CREDENTIALING POLICY

SANTA ROSA MEMORIAL HOSPITAL

Approved: 06/26/18; Revised 04/28/20

CREDENTIALING POLICY

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ARTICLE 1

GENERAL

1.A. TIME LIMITS

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

1.B. DELEGATION OF FUNCTIONS

(1) Unless otherwise specified in this or another Medical Staff document, when a function discussed in this document is to be carried out by a member of the Hospital Administration, by a Medical Staff Officer, or by a Medical Staff committee, the individual, or the committee through its chair, may delegate performance of the function to one or more designees.

(2) When a Medical Staff Member or Allied Health Practitioner is unavailable or unable to perform an assigned function, one or more of the Medical Staff Leaders may perform the function personally or delegate it to another appropriate individual. However, a Medical Staff Member's duty to appear at a meeting to discuss matters related to the Medical Staff Member's clinical competence, performance, or conduct or other concern may not be delegated.

1.C. CONFIDENTIALITY AND PEER REVIEW PROTECTION

1.C.1. Confidentiality:

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

(a) to another authorized individual and for the purpose of conducting professional review activity; or

(b) as authorized by a policy.

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

1.C.2. Peer Review Protection:

All professional review activity will be performed by the peer review committees. Peer review committees include, but are not limited to:

(a) all standing and ad hoc Medical Staff and Hospital committees;

(b) all services;

(c) hearing and appellate review panels;

(d) the Governing Body and its committees, to the extent that they are addressing professional review activity; and

Any individual or body authorized to act for or on behalf of a peer review committee, Medical Staff Leaders, and experts or consultants retained to assist in professional review activity also shall be subject to the peer review protections afforded by the Bylaws.

All oral and written communications, reports, recommendations, actions, and minutes made or taken by peer review committees are confidential and are deemed to be "professional review bodies" as that term is defined in the Health Care Quality Improvement Act of 1986 ("HCQIA"), 42 U.S.C. § 11101 et seq. All such communications shall be covered by the provisions of applicable law, including (but not limited to) Cal. Civ. Code § 43.7, Cal. Civ. Code § 43.8, Cal. Evid. Code § 1156, Cal. Evid. Code § 1157, and their successors.

1.D. INDEMNIFICATION

The Hospital will provide a legal defense for and will indemnify Medical Staff officers, service chairs, committee chairs, committee members, and authorized representatives when acting in those capacities, to the fullest extent permitted by law, in accordance with the Hospital's Bylaws.

1.E. DEFINITIONS

The definitions detailed in the Bylaws shall apply to this Policy.

ARTICLE 2

QUALIFICATIONS, CONDITIONS, AND RESPONSIBILITIES

2.A. QUALIFICATIONS

2.A.1. Threshold Eligibility Criteria:

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

(a) have a current, unrestricted license to practice in California that is not subject to any restrictions, probationary terms, or conditions not generally applicable to all licensees, not be subject at any time while the application is being processed to an Accusation issued by the applicable licensing board, and have never had a license to practice revoked, restricted or suspended by any state licensing agency;

(b) have a current, unrestricted DEA registration that is valid in California (not required for Ortho PA-Cs, or to be listed in CA for telemedicine practitioners);

(c) be located (office and residence) close enough to fulfill Medical Staff responsibilities and to provide timely and continuous care for his or her patients in the Hospital;

(d) have current, valid professional liability insurance coverage in a form and in amounts satisfactory to the Hospital (not required for Honorary or Community Affiliate staff members);

(e) have never been, and not currently be, excluded or precluded from participation in Medicare, Medicaid, or other federal or state governmental health care program;

(f) have never had Medical Staff or Allied Health Staff appointment, clinical privileges or practice authorization, or status as a participating provider denied, revoked, or terminated by any health care facility, including this Hospital, or health plan for reasons related to clinical competence or professional conduct;

(g) have never resigned Medical Staff or Allied Health Staff appointment or relinquished privileges during an investigation or in exchange for not conducting such an investigation at any health care facility, including this Hospital;

(h) since the beginning of professional training, have not been convicted of, or entered a plea of guilty or no contest to, any felony or misdemeanor related to: (i) controlled substances; (ii) illegal drugs; (iii) insurance or health care fraud (including Medicare, Medicaid or other federal or state governmental or private third-party payer fraud or program abuse); (iv) violent acts; (v) sexual misconduct; (vi) moral turpitude; or (vii) child or elder abuse; or been required to pay a civil money penalty for governmental fraud or program abuse;

(i) agree to fulfill all responsibilities regarding emergency call as defined by the on-call policy;

(j) have an appropriate coverage arrangement, as determined by the Credentials Committee, with other members of the Medical Staff for those times when the individual will be unavailable;

(k) document compliance with all applicable training and educational protocols that may be adopted by the Medical Executive Committee and required by the Governing Body, including, but not limited to, those involving electronic medical records or patient safety;

(l) document compliance with any health screening requirements (e.g., health examinations, TB testing, mandatory flu vaccines, and infectious agent exposures);

(m) meet any current or future eligibility requirements that are applicable to the clinical privileges being sought or granted;

(n) if applying for privileges in an area that is covered by an exclusive contract or arrangement, meet the specific requirements set forth in that contract;

(o) demonstrate recent clinical activity in their primary area of practice, in an acute care hospital or other accredited health care facility, during the last two years;

(p) have successfully completed:

(1) a residency and, if applicable, fellowship training program approved by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association in the specialty in which the applicant seeks clinical privileges;

(2) a dental or an oral and maxillofacial surgery training program accredited by the Commission on Dental Accreditation of the American Dental Association;

(3) a podiatric surgical residency program accredited by the Council on Podiatric Medical Education of the American Podiatric Medical Association;

(4) one year of supervised experience in psychological health care delivery within an acute inpatient hospital setting assessing and treating seriously mentally disordered patients; or

(5) with regard to Allied Health Professionals, all applicable training requirements as established by the Medical Executive Committee;

(q) be board certified in their primary area of practice at the Hospital by the appropriate specialty/subspecialty board of the American Board of Medical Specialties, the American Osteopathic Association, the American Board of Oral and Maxillofacial Surgery, the American Dental Association, the American Board of Foot and Ankle Surgery, or the American Board of Podiatric Medicine, as applicable. For Allied Health Professionals, the Medical Executive Committee will determine board certification requirements. Applicants who are not board certified at the time of application but who have completed their residency or fellowship training within the last five years will be eligible for Medical Staff appointment. However, in order to remain eligible, those applicants must achieve board certification in their primary area of practice within five years from the date of completion of their residency or fellowship training;

(r) maintain board certification in their primary area of practice at the Hospital and, to the extent required by the applicable specialty/subspecialty board, satisfy recertification requirements. Recertification will be assessed at expiration;

(s) if seeking to practice as a psychologist, meet the definition of "clinical psychologist" per Cal. Health & Safety Code § 1316.5 (or its successors); and

(t) if seeking to practice as an AHP, must abide by all supervision requirements and conditions of practice set forth under California law and under Hospital policy, including a written delegation agreement, if applicable.

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

(a) Any applicant who does not satisfy one or more of the threshold eligibility criteria may request that it be waived. Waivers of threshold eligibility criteria will not be granted routinely. The applicant requesting the waiver bears the burden of demonstrating exceptional circumstances, and that his or her qualifications are equivalent to, or exceed, the criterion in question.

(b) A request for a waiver must be supported by a member of the active medical staff and submitted to the Credentials Committee for consideration. In reviewing the request for a waiver, the Credentials Committee may consider the specific qualifications of the applicant in question, input from the relevant service chair, and the best interests of the Hospital and the communities it serves. Additionally, the Credentials Committee may, in its discretion, consider the application form and other information supplied by the applicant.

(c) The Credentials Committee will forward its recommendation, including the basis for such, to the Medical Executive Committee. Any recommendation to grant a waiver must include the specific basis for the recommendation.

(d) The Medical Executive Committee will review the recommendation of the Credentials Committee and make a recommendation to the Board regarding whether to grant or deny the request for a waiver. Any recommendation to grant a waiver must include the specific basis for the recommendation.

(e) The Board's determination regarding whether to grant a waiver is final. A determination not to grant a waiver is not a "denial" of appointment or clinical privileges and the individual who requested the waiver is not entitled to a hearing. A determination to grant a waiver in a particular case is not intended to set a precedent. A determination to grant a waiver does not mean that appointment will be granted, only that processing of the application can begin.

2.A.3. Factors for Evaluation:

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

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

(b) adherence to the ethics of the profession, as described by the American Medical Association, practitioner's national professional society; and adherence to the Catholic Ethical and Religious Directives; continuous professional development; an understanding of and sensitivity to diversity; and responsible attitude toward patients and the profession;

(c) good reputation and character;

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

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

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

2.A.4. No Entitlement to Appointment:

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

(a) is employed by this Hospital or its subsidiaries or has a contract with this Hospital;

(b) is or is not a member or employee of any particular physician group;

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

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

(e) has had in the past, or currently has, Medical Staff or Allied Health Professional appointment or privileges at any hospital or health care facility;

(f) resides in the geographic service area of the Hospital; or

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

2.A.5. Nondiscrimination:

Medical Staff membership or privileges shall not be denied on the basis of sex, gender identity and gender expression, age, religion, race, creed, color, national origin, sexual orientation, genetic information, military or veteran status, political affiliations or activities, marital status, or any other legally-protected status. Medical Staff membership or privileges shall not be denied on the basis of any physical or mental disability if the applicant meets the standards set forth in the Medical Staff's governing documents with or without reasonable accommodation.

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

2.B.1. Basic Responsibilities and Requirements:

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

(a) to provide continuous and timely care;

(b) to abide by the bylaws, policies, and rules and regulations of the Hospital and Medical Staff and any revisions or amendments thereto;

(c) to participate in Medical Staff affairs through committee service and participation in performance improvement and peer review activities, and to perform such other reasonable duties and responsibilities as may be assigned;

(d) be available on a continuous basis, either personally or by arranging appropriate coverage, to respond to the needs of inpatients and Emergency Department patients in a prompt, efficient, and conscientious manner. ("Appropriate coverage" means coverage by another member of the Medical Staff with appropriate specialty-specific privileges as determined by the Credentials Committee.) Compliance with this responsibility means that the practitioner must be willing and able to:

(1) respond within 30 minutes, via phone or in person, to all pages; and

(2) appear in person to attend to a patient within 60 minutes of being requested to do so (or more quickly based upon (i) the acute nature of the patient's condition or (ii) as required for a particular specialty as recommended by the Medical Executive Committee and approved by the Governing Body);

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

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

(g) to participate in personal or phone interviews in regard to an application for initial appointment or reappointment, if requested;

(h) to use the Hospital sufficiently to allow continuing assessment of current competence, or provide sufficient information to allow such assessment;

(i) to seek consultation whenever necessary;

(j) to complete in a timely manner all medical and other required records in accordance with policy;

(k) to perform all services and to act in a cooperative and professional manner in accordance with the Medical Staff Professionalism Policy;

(1) to promptly pay any applicable dues, assessments, or fines in accordance with policy;

(m) to utilize the Hospital's electronic medical record system;

(n) to attend and participate in any applicable orientation programs at the Hospital in accordance with policy;

(o) to comply with all applicable training and educational protocols that may be adopted by the Medical Executive Committee or hospital, including, but not limited to, those involving electronic medical records, patient safety, and infection control;

(p) to maintain a current e-mail address with Medical Staff Administration, which will be the primary mechanism used to communicate all Medical Staff or Allied Health Staff information to the member;

(q) to disclose conflicts of interest regarding relationships with pharmaceutical companies, device manufacturers, other vendors or other persons or entities as may be required by Hospital or Medical Staff policies, including, but not limited to, disclosure of financial interests in any product, service, or medical device not

already in use at the Hospital that a Medical Staff member may request the Hospital to purchase;

(r) if the individual is a member of the Medical Staff who serves or plans to serve as a Supervising Physician, that the member of the Medical Staff will abide by all supervision requirements and conditions of practice set forth under California law and under Hospital policy; and

(s) that, if the individual is an AHP, he or she will abide by the conditions of practice set forth under California law and under Hospital policy.

