any adverse action taken against the clinical privileges or Medical Staff membership of a practitioner to the National Practitioner Data Bank. The report of the National Practitioner Data Bank will be in accord with the requirements of 45 Code of Federal Regulations Part 60, et. seq. and reported on an Adverse Action Report form as provided by the National Practitioner Data Bank. The President of the Medical Staff (or his designee) will be responsible to review the Report Verification Document, when received from the National Practitioner Data Bank, to ensure the accuracy of and the appropriate coding of the report submitted on the Adverse Action Report form.

Within sixty (60) days after the completion of a formal disciplinary procedure recommended by the Medical Staff and adopted by the Board of Trustees resulting in the

revocation, restriction, reduction, or termination of clinical privileges for violation of professional ethics, or for reasons of medical incompetence, medical malpractice, or drug or alcohol abuse, against any physician, dentist, or podiatrist, the Chief Executive Officer of the facility shall report to the Ohio State Medical Board the name of the individual, the action taken, and a summary of the underlying facts as approved by the Peer Review Committee which reviewed the case.

11. Non-Reportable Action

A. The following actions are not reportable to the National Practitioner Data Bank:

1. Suspension of a practitioner's clinical privileges or Medical Staff membership based solely on a failure to complete medical records in a timely manner.
2. Suspension, denial or non-renewal of clinical privileges or Medical Staff membership due to a failure to obtain or maintain professional liability insurance at a specified level as determined by the Medical Executive Committee.

B. "Formal disciplinary procedure" does not include any action taken for the sole reason of failure to maintain records on a timely basis or failure to attend staff or department meetings.

12. Miscellaneous

Time requirements:

The time period specified in this Manual are intended to provide a guideline for the routine processing of applications, request for reappointment, or request for corrective action. Deviation from the time period set forth herein shall not be grounds for invalidating the action taken.

CR 8.002

Procedure for Leave of Absence

1. An individual appointed to the Medical Staff may request a leave of absence by submitting a written request to the CEO. The request must state the beginning and ending dates of the leave, which will not exceed one year, and the reasons for the leave.

2. Members of the Medical Staff must report to the CEO any time they are away from Medical Staff and/or patient care responsibilities for longer than 30 days and the reason for such absence is related to their physical or mental health or otherwise to their ability to care for patients safely and competently. Under such circumstances, the CEO, in consultation with the President of the Medical Staff, may trigger an automatic leave of absence.

3. The CEO will determine whether a request for a leave of absence will be granted. In determining whether to grant a request, the CEO will consult with the President of the Medical Staff and the relevant department chief. The granting of a leave of absence, or reinstatement, as appropriate, may be conditioned upon the individual's completion of all medical records.

4. During the leave of absence, the individual will not exercise any clinical privileges. In addition, the individual will be excused from all Medical Staff responsibilities (e.g., meeting attendance, committee service, emergency service call obligations) during this period.

5. Individuals requesting reinstatement will submit a written summary of their professional activities during the leave, and any other information that may be

requested by the Hospital. Requests for reinstatement will then be reviewed by the relevant department chief, the chair of the Credentials Committee, the President of the Medical Staff, and the CEO. If all these individuals make a favorable recommendation on reinstatement, the Medical Staff member may immediately resume clinical practice at the Hospital. This determination will then be forwarded to the Credentials Committee, the MEC, and the Board for ratification. If, however, any of the individuals reviewing the request have any questions or concerns, those questions will be noted and the reinstatement request will be forwarded to the full Credentials Committee, MEC, and Board for review and recommendation. However, if a request for reinstatement is not granted, for reasons related to clinical competence or professional conduct, the individual will be entitled to request a hearing and appeal.

6. 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.

7. Absence for longer than one year will result in automatic relinquishment of Medical Staff appointment and clinical privileges unless an extension is granted by the CEO. 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's appointment and clinical privileges will lapse at the end of the appointment period, and the individual will be required to apply for reappointment.

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

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where a request for extension is not granted, the determination will be final, with no recourse to a hearing and appeal.

CR 9.001

Advanced Practice Professionals:

1. Physician Assistant
   a. *Definition of Terms*: A physician assistant (PA) is an individual who is a graduate of a physician assistant program approved by the Accreditation Review Commission on Education for the Physician Assistant (ARC-PA) or one of its predecessor agencies, and/or has been certified by the National Commission on Certification of Physician Assistants (NCCPA). The individual meets the necessary legal requirements for licensure to practice medicine with physician supervision. Such professionals shall hold a license, certificate, or other legal credential as required by state law, and document their experience, background training, demonstrated ability, and physical and mental health status with sufficient adequacy to demonstrate that any patient service provided by them will be of the generally recognized professional level of quality and efficiency. They shall also be qualified to provide a needed service within Union Hospital and shall be eligible to provide specified patient care services in Union Hospital.
   b. Where appropriate, the Credentials Committee and/or the department involved may establish particular qualifications required of Physician Assistants.

2. Advanced Practice Nurses
   a. *Definition of Terms*: Advanced Practice Nurses shall consist of the following certified registered nurse anesthetists, certified clinical nurse specialists, certified family nurse practitioners, and other certified nurse specialists. Such professionals shall hold a license, certificate, or other legal credential as required by state law, and document their experience, background training, demonstrated ability, and physical and mental health status with sufficient adequacy to demonstrate that any patient service provided by them will be of the generally recognized professional level of quality and efficiency. They shall also be qualified to provide a needed service within

Union Hospital and shall be eligible to provide specified patient care services in Union Hospital.

