cc

PROVIDENCE REGIONAL MEDICAL CENTER EVERETT

CREDENTIALS & PROCEDURAL POLICY

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ARTICLE 1

GENERAL

1.A. DEFINITIONS

Unless otherwise indicated, the following definitions shall apply to terms used in the Medical Staff Bylaws, this Policy, and the Medical Staff Organization Manual:

(1) "ADMINISTRATIVE LEADERSHIP" means the CEO, Chief Medical Officer, or any administrator on call at the Hospital.

(2) "ADVANCED PRACTICE CLINICIAN" means a practitioner credentialed by the Medical Staff as an ARNP, CNM, CRNA, or PA-C. Advanced Practice Clinicians may provide services independently or under the supervision of a physician, consistent with the clinical privileges granted and in accordance with state law and Hospital policy.

(3) "ALLIED HEALTH PROFESSIONAL" means an individual who is qualified by training, experience and current competence in a discipline which the Board, with the MEC's recommendation, has determined by policy to allow to practice in the Hospital and who is credentialed by the MEC and Board, but who does not have voting rights as a Medical Staff member.

(4) "APPOINTMENT" means the granting of membership to the Medical Staff by the Board to one of the defined categories outlined in Article 2 of the Medical Staff Bylaws or the Board granting permission to practice to an Allied Health Professional.

(5) "BOARD" means the Board of Directors of the Hospital or its designated committee.

(6) "CHIEF EXECUTIVE OFFICER" or "CEO" means the individual, irrespective of organizational title, appointed by the Board to act on its behalf in the overall management of the Hospital.

(7) "CHIEF MEDICAL OFFICER" or "CMO" means the individual appointed by the Board to act as the chief medical officer or those with similar positions and titles.

(8) "CLINICAL PRIVILEGES" or "PRIVILEGES" means the authorization granted by the Board of the Hospital to render specific patient care services, for which the Medical Staff Leaders and Board have developed eligibility and other credentialing criteria and FPPE and OPPE standards. There are several types of clinical privileges, including, but not limited to, telemedicine privileges, temporary privileges, and disaster privileges.

(9) "CONFIDENTIAL FILE" means any file, paper or electronic, containing credentialing, privileging, PPE/Peer Review, or quality information related to a Practitioner.

(10) "CORE PRIVILEGES" means a defined grouping of privileges for a specialty or subspecialty that includes the fundamental patient care services that are routinely taught in residency and/or fellowship training for that specialty or subspecialty and which have been determined by the Medical Staff Leaders and Board to require closely related skills and experience.

(11) "DAYS" means calendar days.

(12) "DIVISION CHIEF" means the applicable head of a Medical Staff division at the Hospital.

(13) "HOSPITAL" means Providence Regional Medical Center Everett and any outpatient facilities that bill under the Hospital's Medicare certification number.

(14) "INVESTIGATION" means a non-routine, formal process to review questions or concerns pertaining to a Practitioner. Only the Medical Executive Committee has the authority to initiate and conduct an Investigation. By contrast, the processes that address issues of clinical performance, professional conduct, and health involving Practitioners that utilize collegial efforts or progressive steps do not constitute Investigations.

(15) "MEDICAL STAFF" means all doctors of medicine or osteopathy, podiatrists, dentists, chiropractors, clinical psychologists, optometrists, nurse practitioners, certified nurse midwives, certified nurse anesthetists, physician assistants, doctors of acupuncture and oriental medicine (DAOM), registered nurses first assist, or naturopaths who are credentialed through the Medical Staff and designated as a member of the Medical Staff by the Hospital's Medical Staff and Board.

(16) "MEDICAL STAFF LEADER" means any Medical Staff Officer, Division Chief or Committee Chair.

(17) "MEDICAL STAFF MEMBER" means any *[physician, dentist, oral and maxillofacial surgeon, podiatrist, psychologist, chiropractor, optometrist, nurse practitioner, physician assistant, RNFA, acupuncturist, and naturopath]* who has been granted appointment by the Board at the Hospital.

(18) "MEDICAL STAFF SERVICES" means the Medical Staff Office at the Hospital or any delegated Credentials Verification Office ("CVO").

(19) "NOTICE" means written communication by regular U.S. mail, Hospital mail, hand delivery, e-mail, facsimile, website, or other electronic method.

(20) "PRACTITIONER" means any individual who has been granted clinical privileges and/or membership by the Board, including doctor of medicine or osteopathy, podiatrist, dentist, chiropractor, clinical psychologist, optometrist, nurse practitioner, certified nurse midwife, certified nurse anesthetist, physician assistant, doctors of acupuncture and oriental medicine (DAOM), registered nurse first assist, or naturopath

(21) "PROVIDENCE SWEDISH" means the hospitals and related facilities and entities of Providence Swedish.

(22) "REAPPOINTMENT" means the granting of continued appointment to the Medical Staff by the Board or Board granting continued permission to practice as an Allied Health Professional.

(23) "RESTRICTION" means a professional review action that:

(a) is recommended by the Medical Executive Committee as part of an Investigation or agreed to by the Practitioner while he or she is under Investigation or in exchange for the Medical Executive Committee not conducting an Investigation or taking an adverse professional review action; <u>and</u>

(b) limits the individual's ability to independently exercise his or her clinical judgment (i.e., a mandatory concurring consulting requirement in which the consultant must approve the course of treatment in advance or a proctoring requirement in which the proctor must be present for the case and has the authority to intervene in the case, if necessary).

Restrictions do not include the following, whether recommended by the Medical Executive Committee or by any other Medical Staff committee:

(a) general consultation requirements, in which the Practitioner agrees to seek input from a consultant prior to providing care;

(b) observational proctoring requirements, in which the Practitioner agrees to have a proctor present to observe his or her provision of care; and

(c) other collegial performance improvement efforts, including informational letters, educational letters, or Performance Improvement Plans that are suggested by the Medical Staff leadership and voluntarily agreed to by the Practitioner as a part of the routine PPE process.

(24) "SPECIAL NOTICE" means hand delivery, certified mail (return receipt requested), or overnight delivery service providing receipt.

(25) "SPECIAL PRIVILEGES" means clinical privileges that fall outside of the core privileges for a given specialty, which require additional education, training, and/or experience beyond that required for core privileges in order to demonstrate competence.

(26) "VOTING STAFF" means those practitioners who have been given the right to vote in all general and special meetings of the Medical Staff. Voting rights are defined in the prerogatives of each Medical Staff category in Article 2 of the Medical Staff Bylaws.

1.B. DELEGATION OF FUNCTIONS

(1) When a function under this Policy is to be carried out by one of the individuals identified in the prior subsection, by a member of Administrative Leadership, by a Medical Staff member, or by a Medical Staff committee, the individual, or the committee through its chair, may delegate performance of the function to a qualified designee who is a Practitioner or Hospital employee (or a committee of such individuals). Any such designee must treat and maintain all information in a strictly confidential manner and is bound by all other terms, conditions, and requirements of this Policy. In addition, the delegating individual or committee is responsible for ensuring that the designee appropriately performs the function in question. Any documentation created by the designee are records of the committee that is ultimately responsible for the review in a particular matter.

(2) When an individual assigned a function under this Policy is unavailable or unable to perform that function, one or more Medical Staff Leaders may perform the function personally or delegate it to another appropriate individual as set forth above.

1.C. SUBSTANTIAL COMPLIANCE

While every effort will be made to comply with all provisions of this Policy, technical or minor deviations from the procedures set forth within this Policy do not invalidate any review or action taken.

ARTICLE 2

QUALIFICATIONS, CONDITIONS, AND RESPONSIBILITIES

2.A. QUALIFICATIONS

2.A.1. Threshold Eligibility Criteria:

To be eligible to apply for initial appointment, reappointment, and/or clinical privileges and as a condition of maintaining ongoing appointment and/or clinical privileges, individuals must satisfy the applicable eligibility criteria:

(a) have a current, unrestricted license to practice in Washington (or be in the process of successfully obtaining such a license if a new applicant) that is not subject to any restrictions, conditions or probationary terms;

(b) not currently be under investigation by any state licensing agency and have never had a license to practice denied, revoked, restricted or suspended by any state licensing agency;

(c) where applicable to their practice, have a current, unrestricted DEA registration and state-controlled substance license and have never had a DEA registration or state-controlled substance license denied, revoked, restricted or suspended;

(d) have current, valid professional liability insurance coverage in a form and in amounts satisfactory to the Hospital;

(e) not currently under indictment or have not been convicted of, or entered a plea of guilty or no contest to Medicare, Medicaid, or other federal or state governmental or private third-party payer fraud or program abuse, nor have been required to pay civil monetary penalties for the same;

(f) have not been, and are not currently, excluded, precluded, or debarred from participation in Medicare, Medicaid, or other federal or state governmental health care program;

(g) have not been terminated from a post-graduate training program for reasons related to clinical competence or professional conduct (residency or fellowship or a similarly equivalent program for other categories of Practitioners), nor resigned from such a program during an investigation or in exchange for the program not conducting an investigation;

(h) have not had appointment or clinical privileges denied, suspended, revoked, or terminated by any health care facility or health plan, including this Hospital, for reasons related to clinical competence or professional conduct;

(i) have not resigned appointment or relinquished clinical privileges during an Investigation or in exchange for not conducting such an Investigation, including this Hospital;

(j) not currently be under indictment or have not been convicted of, or entered a plea of guilty or no contest to, any felony; or to any misdemeanor relating to (i) controlled substances, (ii) illegal drugs, (iii) insurance or health care fraud or abuse, (iv) child abuse, (v) elder abuse, (vi) violence, (vii) sexual misconduct, or (viii) abusing the Practitioner-patient relationship;

(k) have appropriate coverage arrangements ("appropriate coverage" means coverage by another credentialed Practitioner with appropriate specialty-specific privileges as determined by the Credentials Committee) with other Practitioners for those times when the individual will be unavailable;

(l) demonstrate recent clinical activity in their primary area of practice during the last year;

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

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

(o) document compliance with any immunization, vaccination, and/or health screening requirements as may be adopted by the MEC, the Hospital, or Providence Swedish (e.g., TB testing, mandatory flu vaccines, and infectious agent exposures);

(p) agree to serve on the on-call roster for their specialty as may be requested during the term of their appointment;

(q) have completed all professional education requirements relevant to their practice/specialty;

(r) be certified in their primary area of practice at the Hospital by the appropriate specialty/subspecialty board (See **Appendix A** for board certification requirements); and

(s) in the case of PA-C, have a written collobortaive agreement, as applicable, with a supervising physician, that meets all applicable requirements of state law and Hospital policy.

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

(a) Any applicant who does not satisfy one or more of the threshold eligibility criteria outlined above 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 (i) that he or she is otherwise qualified, and (ii) circumstances exist such that the criteria in question does not reflect on an otherwise qualified provider's ability to practice successfully and safely in this hospital.

(b) A request for a waiver shall be submitted to the Credentials Committee for consideration. In reviewing the request for a waiver, the Credentials Committee may consider the specific qualifications of the applicant in question, including the application form and any additional information submitted, input from the relevant Division Chief, and the best interests of the Hospital and the communities it serves. The Credentials Committee will forward its recommendation to the MEC. Any recommendation to grant a waiver must include the specific basis for the recommendation while remaining respectful of the provider in question, presenting relevant information in a discreet manner with as much confidentiality as the discussion will allow.

(c) The MEC shall review the recommendation of the Credentials Committee and decide whether to grant or deny the request for a waiver. The MEC's determination regarding whether to grant a waiver is final. No applicant is entitled to a hearing if the MEC determines not to grant a waiver. A determination that an applicant is not entitled to a waiver is not a "denial" of appointment or clinical privileges. Rather, that individual is ineligible to request appointment or clinical privileges. A determination of ineligibility is not a matter that is reportable to either the state licensure board or the National Practitioner Data Bank.

(d) A determination to grant a waiver does not mean that the appointment or clinical privileges will be granted, only that processing of the application can begin.

(e) The granting of a waiver in a particular case does not set a precedent for any other applicant or group of applicants.

(f) If a waiver is granted that does not specifically include a time limitation, the waiver is considered to be permanent and the individual does not have to request a waiver at subsequent recredentialing cycles.

