CENTRACARE SURGICAL CENTER

MEDICAL STAFF BYLAWS, POLICIES AND RULES AND REGULATIONS

CREDENTIALS POLICY

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ARTICLE 1

GENERAL

1.A. PREAMBLE

All Medical Staff, Advanced Practice Provider Staff, and Medical Associate Staff ("Medical Staff/APP/MAS") members commit to working cooperatively and professionally with each other and Facility employees and management to promote safe, appropriate patient care. Medical Staff leaders will strive to address professional practice issues fairly, reasonably, and collegially in a manner that is consistent with quality care and patient safety.

1.B. TIME LIMITS

Time limits referred to in this Policy and related policies and manuals are advisory only and are not mandatory, unless it is expressly stated. Medical Staff leaders will strive to be fair under the circumstances.

1.C. DELEGATION OF FUNCTIONS

Functions assigned to an identified individual or committee may be delegated to one or more designees.

1.D. CONFIDENTIALITY AND PEER REVIEW PROTECTION

1.D.1. Confidentiality:

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

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

(b) as authorized by a policy; or

(c) as authorized, in writing, by the Director or by legal counsel to the Facility.

Any breach of confidentiality will result in appropriate sanctions.

1.D.2. Peer Review Protection:

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

(1) all standing and ad hoc committees of the Medical Staff and committees of the Facility;

(2) all departments;

(3) hearing and appellate review panels;

(4) the Board and its committees; and

(5) any individual acting for or on behalf of any such entity, including but not limited to Medical Staff leaders, and experts or consultants retained to assist in professional review activities.

(b) All reports, recommendations, actions, and minutes made or taken by peer review committees are confidential and covered by the provisions of applicable law.

1.E. INDEMNIFICATION

The Facility will provide a legal defense for, and will indemnify, Medical Staff leaders, peer review committees, members, and authorized representatives when engaged in professional review activity, to the fullest extent permitted by law, in accordance with the Facility's Bylaws.

ARTICLE 2

QUALIFICATIONS, CONDITIONS, AND RESPONSIBILITIES

2.A. QUALIFICATIONS

2.A.1. Threshold Eligibility Criteria:

To be eligible to apply for, and maintain, initial appointment or reappointment to the Medical Staff/APP/MAS, and for clinical privileges, an individual must, as applicable:

(a) have a current unrestricted license to practice, which is not subject to any probationary terms or conditions not generally applicable to all licensees;

(b) have a current unrestricted DEA registration;

(c) maintain clinical privileges as an active staff member and who fulfills one of the following requirements:

1. practitioner has similar clinical privileges at St. Cloud Hospital;

2. practitioner has a written agreement with a practitioner of comparable specialty, who holds appropriate privileges at St. Cloud Hospital, and who also agrees to provide coverage of any patient who requires admission to St. Cloud Hospital;

3. dentist who provides only such dental services as would usually be performed in a dental office, providing an Oral Surgeon who holds privileges at St. Cloud Hospital agrees to provide coverage of a patient who requires admission.

(d) be able to attend to a patient in the Facility within 30 minutes response time unless a lesser time is otherwise specified by the Medical Staff, or unless exempted by the Board;

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

(f) have never been convicted of Medicare, Medicaid, or other federal or state governmental or private third-party payer fraud;

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

(h) have never had medical staff appointment, affiliation, clinical privileges, or status as a participating provider denied, revoked, or terminated by any health care facility or health plan for reasons related to clinical competence or professional conduct;

(i) have never resigned medical staff appointment or affiliation, or relinquished privileges during an investigation or in exchange for not conducting such an investigation;

(j) have never been convicted of, or entered a plea of guilty or no contest, to any felony; or to any misdemeanor relating to controlled substances, illegal drugs, insurance or health care fraud or abuse, violence, sexual misconduct, or moral turpitude;

(k) have or agree to make coverage arrangements with other members of the Medical Staff with appropriate clinical privileges for those times when the member will be unavailable;

(l) demonstrate recent clinical activity in their primary area of practice during at least two of the last four years;

(m) have successfully completed a residency training program approved by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association in the specialty in which the applicant seeks clinical privileges, or an oral and maxillofacial surgery training program accredited by the Commission on Dental Accreditation of the American Dental Association, or a podiatric surgical residency program accredited by the Council on Podiatric Medical Education of the American Podiatric Medical Association;

(n) obtain board certification in the primary area of practice at the Facility within five years from the date of completion of training;

(o) maintain board certification and, to the extent required by the applicable specialty/subspecialty board, satisfy recertification requirements. Recertification will be assessed at reappointment; and

(p) if seeking to practice as an advanced practice provider, have a written agreement with a member of the Medical Staff to provide the requisite supervision or collaboration and provide the Facility with a copy of the agreement and with confirmation that the agreement has been filed with the applicable state board, as may be required.