Credentialing Advanced Practice Professionals

3. An initial application for specified patient care services for an Advanced Practice Professional and an application for reappointment shall be submitted and processed in the same manner as provided in CR1.001 except that any such application shall be co-signed by at least one of the physicians who will be responsible for the supervision and direction of the applicant. An Advanced Practice Professional shall be individually assigned to the clinical department appropriate to the applicant's professional training.

4. Advanced Practice Professionals shall:
   a. Provide specified patient care services only upon request of the patient's physician and under the supervision and direction of a responsible physician member of the Medical Staff. Qualified Advanced Practice Professionals may perform routine patient consults at the direction of the supervising physician. The supervising physician must see the patient within 24 hours of notification of the consult and sign off on the consult performed by the Advanced Practice Professional.

   b. Be subject to the provisions of the Department and Medical Staff Bylaws, Rules and Regulations.

5. Advanced Practice Nurses and Physician Assistants shall have the right to order diagnostic testing, diagnostic aids, durable medical equipment, and write orders within their Delineation of Privileges and Standard Care Arrangement/Physician Supervisory Plan ("SCAPSP") with their collaborating/ supervising physician. A current copy of the SCAPSP shall be provided to the hospital.
   a. Certified nurse practitioners with a certificate to prescribe issued under section 4723.48 of the Ohio Revised Code and in accordance with Chapter 4723-9 of the Ohio Administrative Code may prescribe medications.

b. Physician Assistants with a certificate to prescribe issued under section 4730-45 of the Ohio Revised Code and in accordance with Chapter 4730-2 of the Ohio Administrative Code may prescribe medications.
c. All other Advanced Practice Professionals shall not have the authority to write orders or prescribe medications.

6. Advanced Practice Professionals shall not:
   a. Admit or discharge patients.
   b. Attend Department or Staff meetings except by invitation of the chief of such meetings.
   c. Vote at any committee, department or staff meeting.
   d. Hold any elected or appointed office on the Union Hospital.
   e. Chair any Union Hospital Medical Staff committee.

7. Applications of Advanced Practice Nurses and Physician Assistants shall be co-signed by the physician member(s) of the hospital's Medical Staff who has agreed to direct and supervise the applicants in accordance with Ohio law.

8. Advanced Practice Professionals are entitled to a hearing and appeal mechanism. A copy of the rules and procedures governing that process shall be made available in the Medical Staff Office.

F. Background Checks for Advanced Practice Professionals.
   a. All applicants for credentials will be subject to licensure checks, reference checks, and criminal record checks.
   b. The application for privileges shall contain an authorization separately signed by the applicant authorizing the above-referenced background checks and releasing the hospital and all persons and entities contacted from any liability or claims with respect to questions and responses.

G. The employer of the Advanced Practice Professional shall indemnify and hold harmless the hospital with respect to any claims or suits regarding the activities of the Advanced Practice Professional in the hospital or otherwise practicing pursuant to Hospital-issued credentials. By signing the application for privileges for the Advanced Practice Professional the physician represents that the physician has the authority to so bind the employer and agrees to this condition.

11. Privileges

Qualifications:

a. Categories of healthcare professionals approved by the Board, who are licensed or certified by their respective licensing or certifying agencies and who provide services as employees of or under the supervision of physicians who are presently appointed to the Medical Staff are eligible to practice as Advanced Practice Professionals.

Selection Process:

a. To the extent the Board determines to permit such Advanced Practice Professionals to act in the Hospital, the Credentials Committee shall recommend each individual's delineation of privileges within the Hospital.
b. No such individual shall provide services in the Hospital as an Advanced Practice Professional unless and until the Credentials Committee has received, on a form approved by the Board, sufficient information about the qualification of that individual to permit the Credentials Committee to recommend the privileges the individual will be permitted to undertake in the Hospital. The form shall be prepared by the individual's employer, if appropriate, and signed by the individual and at least one of the physicians who will be responsible for the supervision and direction of the individual.
c. The Credentials Committee, on the recommendation of the chairman of the applicable department, shall recommend to the Board a written delineation of privileges each Advanced Practice Professional is permitted to undertake in the Hospital. The qualifications of the supervision physician and that physician’s ability to provide supervision for the applicant will be considered. The Advanced Practice Professional

may act in the Hospital pursuant to the approved delineation only so long as he/she remains an employee of a Medical Staff member currently appointed to the Medical Staff.

Conditions of Practice:

a. Advanced Practice Professionals are not members of the Medical Staff and shall not be entitled to the rights, privileges, and responsibilities of appointment to the Medical Staff and may only engage in the delineation of privileges specifically granted by the Board.
b. Any activities permitted by the Board to be done in the Hospital by Advanced Practice Professionals shall be done only under the direct and immediate supervision of his/her employer. However, "direct and immediate supervision" shall not require the actual physical presence of the employer unless so provided in the Advanced Practice Professional's delineation of privileges.
c. Should any Hospital employee who is licensed or certified by the state have any question regarding the clinical competence or authority of the Advanced Practice Professional either to act or to issue instructions outside the physical presence of the employer in a particular instance, such Hospital employee has the right to require that the Advanced Practice Professional's employer or supervisor validate, either at the time or later, the instructions of the Advanced Practice Professional. Any act or instruction of the Advanced Practice Professional shall be delayed until such time as the Hospital employee shall be certain that the act is clearly within the delineation of privileges of the Advanced Practice Professional's as permitted by the Board. At all times the employing or supervising physician will remain responsible for all acts of any of the Advanced Practice Professionals within the Hospital or the practice setting.
d. The number of Advanced Practice Professionals acting as employees of one physician, as well as the acts they may undertake, shall be consistent with applicable state statutes and regulations, the rules and regulations of the Medical Staff and the policies of the Board.