2.A.3. Factors for Evaluation:

The six ACGME general competencies (patient care, medical knowledge, professionalism, system-based practice, practice-based learning, and interpersonal communications) will be evaluated as part of the assessment of the initial grant or renewal of clinical privileges at time of appointment and reappointment, as reflected in the following factors:

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

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

(c) good reputation and character;

(d) ability to 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, the Hospital's and Medical Staff's commitment to quality care and a recognition that interpersonal skills and collegiality are essential to the provision of quality patient care.

2.A.4. No Entitlement to Appointment or Permission to Practice:

No individual is entitled to receive an application or to be granted appointment, reappointment, or particular clinical privileges merely because he or she:

(a) is employed by the Hospital or its subsidiaries or has a contract with the 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 appointment, permission to practice as an Allied Health Professional, or clinical 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:

Neither the Hospital nor the Medical Staff will discriminate in granting appointment, reappointment, and/or clinical privileges on any basis prohibited by local, state or federal laws, including but not limited to on the basis of race, color, religious creed (including religious dress and grooming practices), national origin (including certain language use restrictions), ancestry, disability (mental and physical including HIV and AIDS), medical condition (including cancer and genetic characteristics), marital status, age, sex (including pregnancy, childbirth, breastfeeding and related medical conditions, gender, gender identity, gender expression and sexual orientation, genetic information (including family medical history), or military/veteran status as those terms are defined under federal and state laws and rules.

2.B. GENERAL CONDITIONS OF APPOINTMENT AND REAPPOINTMENT

2.B.1 General Rules of Membership

Each Medical Staff Member with active privileges, upon appointment/reappointment to the Staff, shall file with the Medical Staff Office the name(s) of at least one appropriately qualified Staff Member or call group who has agreed to serve as his/her alternate. This alternate may be called to manage an urgent problem in the event that the Staff Member cannot be reached within a reasonable amount of time. In the unlikely event that the alternate cannot be reached, the President or the Administrator is empowered to appoint an available physician to serve until the emergency has passed or the Member is contacted.

2.B.2. Basic Responsibilities and Requirements:

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

(a) to abide by all Bylaws, policies, rules, and regulations of the Medical Staff, the Hospital, and Providence Swedish in force during the time the individual is appointed;

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

(c) within the scope of his or her clinical privileges, to serve on the on-call roster for their specialty, provide consultations, and care for unassigned patients as may be requested;

(d) to comply with clinical practice or evidence-based medicine protocols that are established by, and must be reported to, regulatory or accrediting agencies or

patient safety organizations, including those related to national patient safety initiatives and core measures, or clearly document the clinical reasons for variance;

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

(f) to comply with all policies, training and educational protocols, and orientation requirements that may be adopted by the MEC, the Hospital or Providence Swedish, including, but not limited to, those involving electronic medical records, computerized provider order entry ("CPOE"), the privacy and security of protected health information, infection control, patient safety initiatives, clinical protocols, and Medical Staff functions;

(g) to obtain, when requested, an appropriate fitness for practice evaluation, which may include diagnostic testing (e.g., blood, urine, or hair testing) or a complete physical, psychiatric, or behavioral evaluation, as set forth in this Policy or other Medical Staff policy;

(h) to meet with Medical Staff Leaders and/or members of the Administrative Leadership upon request, to provide information regarding professional qualifications upon written request, and to participate in collegial efforts with Medical Staff leaders and/or members of the Administrative Team as may be requested;

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

(j) to provide Medical Staff Services with a current professional e-mail address that is checked on a regular basis, which will be the primary mechanism used to communicate all Medical Staff information to the Practitioner;

(k) to provide a valid mobile phone number, with texting capability, in order to facilitate Practitioner-to-Practitioner communication;

(l) to not delegate responsibility for hospitalized patients to any individual who is not qualified or adequately supervised;

(m) to not deceive patients as to the identity of any individual providing treatment or services and to always wear proper Hospital identification of their name and status;

(n) to seek consultation whenever required or necessary;

(o) to complete in a timely and legible manner all medical and other required records, containing all information required by the Hospital, and to utilize the electronic medical record system for patients referred or admitted to the Hospital;

(p) to cooperate with all care management activities;

(q) to perform all services and conduct himself or herself at all times in a cooperative and professional manner;

(r) to at all times conduct themselves in compliance with the highest standards of business ethics and integrity, as reflected in the Hospital's Corporate Responsibility Program including, without limitation, the Hospital's Standards of Conduct and the Ethical and Religious Directives for Catholic Health Services (the "ERDs");

(s) to promptly pay any applicable dues (as described in dues policy), fees, and/or fines;

(t) to attend and participate in any applicable orientation programs at the Hospital before participating in direct patient care; and

(u) to participate in an Organized Health Care Arrangement with the Hospital and abide by the terms of the Hospital's Notice of Privacy Practices as well as federal and state privacy laws with respect to health care delivered in the Hospital.

2.B.3. Burden of Providing Information:

(a) Individuals seeking appointment, reappointment, and/or clinical privileges have the burden of producing information deemed adequate by the Hospital for a proper evaluation of current competence, character, ethics, and other qualifications and for resolving any doubts about an individual's qualifications. The information to be produced includes such quality data and other information as may be needed to assist in an appropriate assessment of overall qualifications for appointment, reappointment, and current clinical competence for any requested clinical privileges, including, but not limited to, information from other hospitals, information from the individual's office practice, information from insurers or managed care organizations in which the individual participates, and/or receipt of confidential evaluation forms completed by referring/referred to practitioners.

(b) Individuals seeking appointment, reappointment, and/or clinical privileges have the burden of providing evidence that all the statements made and information given on the application are accurate and complete.

(c) Complete Application: An application shall be complete when all questions on the application form have been answered, all supporting documentation has been supplied, all information has been verified from primary sources, and any required application fees and applicable fines have been paid. An application shall become incomplete if the need arises for new, additional, or clarifying information at any time during the credentialing process. Whenever there is a need for new, additional, or clarifying information – outside of the normal, routine credentialing process –

the application will not be processed until the information is provided. If the application continues to be incomplete 30 days after the individual has been notified of the additional information required, the application will be deemed to be withdrawn and the individual may not submit another application for appointment or clinical privileges for a period of two years.

(d) The individual seeking appointment, reappointment and/or clinical privileges is responsible for providing a complete application, including adequate responses from references. An incomplete application shall not be processed.

(e) Applicants and members are responsible for notifying the Medical Staff Services, in writing, of any change in status or any change in the information provided on the application form. This information is required to be provided with or without request, promptly but no later than ten days of the change occurring, and includes, but is not limited to:

(1) any information on the application form;

(2) any threshold eligibility criteria for appointment or clinical privileges;

(3) complaints, documents or other information known to the Practitioner regarding, or changes in, licensure status or DEA registration or state-controlled substance license;

(4) changes in professional liability insurance coverage;

(5) the filing of any lawsuit or administrative complaint or proceeding by any government agency related to the individual's professional practice;

(6) a charge, indictment, conviction, or a plea of guilty or no contest in any criminal matter other than a misdemeanor

(7) exclusion or preclusion from participation on any private health insurance panel of providers or in Medicare, Medicaid, or any other federal or state healthcare program, or any sanctions imposed with respect to the same;

(8) changes in status (e.g., appointment, clinical privileges, or employment) at any medical group or health care entity because of issues with clinical competence or professional conduct; 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).

2.C. APPLICATION

2.C.1. Information:

(a) The Washington Practitioner Application will be used as the application for requests for appointment and reappointment. The application may be supplemented to address requests for specific clinical privileges and other information concerning the individual's professional qualifications.

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

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

By requesting an application and/or applying for appointment, reappointment, or clinical privileges, the individual expressly accepts the conditions set forth in this Section:

(a) Immunity:

To the fullest extent permitted by law, the individual releases from any and all liability, extends immunity to, and agrees not to sue Providence Swedish, the Hospital or any of its affiliates or subsidiaries, or any of their Boards, Board members, Practitioners, representatives or agents, or any third parties who provide information for any matter relating to appointment, reappointment, clinical privileges, or the individual's qualifications for the same. This immunity covers any actions, recommendations, communications, and/or disclosures involving the individual that are made, taken, or received by any entities or individuals named above in the course of credentialing and peer review activities. This immunity also extends to any reports that may be made to government regulatory and licensure boards or agencies pursuant to federal or state law.

(b) Authorization to Obtain Information from Third Parties:

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

reporting agency to conduct a criminal background check on the individual and report the results to the Hospital.

(c) Authorization to Release Information to Third Parties:

The individual also authorizes Hospital, its Medical Staff, and their authorized representatives to release information to (i) other hospitals, health care facilities, managed care organizations, and their agents when information is requested in order to evaluate his or her professional qualifications for appointment, privileges, and/or participation at the requesting organization/facility, (ii) persons or entities external to the Hospital that are assessing the individual's professional qualifications, competence, or health pursuant to a review that the individual has been notified is occurring under applicable Hospital or Medical Staff policies, and (iii) any government regulatory and licensure boards or agencies pursuant to federal or state law. The disclosure of any peer review information in response to such inquiries does not waive any associated privilege, and any and all disclosures shall be made with the understanding that the receiving entity will only use such peer review information for peer review purposes.

(d) Authorization to Share Information Among Providence Swedish Affiliated Entities:

The Practitioner specifically authorizes any entity affiliated with Providence Swedish to share with each other any and all credentialing and peer review information pertaining to the individual's clinical competence and/or professional conduct, in accordance with the Puget Sound Region Providence Swedish Information Sharing Agreement or subsequent agreements or policies related to information sharing. This information may be shared at initial appointment, reappointment, or at any other time during the individual's affiliation with Providence Swedish.

(e) Hearing and Appeal Procedures:

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

(f) Legal Actions:

If, despite this Section, an individual institutes legal action challenging any credentialing, privileging, peer review, or other action affecting appointment or clinical privileges, or any report that may be made to a regulatory board or agency, and does not prevail, he or she shall reimburse Providence Swedish, the Hospital, any of its affiliates or subsidiaries, and any of their Board members, Practitioners, authorized representatives, agents, and employees who are involved in the action for all costs incurred in defending such legal action, including reasonable attorney's fees, expert witness fees, and lost revenues.

(g) Scope of Section:

All of the provisions in this Section 2.C.2 are applicable in the following situations:

(1) whether or not appointment or clinical privileges are granted;

(2) throughout the term of any appointment or reappointment period and thereafter;

(3) should appointment, reappointment, or clinical privileges be revoked, reduced, restricted, suspended, and/or otherwise affected as part of the Hospital's professional review activities;

(4) as applicable, to any third-party inquiries received after the individual leaves the Medical Staff or no longer practices as an Allied Health Professional about his or her tenure at the Hospital; and

(5) as applicable, to any reports that may be made to government regulatory and licensing boards or agencies pursuant to federal or state law.

2.C.3. 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 Credentials Committee will review the response and determine whether the application should be processed further.

(b) If appointment has been granted prior to the discovery of a misstatement or omission, the individual will be informed in writing of the nature of the misstatement or omission and permitted to provide a written response. The individual will also have an opportunity to meet with the Credentials Committee to explain the misstatement or omission. The Credentials Committee will review the response and determine whether appointment and privileges should be deemed to be automatically relinquished pursuant to this Policy.

(c) If the determination is made to not process an application or that appointment and privileges should be automatically relinquished pursuant to this provision, the individual may not reapply for a period of at least two years.

(d) No action taken pursuant to this Section will entitle the applicant or member to a hearing or appeal.

ARTICLE 3

PROCEDURE FOR INITIAL APPOINTMENT

3.A. PROCEDURE FOR INITIAL APPOINTMENT

3.A.1. Request for Application:

(a) Applications for appointment will be submitted in accordance with current Hospital protocol (i.e., on approved forms or submitted through an approved portal/website).

(b) An individual seeking initial appointment will be provided access to information that (i) outlines the threshold eligibility criteria for appointment outlined earlier in this Policy, (ii) outlines the applicable criteria for any clinical privileges being sought, and (iii) provides access to the application form.

(c) Residents or fellows who are in the final 180 days of their training may apply to the Medical Staff. Such applications may be processed, but final action on the applications shall not become effective until all applicable threshold eligibility criteria are satisfied.

3.A.2. Initial Review of Application:

(a) A completed application form with copies of all required documents must be returned to Medical Staff Services. Dues will be paid with application as described in Medical Staff policy.