2.B.2. Burden of Providing Information:

(a) All individuals and members have the burden of producing information deemed adequate by the Medical Staff and Hospital for a proper evaluation of current competence, character, ethics, and other qualifications and for resolving any doubts about them.

(b) As part of their burden to provide information, applicants must provide the full details of the reasons and results of any pending or prior investigations, corrective actions, suspensions, restrictions, revocations, peer review hearings, appeals, and/or litigation involving their (i) licensure, (ii) membership, or (iii) privileges at any other health care facility or managed care plan (as well as any other information the Medical Executive Committee may request). Failure of the applicant to provide full details shall render the application incomplete and it will not be processed further. Additionally, the hospital, in its discretion, may require that the full details be available for review from a primary source other than the applicant; in these circumstances, if the primary source is not available, regardless of the reason, then the application shall be deemed incomplete and not be processed further.

(c) Individuals have the burden of providing evidence that all the statements made and all information provided by the applicant in support of the application are accurate and complete.

(d) An application will be complete when all questions on the application form have been answered, all supporting documentation has been supplied, and all information has been verified from primary sources. An application will become incomplete if the need arises for new, additional, or clarifying information, including, but not limited to, any information determined by any person or committee charged with evaluating the application, or by the Governing Body, as necessary for evaluating the application. Any application that continues to be incomplete 30 days after the applicant has been given final notification of the additional information required will be deemed to be voluntarily withdrawn. Once withdrawn, the applicant may not reapply for a period of one year.

(e) Applicants are responsible for providing a complete application, including adequate responses from references and all information requested from third parties, for a proper evaluation. An incomplete application will not be processed.

(f) Applicants and members are responsible for notifying the Chief of Staff or the President, via Medical Staff Administration, of any change in status or any change in the information provided on the application form. Unless stated otherwise, all information must be provided within 14 days of the change, with or without request. Such information includes (but is not limited to):

(1) any information on the application form;

(2) any information on the National Practitioner Data Bank;

(3) any threshold eligibility criteria for appointment or clinical privileges or practice authorizations;

(4) any and all complaints, documents or other information known to the practitioner regarding, or changes in, licensure status or DEA controlled substance authorization (**immediate notification required if this affects the ability to exercise privileges or otherwise practice at the** Hospital);

(5) changes in professional liability insurance coverage (**immediate notification required**);

(6) the filing of a professional liability lawsuit against the practitioner;

(7) arrest, charge, indictment, conviction, or a plea of guilty or no contest in any criminal matter (**immediate notification required**);

(8) exclusion or preclusion from participation in Medicare, Medicaid or any other federal or state health care program or any sanctions imposed with respect to the same (**immediate notification required**); and

(9) any changes in the practitioner's ability to safely and competently exercise clinical privileges or perform the duties and responsibilities of appointment because of health status issues, including, but not limited to, impairment due to addiction (all of which will be referred for review under the policy on practitioner health) (**immediate notification required**).

2.C. APPLICATION

The Hospital may at its discretion designate a Centralized Credentials Verification Organization (CCVO) to process applications for primary source verifications. In this case, the CCVO application may be utilized to request Facility staff membership and clinical privileges.

The Hospital may at its discretion execute delegated credentialing contracts with accredited organizations to facilitate the credentialing process by utilizing their applications and primary source verifications to request Hospital staff membership and clinical privileges.

The Hospital may at its discretion execute credentialing by proxy contracts with accredited organizations to facilitate the credentialing process by utilizing their applications, primary source verifications and privilege decisions to request Hospital staff membership and clinical privileges.

The receipt of an application by the Hospital, whether from the CCVO, a Hospital under a delegated credentialing contract or a Hospital providing Credentialing by Proxy, from the applicant requesting that application, credentials and privileging information be submitted to the Hospital in no way obligates the Hospital to process the application. If at any time during the processing of an application the Hospital determines that an applicant does not meet the minimum qualifications for membership and/or clinical privileges, the application process may be terminated.

Medical Staff Administration will notify an applicant if the application is not processed due to failure to meet the minimum qualifications of the Hospital or clinical department, or for being incomplete. In such cases, the hearing and appellate review procedures in the Medical Staff Bylaws do not apply.

The Governing Board makes all final decisions concerning medical staff membership and the granting of clinical privileges.

2.C.1. Information:

(a) Application forms for appointment, reappointment, and clinical privileges will be approved by the Governing Body, upon recommendation by the Credentials Committee and the Medical Executive Committee.

(b) The applications for initial appointment, reappointment, and clinical privileges existing now and as may be revised are incorporated by reference and made a part of this Policy.

(c) The application will contain a request for specific clinical privileges and will require detailed information concerning the applicant's professional qualifications. The applicant will sign the application and certify that he or she is able to perform the privileges requested and the responsibilities of appointment.

2.C.2. Misstatements and Omissions:

(a) Any misstatement in, or omission from, the application is grounds to stop processing the application. The applicant will be informed in writing of the nature of the misstatement or omission and permitted to provide a written response. The Chief of Staff and President will review the response and determine whether the application should be processed further. If the misstatement or omission involves the failure to inform the Medical Staff of a prior or pending investigation, corrective action, suspension, restriction, revocation, peer review hearing, appeal, or litigation involving his/her licensure or membership and/or privileges at any healthcare facility or managed care plan, then regardless of the applicant's written response,

the application will not be processed further. If the application is not processed further, the applicant may not reapply for a period of one year.

(b) 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 this Policy.

(c) No action taken pursuant to this section will entitle the applicant or member to a hearing or appeal unless the Hospital is required to file an 805 report or a report to the National Practitioner Data Bank.

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

(a) Conditions Prerequisite to Application and Consideration:

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

(b) Scope of Conditions:

The terms set forth in this Section:

(i) commence with the individual's initial contact with the Hospital, whether an application is furnished or appointment, clinical privileges, or scope of practice are granted;

(ii) apply throughout the credentialing process and the term of any appointment, reappointment, clinical privileges, or scope of practice; and

(iii) survive for all time, even if appointment, reappointment, clinical privileges, or scope of practice is denied, revoked, reduced, restricted, suspended, or otherwise affected as part of the Hospital's professional review activities and even if the individual no longer maintains appointment, clinical privileges, or scope of practice at the Hospital.

(c) Use and Disclosure of Information about Individuals:

(1) Information Defined:

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

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

(ii) any matter addressed on the application form or in the Medical Staff Bylaws, Credentialing Policy, and other Hospital or Medical Staff policies and rules and regulations;

(iii) any reports about the individual which are made by the Hospital, its Medical Staff Leaders, or their representatives to the National Practitioner Data Bank or relevant state licensing boards/agencies; and

(iv) any references received or given about the individual.

(2) Authorization for Criminal Background Check:

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

(3) Authorization to Obtain Information from Third Parties:

The individual authorizes the Hospital, Medical Staff Leaders, and their representatives to request or obtain information from third parties and specifically authorizes third parties to release information to the Hospital.

(4) Authorization to Disclose Information to Third Parties:

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

(d) Hearing and Appeal Procedures:

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

(e) Immunity:

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

This immunity covers any actions, recommendations, reports, statements, communications, or disclosures that are made, taken, or received by the Hospital, its representatives, or third parties in the course of credentialing and peer review activities or when using or disclosing information as described in this Section. Nothing herein will be deemed to waive any other immunity or privilege provided by federal or California law.

(f) Legal Actions:

If, despite this Section, an individual institutes legal action challenging any credentialing, privileging, peer review, or other professional review action or activity and does not prevail, he or she will reimburse the Hospital, the Board, and the Medical Staff, their authorized representatives, any members of the Medical Staff, or Allied Health Staff, or Board, and any third party who provides information involved in the action for all costs incurred in defending such legal action, including costs and attorneys' fees, and expert witness fees. As used in this provision, the term "legal actions" does not refer to any of the Hospital's internal hearing and appeal procedures.

ARTICLE 3

PROCEDURE FOR INITIAL APPOINTMENT AND PRIVILEGES OR PRACTICE AUTHORIZATIONS

3.A. PROCEDURE FOR INITIAL APPOINTMENT AND PRIVILEGES OR PRACTICE AUTHORIZATIONS

3.A.1. Application:

(a) Prospective applicants will be sent the application form and a letter that outlines the threshold eligibility criteria for appointment and the applicable criteria for clinical privileges or practice authorization.

(b) A completed application form with copies of all required documents must be returned to Medical Staff Administration within 30 days after receipt. The application must be accompanied by the application fee.

(c) Applications may be provided to residents who are in the final six months of their training. Final action will not be taken until all applicable threshold eligibility criteria are satisfied.

3.A.2. Initial Review of Application:

(a) As a preliminary step, the application will be reviewed by Medical Staff Administration to determine that all questions have been answered and that the applicant satisfies all threshold eligibility criteria. Applicants who fail to return completed applications or fail to meet the threshold eligibility criteria will be notified that their applications will not be processed. A determination of ineligibility does not entitle the individual to a hearing and appeal.

(b) Medical Staff Administration will oversee the process of gathering and verifying relevant information, and confirming that all references and other information deemed pertinent have been received. This will include querying relevant state licensing boards/agencies, as applicable.

(c) Evidence of the applicant's character, professional competence, qualifications, behavior, and ethical standing will be examined. This information may be contained in the application, and obtained from references and other available sources, including the applicant's past or current service chair at other health care entities, residency training director, and others who may have knowledge about the applicant's education, training, experience, and ability to work with others. The National Practitioner Data Bank and the Office of Inspector General, Medicare/Medicaid Exclusions will be queried, as required, and a criminal background check will be obtained.

(d) An interview(s) with the applicant may be conducted. The purpose of the interview is to discuss and review any aspect of the applicant's application, qualifications, and requested clinical privileges or practice authorization. This interview will be conducted by one or any combination of any of the following: service chair, the Credentials Committee, a Credentials Committee representative, the Medical Executive Committee, the Chief of Staff, the Chief Medical Officer, or the President.