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e. It shall be the responsibility of the physician employing the Advanced Practice Professional to provide professional liability insurance for his Advanced Practice Professional in amounts required by the Board that covers any activities in the Hospital and furnish evidence of such to the Hospital so that it can be ascertained that such professional liability insurance covers the activities of the Advanced Practice Professional in the Hospital and shall act in the Hospital or in the practice setting only while such coverage is in effect.

12. Advanced Practice Professionals Credentialing, Reappointment & Request for Additional Privileges:

Policy

a. The Medical Staff Office will coordinate the credentialing, biennial review and reappointment and request for additional privileges of the advanced practice professional.

Procedure

Initial Appointment Credentialing

a. The advanced practice professional will contact the medical staff office and request a Preapplication.

Preapplication:

a. Upon receipt of the completed Preapplication, the Medical Staff Office will verify the following:
   - Valid and unrestricted licensure for the State of Ohio
   - The advanced practice professional certificate of authority for the State of Ohio and national certification as current
   - The collaborating/ supervising physician is an active member of the Union Hospital Medical Staff for a certified nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist or physician assistant with privileges in the appropriate specialty.

b. Preapplication and verified documents will be reviewed by the Vice President of Medical Affairs. If verified information provides no problems, an

application will be provided to the advanced practice professional for completion.

Initial Application:

a. The completed application with the requested supporting documentation will be submitted to the Medical Staff Office. Incomplete applications will be returned to the applicant for missing information, clarification or documentation.

b. If the application is determined to be complete by the Medical Staff Office, the following information will be collected and verified:

- A valid active license in their specialty to practice in the State of Ohio and a valid certificate of authority
- Primary verification/confirmation of training/education
- Former employers and hospital affiliations will be contacted for evaluation of the applicant (including post licensure as an advanced practice professional)
- Evaluations will be requested from a person in same specialty, a member of the Medical Staff and a previous supervising physician or physician director from the training program
- Completed privilege forms
- Malpractice liability insurance certificate evidencing a minimum coverage of $1million/$3million in the applicant's name
- Copy of the appropriate certification/recertification from the national certifying organization for the advanced practice professional
- Copy of the Standard Care Agreement (SCA) for the Clinical Nurse Specialist or Nurse Practitioner
- Copy of the supervisory agreement, supervisory plan, and a special services plan for a physician assistant
- Query National Practitioners Data Bank
- Signed verification of receipt of Medical Staff Manual and Professional Conduct Agreement.

c. Following collection and verification of information, the Medical Staff Office will forward the application to chief of the appropriate department for review and to make a recommendation regarding application and delineation of privileges.
d. The completed application with recommendations will be forwarded to the Credentials Committee for recommendation.
e. After review and recommendation by the Credentials Committee, the Medical Executive Committee will review, recommend, and forward the application to the Board of Trustees for final approval.
f. Initial appointment and privileges will be provisional for a period of one year as stated in the Medical Staff Credentials Manual.

Biennial Reappointment

a. Reappointment application will be sent to the Advanced Practice Professional by the Medical Staff Office.
b. Completed reappointment application must be returned by the date stated in the application.
c. Following collection and verification of information, the Medical Staff Office will forward the request for reappointment to the chief of the appropriate department for review and recommendation for reappointment.
d. The completed application will then be forwarded to the Credentials Committee for reappointment.
e. After review and recommendation by the Credentials Committee, the Medical Executive Committee will review, recommend and forward the reappointment application to the Board of Directors for final approval.

To Request Additional Privileges

a. Contact the Medical Staff Office to request form to upgrade privileges.
b. Complete the request form with required proof of education training and competency.

c. Applicant will provide a revised Standard Care Arrangement/Physician Supervisory Plan to include requested privileges for the certificated nurse practitioner or physician assistant.

d. Medical Staff Office will forward the completed form to the chief of the department for review, to define the proctorship to upgrade the privileges, and recommendation regarding the request.

f. The completed request will be forwarded to the Credentials Committee for review and recommendation.

g. The request will be forwarded to the Medical Executive Committee for recommendation.

h. The recommendation on the requested additional privileges will be forward to the Board of Trustees for final approval.

e. Once the defined proctorship is completed by the applicant, the following will review for approval to upgrade the privilege.