(b) As a preliminary step, the application shall be reviewed by Medical Staff Services to determine that all questions have been answered and that the individual satisfies all threshold eligibility criteria. Incomplete applications shall not be processed. Individuals who fail to return completed applications or fail to meet the threshold eligibility criteria shall be notified that their applications shall not be processed. A determination of ineligibility does not entitle the individual to the hearing and appeal rights outlined in this Policy and is not reportable to any state agency or to the National Practitioner Data Bank.

(c) Medical Staff Services shall oversee the process of gathering and verifying relevant information and confirming that all references and other information or materials deemed pertinent have been received.

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

(a) Evidence of the applicant’s character, professional competence, qualifications, behavior, and ethical standing will be examined. This information may be contained in the application and obtained from peer references (at least two

references are required from the same discipline, where practicable) and from other available sources, including the applicant's past or current department chairs at other health care entities, residency training director, and others who may have knowledge about the applicant's education, training, experience, and ability to work with others.

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

3.A.4. Division Chief Procedure:

(a) Member assigned to the Division and section in which they have the majority of clinical privileges. It is understood that some members will have clinical activity in more than one division or section.

(b) Medical Staff Services shall transmit the complete application and all supporting materials to the relevant Division Chief(s) in which the applicant seeks clinical privileges. The Division Chief shall prepare a written report regarding whether the applicant has satisfied all of the qualifications for appointment and the clinical privileges requested on a form provided by Medical Staff Services.

(c) The Division Chief shall be available to the Credentials Committee, the MEC, and the Board to answer any questions that may be raised with respect to the report and findings of that individual.

3.A.5. Credentials Committee Procedure:

(a) The Credentials Committee shall review and consider the report prepared by the relevant Division Chief and shall make a recommendation.

(b) The Credentials Committee may use the expertise of the Division Chief or any member of the division, 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, the Credentials Committee may require the applicant to provide information regarding his or her health status and/or to undergo a physical, mental, and/or behavioral examination by a physician(s) satisfactory to the Credentials Committee if there is any question about the applicant's ability to perform the clinical privileges requested and the responsibilities of appointment. The results of

this examination shall be made available to the committee for its consideration. Failure of an applicant to undergo an examination within a reasonable time after being requested to do so in writing by the Credentials Committee shall be considered a voluntary withdrawal of the application and all processing of the application shall cease. The cost of the health assessment will be borne by the applicant.

(d) The Credentials Committee may recommend specific conditions on appointment and/or clinical privileges. These conditions may relate to behavior (e.g., personal code of conduct) or to clinical issues (e.g., general consultation requirements, appropriate documentation requirements, proctoring, completion of CME requirements). The Credentials Committee may also recommend that appointment be granted for a period of less than two years in order to permit closer monitoring of an individual's compliance with any conditions. Unless these matters involve the specific recommendations set forth in Section 7.A.1(a) of this Policy, as pertinent, such conditions do not entitle an individual to request the procedural rights set forth in Article 7 of this Policy.

3.A.6. MEC Recommendation:

(a) At its next regular meeting after receipt of the written findings and recommendation of the Credentials Committee, the MEC shall:

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

(2) refer the matter back to the Credentials Committee for further consideration and responses to specific questions raised by the MEC prior to its final recommendation; or

(3) state its reasons in its report and recommendation, along with supporting information, for its disagreement with the Credentials Committee's recommendation.

(b) If the recommendation of the MEC is to appoint, the recommendation shall be forwarded to the Board.

(c) If the recommendation of the MEC is unfavorable and would entitle the applicant to request a hearing in accordance with Section 7.A.1(a) of this Policy, the MEC shall forward its recommendation to the CEO, who shall promptly send Special Notice to the applicant. The CEO shall then hold the application until after the applicant has completed or waived a hearing and appeal.

3.A.7. Board Action:

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

(1) appoint the applicant and grant clinical privileges as recommended; or

(2) refer the matter back to the Credentials Committee or MEC or to another source inside or outside the Hospital for additional research or information; or

(3) reject or modify the recommendation.

(b) If the Board determines to reject a favorable recommendation, it should first discuss the matter with the Chair of the Credentials Committee and the Chair of the MEC. If the Board's determination remains unfavorable to the applicant, the CEO shall promptly send Special Notice to the applicant that the applicant is entitled to request a hearing.

(c) Any final decision by the Board to grant, deny, revise or revoke appointment and/or clinical privileges will be disseminated to appropriate individuals and, as required, reported to appropriate entities.

3.A.8. Time Periods for Processing:

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

3.A.9. Duration of Appointment:

All initial appointments and any other initial grants of clinical privileges pursuant to this Policy shall be for a duration of not more than two years.

3.B. FPPE TO CONFIRM COMPETENCE AND PROFESSIONALISM

All 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 ("FPPE") in order to confirm competence, which may be more fully described in Medical Staff policy.

ARTICLE 4

CLINICAL PRIVILEGES

4.A. CLINICAL PRIVILEGES

4.A.1. General:

(a) Appointment or reappointment shall not confer any clinical privileges or right to admit or treat patients at the Hospital. Each Practitioner who has been granted appointment is entitled to exercise only those clinical privileges specifically granted by the Board. Clinical privileges, once granted, may be exercised in person or via technology-enabled direct communication and evaluation (i.e., telemedicine) when that modality of treatment is available and has not been otherwise limited on the relevant delineation of privileges.

(b) A request for privileges will be processed only if an applicant satisfies threshold eligibility criteria for the delineated privileges. An individual who does not satisfy the eligibility criteria for clinical privileges may request that the criteria be waived and the waiver process outlined in Article 2 will be followed.

(c) Requests for clinical privileges that are subject to an exclusive contract or arrangement will not be processed except as consistent with the applicable contract. Similarly, requests for clinical privileges will not be processed if the Hospital has determined not to accept an application in the specialty.

(d) The granting of clinical privileges includes the responsibility to serve on the on-call roster for their specialty as may be requested in order for the Hospital to satisfy its obligations under the Emergency Medical Treatment and Active Labor Act.

(e) Recommendations for clinical privileges shall be based on consideration of the following, as applicable:

(1) education, relevant training, experience, and demonstrated current competence, including medical/clinical knowledge, technical and clinical skills, clinical judgment, interpersonal and communication skills, and professionalism with patients, families, and other members of the health care team and peer 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 peer review and other performance improvement activities, as applicable;

(5) availability of other qualified staff members with appropriate privileges (as determined by the Credentials Committee) to provide coverage in case of the applicant's illness or unavailability;

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

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

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

(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 related to the specific individual, and when statistically and qualitatively significant and meaningful, when available; and

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

(f) The Medical Staff Credentialer will utilize the new reports from the ACOE to verify that the required minimum number of procedures are fulfilled.

(1) If there is a gap, the credentialer will reach out to the medical staff member for evidence. This could be cases from elsewhere, including their own office

(2) Ongoing gaps will be flagged by the credentialer in the software

(g) Core privileges, special privileges, clinical privilege delineations, and/or the criteria for the same shall be developed or endorsed by the relevant Division Chief and shall be forwarded to the Credentials Committee for review and recommendation. The Credentials Committee will forward its recommendations to the MEC, which will review the matter and forward its recommendations to the Board for final action.

(h) The applicant has the burden of establishing his or her qualifications and current competence for all clinical privileges requested.

(i) The report of the Division Chief(s) in which clinical privileges are sought shall be forwarded to the Chair of the Credentials Committee and processed as a part of the initial application for staff appointment. The Division Chief report should address the gaps which were identified by the Credentialer as described above

(j) If there are gaps in the performance of procedures, the Credentials committee may:

(1) Notify the member that they have one subsequent 2- yr period to meet the minimum requirements for procedure numbers

(2) Ask the member to withdraw the request for that privilege

(3) Notify the member that the request for the procedure privilege was not granted

(4) Hold the request while further information is being gathered.

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

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

(b) An individual may request an exception to this requirement (i.e., for limited clinical privileges within a core or specialty). The request must indicate the specific clinical privileges within the core or specialty that the individual does not wish to provide, state a basis for the request, and include evidence that the individual does **not** provide the patient care services in any health care facility in that area.

(c) A request for limited clinical privileges will be reviewed by the relevant Division Chief, Credentials Committee, Medical Executive Committee, and Board.

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

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

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

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

(4) fairness to the individual requesting the waiver;

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

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

(e) No one is entitled to be granted limited clinical privileges, and denial of such a request does not trigger a right to a hearing or appeal.

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

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

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

A request to resign appointment and relinquish all clinical privileges must specify the desired date of resignation, which should be at least 30 days from the date of the request, and be accompanied by evidence that the individual will be able to accomplish the following by the specified end date:

(1) completion of all medical records;

(2) as applicable, the appropriate discharge or transfer of responsibility for the care of any hospitalized patient who is under the individual's care at the time of resignation; and

(3) as applicable, the completion of scheduled time on the on-call roster or formal arrangement for appropriate coverage to satisfy this responsibility.

After consulting with the Medical Staff President, the CEO will act on the resignation request with a report on the matter forwarded to the MEC. If an individual fails to complete the tasks listed above prior to the effective date of the resignation, he or she will not be considered to have resigned "in good standing" for purposes of future reference responses.

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 (hereafter, "new procedure") shall not be processed until (1) a determination has been made by Administrative Leadership that the procedure shall be offered by the Hospital, and (2) criteria to be eligible to request those clinical privileges have been established as set forth in this Section.

(b) As an initial step in the process, the Practitioner seeking to perform the new procedure will prepare and submit a report to Medical Staff Services addressing the following:

(1) appropriate 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.

Hospital administration shall review this report and consult with the Medical Staff President, the Division Chief, and the Credentials Committee (any of which may conduct additional research as may be necessary) and shall make a preliminary determination as to whether the new procedure should be offered to the community.

(c) If the preliminary determination of the Hospital is favorable, the Credentials Committee will determine whether the request constitutes a "new procedure" as defined by this Section or if it is an extension of an existing privilege. If it is determined that it does constitute a "new procedure," the Credentials Committee will then develop threshold credentialing criteria to determine those individuals who are eligible to request the clinical privileges at the Hospital. In developing the criteria, the Credentials Committee may conduct additional research and consult with experts, as necessary, and develop recommendations regarding:

(1) the appropriate 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 manner of addressing the most common complications that may arise in the performance of the new procedure;

(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; and

(5) 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 MEC, which will review the matter and forward its recommendations to the Board for final action.

(e) The Board will make a reasonable effort to render the final decision within 60 days of receipt of the MEC's recommendation. If the Board determines to offer the procedure or service, it will then establish the minimum threshold qualifications that an individual must demonstrate in order to be eligible to request the clinical privileges in question.

(f) Once the foregoing steps are completed, specific requests from eligible Practitioners who wish to perform the procedure or service may be processed.

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

(a) Requests for clinical privileges that previously at the Hospital have been exercised only by individuals from another specialty shall not be processed until the steps outlined in this Section have been completed and a determination has been made regarding the individual's eligibility to request the clinical privileges in question.

(b) As an initial step in the process, the Practitioner seeking the privilege will prepare and 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 privilege at other similar hospitals, and the experiences of those other hospitals in terms of patient care outcomes and quality of care. The Administrative Leadership will confirm the request is permissible under any existing exclusive contracts or Board directives regarding a closed service that are in place at the Hospital before the request is forwarded to the Credentials Committee.

(c) The Credentials Committee shall then conduct additional research and consult with experts, as necessary, including those on the Medical Staff (e.g., Division Chiefs, individuals on the Medical Staff with special interest and/or expertise) and those outside the Hospital (e.g., other hospitals, residency training programs, specialty societies).

(d) The Credentials Committee may or may not recommend that individuals from different specialties be permitted to request the privileges at issue. If it does, the committee may develop recommendations regarding:

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

(2) 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;

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

(4) the manner in which the privileges 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

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

(e) The Credentials Committee shall forward its recommendations to the MEC, which shall review the matter and forward its recommendations to the Board for final action. The Board shall make a reasonable effort to render the final decision within 60 days of receipt of the MEC's recommendation.

(f) Once the foregoing steps are completed, specific requests from eligible Practitioners who wish to exercise the privileges in question may be processed.

4.A.7. Post-Graduate Trainees (Residents and Fellows):

(a) Residents in a Training Program.

Physicians in residency training shall not hold appointments to the Medical Staff and shall not be granted clinical privileges. The program director, clinical faculty, and/or attending staff member shall be responsible for the direction and supervision of the on-site and/or day-to-day patient care activities of each trainee, who shall be permitted to perform only those clinical functions set out in curriculum requirements, affiliation agreements, and/or training protocols approved by the Hospital. The applicable program director shall be responsible for verifying and evaluating the qualifications of each physician in training.