3.A.3. Service Chair and Chief Nursing Executive Procedure:

Medical Staff Administration will transmit the complete application and all supporting materials to the chair of each service in which the applicant seeks clinical privileges. The chair will prepare a written report regarding whether the applicant has satisfied all of the qualifications for appointment and the clinical privileges requested. The report will be on a form provided by Medical Staff Administration. The Chief Nursing Executive will also review and report on the applications for all advanced practice registered nurses.

3.A.4. Credentials Committee Procedure:

(a) The Credentials Committee will consider the report prepared by the chair(s) and will make a recommendation.

(b) The Credentials Committee may use the expertise of the chair(s), or any member of the service, or an outside consultant, if additional information is required regarding the applicant's qualifications.

(c) After determining that an applicant is otherwise qualified for appointment and privileges or practice authorization, if there is any question about the applicant's ability to perform the privileges requested and the responsibilities of appointment, the Credentials Committee may require a fitness for practice evaluation by a physician(s) satisfactory to the Credentials Committee. The results of this evaluation will be made available to the Committee.

(d) The Credentials Committee may recommend the imposition of specific conditions related to behavior, health or clinical issues. The Credentials Committee may also recommend that appointment be granted for a period of less than one year in order to permit closer monitoring of the applicant's compliance with any conditions.

(e) If the recommendation of the Credentials Committee is delayed longer than 60 days, the chair of the Credentials Committee will send a letter to the applicant, with a copy to the President, explaining the reasons for the delay.

3.A.5. Medical Executive Committee Recommendation:

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

(1) adopt the report and recommendation of the Credentials Committee as its own; or

(2) refer the matter back to the Credentials Committee for further consideration of specific questions; or

(3) state its reasons for disagreement with the report and recommendation of the Credentials Committee.

(b) If the recommendation of the Medical Executive Committee is to appoint, the recommendation will be forwarded to the Governing Body.

(c) If the recommendation of the Medical Executive Committee would entitle the applicant to request a hearing, the Medical Executive Committee will promptly send special notice to the applicant. The application will be held until after the applicant has completed or waived a hearing and appeal.

3.A.6. Governing Body Action:

(a) If consistent with the Governing Body's own Bylaws, the Governing Body may delegate to a committee action on appointment, reappointment, or clinical privileges if there has been a favorable recommendation from the Credentials Committee and the Medical Executive Committee and there is no evidence of any of the following:

(1) a current or previously successful challenge to any license or registration;

(2) an involuntary termination, limitation, reduction, denial, or loss of appointment or privileges at any other hospital or other entity; or

(3) an unusual pattern of, or an excessive number of, professional liability actions resulting in a final judgment against the applicant.

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

(b) When there has been no delegation to the Governing Body Committee, upon receipt of a recommendation that the applicant be granted appointment and clinical privileges, the Governing Body may:

(1) grant appointment and clinical privileges as recommended; or

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

(3) modify the recommendation.

(c) If the Board disagrees with a favorable recommendation, it should first discuss the matter with the chair of the Credentials Committee and the chair of the Medical Executive Committee. If the Governing Body's determination remains unfavorable, it shall refer the matter to an ad hoc committee consisting of three members of the Medical Staff, one of whom shall be the Chief of Staff, three non-physician members of the Governing Body, and the Chief Executive Officer for review and recommendation before the Governing Body makes a final decision. If, after the ad hoc committee meets, the decision remains unfavorable, the President will promptly send special notice that the applicant is entitled to request a hearing.

(d) Any final decision by the Governing Body to grant, deny, modify, or revoke appointment or clinical privileges will be disseminated to appropriate individuals and, as required, reported to appropriate entities.

3.A.7. Time Periods for Processing:

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

3.A.8. Term of Appointment:

(a) Initial:

Initial appointment to the medical staff shall be made on a provisional basis by the Governing Board, upon recommendation of the MEC, for a period of one (1) year. During the provisional term, the staff member shall not be eligible to vote, to hold office. The provisional designation is removed if and when the MEC and Governing Body receive satisfactory assurance that the practitioner is capable and willing to fulfill the responsibilities of appointment in the practitioner's chosen area of clinical practice and the Focused Professional Practice Evaluation process is complete. The provisional period may be extended once, for good cause, at the recommendation of the MEC and approval of the Board. Such extension can be for no longer than one year. If the practitioner's performance is not satisfactory at the end of the extension or the Focused Professional Practice Evaluation process is not complete, then appointment, privileges, or a specific privilege, whatever has been the subject of the extension, shall not be granted. In that case, the applicant shall be entitled to rights of hearing and appellate review.

(b) Reappointment:

Formal application for membership reappointment and privileges delineation must be made at the end of the provisional period and shall be for a period of

time that is consistent with current accreditation and regulatory requirements but not longer than 24 months.

ARTICLE 4

CLINICAL PRIVILEGES

4.A. CLINICAL PRIVILEGES

4.A.1. General:

(a) Appointment or reappointment will not confer any clinical privileges or right to practice at the Hospital. Only those clinical privileges granted by the Governing Body may be exercised, subject to the terms of this Policy.

(b) A request for privileges will be processed only when an applicant satisfies threshold eligibility criteria for the delineated privileges. An individual who does not satisfy the eligibility criteria for clinical privileges may request that the criteria be waived.

(c) Requests for clinical privileges that are subject to an exclusive contract or arrangement will not be processed except as consistent with the applicable contract.

(d) Recommendations for clinical privileges will be based on consideration of the following:

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

(2) appropriateness of utilization patterns;

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

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

(5) availability of coverage in case of the applicant's illness or unavailability;

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

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

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

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

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

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

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

(e) Requests for additional clinical privileges must state the additional clinical privileges requested and provide information sufficient to establish eligibility. If the member is eligible and the request is complete, it will be processed in the same manner as an application for initial clinical privileges.

4.A.2. Core/Specialty Privilege Waivers:

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

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

(c) Requests for waivers will be processed in the same manner as requests for waivers of appointment criteria.

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

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

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

(3) the expectations of members who rely on the specialty;

(4) fairness to the individual requesting the waiver;

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

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

(e) If the Governing Body grants a waiver related to privileges, it will specify the effective date. In addition, the Governing Body will determine whether the individual granted the waiver must continue to participate in the general on-call schedule for the relevant specialty and maintain sufficient competency to assist the Emergency Medicine physicians in assessing and stabilizing patients who require services within that specialty. If, upon assessment, a patient needs a service that is no longer provided by the individual pursuant to the waiver, the individual will work cooperatively with the Emergency Medicine physician(s) in arranging for another individual with appropriate clinical privileges to care for the patient or, if such an individual is not available, in arranging for the patient's transfer.

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

A.3. Relinquishment of Individual Clinical Privileges:

A request to relinquish any individual clinical privilege, whether or not part of the core, must provide a good cause basis for the modification of clinical privileges. All such requests will be processed in the same manner as a request for core/specialty privileges waiver, as described above.

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

A request to resign all clinical privileges must specify the desired date of resignation. If a date is not specified, then the resignation will be considered effective upon receipt of the resignation. Practitioners must complete all medical records and appropriately discharge or transfer responsibility for the care of any hospitalized patient prior to the resignation's effective date, otherwise, the practitioner will be deemed to have been out of good standing at the time of resignation and this designation may be transmitted to querying hospitals. If the practitioner is scheduled for inpatient or call responsibilities prior to resignation, the practitioner must either (a) specify a date for resignation that goes into effect after the fulfillment of those responsibilities, or (b) arrange alternative coverage. Failure to fulfill or ensure coverage for call or other scheduled responsibilities shall result in the practitioner being deemed out of good standing at the time of resignation, and this designation may be transmitted to querying hospitals.

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

(a) Requests for clinical privileges to perform either a procedure not currently being performed at the Hospital or a new technique to perform an existing procedure ("new procedure") will not be processed until a determination has been made that

the procedure will be offered by the Hospital and criteria for the clinical privilege(s) have been adopted.

(b) As an initial step in the process, the individual seeking to perform the new procedure will prepare and submit a report to the service chair and the Credentials Committee addressing the following:

(1) minimum education, training, and experience necessary to perform the new procedure safely and competently;

(2) clinical indications for when the new procedure is appropriate;

(3) whether there is empirical evidence of improved patient outcomes with the new procedure or other clinical benefits to patients;

(4) whether proficiency for the new procedure is volume-sensitive and if the requisite volume would be available;

(5) whether the new procedure is being performed at other similar hospitals and the experiences of those institutions; and

(6) whether the Hospital currently has the resources, including space, equipment, personnel, and other support services, to safely and effectively perform the new procedure.

The chair and the Credentials Committee will review this report. The Credentials Committee or the New Technology Committee will conduct additional research as necessary, and make a preliminary recommendation as to whether the new procedure should be offered at the Hospital.

(c) If the preliminary recommendation is favorable, the Credentials Committee or New Technology Committee will then develop, in conjunction with the relevant services, threshold credentialing criteria to determine those individuals who are eligible to request the clinical privileges. In developing the criteria, the committees may conduct additional research and consult with experts, as necessary, and develop recommendations regarding:

(1) the minimum education, training, and experience necessary to perform the procedure or service;

(2) the clinical indications for when the procedure or service is appropriate;

(3) the extent (time frame and mechanism) of focused monitoring and supervision that should occur if the privileges are granted; and

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

(d) The Credentials Committee will forward its recommendations to the Medical Executive Committee, which will review the matter and forward its recommendations to the Governing Body for final action.

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

(a) Requests for clinical privileges that previously have been exercised only by members in another specialty will not be processed until the steps outlined in this section have been completed and a determination has been made regarding the member's eligibility to request the clinical privilege(s) in question.

(b) As an initial step in the process, the individual seeking the privilege will submit a report to the Credentials Committee that specifies the minimum qualifications needed to perform the procedure safely and competently, whether the individual's specialty is performing the clinical privilege at other similar hospitals, and the experiences of those other hospitals.

(c) The Credentials Committee, Multi-Specialty Privileges Committee, or an ad hoc committee will then conduct additional research and consult with experts, as necessary, including those on the Medical Staff (e.g., chairs, individuals on the Medical Staff with special interest and/or expertise) and those outside the Hospital (e.g., other hospitals, residency training programs, specialty societies).

(d) The Credentials Committee, in consultation with the Multi-Specialty Privileges Committee, may or may not recommend that individuals from different specialties be permitted to request the clinical privileges at issue. If it does, the committees, in conjunction with the relevant specialties, may develop recommendations regarding:

(1) the minimum education, training, and experience necessary to perform the clinical privileges in question;

(2) the clinical indications for when the procedure is appropriate;

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

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

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

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

(e) The Credentials Committee will forward its recommendations to the Medical Executive Committee, which will review the matter and forward its recommendations to the Governing Body for final action.