- Chief of department
- Credentials Committee

13. Advanced Practice Professional Credentialing with Supervision

Definition:

a. *Direct Supervision*: The collaborating/supervising physician is physically present with the patient and the practitioner for a pertinent portion of the examination and patient history. Planning of care, ordering of treatment, and documentation of the note is discussed with the practitioner. The physician is responsible to make notation in conjunction with the practitioner. Direct supervision and evaluation of the practitioner will be conducted for a period of 3 months. The practitioner may progress to indirect supervision upon successful completion of the direct supervision period and recommendation of the collaborating physician.

b. *Indirect Supervision*: The collaborating/supervision physician is not physically present with the practitioner but is immediately available by means

of a telephone and/or electronic modalities and is available to provide direct supervision in a timely manner. The physician will be responsible to review the plan of care with the practitioner and document in the medical record. A senior practitioner may, at the direction of the collaborating physician, provide supervision during this period of 3 months. The practitioner may progress to full clinical privileges upon successful completion of the supervision period, recommendation of the collaborating physician(s) and approval of the credentialing committee.

c. *Practitioner:* Any advanced practice professional granted clinical privileges by the Union Hospital Board of Trustees.

Recommendation for Credentialing with Supervision:

a. The completed application for privileges is first reviewed by the Credentials Committee. Supervision will be recommended for any practitioner that is applying for privileges without the necessary education, training, certification, or previous experience for that specific area of practice.

Measurement of Competency:

a. Completion of 5 chart audits by the collaborating/supervising physician along with review of general competency is required at the end of the 3 month directed supervision period. If performance is acceptable, the practitioner can move to indirect supervision. At the completion of the 3 month indirect supervision period, an additional 5 chart audits must be submitted. All documentation will be added to the practitioner file and brought back through committee for approval.

Committee Approval Credentialing with Supervision:

a. A designee of the Credentials Committee will review all chart audits and physician documentation for approval for full privileges. Once approved by the Credentials Committee, full privileges will be communicated to the Medical Executive Committee and Board of Trustees for approval.

b. Requirements:

- A minimum of 10 charts are to be reviewed annually. If the advanced practice professional has multiple collaborating physicians, each physician performing the chart audits should complete no less than three.
- Meet with a collaborating/supervising physician to review the information and to discuss the advanced practice professional's strengths, identify opportunities for improvement, and develop goals for next review cycle.
- At the time of request for reappointment, the documentation of the chart audits on the standardized template will be required by the Medical Staff Office.
- Along with the audits a summative evaluation form must also be completed by each collaborating physician who performed chart audits.

c. Reappointment request, with chart review, will then be presented to the Credentials Committee for review and recommendation to the Medical Executive Committee and the Board of Trustees.

14. Advanced Practice Professionals Specific Performance Data Evaluation and Analysis Process:

a. Periodic Review and Approval of the Standard Care Arrangement for Certified Nurse Practitioners: The SCA shall be reviewed and reapproved at least annually using the Standard Care Arrangement Checklist.

b. Annually each nurse practitioner shall verify the licensure and, if applicable, certification status of each collaborating physician or podiatrist with whom the nurse has a SCA.

c. Each nurse who is a party to the arrangement and at least one collaborating physician or podiatrist shall sign and date the annual review of the standard care arrangement.

d. The supervising/collaborating physician will use the following standards to review charts and summarize on the Criteria Based Review. The cases and summary will be reviewed referencing the ANA Standards of Care for the Allied Health Professionals. Ten (10) charts will be reviewed annually for reappointment.

- Assessment: Collects comprehensive patient health data and documents in the record. Performs comprehensive system-focused assessment with documentation.
- Diagnosis: Critically analyzes the assessment data to determine an accurate diagnosis.
- Outcome Identification: Identifies expected outcomes derived from the assessment data and diagnoses and individualizes expected outcomes with the client, and with the health care team when appropriate. Evaluates patient's progress in attaining expected outcomes during rounds. Dictates complete but concise discharge summary when appropriate.
- Planning: Develops a comprehensive plan that included interventions and treatments to attain the expected outcomes.
- Implementation: Implements the plan and utilizes safe and appropriate order entry.
    1) Case Management/Coordination of Care: Provides comprehensive clinical coordination of care and case management.
    2) Consultation: Provides consultation to influence the plan of care for clients, enhance the abilities of others and effect change in the system.
    3) Health Promotion, Health Maintenance and Health Teaching: Employs complex strategies, interventions, and teaching to promote, maintain and improve health, and prevent illness and injury.
    4) Prescriptive Authority and Treatment: Uses prescriptive authority, procedures, treatments in accordance with the state and federal laws and regulations to treat illness and improve functional health status or to provide preventative care.

5) Referral: Identifies the need for additional care and makes referrals as needed.
6) Infection Control: Verify that infection control policies and procedures for personnel and equipment exist within the practice setting. Adhere to infection control policies and procedures as established within the practice setting to minimize the risk of infection to the patient and other healthcare providers.

e. Annually, the Nurse Practitioner will review and complete the Procedure Competency Form for review by the Supervising/Collaborative Physician. All data will be presented to the Chief of the Department with recommendations regarding:
   - Competency
   - Need for further training, education, or proctoring
   - Effectiveness of the actions taken

f. On Reappointment, the Quality Profile will be presented for review and recommendation to the Credentials Committee.

15. Periodic Review and Approval of the Physician Supervisory Plan for Physician Assistants:

a. The PSP shall be reviewed and reapproved at least annually using the Standard Care Arrangement Checklist.

b. Annually each physician assistant shall verify the licensure and, if applicable, certification status of each collaborating physician or podiatrist with whom the practitioner has a SCA.

c. Each physician assistant who is a party to the arrangement and at least one collaborating physician or podiatrist shall sign and date the annual review of the standard care arrangement.

d. The supervising/collaborating physician will use the following standards to review charts and summarize on the Criteria Based Review. The cases and summary will be reviewed referencing the ANA Standards of Care for the Allied Health Professionals. Ten (10) charts will be reviewed annually for reappointment.