(b) Moonlighting Trainees.

(1) Physicians who are in a fellowship or their final year of a residency program at the Hospital and who wish to moonlight outside of their training program may be granted specific privileges in accordance with the review process described in this Policy. In order to be eligible for moonlighting privileges,

an individual must meet all relevant eligibility criteria for the clinical privileges requested (or be granted a waiver) and must:

(i) have a license to practice in Washington;

(ii) where applicable to their practice, have a current, unrestricted DEA registration; and

(iii) in the case of a resident, comply with the 80-hour work week restriction.

(2) A resident who is moonlighting must comply with the institutional and program training requirements. Failure to comply with these requirements or termination from the training program will result in the automatic relinquishment of clinical privileges, without a right to the hearing and appeal procedures.

4.A.8. Telemedicine Privileges for Distant-Site Practitioners:

(a) PRMCE allows for credentialing and privileging by proxy for Licensed Independent Practitioners who have either total or shared responsibility for patient care, treatment, and services through a telemedicine link. The originating site (the site where the patient is located at the time the service is provided) is allowed to accept the privileging decisions of the distant site (the site where the practitioner providing the professional service is located).

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

(1) A request for telemedicine privileges may be processed through the same process for Medical Staff applications, as set forth in this Policy. In such case, the distant-site Practitioner must satisfy all qualifications and requirements set forth in this Policy, unless excepted based on Medical Staff Bylaws.

(2) If the distant-site Practitioner is practicing at a distant hospital that participates in Medicare or a telemedicine entity (as that term is defined by Medicare), a request for telemedicine privileges may be processed using an abbreviated 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 will comply with all applicable Medicare regulations and accreditation standards. The distant hospital or telemedicine entity must provide:

(i) confirmation that the distant-site Practitioner is licensed in Washington;

(ii) a current list of clinical privileges granted to the distant-site Practitioner;

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

(iv) confirmation that the distant-site Practitioner satisfies all of the distant hospital or telemedicine entity's qualifications for the clinical privileges granted;

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

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

(vii) Current CV

(vii) Evidence of current DEA registration

(viii) Evidence of current professional liability insurance

This information shall be provided to the MEC for review and recommendation to the Board for final action. Notwithstanding the process set forth in this subsection, the Hospital may determine that a distant-site Practitioner is ineligible for appointment or clinical privileges if the individual fails to satisfy the threshold eligibility criteria set forth in this Policy.

(c) When a provider is being credentialed by relying on the privileging decision of the distant site, the following signature pages are required to be signed by the practitioner prior to being credentialed:

1. Medical Staff Standards of Conduct
2. Confidentiality and Non-disclosure statement
3. Request for Membership status
4. Practice Standards
5. Agreement to Abide
6. Acknowledgment of Receipt of Medicare/Tricare Notification

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

(e) Distant-site Practitioners who have been granted telemedicine privileges shall 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 distant-site Practitioner by patients, other Practitioners or staff, will be shared with the hospital or entity providing telemedicine services.

(f) Telemedicine privileges granted in conjunction with a contractual agreement shall be incident to and coterminous with the agreement.

(g) All clinical services offered through telemedicine will be consistent with commonly accepted quality standards

4.B. TEMPORARY CLINICAL PRIVILEGES

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

(a) New Applicants. Temporary privileges for an applicant for initial appointment may be granted by the CEO under the following conditions:

(1) the applicant has submitted a complete application, along with any application fee;

(2) the verification process is complete, including verification of current licensure, relevant training or experience, current competence, ability to exercise the privileges requested, and current professional liability coverage; compliance with privileges criteria; and consideration of information from the National Practitioner Data Bank, from a criminal background check, and from OIG queries;

(3) the applicant demonstrates that (i) there are no current or previously successful challenges to his or her licensure or registration, and (ii) he or she has not been subject to involuntary termination of appointment or involuntary limitation, reduction, denial, or loss of clinical privileges, at another health care facility;

(4) the application is pending review by the MEC and the Board, following a favorable recommendation by the Medical Staff President and the Credentials Committee or its Chair, and after considering the evaluation of the Division Chief; and

(5) temporary privileges for a new applicant will be granted for a maximum period of 120 consecutive days.

(b) Urgent Need. The CEO, upon recommendation of the Medical Staff President and the applicable Division Chief, may also grant temporary privileges in other limited situations when there is an urgent patient care, treatment, or service need, under the following circumstances:

(1) the temporary privileges are needed (i) for the care of a specific patient; (ii) when a proctoring or consulting Practitioner is needed, but is otherwise unavailable; or (iii) when necessary to prevent a lack or lapse of services in a needed specialty area (e.g., locums);

(2) the following factors are considered and/or verified prior to the granting of temporary privileges: current licensure, relevant training or experience, current competence (verification of good standing in the individual's most recent hospital affiliation), current professional liability coverage acceptable to the Hospital, and results of a query to the National Practitioner Data Bank, and from OIG queries; and

(3) the grant of clinical privileges in these situations will not exceed 60 days; however, in exceptional situations, this period of time may be extended in the discretion of the CEO and the Medical Staff President.

Any individual seeking emergent privileges who is currently appointed in good standing to another Providence Swedish Hospital with a grant of clinical privileges relevant to the request for emergent privileges shall be immediately authorized to exercise emergent privileges upon verification of good standing by Medical Staff Services and the completion of a query to the National Practitioner Data Bank; verification of the additional factors referenced above is not required. For all other individuals, the verifications for such grants of emergent privileges shall generally be accomplished in advance; however, in an emergency situation, where life-threatening circumstances exist, the verifications listed above may be completed immediately after the grant of emergent privileges.

(c) Automatic Expiration. All grants of temporary privileges shall automatically expire upon the date specified at the time of initial granting unless further affirmative action is taken to renew such temporary privileges by the relevant Division Chief, the Chair of the Credentials Committee, the Medical Staff President, and the CEO.

(d) Compliance with Bylaws and Policies. Prior to any temporary privileges being granted, the individual must agree in writing to be bound by the Bylaws, Rules and Regulations, policies, procedures, and protocols of the Medical Staff and the Hospital.

(e) FPPE. Individuals who are granted temporary privileges will be subject to the Hospital policy regarding focused professional practice evaluation.

4.B.2. Supervision Requirements:

Special requirements of supervision and reporting may be imposed on any individual granted temporary clinical privileges.

4.B.3. Withdrawal of Temporary Clinical Privileges:

(a) The CEO may withdraw temporary admitting privileges at any time, after consulting with the Medical Staff President, the Chair of the Credentials Committee, the Division Chief, or the CMO. Clinical privileges shall then expire as soon as patients have been discharged or alternate care has been arranged.

(b) If the care or safety of patients might be endangered by continued treatment by the individual granted temporary privileges, the CEO, the Division Chief, the Medical Staff President, or the CMO may immediately withdraw all temporary privileges. The Division Chief or the Medical Staff President shall assign to another Practitioner responsibility for the care of such individual's patients until they are discharged or an appropriate transfer arranged. Whenever possible, consideration shall be given to the wishes of the patient in the selection of a substitute physician.

4.C. EMERGENCY SITUATIONS

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

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

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

4.D. DISASTER PRIVILEGES

(1) When the disaster plan has been implemented and the immediate needs of patients in the facility cannot be met, the CEO, the CMO, or the Medical Staff President 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.

(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: (i) current license to practice; (ii) primary source verification of the license; or (iii) 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 Reserve Corps, the Emergency System for Advance Registration of Volunteer Health Professionals, or other recognized state or federal organizations or groups.

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

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

(5) The Medical Staff will oversee the care provided by volunteer licensed independent practitioners. This oversight shall be conducted through direct observation, mentoring, clinical record review, or other appropriate mechanism developed by the Medical Staff and Hospital.

ARTICLE 5

PROCEDURE FOR REAPPOINTMENT

5.A. PROCEDURE FOR REAPPOINTMENT

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

5.A.1. Eligibility for Reappointment:

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

(a) completed all medical records and be current at the time of reappointment;

(b) completed all continuing medical education requirements;

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

(d) continued to meet all qualifications and criteria for appointment and the clinical privileges requested, including those set forth in Section 2.A.1 of this Policy;

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

(f) paid the reappointment processing fee, if any.

5.A.2. Factors for Evaluation:

In considering an individual's 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, serving on the on-call roster, consultation requests, quality of medical record documentation, cooperation with case management, participation in quality improvement, utilization activities, and peer review activities, and such other reasonable duties and responsibilities as assigned;

(c) the results of the Hospital's performance improvement and peer review 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, families, and/or staff; and

(f) other reasonable indicators of continuing qualifications.

5.A.3. Reappointment Application:

(a) An application for reappointment shall be made available to Practitioners at least five months prior to the expiration of their current appointment term. A completed reappointment application must be submitted to Medical Staff Services within 30 days.

(b) In addition, failure to submit a complete application at least three months prior to the expiration of the Practitioner's current term may result in the automatic expiration of appointment and clinical privileges at the end of the then current term of appointment unless the application can still be processed in the normal course, without extraordinary effort on the part of Medical Staff Services and the Medical Staff Leaders. If an individual's privileges lapse due to a processing delay, subsequent Board action may be to grant reappointment and renewal of clinical privileges using the filed application, in accordance with the expedited process set forth in Section 3.A.7(a).

(c) Reappointment shall be for a period of not more than two years.

(d) The application shall be reviewed by Medical Staff Services to determine that all relevant information has been received and verified and that the individual satisfies all threshold eligibility criteria for reappointment and for the clinical privileges requested.

(e) The steps outlined in Article 3 for the initial appointment process shall then be followed for the reappointment process

5.A.4. Processing Applications for Reappointment:

(a) Medical Staff Services shall forward the application to the relevant Division Chief and the application for reappointment shall be processed in a manner consistent with applications for initial appointment.

(b) Additional information may be requested from the applicant if any questions or concerns are raised with the application or if new privileges are requested.

5.A.5. Conditional Reappointments:

(a) Recommendations for reappointment and renewed privileges may be contingent on a Practitioner's compliance with certain specific conditions that have been recommended. These conditions may relate to behavior (e.g., personal code of conduct) or to clinical issues (e.g., general consultation requirements, appropriate documentation requirements, including timely completion of medical records, proctoring, completion of CME requirements). Unless the conditions involve the matters set forth in Section 7.A.1(a) of this Policy, such conditions do not entitle an individual to request the procedural rights set forth in Article 7 of this Policy.

(b) reappointments may be recommended for periods of less than two years in order to permit closer monitoring of an individual's compliance with any conditions that have been recommended. A recommendation for reappointment for a period of less than two years does not, in and of itself, entitle an individual to the procedural rights set forth in Article 7.

(c) In addition, in the event the applicant for reappointment is the subject of an unresolved peer review concern, a formal 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.A.6. Potential Adverse Recommendation:

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

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

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

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

at this meeting and no recording (audio or video) of the meeting shall be permitted or made.

(e) If the Board determines to reject a favorable recommendation from the MEC, it should first discuss the matter with the Chair of the Credentials Committee and the Chair of the MEC. If the Board's determination remains unfavorable to the applicant, the CEO shall promptly send a Special Notice to the applicant that the applicant is entitled to request a hearing under this Policy.

5.A.7. Time Periods for Processing:

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

5.B. FPPE TO CONFIRM COMPETENCE AND PROFESSIONALISM

All 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 ("FPPE") in order to confirm competence. The FPPE process for these situations is outlined in medical staff policy.

ARTICLE 6

REVIEW OF PRACTITIONER PERFORMANCE

6.A. INITIAL COLLEGIAL EFFORTS AND OTHER PROGRESSIVE STEPS

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

(a) This Policy and other Medical Staff policies (e.g., Peer Review policy, code of conduct) encourage and outline the use of collegial efforts and other progressive steps to address and resolve questions that may be raised about a member's competence, health or behavior.

(b) The goal of these initial collegial efforts and other progressive steps is to arrive at voluntary, responsive actions by the member to resolve the questions that have been raised.

(c) Medical Staff leaders and Administrative Leadership have been authorized by the MEC to engage in initial collegial efforts and other progressive steps as part of the Medical Staff's peer review functions and on behalf of its committees that perform those functions in accordance with Medical Staff policy.