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

(a) For any otherwise healthy patient, dentists and oral and maxillofacial surgeons may admit the patient and perform a complete admission history and physical examination, and assess the medical risks of the procedure on the patient, if they are deemed qualified to do so by the Credentials Committee and Medical Executive Committee and granted privileges to do so. They must, nevertheless, have an agreement with a physician on the Medical Staff (established and declared in advance) who is available to respond should any medical issue arise with the patient.

(b) For all other patients, a medical history and physical examination of the patient will be made and recorded by a physician who is a member of the Medical Staff before dental or oral surgery may be performed. In addition, a designated physician will be responsible for the medical care of the patient throughout the period of hospitalization.

(c) The dentist or oral and maxillofacial surgeon will be responsible for the oral surgery care of the patient, including the appropriate history and physical examination, as well as all other appropriate elements of the patient's record. Dentists and oral and maxillofacial surgeons may write orders within the scope of their licenses and consistent with relevant Hospital policies and rules and regulations.

4.A.8. Clinical Privileges for Podiatrists:

(a) For any otherwise healthy patient, podiatrists may admit the patient and perform a complete admission history and physical examination, and assess the medical risks of the procedure on the patient, if they are deemed qualified to do so by the Credentials Committee and Medical Executive Committee and granted privileges to do so. They must, nevertheless, have an agreement with a physician on the Medical Staff (established and declared in advance) who is available to respond should any medical issue arise with the patient.

(b) For all other patients, a medical history and physical examination of the patient will be made and recorded by a physician who is a member of the Medical Staff before podiatric surgery will be performed. In addition, a designated physician will be responsible for the medical care of the patient throughout the period of hospitalization.

(c) The podiatrist will be responsible for the podiatric care of the patient, including the podiatric history and the podiatric physical examination, as well as all appropriate elements of the patient's record. Podiatrists may write orders which are within the

scope of their license and consistent with relevant Hospital policies and rules and regulations.

4.A.9. Telemedicine Privileges:

(a) Telemedicine is the provision of clinical services to patients by practitioners from a distance, exclusively via electronic communications.

(b) Requests for initial or renewed telemedicine privileges will be processed through one of the following options, as determined by the President in consultation with the Chief of Staff:

(1) A request for telemedicine privileges may be processed through the same process for Medical Staff and Allied Health Professional applications, as set forth in this Policy. In such case, the individual must satisfy all qualifications and requirements set forth in this Policy, except those relating to geographic location, coverage arrangements, and emergency call responsibilities.

(2) If the individual requesting telemedicine privileges is practicing at a distant hospital that participates in Medicare or a telemedicine entity (as that term is defined by Medicare), and the hospital or telemedicine entity is accredited by the Joint Commission, a request for telemedicine privileges may be processed using an alternative process that relies on the credentialing and privileging decisions made by the distant hospital or telemedicine entity. In such cases, the Hospital must ensure through a written agreement that the distant hospital or telemedicine entity complies with all applicable Medicare regulations and accreditation standards. The distant hospital or telemedicine entity must provide:

(i) confirmation that the practitioner is licensed in the state where the Hospital is located;

(ii) a current list of privileges granted to the practitioner;

(iii) information indicating that the applicant has actively exercised the relevant privileges during the previous 12 months and has done so in a competent manner;

(iv) a signed attestation that the applicant satisfies all of the distant hospital or telemedicine entity's qualifications for the clinical privileges granted;

(v) a signed attestation that all information provided by the distant hospital or telemedicine entity is complete, accurate, and up-to-date; and

(vi) any other attestations or information required by the agreement or requested by the Hospital.

(c) This information received about the individual requesting telemedicine privileges will be provided to the Medical Executive Committee for review and recommendation and to the Board for final action. Notwithstanding the process set forth in this subsection, the Hospital may determine that an applicant for telemedicine privileges is ineligible for appointment or clinical privileges if the applicant fails to satisfy the threshold eligibility criteria set forth in this Policy.

(d) Additionally, the Hospital will independently query the relevant California licensing board, the National Practitioner Data Bank, and the Medicare Office of Inspector General.

(e) Telemedicine privileges, if granted, will be for a period of not more than one year initially and then not more than two years at reappointment.

(f) Individuals granted telemedicine privileges will be subject to the Hospital's peer review activities. The results of the peer review activities, including any adverse events and complaints filed about the practitioner providing telemedicine services from patients, other practitioners or staff, will be shared with the hospital or entity providing telemedicine services. Those granted telemedicine privileges may have Focused Professional Practice Evaluations and Ongoing Professional Practice Evaluations completed by external review by the distant site.

(g) Telemedicine privileges granted in conjunction with a contractual agreement will be incident to and coterminous with the agreement. If clinical privileges are granted based on those held at the distant-site or telemedicine entity, then if the distant hospital or telemedicine entity informs the Hospital that the practitioner's privileges have been suspended or restricted at the distant site or telemedicine site, the practitioner's privileges will likewise be automatically suspended and restricted at the Hospital, without a right to a hearing under the Medical Staff Bylaws.

4.A.10. Focused Professional Practice Evaluation for Initial Privileges:

(a) All initial grants of clinical privileges, whether at the time of appointment, reappointment, or during the term of an appointment, will be subject to focused professional practice evaluation by the service chair or by a physician(s) designated by the Credentials Committee.

(b) This focused professional practice evaluation may include chart review, monitoring, proctoring, external review, and other information. The clinical activity requirements, including numbers and types of cases to be reviewed, will be determined by the Service Chair and Credentials Committee.

(c) A newly appointed member's appointment and privileges will expire if he or she fails to fulfill the clinical activity requirements for core privileges within the

timeframe recommended by the Credentials Committee. In such case, the individual may not reapply for initial appointment or privileges for one year.

(d) If a member who has been granted additional or special clinical privileges fails to fulfill the clinical activity requirements within the timeframe recommended by the Credentials Committee, the additional clinical privileges will expire and the member may not reapply for the privileges in question for one year.

4.B. TEMPORARY CLINICAL PRIVILEGES

4.B.1. Temporary Clinical Privileges:

(a) Requests for temporary privileges to fulfill an important patient care, treatment, or service need must include:

(i) a description of the need and its immediacy; and,

(ii) a description of the specialized skills and experience required to meet that need.

Those who are responsible for granting temporary privileges shall determine the method of Focused Professional Practice Evaluation which will be utilized.

(b) Temporary privileges may be granted by the Governing Body, pursuant to its own procedures, upon recommendation of the Chief of Staff, to:

(1) applicants for initial appointment whose complete application is pending review by the Medical Executive Committee and Governing Body, following a favorable recommendation of the Credentials Committee. In order to be eligible for temporary clinical privileges, an applicant must have demonstrated ability to perform the clinical privileges requested and have had no (i) current or previously successful challenges to licensure or registration or (ii) involuntary restriction, reduction, denial or termination of membership or clinical privileges at another health care facility.

(2) non-applicants, when there is an important patient care, treatment, or service need, including the following:

(i) the care of a specific patient;

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

(iii) Sudden unexpected absence of a physician who was scheduled to provide critical patient care services unable to be provided by another physician on the Medical Staff;

(iv) Previously unforeseen need for regulatory compliance that would mandate additional physician services;

(c) proctoring; or

(vi) when serving as a locum tenens for a member of the Medical Staff or Allied Health Professional.

(b) The following verified information will be considered prior to the granting of any temporary clinical privileges: current licensure (including any peer review or other actions reported to the licensing board), relevant training, experience, current competence, current professional liability coverage acceptable to the Hospital, and results of a query to the National Practitioner Data Bank.

(c) The grant of temporary clinical privileges will not exceed 120 days.

(d) For non-applicants who are granted temporary locum tenens privileges, the individual may exercise locum tenens privileges for a maximum of 120 days, consecutive or not, anytime during the 24-month period following the grant of privileges, subject to the following conditions:

(1) the individual must notify Medical Staff Administration at least 15 days prior to exercising these privileges (exceptions for shorter notice periods may be considered in situations involving health issues); and

(2) the individual must inform Medical Staff Administration of any change that has occurred to the information provided on the application form for locum tenens privileges.

(e) Prior to any temporary clinical privileges being granted, the individual must agree in writing to be bound by the bylaws, rules and regulations, policies, procedures and protocols of the Medical Staff and the Hospital.

4.C. EMERGENCY SITUATIONS

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

(2) In an emergency situation, a member may administer treatment to the extent permitted by his or her license, regardless of service status or specific grant of clinical privileges.

(3) When the emergency situation no longer exists, the patient will be assigned by the service chair or the Chief of Staff to a member with appropriate clinical privileges, considering the wishes of the patient.

4.D. DISASTER PRIVILEGES

(1) When the disaster plan has been implemented and the immediate needs of patients in the Hospital cannot be met, the President or the Chief of Staff may use a modified credentialing process to grant disaster privileges to eligible volunteer Licensed Independent Practitioners ("volunteers"). Safeguards must be in place to verify that volunteers are competent to provide safe and adequate care. Volunteers will complete the appropriate forms for disaster privileges.

(2) Disaster privileges are granted on a case-by-case basis after verification of identity and licensure.

(a) A volunteer's identity may be verified through a valid government-issued photo identification (i.e., driver's license or passport).

(b) A volunteer's license may be verified in any of the following ways: (1) current Hospital picture ID card that clearly identifies the individual's professional designation; (2) current license to practice; (3) primary source verification of the license; (4) identification indicating that the individual has been granted authority to render patient care in disaster circumstances or is a member of a Disaster Medical Assistance Team, the Medical Resource Corps, the Emergency System for Advance Registration of Volunteer Health Professionals, or other recognized state or federal organizations or groups; or (5) identification by a current Hospital employee or Medical Staff or Allied Health Professional who possesses personal knowledge regarding the individual's ability to act as a volunteer during a disaster.

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

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

(5) The Medical Staff will oversee the care provided by volunteer Licensed Independent Practitioners. Each practitioner will be assigned to a Service Line and a designated member of the Medical Staff. This oversight will be conducted through direct observation, mentoring, clinical record review, or other appropriate mechanism developed by the Medical Staff and Hospital.

(6) Medical Staff Administration will retain the disaster privileges form, verifications, approvals and other documentation of the volunteer's participation.

4.E. CONTRACTS FOR SERVICES

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

(2) To the extent that any such contract or arrangement confers the exclusive right to perform specified services to one or more practitioners or groups of practitioners, no other practitioners except those authorized by or pursuant to the contract or arrangement may exercise clinical privileges to perform the specified services while the contract is in effect. This means that only practitioners so authorized are eligible to apply for appointment or reappointment to the Medical Staff and for the clinical privileges in question. No other applications will be processed.

(3) Prior to the Hospital entering into any exclusive contract described in paragraph (2) in a specialty area that has not previously been subject to such a contract or arrangement, the Governing Body will initiate a notice-and-comment process consistent with state law requirements. The Medical Executive Committee shall provide input to the Governing Body as part of this process, and the medical staff shall have the opportunity to provide input to the Medical Executive Committee or the Governing Body.