- Assessment: Collects comprehensive patient health data and documents in the record. Performs comprehensive system-focused assessment with documentation.
- Diagnosis: Critically analyzes the assessment data to determine an accurate diagnosis.
- Outcome Identification: Identifies expected outcomes derived from the assessment data and diagnoses and individualizes expected outcomes with the client, and with the health care team when appropriate. Evaluates patient's progress in attaining expected outcomes during rounds. Dictates complete but concise discharge summary when appropriate.
- Planning: Develops a comprehensive plan that included interventions and treatments to attain the expected outcomes.
- Implementation: Implements the plan and utilizes safe and appropriate order entry.
    1) Case Management/Coordination of Care: Provides comprehensive clinical coordination of care and case management.
    2) Consultation: Provides consultation to influence the plan of care for clients, enhance the abilities of others and effect change in the system.
    3) Health Promotion, Health Maintenance and Health Teaching: Employs complex strategies, interventions, and teaching to promote, maintain and improve health, and prevent illness and injury.

4) Prescriptive Authority and Treatment: Uses prescriptive authority, procedures, treatments in accordance with the state and federal laws and regulations to treat illness and improve functional health status or to provide preventative care.
5) Referral: Identifies the need for additional care and makes referrals as needed.
6) Infection Control: Verify that infection control policies and procedures for personnel and equipment exist within the practice setting. Adhere to infection control policies and procedures as established within the practice setting to minimize the risk of infection to the patient and other healthcare providers.

e. Annually, the Physician Assistant will review and complete the Procedure Competency Form for review by the Supervising/Collaborative Physician. All data will be presented to the Chief of the Department with recommendations regarding:
    - Competency
    - Need for further training, education, or proctoring
    - Effectiveness of the actions taken

f. On Reappointment, the Quality Profile will be presented for review and recommendation to the Credentials Committee.

16. Advanced Practice Professional Staff Proctoring Policy

a. At Union Hospital proctoring of advanced practice professional staff is used:
    - To provide oversight, guidance and training in the role for a practitioner that is employed by Union Hospital.
    - To provide oversight, guidance and training for a practitioner that is newly privileged for procedures.

- When a practitioner has competency concerns related to our ongoing professional practice evaluation or peer review process, a period of documented proctorship may be indicated.

Definitions:

Practitioner: Any advanced practice professional granted clinical privileges by Union Hospital Medical Staff.

Proctor: The medical staff member or designated expert that will directly observe and evaluate the current competency of the practitioner related to some or all privileges.

Proctoring: Proctoring is the direct observation of a procedure or treatment to evaluate an individual practitioner's competence. It may also include concurrent observation of all portions of the no-procedural evaluation and care rendered by the practitioner.

Focused Practice Evaluation is the process of monitoring and evaluating practitioner competence. Proctoring is a tool used within the practice evaluation.

Practitioner Focused Practice Plan: The specific methods and extent of evaluation for a given practitioner, which is recommended/directed by the Medical Staff Credentials Committee.

On-Site Proctoring: Proctoring performed at Union Hospital facilities.

Off-Site Proctoring: Documented evidence of proctoring performed at a non-Union Hospital Facility but proctored by a physician who is a member of the Union Hospital staff or a designated expert.

Procedure:

Hospital-employed newly credentialed members of the advanced practice professional staff are required to be proctored by either a collaborating physician(s) or another experienced practitioner. During this proctorship, any new procedures that are part of the practitioner's role are also to be proctored.

17. Advanced Practice Professional Proctoring Guidelines:

a. The proctor's role is that of an evaluator, preceptor, and mentor. A practitioner serving as a proctor must be an experienced practitioner and be able to provide guidance and direction for the new employee. A collaborating physician may also serve as a proctor to an advanced practice professional member, again providing guidance and support and assuring competency by the end of the proctorship. A minimum of 2 proctors must work with the new practitioner.
b. It is the responsibility of the proctor to work side by side with the practitioner and assure competence for specific processes that pertain to their role. During procedures, the proctor is there once again to provide guidance and direction assuring the procedure is being completed according to our guidelines. The proctor(s) can make the decision to recommend additional hours of proctoring when necessary.
c. Procedure logs will be maintained for all new procedures being proctored. For Advanced Practice Professionals, any non-core privileges or procedures have a required number to perform before the privilege will be approved. It is the responsibility of the proctor to observe and then sign off on each. Complete procedure logs will be kept with the proctorship paperwork and delivered to the Medical Staff Office.
d. Proctors will maintain confidentiality of all proctoring results and forms. Once the proctorship is complete, the paperwork will be signed by the collaborating physician(s) and the proctors and delivered to the Medical Staff Office in a timely manner.
e. Completion of a proctorship for a newly employed practitioner will be brought to the Credentials Committee for information purposes.

- Duties of the Practitioner Being Proctored
    a. Patient care will be conducted by the practitioner with oversight by the proctor.
    b. The practitioner will accept feedback from the proctor and make improvements or changes as recommended.

c. The practitioner being proctored shall take ownership for getting the paperwork completed.
d. The practitioner will then bring the completed paperwork to the Vice President of Medical Affairs.