(d) Initial collegial efforts include activities such as:

(1) informal mentoring, coaching, or counseling by a Medical Staff leader (e.g., advising an individual of policies regarding appropriate behavior, communication issues, on-call roster obligations, or the timely and adequate completion of medical records); and

(2) sharing comparative data, including any variations from clinical practice or evidence-based protocols or guidelines, in order to assist the individual with conforming their practice to appropriate norms.

(e) Other progressive steps include, but are not limited to, the following actions:

(1) addressing minor performance issues through an informational letter (e.g., for delinquent medical records);

(2) sending an educational letter that describes opportunities for improvement and provides specific guidance and suggestions;

(3) facilitating a formal collegial intervention (i.e., a planned, face-to-face meeting between an individual and one or more Medical Staff leaders) in order to directly discuss a matter and the steps needed to be taken to resolve it; and

(4) developing a performance improvement plan that can be used to address a concern.

(f) All initial collegial efforts and progressive steps are to be documented and included in a member's confidential file, as appropriate based on the level of intervention. The written response by the member to any of these efforts or steps will also be included in the member's confidential file.

(g) These efforts and steps are fundamental and integral components of the Hospital's peer review activities and are confidential and protected in accordance with state law.

(h) Initial collegial efforts and other progressive steps are encouraged, but are not mandatory, and are within the discretion of the appropriate Medical Staff leaders and Hospital Leadership. When a question arises, the Medical Staff leaders and/or Hospital Leadership may:

(1) address the question in accordance with this Policy or refer the matter to be addressed pursuant to the initial collegial efforts and other progressive steps described in the peer review policy, practitioner health policy, professionalism policy/code of conduct, or other relevant policy; or

(2) refer it to the MEC for its review and action.

6.B. GUIDELINES FOR COLLEGIAL INTERVENTION

6.B.1. No Recording:

There will be no recording (audio or video) or transcript made of any meetings that involve initial collegial efforts or other progressive steps activities.

6.B.2. No Right to the Presence of Others:

(a) Credentialing and peer review activities, including all activities set forth in this Article, 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. By agreement of the Medical Staff President and Chief Medical Officer, an exception may be made to this general rule.

(b) If the individual refuses to meet, the meeting will be canceled and it will be reported to the MEC that the individual declined to attend the meeting.

6.B.3. No Right to Counsel:

(a) Members do not have the right to be accompanied by counsel when the Medical Staff leaders and Administrative Leadership engage in initial collegial efforts or other progressive steps. These efforts are intended to resolve issues in a constructive manner. By agreement of the Medical Staff President and Chief Medical Officer, an exception may be made to this general rule.

(b) If the individual refuses to meet without their lawyer present, the meeting will be canceled and it will be reported to the MEC that the individual declined to attend the meeting.

6.B.4. Involvement of Supervising Physician in Matters Pertaining to a Supervised Advanced Practice Clinician or Allied Health Professional:

If any peer review activity pertains to the clinical competence or professional conduct of a supervised Advanced Practice Clinician or an Allied Health Professional, the supervising physician (if any) will be notified and may be invited to participate.

6.C. ADDITIONAL METHODS FOR PROGRESSIVE STEPS

6.C.1. Mandatory Meeting:

(a) 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.

(b) 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.

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

6.C.2. Fitness for Practice Evaluation:

(a) An individual may be requested to submit to an appropriate evaluation (such as blood and/or urine test), or a comprehensive fitness for practice evaluation which may include a physical, psychological, or cognitive assessment, to determine their ability to safely and competently practice.

(b) A request for a fitness for practice evaluation may be made as follows:

(1) of an applicant during the initial appointment or reappointment processes when requested by the Credentials Committee;

(2) of a member during an investigation; and

(3) of a member seeking reinstatement from a leave of absence.

(c) A request for an immediate evaluation may also be made when two members of MEC or one member of MEC and one member of the Administrative Leadership) are concerned with the individual's ability to safely and competently care for patients.

(d) The Medical Staff leaders, Administrative Leadership, 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.

(e) 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.C.3. Fitness for Practice Assessment:

(a) An individual may be requested to participate in a Fitness for Practice assessment to determine their ability to safely and competently practice.

(b) A request for a Fitness for Practice assessment may be made of a member during the reappointment process, as part of the collegial intervention process, or during an investigation. The request may be made by Medical Staff leaders, the Credentials Committee, the MEC, an investigating committee or other committees as authorized in Medical Staff policy.

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

(d) Failure to obtain the requested assessment may result in an automatic relinquishment of appointment and privileges as set forth below.

6.D. LEAVES OF ABSENCE

6.D.1. Initiation:

(a) A Practitioner may request a leave of absence by submitting a written request to Medical Staff Services or another Medical Staff Leader. The request must state the beginning and ending dates of the leave, which shall not exceed one year, and the reasons for the leave.

(b) MEC shall determine whether a request for a leave of absence shall be granted, recommendation can be solicited from credentials committee if desired. In determining whether to grant a request, the Medical Staff President shall consult with the relevant Division Chief. The granting of a leave of absence, or reinstatement, as appropriate, may be conditioned upon the individual's completion of all medical records.

(c) Leaves for Health Issues. Except for parental leaves, Practitioners must report to the Medical Staff President any time they are away from Medical Staff and/or patient care responsibilities for longer than 30 Days and the reason for such absence is related to their physical or mental health or otherwise to their ability to care for patients safely and competently. Upon becoming aware of such circumstances (whether by report of the Practitioner or otherwise), the CEO and/or Medical Staff President, in consultation with the relevant Division Chief, may trigger an automatic medical leave of absence at any point after becoming aware of the Practitioner's absence from patient care. The Practitioner will be sent Special Notice informing him or her that a leave of absence has been enacted.

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

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

6.D.3. Reinstatement:

(a) Individuals requesting reinstatement shall 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 shall then be reviewed by the Credential Committee and MEC. If the MEC makes a favorable recommendation on reinstatement, or if the Credentials Committee makes a favorable recommendation and the MEC votes to accept it, the Medical Staff member may immediately resume clinical practice at the Hospital. If, however, the MEC has any questions or concerns, those questions shall be noted and the reinstatement request shall be forwarded to the Board for review and recommendation. If a request for reinstatement is not granted for reasons related

to clinical competence or professional conduct, the individual shall be entitled to request a hearing and appeal.

(b) If the leave of absence was for health reasons (except for normal maternity leaves, which are not required to be processed for reinstatement as a leave for a health issue), the request for reinstatement must be accompanied by a report from the individual's health care practitioner indicating that the individual is physically and/or mentally capable of resuming a hospital practice and safely exercising the clinical privileges requested. Before acting on a Practitioner's request for reinstatement, the Credentials committee or MEC may request any additional information or documentation that it believes is necessary to evaluate the Practitioner's ability to safely and competently exercise clinical privileges. This may include requiring the Practitioner to undergo a health assessment conducted by a physician or entity chosen by the Credentials Committee in order to obtain a second opinion on the Practitioner's ability to practice safely and competently.

(c) Absence for longer than one year shall result in automatic relinquishment of appointment and clinical privileges unless an extension is granted by the Medical Staff President, in consultation with the relevant Division Chief. Extensions shall be considered only in extraordinary cases where the extension of a leave is in the best interest of the Hospital.

(d) If an individual's current appointment is due to expire during the leave, the individual must apply for reappointment, or appointment and clinical privileges shall lapse at the end of the appointment period.

(e) Failure to request reinstatement from a leave of absence in a timely manner shall be deemed a voluntary resignation of appointment and clinical privileges.

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

6.E. PRECAUTIONARY SUSPENSION OR RESTRICTION OF CLINICAL PRIVILEGES

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

(a) Whenever failure to take action may result in imminent danger to the health and/or safety of any individual, the CEO, Medical Staff President, relevant Division Chief, CMO, MEC, or Board chair is authorized to (1) suspend or restrict all or any portion of an individual's clinical privileges or (2) afford the individual an opportunity to voluntarily refrain from exercising clinical privileges while the matter is being reviewed. The process defined below will apply regardless of the option used in this paragraph.

(b) A precautionary suspension can be imposed at any time, including after a specific event, a pattern of events, or a recommendation by the MEC that would entitle the individual to request a hearing. When possible, prior to the imposition of a precautionary suspension or restriction, reasonable efforts will be made to meet with the individual in question and review the concerns and afford the individual an opportunity to respond.

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

(d) A precautionary suspension is effective immediately and will be promptly reported to the CEO and the Medical Staff President. A precautionary suspension will remain in effect unless it is modified by the CEO or the Board.

(e) Within three business 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 relevant collaborating physician will be notified when the affected individual is a PA or an Allied Health Professional.

(f) Upon the imposition of a precautionary suspension, the Medical Staff President will assign responsibility for the care of any hospitalized patients to another individual with appropriate clinical privileges. Whenever possible, consideration will be given to the wishes of the patient in the selection of a covering physician.

6.E.2. MEC Procedure:

(a) Within a reasonable time, not to exceed 14 days of the imposition of the suspension or restriction, the MEC will review the reasons for the action.

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

(c) At the meeting, the individual may provide information to the MEC and must respond to questions raised by committee members. The individual may also propose ways, other than precautionary suspension or restriction, 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 MEC will recommend whether the precautionary suspension should be continued, modified, or lifted. The MEC may also determine whether to begin an investigation or whether to refer the matter for further review consistent with this or another policy.

(e) If the MEC recommends that the suspension be continued, it will send the individual written notice of its recommendation, including the basis for it. If the MEC recommends that the suspension be modified, or lifted, this recommendation will be forwarded to the CEO for final action.

(f) A precautionary suspension that lasts for more than 30 days will be reportable to the National Practitioner Data Bank. However, there is no right to a hearing based on the imposition or continuation of a precautionary suspension, as the procedures outlined above are deemed to be fair under the circumstances.

6.F. INVESTIGATIONS

6.F.1. Initial Review:

(a) Where initial collegial efforts or other progressive steps under one or more of the policies referenced in this Article have not resolved an issue and/or when there is a single instance of such severity that in the discretion of Medical Staff Leaders it requires further review, regarding:

(1) the clinical competence or clinical practice of any Practitioner, including the care, treatment or management of a patient or patients;

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

(3) the known or suspected violation by any Practitioner of applicable ethical standards or the Bylaws, Rules and Regulations, and policies of the Hospital or the Medical Staff; and/or

(4) conduct by any Practitioner that is considered lower than the standards of the Hospital or disruptive to the orderly operation of the Hospital or its Medical Staff, including the inability of the Practitioner to work harmoniously with others,

the matter may be referred to the Medical Staff President, the relevant Division Chief, the chair of a standing committee, or the CEO.

(b) In addition, if the Board becomes aware of information that raises concerns about any Practitioner, the matter shall be referred to the Medical Staff President, the relevant Division Chief, the chair of a standing committee, or the CEO for review and appropriate action in accordance with this Policy.

(c) The person to whom the matter is referred shall conduct or arrange for an inquiry to determine whether the question raised has sufficient credibility to warrant further review and, if so, shall forward it in writing to the MEC.

(d) No action taken pursuant to this Section shall constitute an Investigation.

6.F.2. Initiation of Investigation:

(a) When a question involving a Practitioner's clinical competence or professional conduct is referred to, or raised by, the MEC, the MEC shall review the matter and determine whether to conduct an Investigation, to direct the matter to be handled pursuant to another policy (e.g., peer review policy, professionalism policy/code of conduct, practitioner health policy), or to proceed in another manner. Prior to making its determination, the MEC may discuss the matter with the individual. An Investigation shall begin only after a formal determination by the MEC to do so. The MEC's determination shall be recorded in the minutes of the meeting where the determination is made.

(b) The MEC shall inform the individual that an Investigation has begun. The notification shall include:

(1) the date on which the Investigation was commenced;

(2) the committee that will be conducting the Investigation, if already identified;

(3) a statement that the practitioner will be given the opportunity to meet with the committee conducting the Investigation before the Investigation concludes; and

(4) a copy of Section 6.F.3 of this Policy, which outlines the process for Investigations.

This notification may be delayed if, in the MEC's judgment, informing the individual immediately would compromise the Investigation or disrupt the operation of the Hospital or Medical Staff.

6.F.3. Investigative Procedure:

(a) Selection of Investigating Committee.