The requirements in (m) and (n) and (o) will be applicable only to those individuals who apply for initial staff appointment after the date of adoption of this Policy. Existing members will be governed by the residency training and board certification requirements in effect at the time of their initial appointment.

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

(a) Waivers of threshold eligibility criteria will not be granted routinely. No one is entitled to a waiver. An application from an applicant who does not meet the threshold criteria for appointment, reappointment or clinical privileges will not be processed unless the Board has granted the requested waiver.

(b) A request for a waiver will only be considered if the applicant provides information sufficient to demonstrate that his or her qualifications are equivalent to, or exceed, the criterion in question and that there are exceptional circumstances that warrant a waiver.

(c) In deciding whether to grant a waiver, the Medical Executive Committee may consider supporting documentation submitted by the applicant, any relevant information from third parties, input from Medical Staff members, and the best interests of the Facility and the communities it serves.

(d) The Medical Executive Committee will make a recommendation to the Board regarding whether to grant or deny the request for a waiver and the basis for its recommendation.

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

2.A.3. Factors for Evaluation:

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

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

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

(c) good reputation and character;

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

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

(f) recognition of the importance of, and willingness to support, the commitment of the Medical Staff and Facility 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:

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

(a) is employed by or contracts with Facility or any organization related to Facility or its subsidiaries;

(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, affiliation, or privileges at any Facility or health care facility;

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

(g) is affiliated with, or under contract to, any managed care plan, insurance plan, health maintenance organization, preferred provider organization, or other entity.

2.A.5. Nondiscrimination:

No one will be denied appointment or clinical privileges on the basis of gender, race, creed, sexual orientation, or national origin.

2.A.6. Ethical Directives:

All Medical Staff appointees and others, while exercising privileges in the Facility, shall strictly abide by the Code of Ethics of the American Medical Association, American Dental Association, American Podiatric Medical Association, or American Osteopathic Association, whichever is applicable, regardless if the applicant is a member of the association.

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

2.B.1. Basic Responsibilities and Requirements:

(a) As a condition of appointment, reappointment, and the grant of clinical privileges, every applicant and member of the Medical Staff/APP/MAS specifically agree to the following, as applicable:

(1) to provide continuous and timely care;

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

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

(4) to provide emergency call coverage, and, if the need arises, care for unassigned patients;

(5) to comply with applicable clinical practice protocols and guidelines, as adopted by the Medical Executive Committee, or document the clinical reasons for variance;

(6) to submit to mandatory drug testing at initial appointment;

(7) to immediately submit to a blood, hair or urine test, or to a complete physical or mental evaluation, if at least two Medical Executive Committee members are concerned about his or her ability to safely and competently care for patients. The health care professional(s) to perform the testing or evaluations will be determined by the Medical Director;

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

(9) to use the Facility sufficiently, as appropriate to the individual's medical specialty, to allow continuing assessment of current competence;

(10) to seek consultation whenever necessary;

(11) to complete all medical and other required records in accordance with Facility policy;

(12) to perform all services and to act in a cooperative and professional manner;

(13) to promptly pay any applicable dues, assessments, or fines;

(14) to satisfy continuing medical education requirements;

(15) to maintain a current e-mail address with the Facility, which will be the official mechanism used to communicate all information to the member other than peer review information pertaining to the member and protected health information of patients;

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

(17) to fulfill any other responsibilities that are determined by the Medical Executive Committee to be reasonable and necessary to facilitate the delivery of safe and competent care or for the orderly operation of the Medical Staff or Facility.

(b) In addition to the above, as a condition of appointment and privileges, every individual seeking appointment to the APP Staff will specifically agree, as applicable, to the following:

(1) any privileges granted by the Board will be performed in the Facility under the supervision of, or in collaboration with, a Supervising/Collaborating Physician;

(2) the number of advanced practice providers employed by or under the supervision of, or working in collaboration with, a member of the Medical Staff will be consistent with state law and the rules and regulations of the Medical Staff; and

(3) to give notice, within three days, to the Medical Director of any revisions or modifications that are made to the supervision/collaboration agreement.

(c) Additional collaboration and supervision requirements for members of the APP Staff are included in Appendix B.

2.B.2. Burden of Providing Information:

(a) Applicants and members have the burden of producing information deemed adequate by the Facility for a proper evaluation of current competence, character, ethics, and other qualifications and for resolving any doubts.

(b) Applicants have the burden of providing evidence that all the statements made and information given on the application are accurate and complete.