- Duties of the Vice President of Medical Affairs
  a. Assist with the arrangement of proctorship and assure appropriate paperwork is received.
  b. Oversee proctorship completion and evaluate data submitted by the practitioner to determine if the proctorship conditions have been met.
  c. Assure completed and signed paperwork is delivered to the Medical Staff Office.

- Duties of the Medical Staff Office
  a. Maintain proctoring records and maintain appropriate documents in the practitioner's file.
- Role of Medical Staff Departments
  a. Departments may develop their own criteria and requirements related to proctoring, but to the extent such criteria and policies are inconsistent or conflict with this policy, the guidelines set forth in this policy will govern.

18. Focused Practice Evaluation

Definition: Focused Professional Practice Evaluation is a time-limited period during which information is obtained to evaluate the practitioner's professional performance. Validation may consist of direct observation, review of medical records and evaluation of the six general competencies, including (but not limited to) communication with members of the healthcare team and hospital administration.

a. Circumstances that require a Focused Practice Evaluation

- New Practitioner – When a practitioner is appointed to the Advanced Practice Professional Staff the focused practice evaluation documentation will be submitted to the collaborating physician for completion within 6 months after the credential date. Requirements for the FPPE will include documentation of a minimum of 10 chart audits and completion of the FPPE evaluation form with signature and date.
- Upgrade or New Privileges – When practitioner has an update in privileges the focused practice evaluation will be completed.
- Event Review (risk management, sentinel event) – An event, occurrence or situation that involves or could involve the clinical care of a patient that results in death or compromised patient safety and results in an unanticipated injury requiring the delivery of additional health care services.
- Other Trigger – A variant pattern or trend of patient care identified through the Advanced Practice Professional Ongoing Practice Evaluation process. This will include greater than 5 prescribing variances in a 6 month period of time.

b. General Competencies: The competencies defined are:

Professionalism –

- Takes responsibility for finding opportunities to work on skill requirements and maintain clinical competencies.
- Accepts guidance and constructive feedback in a professional manner.
- Follows strict ethical principles regarding patient confidentiality, informed consent and unanticipated adverse outcomes.
- Demonstrates the highest level of accountability for professional practice including attendance, team work, patient satisfaction, case load, and committee or meeting participation.

Communication-

- Maintains accurate and timely electronic medical record documentation.

- Provides clear verbal and written reports of patient condition to healthcare team members.
- Communicates verbally with clarity and attention to details pertinent to continuity during hand-offs.
- Develops relationships with multidisciplinary team members, promoting mutual respect and trust.

Clinical Skills -

- Performs accurate physical assessment of the patient.
- Selects, orders, and correctly interprets diagnostic tests.
- Develops an appropriate plan of care for the patient.
- Appropriately evaluates the patient response to the plan of care.
- Responds rapidly and appropriately to signs of clinical deterioration
- Demonstrates knowledge of pharmacologic principles of commonly used medications.
- Demonstrates proficiency in procedural skills.

Knowledge –

- Systematically assesses the patient's health status and develops the plan of care
- Incorporates the patient's family in the treatment of the disease and care of the patient.
- Makes informed diagnostic and therapeutic decisions.
- Utilizes and integrates evidence based practice standards
- Facilitates a multidisciplinary approach to provide patient focused care.

Systems Practice –

- Appropriately utilizes resources such as labs, radiology, referrals and consultations.
- Adapts well to changing clinical demands affecting work load and resource utilization.

- Complies with hospital efforts to maintain a culture of patient safety.

Practice Improvement –

- Demonstrates the ability to access resources for learning.
- Collaborates effectively with all members of the healthcare team to provide patient focused care.
- Evaluates his/her patient care practices and makes improvements as needed.

Data Collection Methods

a. Information reported for a Focused Practice Evaluation may include:
   - Chart Review
   - Discussion with colleagues or collaborating physicians
   - Proctoring or observation
   - External peer review process
   - Discussion with other individuals involved in the care of a patient

19. Procedure for Newly Granted or Upgraded Privileges for Advanced Practice Professional Staff

a. The Medical Staff Office and the Care Management Department will assist in providing data for review.

- All hospital employed Advanced Practice Professional Staff are required to have proof of proctorship documentation to be signed off by the collaborating physician(s).
- Completed proctorship paperwork is placed in the file in the Medical Staff Office.
- The completed Focused Professional Review form for the credentialed, non-employed practitioner is submitted to the Medical Staff Office and will be reviewed and signed off by the Medical Staff Credentialing Committee and on to the Medical Executive Committee before placed in the Advanced Practice Professional file.

21. Procedure for Detected Trends or Serious Events

a. Variant patterns of patient care or serious events will be evaluated first by the Care Management Department and then brought to the Credentials Committee. The Committee will make a recommendation to begin focused practice evaluation.
b. The Vice President of Medical Affairs will meet with the collaborating/supervising physician and the employee manager if appropriate. These cases will be individualized to the issue(s) of concern and the focused practice evaluation form will define the required length of time and/or number of cases and elements that will be monitored.
c. The completed focused practice evaluation form with needed documentation is submitted to the Medical Staff Office and will be reviewed by the Vice President of Medical Affairs, proceed to the Medical Staff Credentialing Committee and on to the Medical Executive Committee before placed in the Advanced Practice Professionals file.
d. All documentation and meetings pertaining to the focused practice evaluation will be kept confidential.