Once a determination has been made to begin an Investigation, the MEC shall either investigate the matter itself or appoint an ad hoc committee to conduct the Investigation, keeping in mind the conflict of interest guidelines outlined in Article 8 and **Appendix B**. Any ad hoc committee may include individuals not on the Medical Staff. Whenever the questions raised concern the clinical competence of the individual under review, the ad hoc committee shall include a peer of the individual (e.g., physician, dentist, podiatrist, oral surgeon, or relevant discipline of Advanced Practice Clinician).

(b) Investigating Committee's Review Process.

(1) The committee conducting the Investigation ("investigating committee") shall have the authority to review relevant documents and interview individuals. A summary of each interview will be prepared and the interviewee will be asked to review, revise, and sign his or her summary, which will then be included as an attachment to the investigating committee's report.

(2) The investigating committee shall also have available to it the full resources of the Medical Staff and the Hospital, including the authority to arrange for an external review, if needed. An external review may be used whenever the Hospital and investigating committee determine that:

(i) there are ambiguous or conflicting findings by internal reviewers;

(ii) the clinical expertise needed to conduct the review is not available on the Medical Staff;

(iii) an external review is advisable to prevent allegations of bias, even if unfounded; or

(iv) the thoroughness and objectivity of the Investigation would be aided by such an external review.

If a decision is made to obtain an external review, the individual under Investigation shall be notified of that decision and the nature of the external review. However, the individual under Investigation may not demand an external review or dictate who performs the external review. Upon completion of the external review, the individual shall be provided a copy of the reviewer's report and provided an opportunity to respond to it in writing.

(3) The investigating committee may require a physical, mental, and/or behavioral examination of the individual by a health care professional(s) acceptable to it. The individual being investigated shall execute a release (in a form approved or provided by the investigating committee) allowing (i) the investigating committee (or its representative) to discuss with the health care professional(s) conducting the examination the reasons for the examination; and (ii) the health care professional(s) conducting the examination to discuss and provide documentation of the results of such examination directly to the investigating committee. The cost of such health examination shall be borne by the individual.

(c) Meeting with the Investigating Committee.

(1) The individual under Investigation shall have an opportunity to meet with the investigating committee before it makes its report. Prior to this meeting, the individual shall be informed of the general questions being investigated. The investigating committee may also ask the individual to provide written responses to specific questions related to the Investigation and/or a written explanation of his or her perspective on the events that led to the Investigation for review by the investigating committee prior to the meeting.

(2) This meeting is not a hearing, and none of the procedural rules for hearings shall apply. No recording (audio or video) or transcript of the meeting shall be permitted or made. Neither the individual being investigated nor the investigating committee will be accompanied by legal counsel at this meeting.

(3) At the meeting, the individual shall be invited to discuss, explain, or refute the questions that gave rise to the Investigation or that have been identified by the investigating committee during its review. A summary of the interview shall be prepared by the investigating committee and included with its report. The interview summary will be shared with the individual prior to the investigating committee finalizing its report, so that he or she may review it and recommend suggested changes. A suggested change should only be accepted if the investigating committee believes it more accurately reflects what occurred at the meeting.

(d) Time Frames for Investigation.

The investigating committee shall make a reasonable effort to complete the Investigation and issue its report within 30 days of the commencement of the Investigation, provided that an external review is not necessary. When an external review is necessary, the investigating committee shall make a reasonable effort to complete the Investigation and issue its report within 30 days of receiving the results of the external review. These time frames are intended to serve as guidelines and, as such, shall not be deemed to create any right for an individual to have an Investigation completed within such time periods.

(e) Investigating Committee's Report.

(1) At the conclusion of the Investigation, the investigating committee shall prepare a report of the Investigation. The report should include a summary of the review process (e.g., a list of documents that were reviewed, any individuals who were interviewed, etc.), specific findings and conclusions regarding each concern that was under review, and the investigating committee's recommendations.

(2) In making its recommendations, the investigating committee shall strive to achieve a consensus as to what is in the best interests of patient care and the smooth operation of the Hospital, while balancing fairness to the individual, recognizing that fairness does not require that the individual agree with the recommendation. Specifically, the committee may consider:

(i) relevant literature and clinical practice guidelines, as appropriate;

(ii) all of the opinions and views that were expressed throughout the review, including report(s) from any external review(s);

(iii) any information or explanations provided by the individual under review; and

(iv) other information as deemed relevant, reasonable, and necessary by the investigating committee.

6.F.4. Recommendation:

(a) The MEC may accept, modify, or reject any recommendation it receives from an ad hoc investigating committee if one was appointed by the MEC. In either case, at the conclusion of the Investigation, the MEC may:

(1) determine that no action is justified;

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

(3) impose conditions for continued appointment;

(4) impose a requirement for monitoring, proctoring, or consultation;

(5) impose a requirement for additional training or education;

(6) recommend reduction of clinical privileges;

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

(8) recommend revocation of appointment and/or clinical privileges; or

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

(b) If a recommendation by the MEC would entitle the individual to request a hearing in accordance with Section 7.A.1, the recommendation will be forwarded to the CEO, who shall promptly inform the individual by Special Notice. The CEO shall

hold the recommendation until after the individual has completed or waived a hearing and appeal.

(c) A determination by the MEC that does not entitle the individual to request a hearing will take effect immediately. All such determinations shall be reported to the Board and will remain in effect unless modified by the Board. In the event the Board considers a modification that would entitle the individual to request a hearing, the CEO shall inform the individual by Special Notice. No final action shall occur until the individual has completed or waived a hearing and appeal.

(d) When applicable, any recommendations or actions that are the result of an Investigation or hearing and appeal shall be monitored by Medical Staff Leaders on an ongoing basis through the Hospital's performance improvement activities or pursuant to the applicable policies regarding conduct, as appropriate.

6.G. AUTOMATIC RELINQUISHMENT/ACTIONS

6.G.1. General:

An automatic relinquishment is considered an administrative action that occurs by operation of this Policy. As such, it does not trigger an obligation on the part of the Hospital to file a report with the National Practitioner Data Bank or any state licensing agency. It takes effect without the right to the procedural rights outlined in this Policy (i.e., there is no right to a hearing or appeal). Any request for reinstatement of appointment and clinical privileges will be reviewed in accordance with the procedures outlined in this Section.

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

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

6.G.3. Criminal Activity:

The occurrence of specific criminal actions may result in the automatic relinquishment of appointment and clinical privileges, subject to confirmation by the MEC that the underlying matter raises concerns about the individual's professional qualifications and/or ability to competently and safely exercise clinical privileges. Specifically, a charge, indictment, conviction, plea of guilty or plea of no contest pertaining to any felony, or to any misdemeanor involving the following may result in an automatic relinquishment: (i) controlled substances, (ii) illegal drugs, (iii) Medicare, Medicaid, or insurance or health care fraud or abuse, (iv) child abuse, (v) elder abuse, (vi) violence against another, (vii) sexual misconduct, or (viii) the abuse of the practitioner-patient relationship.

6.G.4. Failure to Provide Required Notification to Medical Staff Services:

Practitioners must notify Medical Staff Services, in writing, within 10 days of the occurrence of any of the following events:

(a) changes in the Practitioner's licensure status or DEA or state-controlled substance authorization;

(b) changes in the Practitioner's appointment or clinical privileges at another hospital or health care facility because of issues related to clinical competence or professional conduct, including the Practitioner's resignation while under investigation;

(c) the Practitioner's exclusion or preclusion from participation in Medicare/Medicaid or any sanctions imposed;

(d) 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;

(e) the Practitioner's participation in a state practitioner health program; and

(f) consistent with the eligibility criteria outlined in Section 2.A.1, the Practitioner's arrest, charge, indictment, conviction, or a plea of guilty or no contest related to any felony or any misdemeanor related to the following: (i) controlled substances, (ii) illegal drugs, (iii) Medicare, Medicaid, or insurance or health care fraud or abuse, (iv) child abuse, (v) elder abuse, (vi) violence against another, (vii) sexual misconduct, or (viii) the abuse of the Practitioner-patient relationship,

Failure of a Practitioner to provide this notification shall result in the automatic relinquishment of appointment and clinical privileges.

6.G.5. Failure to Provide Requested Information:

Failure to provide information pertaining to an individual's professional qualifications, clinical care, or professionalism, in response to a written request from the Credentials Committee, the MEC, the Medical Staff President, the CEO, or any other committee authorized to request such information, shall result in the automatic relinquishment of appointment and clinical privileges. The information must be provided within the time frame established by the requesting party. Any relinquishment will continue in effect until the information is provided to the satisfaction of the requesting party.

6.G.6. Failure to Attend a Mandatory Meeting:

Failure to attend a mandatory meeting requested by any other authorized Medical Staff committee or the Medical Staff President after appropriate notice has been given will result in the automatic relinquishment of appointment and clinical privileges. The relinquishment

will remain in effect until the individual attends the mandatory meeting and reinstatement is granted as set forth below.

6.G.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 relinquishment of appointment and privileges.

6.G.8. Failure to Comply with Request for Fitness for Practice Assessment:

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

6.G.9. Request for Reinstatement:

(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 to be reinstated.

(b) Requests for reinstatement following the expiration or lapse of a license, DEA/controlled substance authorization, and/or insurance coverage will be processed by Medical Staff Services. If any questions or concerns are noted, Medical Staff Services will refer the matter for further review in accordance with (c) below.

(c) All other requests for reinstatement following a relinquishment of appointment and clinical privileges shall be reviewed by the Medical Staff President and another Medical Staff leader. If they make a favorable recommendation on reinstatement, the individual may immediately resume clinical practice at the Hospital. If, however, they have any questions or concerns, those questions shall be noted, and

the reinstatement request shall be forwarded to the Credentials Committee, MEC, and Board for review and recommendation.

6.H. ACTION AT ANOTHER PROVIDENCE SWEDISH HOSPITAL

(1) Each Providence Swedish Hospital will share information regarding the implementation or occurrence of any of the following actions with all other Providence Swedish Hospitals at which an individual maintains appointment, clinical privileges, or any other permission to care for patients:

(a) ***automatic relinquishment or resignation*** of appointment or clinical privileges for failure to meet any ***threshold eligibility criteria*** set forth in the Medical Staff Bylaws or this Policy or for any of the ***other occurrences*** set forth in Section 6.G of this Policy;

(b) ***voluntary agreement to modify clinical privileges*** or ***to refrain from exercising*** some or all clinical privileges for a period of time for reasons related to the individual's clinical competence, conduct or health;

(c) any ***denial, suspension, revocation, or termination*** of appointment and/or clinical privileges;

(d) participation in a Medical Staff initiated ***Performance Improvement Plan***;

(e) a grant of ***conditional appointment or clinical privileges*** (either at initial appointment or reappointment), or conditional continued appointment or clinical privileges; and/or

(f) any other event which, in the sole discretion of the Providence Swedish Hospital making the notification, raises a ***significant concern about the Practitioner's clinical competence, professional conduct, health/ability to safely practice, or utilization practices***.

(2) Upon receipt of notice that any of the actions set forth in Paragraph (1) above have occurred at any Providence Swedish Hospital, that action will either:

(a) automatically and immediately take effect at the Providence Swedish Hospital receiving the notice; or

(b) be cause for the Providence Swedish Hospital receiving the notice to determine that the individual no longer satisfies the eligibility criteria set forth in this Policy and has therefore automatically relinquished his or her appointment and privileges.

The automatic effectiveness of any such action, or an automatic relinquishment based on such action, will not entitle the individual to any additional procedural

rights (including advance notice, additional peer review, formal Investigation, hearing, or appeal) other than what occurred at the Providence Swedish Hospital taking the original action. All other information that is shared pursuant to Paragraph (1) above will be reviewed by Medical Staff Leaders at the receiving Providence Swedish Hospital to determine whether additional steps may be necessary.

(3) The Board may waive the automatic effectiveness of an action or an automatic relinquishment at the receiving Providence Swedish Hospital, following its review of the MEC's recommendation. However, the automatic effectiveness or relinquishment will continue until such time as a waiver has been granted and the Practitioner has been notified in writing of such. Waivers are within the discretion of the Board and are final. They will be granted only as follows:

(a) based on a finding that the granting of a waiver will not affect patient safety, quality of care, or Hospital operations; and

(b) after a full review of the specific circumstances and any relevant documents (including peer review documents) from the Providence Swedish Hospital where the action first occurred. The burden is on the affected Practitioner to provide evidence showing that a waiver is appropriate.

The denial of a waiver pursuant to this Section will not entitle the individual to any procedural rights, including advance notice, additional peer review, formal Investigation, hearing, or appeal.