(4) A decision to close or continue closure of a department or service pursuant to an exclusive contract or to transfer an exclusive contract shall result in the automatic termination of the practitioner's privileges that are covered by the exclusive contract to which the practitioner is not a party or third party beneficiary. The practitioner shall not be entitled to a hearing or appeal to challenge this termination.

ARTICLE 5

PROCEDURE FOR REAPPOINTMENT

5.A. PROCEDURE FOR REAPPOINTMENT

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

5.B. REAPPOINTMENT CRITERIA

5.B.1. Eligibility for Reappointment:

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

(a) completed all medical records;

(b) completed all continuing medical education requirements;

(c) satisfied all Medical Staff and Allied Health Staff responsibilities, including payment of any dues, fines, and assessments;

(d) continued to meet all qualifications and criteria for appointment and the clinical privileges requested;

(e) paid any applicable reappointment processing fee, dues or other assessments; and

(f) had sufficient patient contacts to enable the assessment of current clinical judgment and competence for the privileges requested. Any member seeking reappointment who has minimal activity at the Hospital must submit such information as may be requested (such as a copy of his or her confidential quality profile from his or her primary hospital, clinical information from his or her private office practice, or a quality profile from a managed care organization or insurer) before the application will be considered complete and processed further.

5.B.2. Factors for Evaluation:

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

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

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

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

(d) any focused professional practice evaluations;

(e) verified complaints received from patients or staff; and

(f) other reasonable indicators of continuing qualifications.

5.C. REAPPOINTMENT PROCESS

5.C.1. Reappointment Application Form:

(a) Appointment terms will not extend beyond two years.

(b) An application for reappointment will be furnished to members at least three months prior to the expiration of their current appointment term. A completed reappointment application form must be returned to Medical Staff Administration within 30 days.

(c) Failure to return a completed application form within 30 days will result in the assessment of a reappointment processing late fee. Failure to return a completed application form within 60 days of receipt may result in the automatic termination of membership and clinical privileges at the end of the then current term of appointment. In the case of automatic expiration, no hearing and appeal rights will be granted and the practitioner will be required to reapply as an initial applicant if he or she wants privileges at this Hospital. In such cases, the practitioner may submit a reappointment appointment form, rather than an initial application, if submitted within 90 days of expiration.

(d) The application will be reviewed by Medical Staff Administration to determine that all questions have been answered and that the member satisfies all threshold eligibility criteria for reappointment and for the clinical privileges requested.

(e) Medical Staff Administration will oversee the process of gathering and verifying relevant information. Medical Staff Administration will also be responsible for confirming that all relevant information has been received.

5.C.2. Conditional Reappointments:

(a) Recommendations for reappointment may be subject to an applicant's compliance with specific conditions. These conditions may relate to behavior (e.g., professional code of conduct) or to clinical issues (e.g., general consultation requirements, proctoring, completion of CME requirements). Reappointments may be recommended for periods of less than two years in order to permit closer

monitoring of a member's clinical performance, professional conduct, and ongoing qualifications for appointment and privileges.

(b) A recommendation of a conditional reappointment or for reappointment for a period of less than two years does not, in and of itself, entitle a member to request a hearing or appeal.

(c) In the event the applicant for reappointment is the subject of an investigation or a hearing at the time reappointment is being considered, a conditional reappointment for a period of less than two years may be granted pending the completion of that process.

5.C.3. Potential Adverse Recommendation:

(a) If the Credentials Committee or the Medical Executive Committee is considering a recommendation to deny reappointment or to reduce clinical privileges or practice authorization, the committee chair will notify the member of the possible recommendation and invite the member to meet prior to any final recommendation being made.

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

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

(d) This meeting is not a hearing, and none of the procedural rules for hearings will apply. The member will not have the right to be represented by legal counsel at this meeting.

ARTICLE 6

CONCERNS INVOLVING MEDICAL STAFF OR ALLIED HEALTH PROFESSIONALS

6.A. OVERVIEW AND GENERAL PRINCIPLES

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

(a) This Policy empowers Medical Staff Leaders to use various options to address and resolve questions that may be raised about the clinical care by, or conduct of, members of the Medical Staff or Allied Health Professionals. The various options available to Medical Staff Leaders and the mechanisms they may use when questions pertaining to competence, health or behavior are raised are outlined below and include, but are not limited to, the following:

(1) collegial intervention and progressive steps;

(2) ongoing and focused professional practice evaluations;

(3) mandatory meeting;

(4) fitness for practice evaluation (including blood and/or urine test);

(5) automatic relinquishment of appointment and clinical privileges or practice authorization;

(6) leaves of absence;

(7) summary suspension; and

(8) formal investigation.

(b) In addition to these options, Medical Staff Leaders and Hospital Administration also have the discretion to determine whether a matter should be handled in accordance with another policy (e.g., code of conduct policy, practitioner health policy, professional performance evaluation policy) or should be referred to the Medical Executive Committee for further action.

6.A.2. No Recordings of Meetings:

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

are prohibited from making audio or video recordings at such meetings unless authorized to do so in writing by the individual chairing the meeting or by the President.

Notwithstanding the above, Medical Staff Administration personnel may make audio recordings of meetings solely to use as a resource when drafting minutes. To further the goal of maintaining confidentiality and promoting open discussion, Medical Staff Administration's policy shall be to destroy recordings after the minutes have been drafted, unless otherwise instructed by Hospital or Medical Staff legal counsel.

6.A.3. No Right to Counsel:

(a) The processes and procedures outlined in this Article are designed to be carried out in an informal manner. Therefore, lawyers will not be present for any meeting that takes place pursuant to this Article. By agreement of the Chief of Staff and President, an exception may be made to this general rule.

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

6.A.4. No Right to the Presence of Others:

Peer review activities are confidential and privileged to the fullest extent permitted by law. Accordingly, the individual may not be accompanied by friends, relatives or colleagues when attending a meeting that takes place pursuant to this Article. The Chief of Staff may, upon request, grant an exception to this general rule.

6.A.5. Involvement of Supervising Physician in Matters Pertaining to Allied Health Professionals:

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

6.B. COLLEGIAL INTERVENTION AND PROGRESSIVE STEPS

(1) The use of collegial intervention efforts and progressive steps by Medical Staff Leaders and Hospital Administration is encouraged.

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

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

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

(b) counseling, mentoring, monitoring, proctoring, consultation, and education;

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

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

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

(f) Performance Improvement Plans.

6.C. ONGOING AND FOCUSED PROFESSIONAL PRACTICE EVALUATION

(1) Individuals who are initially granted clinical privileges, whether at the time of initial appointment, reappointment, or during the term of appointment, will be subject to focused professional practice evaluation to confirm their competence, in accordance with Hospital policy.

(2) All individuals who provide patient care services at the Hospital will have their care evaluated on an ongoing basis, in accordance with Hospital policy. This ongoing professional practice evaluation process may include an analysis of data to provide feedback and to identify issues in an individual's professional performance, if any.

(3) When concerns are raised about an individual's practice through the ongoing practice evaluation process or through a specialty-specific trigger, a reported concern, or other triggers (i.e., clinical trend or specific case that requires further review, patient complaint, corporate compliance issue, or sentinel event), a focused professional practice evaluation will be undertaken to evaluate the concern.

6.D. MANDATORY MEETING

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

(2) Special notice will be given at least three days prior to the meeting and will inform the individual that attendance at the meeting is mandatory.

(3) Failure of an individual to attend a mandatory meeting may result in an automatic relinquishment of appointment and privileges as set forth below.

6.E. FITNESS FOR PRACTICE EVALUATION

(1) An individual may be requested to submit to an appropriate evaluation (such as blood and/or urine test) or a complete fitness for practice evaluation to determine his or her ability to safely practice.

(2) A request for an evaluation may be made of an applicant during the initial appointment or reappointment processes or of a member during an investigation. A request for an evaluation may also be made when at least two Medical Staff Leaders (or one Medical Staff Leader and one member of the Hospital Administration) are concerned with the individual's ability to safely and competently care for patients.

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

(4) Failure to obtain the requested evaluation may result in an application being withdrawn or an automatic relinquishment of appointment and privileges as set forth below.

6.F. AUTOMATIC RELINQUISHMENT, LIMITATION, AND SUSPENSION

Any of the occurrences described in this Section will constitute grounds for the automatic relinquishment, suspension, or limitation of an individual's appointment and clinical privileges or practice authorization. An automatic relinquishment, suspension, or limitation is considered an administrative action and does not trigger an obligation on the part of the Hospital to file a report to the licensing agency or with the National Practitioner Data Bank, unless statute or regulation requires otherwise. A practitioner whose membership or privileges have been automatically relinquished, suspended or limited shall not be entitled to the hearing and appeal rights provided in this document, unless the hospital must file a report to the licensing agency or a report to the National Practitioner Data Bank.

If a member accumulates 90 consecutive or cumulative days of automatic suspension in a 12-month period, his or her membership and privileges shall by automatically relinquished.

Except as otherwise provided below, an automatic relinquishment, limitation, or suspension of appointment and privileges will be effective immediately upon actual or special notice to the individual.

When the practitioner is not entitled to a formal hearing for an automatic relinquishment, limitation, or suspension, the Medical Executive Committee may provide the practitioner

with an opportunity to be heard by the Medical Executive Committee in any forum or manner that it deems appropriate. The issue before the Medical Executive Committee shall be limited solely to the question of whether or not grounds existed for the automatic relinquishment, suspension, or limitation described in this Section. The Medical Executive Committee shall immediately terminate any action that was based on a material mistake of fact as to the basis for such action; however, an automatic relinquishment, suspension, or limitation based on a material mistake of fact that the Medical Executive Committee later terminates shall not be grounds for a civil action for damages against the Hospital, Governing Body, Medical Staff, or Medical Staff members.

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

Failure of an individual to complete medical records, after notification by the medical records department of delinquency in accordance with applicable policies and rules and regulations, will result in automatic suspension of all clinical privileges, unless the Chief of Staff determines that there is a significant patient care need that requires the practitioner to remain off suspension. The suspension will remain in place until the practitioner completes the medical records or until the practitioner's membership and privileges or practice authorization are automatically relinquished.

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

Failure of an individual to continuously satisfy during appointment any of the threshold eligibility criteria set forth in this Policy will result in automatic suspension of clinical privileges or practice authorization. The suspension will remain in place until the individual satisfies the eligibility criteria or until the practitioner's membership and privileges are automatically relinquished.