(c) An application will be complete when all questions on the application form have been answered, all supporting documentation has been received, and all information has been verified from primary sources. An application will become incomplete if the need arises for new, additional, or clarifying information. Any application that continues to be incomplete 30 days after the applicant has been notified of the additional information required will be deemed to be withdrawn.

(d) Applicants are responsible for providing a complete application, including adequate responses from references. An incomplete application will not be processed.

(e) Notification of any change in status or any change in the information provided on the application form will be given to the Medical Director. This information must be provided with or without request, at the time the change occurs.

(f) Failure to provide this information will render the individual ineligible for staff membership or clinical privileges. Failure to provide this information as a member will result in automatic relinquishment of appointment and clinical privileges.

2.B.3. Applicant's Right to Review Information and to Correct Erroneous Information:

(a) Applicants have the right to be informed of the status of their credentialing or recredentialing application upon request.

(b) Applicants for both initial appointment and reappointment have the right to review all information submitted in support of their application, upon request.

(c) If any information that was obtained in the verification process during either initial credentialing or recredentialing conflicts with information provided by an applicant, the applicant will be notified prior to the application being considered by the Medical Executive Committee. The applicant will be given the opportunity to submit in writing any correction or clarification of the conflicting information that was obtained.

2.C. APPLICATION

2.C.1. Information:

Applications for appointment and reappointment will contain a request for specific clinical privileges and will require detailed information concerning the applicant's professional qualifications. The applications for initial appointment and reappointment existing now and as may be revised are incorporated by reference and made a part of this Policy. The applicant will

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

2.C.2. Misstatements and Omissions:

(a) Any misstatement in, or omission from, the application is grounds to stop processing the application. The applicant will be informed in writing of the nature of the misstatement or omission and permitted to provide a written response. The Medical Director 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, appointment and privileges may be deemed to be automatically relinquished.

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

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

By applying for appointment, reappointment, or clinical privileges, the applicant accepts the following conditions throughout the application process, terms of appointment and thereafter as to any inquiries received about the applicant:

(a) Immunity:

To the fullest extent permitted by law, the applicant releases from any and all liability, extends immunity to, and agrees not to sue the Facility or the Board, any member of the Medical Staff/APP/MAS, or Board, their authorized representatives, and third parties who provide information for any matter relating to appointment, reappointment, clinical privileges, or the applicant's qualifications for the same. This immunity covers any actions, recommendations, reports, statements, communications, or disclosures that are made, taken, or received by the Facility, any member of the Medical

Staff/APP/MAS, or Board, their representatives, or third parties in the course of credentialing and peer review activities. Nothing herein shall be deemed to waive any other immunity or privilege provided by federal or state law.

(b) Authorization to Obtain Information from Third Parties:

The applicant authorizes the Facility, Medical Staff, and their representatives (1) to consult with any third party who may have information bearing on the applicant's qualifications, and (2) to obtain any and all information from third parties that may be relevant. The applicant authorizes third parties to release this information to the Facility and its representatives upon request. The applicant also agrees to sign consent forms to permit a consumer reporting agency to conduct a criminal background check and report the results to the Facility.

(c) Authorization to Release Information to Third Parties:

The applicant also authorizes Facility representatives to release information to other facilities, health care facilities, managed care organizations, government regulatory and licensure boards or agencies, and their representatives when information is requested in order to evaluate his or her qualifications.

(d) Hearing and Appeal Procedures:

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

(e) Legal Actions:

If, despite this Section, an individual institutes legal action challenging any credentialing, privileging, peer review, or other professional review action or activity affecting

appointment or privileges and does not prevail, he or she will reimburse the Facility and any member of the Medical Staff/APP/MAS, or Board involved in the action for all costs incurred in defending such legal action, including reasonable attorney's fees.

(f) Authorization to Share Information within the System:

The applicant specifically authorizes the Facility and its affiliates to share information pertaining to the applicant's clinical competence and professional conduct.

(g) Scope of Section:

All of the provisions in this section are applicable in the following situations:

(1) whether 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 Facility's professional review activities; and

(4) as applicable, to any third-party inquiries received after the individual leaves the Medical Staff/APP/MAS about his or her tenure at the Facility.

ARTICLE 3

PROCEDURE FOR INITIAL APPOINTMENT AND PRIVILEGES

3.A. PROCEDURE FOR INITIAL APPOINTMENT AND PRIVILEGES

3.A.1. Application:

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

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

3.A.2. Initial Review of Application:

(a) A completed application form with copies of all required documents must be returned to the Credentialing Verification Office within 30 days after receipt. The application must be accompanied by the application fee.