ARTICLE 7

HEARING AND APPEAL PROCEDURES

7.A. INITIATION OF HEARING

7.A.1. Grounds for Hearing:

(a) An individual is entitled to request a hearing whenever the MEC makes one of the following recommendations:

(1) denial of initial appointment to the Medical Staff;

(2) denial of reappointment to the Medical Staff;

(3) revocation of appointment to the Medical Staff;

(4) denial of requested clinical privileges, whether at the time of initial appointment, reappointment, or during the course of appointment;

(5) revocation of clinical privileges;

(6) suspension of clinical privileges for more than 30 days (other than precautionary suspension which entitles an individual to the procedures outlined in Section 6.E of this Policy, which are deemed fair under the circumstances);

(7) a restriction of clinical privileges for more than 30 days; or

(8) denial of reinstatement from a leave of absence if the reasons relate to clinical competence or professional conduct.

(b) No other recommendations shall entitle the individual to a hearing.

(c) If the Board makes any of these determinations without an adverse recommendation by the MEC, an individual would also be entitled to request a hearing. For ease of use, this Article refers to adverse recommendations of the MEC. When a hearing is triggered by an adverse recommendation of the Board, any reference in this Article to the "MEC" shall be interpreted as a reference to the "Board."

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

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

(a) determination that an applicant for membership fails to meet the threshold eligibility qualifications or criteria for membership;

(b) ineligibility to request membership or privileges, or to continue privileges, because a relevant specialty is closed under a Medical Staff development plan or is covered under an exclusive provider agreement;

(c) determination that an applicant for clinical privileges fails to meet the eligibility criteria to hold the privilege;

(d) determination that an application is incomplete or untimely;

(e) determination that an application shall not be processed due to a misstatement or omission;

(f) change in assigned staff category or a determination that an individual is not eligible for a specific staff category;

(g) expiration of membership and privileges as a result of failure to submit an application for reappointment within the allowable time period;

(h) issuance of an informational letter, educational letter, or any other letter of guidance, counsel, warning, or reprimand;

(i) determination that conditions, monitoring, supervision, proctoring, or a general consultation requirement (i.e., the individual must obtain a consult but need not get prior approval for the treatment) is appropriate for an individual;

(j) determination that a requirement for additional training or continuing education is appropriate for an individual;

(k) the voluntary acceptance of a Performance Improvement Plan;

(l) any requirement to complete a competency or health assessment, diagnostic testing, a complete physical, mental or behavioral evaluation, or a clinical competency evaluation pursuant to any Bylaws-related document;

(m) conducting an Investigation into any matter or the appointment of an ad hoc investigating committee;

(n) grant of conditional appointment or reappointment or of an appointment or reappointment period that is less than two years;

(o) restriction or suspension of clinical privileges for 30 days or less;

(p) precautionary suspension;

(q) automatic relinquishment of appointment or privileges or automatic resignation;

(r) denial of a request for a leave of absence, for an extension of a leave or for reinstatement from a leave if the reasons do not relate to clinical competence or professional conduct;

(s) removal from the on-call roster or any other reading panel;

(t) withdrawal of temporary privileges;

(u) requirement to appear for a mandatory meeting;

(v) termination of any contract with or employment by the Hospital; and

(w) any other action that is not specifically listed in Section 7.A.1(a).

7.B. THE HEARING

7.B.1. Notice of Recommendation:

The CEO shall promptly give Special Notice of a recommendation which entitles an individual to request a hearing. This notice shall contain:

(a) a statement of the recommendation and the general reasons for it;

(b) a statement that the individual has the right to request a hearing on the recommendation within 30 days of receipt of this notice; and

(c) a copy of this Article.

7.B.2. Request for Hearing:

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

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

(a) The CEO shall schedule the hearing and provide, by Special Notice to the individual requesting the hearing, the following:

(1) the time, place, and date of the hearing;

(2) a proposed list of witnesses who shall give testimony at the hearing and a brief summary of the anticipated testimony;

(3) the names of the Hearing Panel members (or Hearing Officer) and Presiding Officer, if known; and

(4) a statement of the specific reasons for the recommendation, including a list of patient records (if applicable), and a general description of the information supporting the recommendation. This statement does not bar presentation of additional evidence or information at the hearing, so long as the additional material is relevant to the recommendation or the individual's qualifications and the individual has a sufficient opportunity to review and rebut the additional information.

(b) The hearing shall begin no sooner than 30 days after the notice of the hearing, unless an earlier hearing date has been specifically agreed to in writing by the parties.

7.B.4. Hearing Panel, Presiding Officer, and Hearing Officer:

(a) Hearing Panel:

The CEO, after consulting with the Medical Staff President, shall appoint a Hearing Panel in accordance with the following guidelines:

(1) The Hearing Panel shall consist of at least three members and may include any combination of:

(i) any member of the Medical Staff, provided the member has not actively participated in the matter at any previous level; and/or

(ii) physicians or laypersons not connected with the Hospital (i.e., physicians not on the Medical Staff or laypersons not affiliated with the Hospital).

(2) Knowledge of the underlying peer review matter, in and of itself, shall not preclude the individual from serving on the Panel.

(3) Employment by, or other contractual arrangement with, the Hospital or an affiliate shall not preclude an individual from serving on the Panel.

(4) The Panel shall not include any individual who is in direct economic competition with the individual requesting the hearing.

(5) The Hearing Panel will not include any individual who is professionally associated with, related to, or involved in a significant referral relationship with, the individual requesting the hearing.

(6) The Panel shall not include any individual who is demonstrated to have an actual bias, prejudice, or conflict of interest that would prevent the individual from fairly and impartially considering the matter.

(7) In addition, the appointment of the Hearing Panel shall comply with the guidelines set forth in the conflict of interest provisions found in Article 8 and **Appendix B** of this Policy.

(b) Presiding Officer:

(1) The CEO, after consulting with the Medical Staff President, shall appoint a Presiding Officer who shall be an attorney. The Presiding Officer may not be, or represent clients who are, in direct competition with the individual who requested the hearing and may not currently represent the Hospital in any legal matters. The Presiding Officer shall not act as an advocate for either side at the hearing.

(2) The Presiding Officer shall:

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

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

(iii) maintain decorum throughout the hearing;

(iv) determine the order of procedure;

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

(vi) conduct argument by counsel on procedural points within or outside the presence of the Hearing Panel at the Presiding Officer's discretion.

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

(4) The Presiding Officer may participate in the private deliberations of the Hearing Panel and be a legal advisor to it but shall not be entitled to vote on its recommendations.

(c) Hearing Officer:

(1) As an alternative to a Hearing Panel, for matters limited to issues involving professional conduct, the CEO, after consulting with the Medical Staff President, may appoint a Hearing Officer, preferably an attorney, to perform the functions of a Hearing Panel. The Hearing Officer may not be, or represent clients who are, in direct economic competition with the individual requesting the hearing.

(2) If a Hearing Officer is appointed instead of a Hearing Panel, all references in this Article to the "Hearing Panel" or "Presiding Officer" shall be deemed to refer to the Hearing Officer.

(d) Objections:

Any objection to any member of the Hearing Panel, to the Presiding Officer, or to the Hearing Officer, shall be made in writing, within 10 days of receipt of notice, to the CEO. A copy of such written objection must be provided to the Medical Staff President and must include the basis for the objection. The Medical Staff President shall be given a reasonable opportunity to comment. The CEO shall rule on the objection and give notice to the parties. The CEO may request that the Presiding Officer make a recommendation as to the validity of the objection.

7.B.5. Counsel:

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

7.C. PRE-HEARING PROCEDURES

7.C.1. General Procedures:

(a) The pre-hearing and hearing processes shall be conducted in an informal manner. Formal rules of evidence or procedure shall not apply.

(b) Neither party has the right to issue subpoenas or interrogatories or to depose witnesses or other individuals prior to the hearing or to otherwise compel any individual to participate in any portion of the pre-hearing or hearing processes.

(c) Neither the individual who has requested the hearing, nor any other person acting on behalf of the individual, may contact Hospital employees or Medical Staff members whose names appear on the MEC's witness list or in documents provided

pursuant to this Article concerning the subject matter of the hearing, until the Hospital has been notified and has contacted the individuals about their willingness to be interviewed. The Hospital will advise the individual who has requested the hearing once it has contacted such employees or Medical Staff members and confirmed their willingness to meet. Any employee or Medical Staff member may agree or decline to be interviewed by or on behalf of the individual who requested a hearing. If an employee or Medical Staff member who is on the MEC's witness list agrees to be interviewed pursuant to this provision, counsel for the MEC may be present during the interview.

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

7.C.2. Time Frames:

The following time frames, unless modified by mutual written agreement of the parties, shall govern the timing of pre-hearing procedures:

(a) the pre-hearing conference shall be scheduled at least 14 days prior to the hearing;

(b) the parties shall exchange witness lists and proposed documentary exhibits at least 10 days prior to the pre-hearing conference; and

(c) any objections to witnesses and/or proposed documentary exhibits must be provided at least five days prior to the pre-hearing conference.

7.C.3. Witness List:

(a) At least 10 days before the pre-hearing conference, the individual requesting the hearing shall provide a written list of the names of witnesses expected to offer testimony on his or her behalf.

(b) The witness list shall include a brief summary of the anticipated testimony.

(c) The witness list of either party may, in the discretion of the Presiding Officer, be amended at any time during the course of the hearing, provided that notice of the change is given to the other party.

7.C.4. Provision of Relevant Information:

(a) Prior to receiving any confidential documents, the individual requesting the hearing must agree that all documents and information shall be maintained as confidential

and shall not be disclosed or used for any purpose outside of the hearing. The individual must also provide a written representation that his or her counsel and any expert(s) have executed Business Associate agreements in connection with any patient Protected Health Information contained in any documents provided.

(b) Upon receipt of the above agreement and representation, the individual requesting the hearing shall be provided with a copy of the following:

(1) copies of, or reasonable access to, all patient medical records referred to in the statement of reasons, at the individual's expense;

(2) reports of experts relied upon by the MEC;

(3) copies of relevant minutes (with portions regarding other physicians and unrelated matters deleted); and

(4) copies of any other documents relied upon by the MEC.

The provision of this information shall not waive any privilege under the state peer review protection statutes.

(c) The individual shall have no right to discovery beyond the above information. No information shall be provided regarding other Practitioners on the Medical Staff.

(d) At least 10 days prior to the pre-hearing conference (or as otherwise agreed upon by both sides), each party shall provide the other party with its proposed exhibits. All objections to documents or witnesses shall be submitted in writing at least five days in advance of the pre-hearing conference. The Presiding Officer shall not entertain subsequent objections unless the party offering the objection demonstrates good cause.

(e) Evidence unrelated to the reasons for the recommendation or to the individual's qualifications for appointment or the relevant clinical privileges shall be excluded.

7.C.5. Pre-Hearing Conference:

The Presiding Officer shall require the individual and the MEC or their representatives (who may be counsel) to participate in a pre-hearing conference, which shall be held no later than 14 days prior to the hearing. At the pre-hearing conference, the Presiding Officer shall establish the time to be allotted to each witness's testimony and cross-examination and shall resolve all procedural questions, including any objections to exhibits, witnesses, or the time limitation for the hearing.

7.C.6. Stipulations:

The parties and their counsel, if applicable, shall use their best efforts to develop and agree upon stipulations, so as to provide for a more orderly and efficient hearing by narrowing the issues on which live testimony is reasonably required.

7.C.7. Provision of Information to the Hearing Panel:

The following documents shall be provided to the Hearing Panel in advance of the hearing: (a) a pre-hearing statement that either party may choose to submit; (b) exhibits offered by the parties following the pre-hearing conference (without the need for authentication); and (c) any stipulations agreed to by the parties.

7.D. HEARING PROCEDURES

7.D.1. Rights of Both Sides and the Hearing Panel at the Hearing:

(a) At a hearing, both sides shall have the following rights, subject to reasonable limits determined by the Presiding Officer:

(1) to call and examine witnesses, to the extent they are available and willing to testify;

(2) to introduce exhibits;

(3) to cross-examine any witness on any matter relevant to the issues;

(4) to have representation by counsel who may call, examine, and cross-examine witnesses and present the case; and

(5) to submit proposed findings, conclusions and recommendations to the Hearing Panel as part of the Post-Hearing statement referenced in this Article, following the close of the hearing session(s).