6.F.3. Criminal Activity:

The occurrence of specific criminal actions may result in the automatic relinquishment or suspension of appointment and clinical privileges or practice authorization, as described below. Specifically, an arrest, charge, or indictment shall result in an automatic suspension until the MEC meets and reviews the situation and determines a course of action; and, a conviction, plea of guilty or plea of no contest shall result in an automatic relinquishment, if the matter pertains to an alleged felony or misdemeanor involving any of the following: (a) Medicare, Medicaid, or other federal or state governmental or private third-party payer fraud or program abuse; (b) controlled substances; (c) illegal drugs; (d) violent act; (e) sexual misconduct; (f) moral turpitude; or (g) child, dependent adult, or elder abuse. Notwithstanding any other provision in this article, if the practitioner is suspended pursuant to this section as a result of an arrest, charge, or indictment, the suspension will remain in place and not result in an automatic termination until (a) the MEC lifts the suspension, or (b) charges are not filed or are dropped, or (c) the practitioner is otherwise cleared of the charges, at which point the suspension shall be lifted, or (d) the practitioner is convicted or pleads guilty or no contest, at which point, the practitioner's membership and privileges are automatically relinquished.

6.F.4. Failure to Provide Information:

(a) Failure of an individual to notify the Chief of Staff of any change in any information provided on an application for initial appointment or reappointment shall result in the automatic relinquishment of appointment and clinical privileges or practice authorization.

(b) Failure of an individual to provide information pertaining to an individual's qualifications for appointment or clinical privileges in response to a written request from the Credentials Committee, the Medical Executive Committee, or any other authorized committee shall result in the automatic suspension of appointment and clinical privileges until the information is provided to the satisfaction of the requesting party, or until the practitioner's membership and privileges are automatically relinquished.

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

Failure to attend a mandatory meeting requested by the Medical Staff Leaders or Hospital Administration, after appropriate notice has been given shall result in the automatic suspension of appointment and clinical privileges or practice authorization. The suspension will remain in effect until the individual attends the mandatory meeting (as rescheduled) or until the practitioner's membership and privileges are automatically relinquished.

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

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

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

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

(b) Failure of a member to undergo a requested fitness for practice evaluation or to execute any of the required releases (i.e., to allow the Medical Staff Leaders, or the relevant committee, to discuss with the health care professional(s) the reasons for the evaluation and to allow the health care professional to report the results to the Medical Staff Leaders or relevant committee) will result in the automatic suspension of appointment and privileges until the practitioner undergoes complies

with the requirement or until the practitioner's membership and privileges or practice authorization are automatically relinquished.

6.F.8. Failure to Pay Dues/Assessments

Failure, without good cause as determined solely by the Medical Executive Committee, to pay dues or assessments, shall result in the automatic suspension of a member's clinical privileges until such dues or assessments are paid, or until the member's privileges are automatically relinquished.

6.F.9. Failure to Execute Releases

Failure to execute a release requested by a Medical Staff Officer or the Medical Executive Committee within 30 days after the request is made shall result in the automatic suspension of a member's clinical privileges until the release is executed or until the member's privileges are automatically relinquished.

6.F.10 Automatic Termination Of Telemedicine Staff Membership And Clinical Privileges

(a) Privileges and membership granted to Telemedicine Staff members may be revoked or limited in a manner consistent with the Bylaws and Credentialing Policy, including those articles and sections that address corrective action and hearing and appeal rights. However, no hearing and appeal rights shall be granted to practitioners whose membership and privileges are terminated, revoked, suspended or limited for reasons detailed in subsections (b) or (c) below.

(b) Telemedicine Staff membership and Clinical Privileges granted in full reliance on the credentialing and clinical privileging decisions of a distant-site hospital or telemedicine entity shall terminate automatically in the event that: (1) the practitioner's medical staff membership and/or clinical privileges at such hospital or telemedicine entity are revoked, suspended, limited or voluntarily relinquished; (2) the practitioner's license to practice medicine in this State is revoked, expired, suspended, or restricted; or (3) such hospital or telemedicine entity no longer has a valid written agreement with the Hospital. Practitioners whose Telemedicine Staff and Clinical Privileges are terminated, revoked, suspended or limited in this manner shall not be entitled to any hearing and appeal procedural rights under these Bylaws.

6.F.11 Reinstatement from Automatic Suspension or Automatic Relinquishment:

(a) If an individual believes that the matter leading to the automatic relinquishment of appointment and privileges has been resolved within 60 days of the relinquishment, the individual may request an application for membership and privileges.

(b) If requested within 60 days following the relinquishment, the individual will be permitted to submit an application for reappointment. If the application is submitted within 90 days of relinquishment, it will be processed as a reappointment rather than an initial application. If processed in this manner, the individual will not be subject to the initial FPPE process.

6.G. LEAVES OF ABSENCE

6.G.1. Initiation:

(a) A leave of absence of up to one year must be requested in writing and submitted to the Chief of Staff. The request should, when possible, state the beginning and ending dates and the reasons for the leave. Except in extraordinary circumstances, the request will be submitted at least 30 days prior to the anticipated start of the leave.

(b) The Chief of Staff will determine whether a request for a leave of absence will be granted, after consulting with the relevant service chair. The granting of a leave of absence or reinstatement may be conditioned upon the individual's completion of all medical records.

(c) Members of the Medical Staff or Allied Health Staff must report to the Chief of Staff any time they are away from Medical Staff, Allied Health Professional, or patient care responsibilities for longer than 30 days and the reason for such absence is related to their physical or mental health or otherwise to their ability to care for patients safely and competently. Upon becoming aware of such circumstances, the Chief of Staff, may trigger an automatic medical leave of absence at any point after becoming aware of the Medical Staff member's absence from patient care.

(d) Leaves of absence are matters of courtesy, not of right. In the event that it is determined that an individual has not demonstrated good cause for a leave, or where a request for extension is not granted, the determination will be final, with no recourse to a hearing and appeal.

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

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

6.G.3. Reinstatement:

(a) Individuals requesting reinstatement will submit a written summary of their professional activities during the leave and any other information that may be requested by the Hospital. Requests for reinstatement will then be reviewed by the relevant service chair, the chair of the Credentials Committee and the Chief of Staff.

(b) If a favorable recommendation on reinstatement is made, the individual may immediately resume clinical practice. However, if any of the individuals reviewing the request have any questions, those questions will be noted and the reinstatement request will be forwarded to the full Credentials Committee, Medical Executive Committee, and Governing Body.

(c) If the leave of absence was for health reasons (except for maternity leave), the request for reinstatement must be accompanied by a report from the individual's physician indicating that the individual is capable of resuming a hospital practice and safely exercising the clinical privileges requested.

(d) Absence for longer than one year will result in resignation of Medical Staff or Allied Health Staff appointment and clinical privileges unless an extension is granted by the Chief of Staff. Extensions will be considered only in extraordinary cases where the extension of a leave is in the best interest of the Hospital.

(e) If an individual's current appointment is due to expire during the leave, the individual's appointment and clinical privileges will expire at the end of the appointment period, unless the individual applies for and is granted reappointment.

6.H. SUMMARY SUSPENSION OR RESTRICTION OF CLINICAL PRIVILEGES OR PRACTICE AUTHORIZATION

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

(a) Whenever failure to take action may result in imminent danger to the health and/or safety of any individual, the Chief of Staff, the Chief of Staff-Elect, Immediate Past Chief of Staff, the relevant Service chair, the Chief Medical Officer, or the Medical Executive Committee, is authorized to (1) afford the individual an opportunity to voluntarily refrain from exercising clinical privileges while the matter is being reviewed;* or (2) summarily suspend or restrict all or any portion of an individual's clinical privileges or practice authorization.

* An agreement to voluntarily refrain from exercising privileges in such situations may require an 805 report if it extends for a cumulative total of 30 days or more for any 12-month period and is agreed to on the basis of a medical disciplinary cause or reason.

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

(c) Summary suspension is an interim step in the professional review activity and does not imply any final finding regarding the concerns supporting the suspension.

(d) A summary suspension is effective immediately and will be promptly reported to the President and the Chief of Staff. A summary suspension will remain in effect unless it is modified by the Medical Executive Committee.

(e) Within three days of the imposition of a suspension, the individual will be provided with a brief written description of the reason(s) for the action, including the names and medical record numbers of the patient(s) involved (if any). The notice will advise the individual that suspensions lasting longer than 14 days will result in an 805 report and that suspensions lasting longer 30 days must be reported to the National Practitioner Data Bank.

(f) The relevant Supervising Physician will be notified when the affected individual is an Allied Health Professional.

(g) If the persons identified in section 6.H.1(a) are not available to summarily restrict or suspend the member's membership or clinical privileges, the Governing Body (or designee) may immediately suspend a member's privileges if a failure to suspend those privileges is likely to result in an imminent danger to the health of any person, provided that the Governing Body (or designee) made reasonable attempts to contact the persons identified in section 6.H.1(a) before the suspension.

Such a suspension is subject to ratification by the Medical Executive Committee. If the Medical Executive Committee does not ratify such a summary suspension within two working days, excluding weekends and holidays, the summary suspension shall terminate automatically. If the Medical Executive Committee does ratify the summary suspension, the provisions below will apply.

6.H.2. Medical Executive Committee Procedure:

(a) Within a reasonable time, not to exceed 14 days of the imposition of the suspension, the Medical Executive Committee will review the reasons for the suspension.

(b) As part of this review, the individual will be invited to meet with the Medical Executive Committee. In advance of the meeting, the individual may submit a written statement and other information to the Medical Executive Committee.

(c) At the meeting, the individual may provide information to the Medical Executive Committee and should respond to questions that may be raised by committee members. The individual may also propose ways, other than summary suspension, to protect patients, employees or others while the matter is being reviewed.

(d) After considering the reasons for the suspension and the individual's response, if any, the Medical Executive Committee will determine whether the summary suspension should be continued, modified, or lifted. The Medical Executive Committee may also determine whether to begin an investigation.

(e) If the Medical Executive Committee decides to continue the suspension, it will send the individual written notice of its decision, including the basis for it.

(f) There is no right to a hearing based on the imposition or continuation of a summary suspension, unless it results in an 805 Report. The procedures outlined above are deemed to be fair under the circumstances.

(g) Upon the imposition of a summary suspension, the Chief of Staff will assign responsibility for the care of any hospitalized patients to another individual with appropriate clinical privileges or practice authorization. Whenever possible, consideration will be given to the wishes of the patient in the selection of a covering physician.

6.I. INVESTIGATIONS

6.I.1. Initial Review:

(a) Whenever a serious question has been raised, or where collegial efforts have not resolved an issue regarding the following, the matter may be referred to the Chief of Staff, Service chair, the chair of a standing committee, or the Chief Medical Officer:

(1) clinical competence or clinical practice, including patient care, treatment or management;

(2) the safety or proper care being provided to patients;

(3) the known or suspected violation of applicable ethical standards or the bylaws, policies, rules and regulations of the Hospital or the Medical Staff; or

(4) conduct that is considered lower than the standards of the Hospital or disruptive to the orderly operation of the Hospital, its Medical Staff or its Allied Health Professionals, including the inability of the member to work harmoniously with others.

(b) In addition, if the Governing Body becomes aware of information that raises concerns about the qualifications of any Medical Staff or Allied Health Professional, the matter will be referred to the Chief of Staff or the Chief Medical Officer.

(c) The person to whom the question is referred will make a sufficient inquiry to determine whether the question is credible and, if so, may forward it to the Medical Executive Committee. If the question pertains to an Allied Health Professional, the Supervising Physician may also be notified.