22. Ongoing Practice Evaluation

a. *Definition*: Ongoing Practice Evaluation is a process whereby the organization regularly and consistently evaluates the privilege-specific competence of a practitioner. The evaluation will be used no less than twice per year for all practitioners on Union Hospital Advanced Practice Professional Staff. OPE is an ongoing practice evaluation that monitors the practitioner's performance as defined by a framework of general competencies.
b. Information collected for an OPE will include the following.
   On-going data collection is performed using the following Advanced Practice Professional indicators:

c. General Competencies: The competencies defined are:

Professionalism –

- Takes responsibility for finding opportunities to work on skill requirements and maintain clinical competencies.
- Accepts guidance and constructive feedback in a professional manner.
- Follows strict ethical principles regarding patient confidentiality, informed consent and unanticipated adverse outcomes.
- Demonstrates the highest level of accountability for professional practice including attendance, team work, patient satisfaction, case load, and committee or meeting participation.

Communication-

- Maintains accurate and timely electronic medical record documentation.
- Provides clear verbal and written reports of patient condition to healthcare team members.
- Communicates verbally with clarity and attention to details pertinent to continuity during hand-offs.
- Develops relationships with multidisciplinary team members, promoting mutual respect and trust.

Clinical Skills -

- Performs accurate physical assessment of the patient.
- Selects, orders, and correctly interprets diagnostic tests.
- Develops an appropriate plan of care for the patient.
- Appropriately evaluates the patient response to the plan of care.
- Responds rapidly and appropriately to signs of clinical deterioration
- Demonstrates knowledge of pharmacologic principles of commonly used medications.
- Demonstrates proficiency in procedural skills.

Knowledge –

- Systematically assesses the patient's health status and develops the plan of care
- Incorporates the patient's family in the treatment of the disease and care of the patient.
- Makes informed diagnostic and therapeutic decisions.
- Utilizes and integrates evidence based practice standards
- Facilitates a multidisciplinary approach to provide patient focused care.

Systems Practice –

- Appropriately utilizes resources such as labs, radiology, referrals and consultations.
- Adapts well to changing clinical demands affecting work load and resource utilization.
- Complies with hospital efforts to maintain a culture of patient safety.

Practice Improvement –

- Demonstrates the ability to access resources for learning.
- Collaborates effectively with all members of the healthcare team to provide patient focused care.
- Evaluates his/her patient care practices and makes improvements as needed.

2. Hearing and Appeals for Advanced Practice Professionals

A. In the event that the Credentials Committee makes a recommendation that an Advanced Practice Professional's scope of practice be restricted or terminated, the Advanced Practice Professional shall be notified of the recommendation, the general reasons for the recommendation and that he or she may request a hearing before the adverse recommendation is transmitted to the Board. This will be applicable to Advanced Practice Professionals only and not include Medical Assistants.

B. If the Advanced Practice Professional desires to request a hearing, he or she must make such request in writing directed to the Chief Executive Officer ("CEO") (or designee) within thirty (30) days after receipt of written notice.

C. If such a request is made, the CEO shall appoint a hearing panel composed of up to three individuals (including, but not limited to, individuals appointed to the Medical Staff, Advanced Practice Professionals, hospital management or individuals not connected to the hospital), and a presiding officer who may be legal counsel to the hospital. The hearing panel shall not include anyone who previously participated in the recommendation, any relatives or practice partners of the Advanced Practice Professional. The hearing shall be convened within thirty (30) days after the request is received.

D. As an alternative to the hearing panel described in paragraph (c) of this Section, the CEO (or designee) may instead appoint a hearing officer to perform the functions that would otherwise be carried out by the hearing panel. The hearing officer shall preferably be an attorney at law. The hearing officer may not be in direct economic competition with the individual requesting the hearing, nor have a conflict of interest with either the individual or the hospital, and shall not act as a prosecuting officer or as an advocate to either side at the hearing. If the hearing officer is an attorney, he or she shall not represent clients who are in direct economic competition with the affected individual. In the event a hearing officer is appointed instead of a hearing panel, all references in this Section to the

Approved: Board of Trustees 2/25/2013; Board of Trustees 6/24/2013; Board of Trustees 8/25/2014; Board of Trustees 3/24/2015

"hearing panel" shall be deemed to refer instead to the hearing officer, unless the context would clearly otherwise require.

E. At the hearing, a representative of the Credentials Committee shall first present the reasons for the recommendation. The Advanced Practice Professional shall be invited to present information both orally and in writing to refute the reasons for the recommendation, subject to a determination by the presiding officer that the information is relevant. The presiding officer shall have the discretion to determine the amount of time allotted to the presentation by the representative of the Credentials Committee and the Advanced Practice Professional.

F. The Advanced Practice Professional shall not have the right to present other witnesses unless he or she can demonstrate to the satisfaction of the presiding officer that the failure to permit witnesses to appear would be fundamentally unfair.

G. Neither the Advanced Practice Professional nor the Credentials Committee shall be represented by counsel at this proceeding.

H. The Advanced Practice Professional shall have the burden of demonstrating that the recommendation was arbitrary, capricious or not supported by credible evidence. The quality of care provided to patients and the smooth operation of the hospital shall be paramount considerations. Minutes shall be kept and shall be attached to the report and recommendation of the hearing panel.