(b) If the individual who requested the hearing does not testify, he or she may be called and questioned.

(c) The Hearing Panel may question witnesses, request the presence of additional witnesses, and/or request documentary evidence.

7.D.2. Record of Hearing:

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

7.D.3. Failure to Appear:

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

7.D.4. Presence of Hearing Panel Members:

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

7.D.5. Persons to Be Present:

The hearing shall be restricted to those individuals involved in the proceeding, the Medical Staff President, and the CEO. In addition, administrative personnel may be present as requested by the CEO or the Medical Staff President.

7.D.6. Order of Presentation:

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

7.D.7. Admissibility of Evidence:

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

7.D.8. Post-Hearing Statement:

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

7.D.9. Postponements and Extensions:

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

7.E. HEARING CONCLUSION, DELIBERATIONS, AND RECOMMENDATIONS

7.E.1. Basis of Hearing Panel Recommendation:

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

7.E.2. Deliberations and Recommendation of the Hearing Panel:

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

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

The Hearing Panel shall deliver its report to the CEO. The CEO shall send by Special Notice a copy of the report to the individual who requested the hearing. The CEO shall also provide a copy of the report to the MEC.

7.F. APPEAL PROCEDURE

7.F.1. Time for Appeal:

(a) Within 10 days after notice of the Hearing Panel's recommendation, either party may request an appeal. The request shall be in writing, delivered to the CEO either in person or by certified mail, return receipt requested, and shall include a statement of the reasons for appeal and the specific facts or circumstances which justify further review.

(b) If an appeal is not requested within 10 days, an appeal is deemed to be waived and the Hearing Panel's report and recommendation shall be forwarded to the Board for final action.

7.F.2. Grounds for Appeal:

The grounds for appeal shall be limited to the following:

(a) there was substantial failure by the Hearing Panel to comply with this Policy and/or the Medical Staff Bylaws during the hearing, so as to deny a fair hearing; and/or

(b) the recommendations of the Hearing Panel were made arbitrarily or capriciously and/or were not supported by credible evidence.

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

Whenever an appeal is requested as set forth in the preceding Sections, the Chair of the Board (or the CEO on behalf of the Chair) shall schedule and arrange for an appeal. The individual shall be given Special Notice of the time, place, and date of the appeal. The appeal shall be held as soon as arrangements can reasonably be made, taking into account the schedules of all the individuals involved.

7.F.4. Nature of Appellate Review:

(a) The Board may serve as the Review Panel or the Chair of the Board may appoint a Review Panel composed of not less than three persons, either members of the Board or others, including but not limited to reputable persons outside the Hospital, to consider the record upon which the recommendation before it was made and recommend final action to the Board.

(b) Each party shall have the right to present a written statement in support of its position on appeal. The party requesting the appeal shall submit a statement first and the other party shall then have ten days to respond. In its sole discretion, the Review Panel may allow each party or its representative to appear personally and make oral argument not to exceed 30 minutes.

(c) When requested by either party, the Review Panel may, in its discretion, accept additional oral or written evidence subject to the same rights of cross-examination provided at the Hearing Panel proceedings. Such additional evidence shall be accepted only if the Review Panel determines that the party seeking to admit it has demonstrated that it is relevant, new evidence that could not have been presented at the hearing, or that any opportunity to admit it at the hearing was improperly denied.

7.G. BOARD ACTION

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

(a) Within 30 days after the Board (i) considers the appeal as a Review Panel, (ii) receives a recommendation from a separate Review Panel, or (iii) receives the Hearing Panel's report and recommendation when no appeal has been requested, the Board shall consider the matter and take final action.

(b) The Board may review any information that it deems relevant, including, but not limited to, the findings and recommendations of the MEC, Hearing Panel, and Review Panel (if applicable). The Board may adopt, modify, or reverse any

recommendation that it receives or, in its discretion, refer the matter to any individual or committee for further review and recommendation, or make its own decision based upon the Board's ultimate legal authority for the operation of the Hospital and the quality of care provided.

(c) The Board shall render its final decision in writing, including specific reasons, and shall send Special Notice to the individual. A copy shall also be provided to the MEC for its information.

7.G.2. Further Review:

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

7.G.3. Right to One Hearing and One Appeal Only:

No member of the Medical Staff shall be entitled to more than one hearing and one appellate review on any matter.

7.H. PROCEDURAL RIGHTS FOR ALLIED HEALTH PROFESSIONALS

(1) In the event a recommendation is made by the MEC that an Allied Health Professional not be granted clinical privileges or that clinical 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 notice will include a general statement of the reasons for the recommendation and will advise the individual that they may request a meeting with the MEC.

(2) If a meeting is requested, the meeting will be scheduled to take place within a reasonable time frame. The meeting will be informal and will not be considered a hearing. The supervising physician and the Allied Health Professional will both be permitted to attend this meeting. However, no counsel for either party will be present.

(3) Following this meeting, the MEC will make a recommendation to the Board, which will take final action on the matter.

ARTICLE 8

CONFLICT OF INTEREST GUIDELINES FOR CREDENTIALING, PRIVILEGING, AND PEER REVIEW ACTIVITIES

8.A.1. General Principles:

(a) All those involved in credentialing, privileging, and peer review activities (referred to collectively as "Medical Staff Functions" in this Article) 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 processes.

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

(c) An assessment of whether a conflict of interest exists will be interpreted reasonably by the persons involved, taking into consideration common sense and objective principles of fairness. Conflict of Interest Guidelines, which are attached as **Appendix B**, may be used as guidance in addressing potential conflict of interest situations, including whether and how an individual may participate.

(d) When performing a function outlined in this Policy, or any other Medical Staff policy, if a member has or reasonably could be perceived as having a conflict of interest or a bias, that member should not participate in the final discussion or voting on the matter and should recuse themselves from the meeting during that time. However, the member may provide relevant information and answer any questions concerning the matter before leaving the meeting. See Rules for Recusal in **Appendix B**.

(e) Any member with knowledge of the existence of an actual or potential conflict of interest or bias on the part of any other member may call the conflict of interest to the attention of the Medical Staff President (or Medical Staff President-Elect if the Medical Staff President is the person with the conflict), CMO, or applicable Division Chief or committee chair.

(f) Additionally, members are obligated to notify the Medical Staff President, Chief Medical Officer, or applicable Division Chief or committee chair of any known or suspected conflicts of interest of those who are involved in reviewing a matter. Any potential conflict of interest that is not timely raised will be deemed to be waived.

(g) The Medical Staff President, or applicable Division Chief or committee chair, will make a final determination as to whether the provisions in this Article should be

triggered or may submit the issue of whether there is a conflict of interest to a vote of the entire committee or division.

(h) The fact that a member is in the same specialty as a member whose request is being considered or performance is being reviewed does not automatically create a conflict.

(i) No member has a right to compel disqualification of another member based on an allegation of conflict of interest.

(j) The fact that a division or committee member or Medical Staff leader chooses to refrain from participation, or is excused from participation, will not be interpreted as a finding of an actual conflict of interest.

ARTICLE 9

CONFIDENTIALITY AND PEER REVIEW PROTECTION

9.A. CONFIDENTIALITY

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

(1) when the disclosures are to another authorized Practitioner or authorized Hospital employee and are for the purpose of researching, investigating, or otherwise conducting legitimate credentialing and peer review activities;

(2) when the disclosures are authorized by a Medical Staff or Hospital policy; or

(3) when the disclosures are authorized, in writing, by the CMO, the CEO, or by legal counsel to the Hospital.

Any breach of confidentiality may result in a professional review action and/or appropriate legal action. Such breaches are unauthorized and do not waive the peer review privilege. Any Practitioner who becomes aware of a breach of confidentiality must immediately inform the CEO or the Medical Staff President (or the Medical Staff President-Elect if the Medical Staff President is the person committing the claimed breach).

9.B. PEER REVIEW PROTECTION

(1) All credentialing and peer review activities pursuant to this Policy and related Medical Staff documents shall be performed by "peer review committees" or "quality improvement committees" in accordance with RCW 4.24.250. These committees include, but are not limited to:

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

(b) all divisions and sections;

(c) hearing panels;

(d) the Board and its committees; and

(e) any individual acting for or on behalf of any such entity, including but not limited to Division Chief(s), Section Medical Directors, committee chairs and members, officers of the Medical Staff, the CMO, all Hospital

personnel, and experts or consultants retained to assist in peer review activities.

All oral or written communications, reports, recommendations, actions, and minutes made or taken by peer review committees are confidential and covered by the applicable provisions of state law.

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

ARTICLE 10

AMENDMENTS

This Policy may be amended as described in the amendment provisions of the Medical Staff Bylaws.

ARTICLE 11

ADOPTION

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

Adopted by the Medical Staff: ________________________

Approved by the Board: ________________________

APPENDIX A

BOARD CERTIFICATION REQUIREMENTS

Subsequent to March 2010, all new members of the Medical Staff assigned to Active Hospital-Based, Active Office-Based, and Consulting Staff categories will be expected to be board certified or actively pursuing board certification within 5 years of appointment, and maintain board certification by the American Board of Medical Specialties or the American Osteopathic Association Board, or certification by an equivalent board as determined by the Credentials Committee. All present members of the Active Hospital-Based, Active Office-Based, and Consulting Staff categories, who are already board certified, will be expected to maintain board certification.

APPENDIX B

CONFLICT OF INTEREST GUIDELINES

Potential Conflicts	Levels of Participation							
	Provide Information	Individual Reviewer	Committee Member					Hearing Panel
			Credentials Committee	Leadership Council	MSQRC	MEC	Investigating Committee	
Employment/contract relationship with Hospital	Y	Y	Y	Y	Y	Y	Y	Y
Self or family member	Y	N	R	R	R	R	N	N
Relevant treatment relationship	Y	N	R	R	R	R	N	N
Significant financial relationship	Y	Y	Y	Y	Y	R	N	N
Partners in same specialty within a group	Y	Y	Y	Y	Y	R	N	N
Direct competitor	Y	Y	Y	Y	Y	R	N	N
Close friends	Y	Y	Y	Y	Y	R	N	N
History of conflict	Y	Y	Y	Y	Y	R	N	N
Provided care in case under review (but not subject of review)	Y	Y	Y	Y	Y	R	N	N
Involvement in prior Voluntary PIP or disciplinary action	Y	Y	Y	Y	Y	R	N	N
Formally raised the concern	Y	Y	Y	Y	Y	R	N	N

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

Y – (“Yes, with infrequent but occasional limitations”) – 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, Leadership Council, and MSQRC have no disciplinary authority.

In addition, the Chair of the Credentials Committee, Leadership Council, or MSQRC 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 (i) inhibit the full and fair discussion of the issue before the committee, (ii) skew the recommendation or determination of the committee, or (iii) otherwise be unfair to the Practitioner under review.

N – (“No”) – means the Interested Member should not serve in the indicated role.

R – (“Recuse”) – means the Interested Member should be recused, in accordance with the guidelines on the next page.

RULES FOR RECUSAL	
STEP 1 Confirm the conflict of interest	The relevant Medical Staff leader should confirm the existence of a conflict of interest relevant to the matter under consideration.
STEP 2 Participation by the Interested Member at the meeting	The interested member may participate in any part of the meeting that does not involve the conflict of interest situation. When the matter implicating the conflict of interest is ready for consideration, relevant Medical Staff leader will note that the interested member will be excused from the meeting prior to the group's deliberation and decision-making. Prior to being excused, the interested member may provide information and answer any questions regarding the following: (i) any factual information for which the interested member is the original source; (ii) clinical expertise that is relevant to the matter under consideration; (iii) any policies or procedures that are applicable to the committee or are relevant to the matter under consideration; (iv) the interested member's prior involvement in the review of the matter at hand (for example, an Investigating Committee member may describe the Investigating Committee's activities and present the Investigating Committee's written report and recommendations to the MEC prior to being excused from the meeting); and (v) how the committee has, in the past, managed issues similar or identical to the matter under consideration.
STEP 3 The Interested Member is excused from the meeting	The interested member will then be excused from the meeting (i.e., physically leave the meeting room and/or disconnect from any telephone or other electronic connection) prior to the committee's deliberation and decision-making.
STEP 4 Record the recusal in the minutes	The recusal should be documented in the minutes of the committee. The minutes should reflect the fact that the interested member was excused from the meeting prior to deliberation and decision-making.