(d) To preserve impartiality, the person to whom the matter is directed will not be a member of the same practice as, or a relative of, the person that is being reviewed, unless such restriction is deemed not practicable, appropriate, or relevant by the Chief of Staff.

(e) No action taken pursuant to this section will constitute an investigation.

6.I.2. Initiation of Investigation:

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

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

(c) Notwithstanding the above, whenever information suggests that corrective action may be warranted, the Chief of Staff may, on behalf of the Medical Executive Committee, immediately investigate and conduct whatever interviews may be indicated. The information developed during this initial review shall be presented to the Medical Executive Committee, which may decide whether or not to initiate a formal investigation or to recommend corrective action.

(d) If the Medical Executive Committee fails to investigate or take disciplinary action contrary to the weight of the evidence, the Governing Body may direct the Medical Executive Committee to initiate investigation or disciplinary action, but only after consultation with the Medical Executive Committee. If the Medical Executive Committee fails to investigate or take action in response to that Governing Body direction, the Governing Body may investigate and/or initiate corrective action after written notice to the Medical Executive Committee. (Nothing in this subsection shall limit the Governing Body from taking summary action consistent with these Bylaws when the failure to take immediate action may result in the imminent danger to health of any person.)

6.I.3. Investigative Procedure:

(a) Once a determination has been made to begin an investigation, the Medical Executive Committee will investigate the matter itself or appoint an individual or committee ("Investigating Committee") to do so. The Investigating Committee may include individuals not on the Medical Staff or Allied Health Staff. The Investigating Committee will not include any individual who the Medical Executive Committee determines

(1) is in direct economic competition with the individual being investigated;

(2) is professionally associated with or a relative of the individual being investigated; or

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

(b) Whenever the questions raised concern the clinical competence of the individual under review, the ad hoc committee will include a peer of the individual, if possible (e.g., physician, dentist, oral surgeon, or podiatrist).

(c) The individual will be notified of the composition of the Investigating Committee. Within five days of receipt of this notice, the individual must submit any reasonable objections to the service of any Investigating Committee member to the President or the Chief of Staff. The objections must be in writing. The President or the Chief Medical Officer or Chief of Staff will review the objection and determine whether another member should be selected to serve on the Investigating Committee.

(d) The Investigating Committee may:

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

(2) conduct interviews;

(3) use outside consultants, as needed, for timeliness, expertise, thoroughness and objectivity; or

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

(e) As part of the investigation, the individual will have an opportunity to meet with the Investigating Committee. Prior to this meeting, the individual will be informed of the questions being investigated and will be invited to discuss, explain, or refute the questions. A summary of the interview will be made and included with the Investigating Committee's report. This meeting is not a hearing, and none of the procedural rules for hearings will apply. Lawyers will not be present at this meeting.

(f) The Investigating Committee will make a reasonable effort to complete the investigation and issue its report within 30 days, provided that an outside review is not necessary. When an outside review is used, the Investigating Committee will make a reasonable effort to complete the investigation and issue its report within 30 days of receiving the results of the outside review. These time frames are intended to serve as guidelines and, as such, will not be deemed to create any right for an individual to have an investigation completed within such time periods.

(g) At the conclusion of the investigation, the Investigating Committee will prepare a report to the Medical Executive Committee with its findings, conclusions, and recommendations.

6.I.4. Recommendation:

(a) The Medical Executive Committee may accept, modify, or reject any recommendation it receives from an Investigating Committee. Specifically, the Medical Executive Committee may:

(1) determine that no action is justified;

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

(3) impose conditions for continued appointment;

(4) require monitoring, proctoring or consultation;

(5) require additional training or education;

(6) recommend reduction or restriction of clinical privileges or practice authorization;

(7) recommend suspension of clinical privileges for a term;

(8) recommend revocation of appointment or clinical privileges or practice authorization; or

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

(b) A recommendation by the Medical Executive Committee that does not entitle the individual to request a hearing will take effect immediately and will remain in effect unless modified by the Governing Body.

(c) A recommendation by the Medical Executive Committee that would entitle the individual to request a hearing will be forwarded to the Chief of Staff, who will promptly inform the individual by special notice. The recommendation will not be forwarded to the Governing Body until after the individual has completed or waived a hearing and appeal.

(d) If the Governing Body makes a modification to the recommendation of the Medical Executive Committee that would entitle the individual to request a hearing, the Chief of Staff will inform the individual by special notice. No final action will occur until the individual has completed or waived a hearing and appeal.

ARTICLE 7

CONDITIONS OF PRACTICE APPLICABLE TO
ALLIED HEALTH PROFESSIONALS

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

7.A.1. Standards of Practice for the Utilization of Allied Health Practitioners (AHP)

(a) AHPs are not permitted to function independently in any Hospital setting. As a condition of being granted permission to practice at the Hospital, all AHPs specifically agree to abide by the standards of practice set forth in this Section. In addition, as a condition of being permitted to utilize the services of AHPs in the Hospital, all Medical Staff members who serve as Supervising Physicians to such individuals also specifically agree to abide by the standards set forth in this Section.

(b) The following standards of practice apply to the functioning of AHPs:

(1) Admitting Privileges. AHPs are not granted admitting privileges and therefore may not admit patients independent of the Supervising Physician.

(2) Consultations. Unless provided for in hospital or Medical Staff Rules and Regulations or policies, AHPs may not independently provide patient consultations in lieu of the practitioners' Supervising Physicians. If allowed, the AHP must be granted the privilege to do so. An AHP may gather data and order tests; however, the Supervising Physician must personally perform the requested consultation within 24 hours (or more timely, as provided in the Rules and Regulations, in the case of any emergency consultation request).

(3) Emergency On-Call Coverage. AHPs may not independently participate in the emergency on-call roster (formally, or informally by agreement with their Supervising Physicians) in lieu of the Supervising Physician. The Supervising Physician (or his or her covering physician) must personally respond to all calls directed to him or her in a timely manner, in accordance with requirements set forth in this Policy. Following discussion with the Emergency Department, the Supervising Physician may direct an AHP to see the patient, gather data, and order tests for further review by the Supervising Physician. However, the Supervising Physician must still personally see the patient when requested by the Emergency Department physician.

(4) Calls Regarding Supervising Physician's Hospitalized Patients. The Supervising Physician must personally respond to all calls directed to him or her in a timely manner.

(5) Daily Inpatient Rounds. An AHP may assist his or her Supervising Physician in fulfilling his or her responsibility to round daily on all inpatients for whom the Supervising Physician is the designated attending physician, as appropriate. However, such rounds will not replace rounds required by the Rules & Regulations.

(c) Allied Health Professionals must always practice in compliance with the recommendations and policies of the Interdisciplinary Practice Committee.

7.A.2. Oversight by Supervising Physician:

(a) AHPs may function in the Hospital only so long as they have a Supervising Physician.

(b) Any activities permitted to be performed at the Hospital by an AHP will be performed only under the oversight of the Supervising Physician.

(c) If the Medical Staff appointment or clinical privileges of a Supervising Physician are resigned, revoked or terminated, or the AHP fails, for any reason, to maintain an appropriate supervision relationship with a Supervising Physician as defined in this Policy, the AHP's clinical privileges will be automatically suspended, unless he or she has another Supervising Physician who has been approved as part of the credentialing process. The suspension shall remain in place until the AHP has an approved Supervising Physician. If the suspension lasts for more than 90 days, the AHP's membership and privileges shall be automatically relinquished.

(d) As a condition of clinical privileges or practice authorization, an AHP and the Supervising Physician must provide the Hospital with notice of any revisions or modifications that are made to the agreements between them. (The agreement cannot supersede the delineation of privileges granted to the AHP. This notice must be provided to Medical Staff Administration within three days of any such change.

7.A.3. Questions Regarding the Authority of an Advanced Dependent Practitioner or Dependent Practitioner:

(a) Should any member of the Medical Staff, or any employee of the Hospital who is licensed or certified by the state, have a reasonable question regarding the clinical competence or authority of an AHP to act or issue instructions or orders outside the presence of the Supervising Physician, such individual will have the right to request that the Supervising Physician validate, either at the time or later, the instructions of the AHP. Unless patient health and wellbeing requires immediate action, any act, order, or instruction of the AHP will be delayed until such time as the individual with the question has ascertained that the act is clearly within the clinical privileges granted to the individual.

(b) Any question regarding the conduct of an AHP will be reported to the Chief of Staff, the chair of the Credentials Committee, the relevant service chair, or the Chief

Medical Officer, for appropriate action. The individual to whom the concern has been reported will also discuss the matter with the Supervising Physician.

7.A.4. Responsibilities of Supervising Physicians:

(a) Physicians who wish to utilize the services of an AHP in their clinical practice at the Hospital must notify Medical Staff Administration of this fact in advance and must ensure that the individual has been appropriately credentialed in accordance with this Policy before the AHP performs services or engages in any kind of activity in the Hospital.

(b) Supervising Physicians who wish to utilize the services of AHPs specifically agree to abide by the standards of practice set forth in Section 8.A.1 above.

(c) The number of AHPs acting under the supervision of one Medical Staff member, as well as the care they may provide, will be consistent with applicable California statutes and regulations and any other policies adopted by the Hospital.

(d) It will be the responsibility of the Supervising Physician to provide, or to arrange for, professional liability insurance coverage for the AHP in amounts required by the Governing Body. The insurance must cover any and all activities of the AHP in the Hospital. The Supervising Physician will furnish evidence of such coverage to the Hospital. The AHP will act in the Hospital only while such coverage is in effect.

7.B. PROCEDURAL RIGHTS FOR ADVANCED PRACTICE PROFESSIONALS

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

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

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

(c) If the Advanced Practice Professional wants to request a hearing, the request must be in writing, directed to the Chief of Staff, within 30 days after receipt of written notice of the adverse recommendation.

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

7.B.2. Hearing Committee:

(a) If a request for a hearing is made timely, the Chief of Staff will appoint a Hearing Committee composed of up to three individuals (including, but not limited to, members of the Medical Staff, Hospital Administration, individuals not connected with the Hospital, or any combination of these individuals). The Hearing Committee will not include anyone who previously participated in the recommendation, any relatives or practice partners of the Advanced Practice Professional, or any competitors of the affected individual.

(b) The Chief of Staff will appoint a Presiding Officer ("Presiding Officer"), who shall be an attorney who is not also legal counsel to the Hospital or Medical Staff. The role of the Presiding Officer will be to allow the participants in the hearing to have a reasonable opportunity to be heard and to present evidence, subject to reasonable limits on the number of witnesses and duration of direct and cross-examination. The Presiding Officer will maintain decorum throughout the hearing.

(c) As an alternative to a Hearing Committee, the Chief of Staff may appoint an arbitrator to perform the functions that would otherwise be carried out by the Hearing Committee. The arbitrator will be an attorney at law. The arbitrator may not be in direct economic competition with the individual requesting the hearing and will not act as a prosecuting officer or as an advocate to either side at the hearing. In the event an arbitrator is appointed instead of a Hearing Committee, all references in this Article to the Hearing Committee or Presiding Officer will be deemed to refer instead to the arbitrator, unless the context would clearly otherwise require.