I. The hearing panel or the hearing officer shall prepare a written report and recommendation within thirty (30) days after the conclusion of the proceeding and shall forward it, along with all supporting information, to the CEO. The CEO shall send a copy of the written report and recommendation, by certified mail, return receipt requested, to the Advanced Practice Professional.

J. If the Advanced Practice Professional is dissatisfied with the recommendation and report, he or she may appeal in writing to the CEO (or designee) within ten (10) days after notice of such recommendation. The request must include a statement of the reasons, including specific facts which justify an appeal. The request shall be delivered to the CEO either in person or by certified mail. If a written request

for appeal is not submitted within the ten (10) day time frame specified herein, the recommendation and supporting information shall be forwarded by the CEO (or designee) to the Chairperson of the Board for final action. If a timely request for appeal is submitted, the CEO shall forward the report and recommendation, the supporting information and the request for appeal to an ad hoc review panel appointed by the Chairperson of the Board.

K. The grounds for appeal shall be limited to the following: (i) there was substantial failure to comply with applicable bylaws or policies of the hospital or the Medical Staff, and/or (ii) the recommendation was arbitrary, capricious or not supported by substantial evidence.

L. The ad hoc review panel will consider the record upon which the adverse recommendation was made. New or additional written information that is relevant, and that the Advanced Practice Professional demonstrates could not have been made available to the hearing panel or the hearing officer during the initial review of the matter, may be considered in the discretion of the ad hoc review panel.

M. Upon completion of the review, the ad hoc review panel shall adopt the recommendation of the hearing panel or the hearing officer, or make a different recommendation. In its discretion, the ad hoc review panel may refer the matter to any committee or individual it deems appropriate for further review and recommendation. The ad hoc review panel shall make its decision on behalf of the Board, based upon the Board's ultimate legal responsibility to authorize the performance of clinical activities at the hospital. Such decision shall be deemed to constitute final action by the Board.

N. Advanced Practice Professionals shall not be entitled to the hearing and appeals procedures set forth in the Medical Staff Hearing and Appeals Manual.

3. Medical Assistants

A. Qualifications:

1. Categories of healthcare professionals approved by the Board, who are licensed or certified by their respective licensing or certifying agencies and who provide services as employees of or under the supervision of physicians who are presently appointed to the Medical Staff are eligible to practice as Medical Assistants. All Medical Assistants shall be registered nurses or as otherwise designated by the Credentials Committee who will be credentialed to assist their employing physician in gathering data and providing patient education and as otherwise determined by the Credentials Committee.

B. Selection Process:

1. To the extent the Board determines to permit such Medical Assistants to act in the Hospital, the Credentials Committee shall recommend the scope of each such individual's activities within the Hospital.
2. No such individual shall provide services in the Hospital as a Medical Assistant unless and until the Credentials Committee has received, on a form approved by the Board, sufficient information about the qualification of that individual to permit the Credentials Committee to recommend the scope of activities the individual will be permitted to undertake in the Hospital. The form shall be prepared by the individual's employer, if appropriate, and signed by the individual and at least one of the physicians who will be responsible for the supervision and direction of the individual.
3. The Credentials Committee, on the recommendation of the chairman of the applicable department, shall recommend to the Board a written delineation of the scope of practice each Medical Assistant is permitted to undertake in the Hospital. The qualifications of the supervising physician and that physician's ability to provide supervision for the applicant will be

considered. This delineation shall be final with no right of hearing or appeal, provided, however, that the physician seeking to employ the Medical Assistant in the Hospital shall have the opportunity to appear before the Credentials Committee and discuss the proposed delineation before any final action or recommendation is made. The Medical Assistant may act in the Hospital pursuant to the approved delineation only so long as he/she remains an employee of a Medical Staff member currently appointed to the Medical Staff.

C. Conditions of Practice:

1. Medical Assistants are not members of the medical staff and shall not be entitled to the rights, privileges, and responsibilities of appointment to the Medical Staff and may only engage in acts within the scope of practice specifically granted by the Board.
2. Any activities permitted by the Board to be done in the Hospital by Medical Assistants shall be done only under the direct and immediate supervision of his/her employer. However, "direct and immediate supervision" shall not require the actual physical presence of the employer unless so provided in the Medical Assistant's scope of activities. Should any Hospital employee who is licensed or certified by the state have any question regarding the clinical competence or authority of the Medical Assistant either to act or to issue instructions outside the physical presence of the employer in a particular instance, such Hospital employee has the right to require that the Medical Assistant's employer or supervisor validate, either at the time or later, the instructions of the Medical Assistant.
3. Any act or instruction of the Medical Assistant shall be delayed until such time as the Hospital employee shall be certain that the act is clearly within the scope of the Medical Assistant's activities as permitted by the Board. At all times the employing or supervising physician will remain

responsible for all acts of any of his Medical Assistants within the Hospital.

4. The number of Medical Assistants acting as employees of one physician, as well as the acts they may undertake, shall be consistent with applicable state statutes and regulations, the rules and regulations of the Medical Staff and the policies of the Board.

5. It shall be the responsibility of the physician employing the Medical Assistant to provide professional liability insurance for his Assistant in amounts required by the Board that covers any activities in the Hospital and furnish evidence of such to the Hospital so that it can be ascertained that such professional liability insurance covers the activities of the Medical Assistant in the Hospital and such Assistant shall act in the Hospital only while such coverage is in effect.