7.B.3. Hearing Process:

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

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

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

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

(e) The AHP and the Medical Executive Committee may be represented at the hearing by legal counsel. However, while counsel may be present at the hearing, counsel will not call, examine, or cross-examine witnesses or present the case.

(f) The AHP will have the burden of demonstrating, by clear and convincing evidence, that the recommendation of the Medical Executive Committee was arbitrary, capricious, or not supported by substantial evidence. The quality of care provided to patients and the smooth operation of the Hospital will be the paramount considerations.

(g) The AHP and the Medical Executive Committee will have the right to prepare a post-hearing memorandum for consideration by the Hearing Committee. The Presiding Officer will establish a reasonable schedule for the submission of such memoranda.

7.B.4. Hearing Committee Report:

(a) Within 20 days after the conclusion of the proceeding or submission of the post-hearing memoranda, whichever date is later, the Hearing Committee will prepare a written report and recommendation. The Hearing Committee will forward the report and recommendation, along with all supporting information, by special notice to the AHP and to the Medical Executive Committee.

(b) Within 10 days after notice of such recommendation, the AHP and/or the Medical Executive Committee may make a written request for an appeal. The request must include a statement of the reasons, including specific facts, which justify an appeal.

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

(d) The request for an appeal will be delivered to the President by special notice.

(e) If a written request for appeal is not submitted timely, the appeal is deemed to be waived and the recommendation and supporting information will be forwarded to the Governing Body for final action. If a timely request for appeal is submitted, the President will forward the report and recommendation, the supporting information and the request for appeal to the Governing Body. The chair of the Governing Body will arrange for an appeal.

7.B.5. Appellate Review:

(a) An Appellate Review Committee appointed by the chair of the Governing Body will consider the record upon which the adverse recommendation was made. New or additional written information that is relevant and could not have been made available to the Hearing Committee may be considered at the discretion of the

Appellate Review Committee. This review will be conducted within 30 days after receiving the request for appeal.

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

(c) At the sole discretion of the Appellate Review Committee, the Advanced Practice Professional and a representative of the Medical Executive Committee may also appear personally to discuss their position.

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

(e) The Advanced Practice Professional will receive special notice of the Governing Body's action. A copy of the Governing Body's final action will also be sent to the Medical Executive Committee for information.

7.C. Categories Of Allied Health Practitioner Covered By This Policy

The determination of the categories of Allied Health Professionals permitted to practice in the Hospital rests exclusively with the Governing Board. Hospital Administration or the MEC may request additional categories for consideration. If requested, the MEC will appoint an ad hoc committee to review the relevant issues, and obtain information, including from any interested parties. The MEC will submit the information with their recommendation to the Governing Board for their consideration.

The Allied Health Professionals currently practicing at the Hospital are as follows:

Certified Nurse Midwife
Clinical Nurse Specialist
Nurse Practitioner
Certified Registered Nurse Anesthetist
Registered Nurse First Assist
Physician Assistant
Advanced Practice Pharmacist

ARTICLE 8

CONFLICTS OF INTEREST

(A chart summarizing the following guidelines can be found in **Appendix A** to this Policy.)

8.A.1. General Principles:

(a) All those involved in credentialing and professional practice evaluation activities must be sensitive to potential conflicts of interest in order to be fair to the individual whose qualifications are under review, to protect the individual with the potential conflict, and to protect the integrity of the review process.

(b) It is also essential that peers participate in credentialing and professional practice evaluation review activities in order for these activities to be meaningful and effective. Therefore, whether and how an individual can participate must be evaluated reasonably, taking into consideration common sense and objective principles of fairness.

8.A.2. Immediate Family Members:

No immediate family member (spouse, parent, child, sibling, or in-law) of a practitioner whose application or care is being reviewed shall participate in any aspect of the review process, except to provide information.

8.A.3. Employment by, or Contractual Relationship with, the Hospital:

Employment by, or other contractual arrangement with, the Hospital or an affiliate shall not, in and of itself, preclude an individual from participating in credentialing and professional practice evaluation activities. Rather, participation by such individuals shall be evaluated as outlined in the paragraphs below.

8.A.4. Actual or Potential Conflict Situations:

With respect to a practitioner whose application or care is under review, actual or potential conflict situations involving other members of the Medical Staff include, but are not limited to, the following:

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

(b) the existence of a physician-patient relationship (including situations where the individual under review is the treating physician as well as when the individual under review is a patient receiving treatment);

(c) being a direct competitor;

(d) close friendship;

(e) a history of personal conflict;

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

(g) raising the concern that triggered the review; or

(h) prior participation in review of the matter at a previous level.

Any such individual shall be referred to as an "Interested Member" in the remainder of this Article for ease of reference.

8.A.5. Guidelines for Participation in Credentialing and Professional Practice Evaluation Activities:

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

(a) Initial Reviewers. An Interested Member may participate as an initial reviewer as long as there is a check and balance provided by subsequent review by a Medical Staff committee. This applies, but is not limited to, the following situations:

(1) participation in the review of applications for appointment, reappointment, and clinical privileges because of the Credentials Committee's and Medical Executive Committee's subsequent review of credentialing matters; and

(2) participation as case reviewers in professional practice evaluation activities because of a Professional Practice Evaluation Committee's (Peer Review Committee's) subsequent review of peer review matters.

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

(c) Ad Hoc Investigating Committee. Once a formal investigation has been initiated, additional precautions are required. Therefore, an Interested Member may not be appointed as a member of an ad hoc investigating committee, but may be interviewed and provide information to the ad hoc investigating committee if necessary for the committee to conduct a full and thorough investigation.

(d) Medical Executive Committee. An Interested Member will be recused and may not participate as a member of the Medical Executive Committee when the Medical Executive Committee is considering a recommendation that could adversely affect the clinical privileges of a practitioner, subject to the rules for recusal outlined below.

(e) Governing Body. An Interested Member will be recused and may not participate as a member of the Governing Body when the Governing Body is considering a recommendation that could adversely affect the clinical privileges of a practitioner, subject to the rules for recusal outlined below.

8.A.6. Guidelines for Participation in Development of Privileging Criteria:

Recognizing that the development of privileging criteria can have a direct or indirect financial impact on particular physicians, the following guidelines apply. Any individual who has a personal interest in privileging criteria, including criteria for privileges that cross specialty lines or criteria for new procedures, may:

(a) provide information and input to the Credentials Committee or an ad hoc committee charged with development of such criteria;

(b) participate in the discussions or actions of the Credentials Committee or an ad hoc committee charged with development of such criteria because these committees do not make the final recommendation regarding the criteria (however, the Chair of the Credentials Committee or ad hoc committee always has the discretion to recuse an Interested Member in a particular situation, in accordance with the rules for recusal outlined below); but

(c) not participate in the discussions or actions of the Medical Executive Committee when it is considering its final recommendation to the Governing Body regarding the criteria or participate in the final discussions or action of the Governing Body related to the criteria, unless requested to participate in the discussion by the Medical Executive Committee or by the Governing Body.

8.A.7. Rules for Recusal:

(a) When determining whether recusal in a particular situation is required, the Chief of Staff or committee chair shall consider whether the Interested Member's presence would inhibit full and fair discussion of the issue before the committee, skew the recommendation or determination of the committee, or otherwise be unfair to the practitioner under review.

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

(c) Any recusal will be documented in the committee's or Governing Body's minutes.

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

8.A.8. Other Considerations:

(a) Any member of the Medical Staff who is concerned about a potential conflict of interest on the part of any other member, including but not limited to the situations noted in the paragraphs above, must call the conflict of interest to the attention of the Chief of Staff (or to the Chief of Staff-Elect if the Chief of Staff is the person with the potential conflict), or the applicable committee/Governing Body chair. The member's failure to notify will constitute a waiver of the claimed conflict. The Chief of Staff or the applicable committee/Governing Body chair has the authority to make a final determination as to how best to manage the situation, guided by this Article, including recusal of the Interested Member, if necessary.

(b) No staff member has a right to compel the disqualification of another staff member based on an allegation of conflict of interest. Rather, that determination is within the discretion of the Medical Staff Leaders or Governing Body chair, guided by this Article.

(c) The fact that an individual chooses to refrain from participation or is excused from participation in any credentialing or peer review activity, shall not be interpreted as a finding of actual conflict that inappropriately influenced the review process.

ARTICLE 9

AMENDMENTS AND ADOPTION

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

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

Adopted by the Medical Staff: May 8, 2018

Approved by the Governing Body: June 26, 2018

APPENDIX A

CONFLICT OF INTEREST GUIDELINES

Potential Conflicts	Levels of Participation								
	Provide Information	Individual Reviewer Application/ Case	Committee Member					Hearing Panel	Governing Body
			Credentials	Leadership Council	PPEC	MEC	Ad Hoc Investigating		
Hospital Employee	Y	Y	Y	Y	Y	Y	Y	Y	Y
Self or family member	Y	N	R	R	R	R	N	N	R
Treatment relationship*	Y**	N	R	R	R	R	N	N	R
Employment relationship with hospital	Y	Y	Y	Y	Y	Y	Y	Y	Y
Significant financial relationship	Y	M	M	M	M	R	N	N	R
Direct competitor	Y	M	M	M	M	R	N	N	R
Close friends	Y	M	M	M	M	R	N	N	R
History of conflict	Y	M	M	M	M	R	N	N	R
Provided care in case under review (but not subject of review)	Y	M	M	M	M	R	N	N	R
Reviewed at prior level	Y	M	M	M	M	R	N	N	R
Raised the concern	Y	M	M	M	M	R	N	N	R

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

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

N – (red "N") means the individual may not serve in the indicated role.

R – (red "R") means the individual must be recused in accordance with the rules for recusal on the following page.

* A "treatment relationship" exists where an individual participating in a review has a significant and ongoing role in providing health care services to the practitioner under review (e.g., as a primary care practitioner or consultant).

** An individual may provide information that was not obtained through the treatment relationship. However, the individual may provide information that was obtained through the treatment relationship only after obtaining the practitioner's HIPAA-compliant authorization for the disclosure.

Rules for Recusal

- Interested Members must leave the meeting room prior to the committee's or **Governing Body**'s final deliberation and determination, but may answer questions and provide input before leaving.

- If an Interested Member is recused on a particular issue, the recusal shall be specifically documented in the minutes.

- Whenever possible, an actual or potential conflict should be raised and resolved prior to meeting by the committee or **Governing Body** chair, and the Interested Member informed of the recusal determination in advance.

- No Medical Staff member has the RIGHT to demand the recusal of another member – that determination is within the discretion of the Medical Staff Leaders in accordance with these guidelines.

- Voluntarily choosing to refrain from participating in a particular situation is not a finding or an admission of an actual conflict or any improper influence on the process.