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

(c) The Credentialing Verification Office will oversee the process of gathering and verifying information on the application with the primary sources, including the information regarding the individual's licensure, DEA registration, current clinical competence and judgment, character, ethical standing, behavior, ability to safely and competently exercise the privileges requested, lack of Medicare/Medicaid/other government health care program exclusion/sanctions, criminal background, if any, and professional liability insurance coverage. The Credentialing Verification Office will also query the National Practitioner Data Bank. Additionally, the Credentialing Verification Office will confirm that all references and other information or materials deemed pertinent have been received.

(d) Evidence of the applicant's character, professional competence, qualifications, behavior, and ethical standing will be examined. This information may be contained in the application, and obtained from references and other available sources, including the applicant's past or current department chairperson 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.

(e) An interview(s) with the applicant may be conducted by the Medical Director of Medical Executive Committee. Every attempt will be made to conduct this interview in-person.

3.A.3. Medical Executive Committee Procedure:

(a) The Medical Director will review the application and all supporting materials and prepare a report and recommendation to the Medical Executive Committee.

(b) After determining that an applicant is otherwise qualified for appointment and privileges, the Medical Executive Committee will review the health status information to determine if there is any question about the applicant's ability to perform the privileges requested and the responsibilities of appointment. The Medical Executive Committee may require a physical or mental examination by a physician(s) satisfactory to the Medical Executive Committee. The results of this examination will be made available to the Committee. Failure to undergo an examination within a reasonable time after a written request from the Medical Executive Committee will be considered a withdrawal of the application.

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

(e) If the recommendation of the Medical Executive Committee is delayed longer than 60 days after the receipt of a completed application, the Medical Director will send a letter to the applicant explaining the reasons for the delay.

3.A.4. Medical Executive Committee Recommendation:

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

(1) adopt the report and recommendation of the Medical Director as its own; or

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

(3) state its reasons for disagreement with the report and recommendation of the Medical Director.

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

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

3.A.5. Board Action:

(a) Upon receipt of a recommendation of the Medical Executive Committee for appointment and clinical privileges, the Board may:

(1) grant appointment and clinical privileges as recommended by the Medical Executive Committee, as appropriate; or

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

(3) disagree with or modify the recommendation.

(c) If the Board disagrees with a favorable recommendation of the Medical Executive Committee, it should first discuss the matter with the chairperson of the Medical Executive Committee. If the Board's determination remains unfavorable, the Director will promptly send special notice that the applicant is entitled to request a hearing.

(d) An applicant will be notified, in writing, within 30 days of the Board's decision regarding appointment.

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

3.A.6. Time Periods for Processing:

Once an application is deemed complete, it is expected to be processed within 190 days, unless it becomes incomplete. This time period is intended to be a guideline only and will not create any right for the applicant to have the application processed within this precise time period.

3.A.7. Provisional Period:

(a) Initial appointment (regardless of the staff category) and all initial grants of clinical privileges, whether at the time of appointment, reappointment, or during the term of an appointment, will be provisional.

(b) During the provisional period, the exercise of clinical privileges will be evaluated by the Medical Director or his or her designee. This focused professional practice evaluation may include chart review, monitoring, proctoring, external review, and other information. The numbers and types of cases to be reviewed will be determined by the Medical Executive Committee.

(c) The duration of the provisional period for initial appointment and privileges will be from 12 to 24 months, as recommended by the Medical Executive Committee. The duration of the provisional period for all other initial grants of privileges will be as recommended by the Medical Executive Committee.

(d) During the provisional period, a member must arrange for, or cooperate in the arrangement of, the required numbers and types of cases to be reviewed by other designated physicians.

(e) Unless an extension is granted by the Medical Executive Committee, a newly appointed member will automatically relinquish his or her appointment and privileges at the end of the provisional period if he or she fails, during the provisional period, to:

(1) cooperate with the monitoring and review conditions; or

(2) fulfill all requirements of appointment, including but not limited to those relating to completion of medical records or emergency call responsibilities.

In such case, the individual may not reapply for initial appointment or privileges for two years.

(f) If a member who has been granted additional clinical privileges fails, during the provisional period, to participate in the required number of cases or cooperate with the monitoring and review conditions, the additional clinical privileges will be automatically relinquished at the end of the provisional period unless an extension is granted by the Medical Executive Committee. The member may not reapply for the privileges in question for two years.

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

ARTICLE 4

CLINICAL PRIVILEGES

4.A. CLINICAL PRIVILEGES

4.A.1. General:

(a) Appointment or reappointment will not confer any clinical privileges or right to practice at the Facility. Only those clinical privileges granted by the Board may be exercised.

(b) A request for privileges will be processed only when an applicant satisfies threshold eligibility criteria.

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

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

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

(2) appropriateness of utilization patterns;

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

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

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

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

(7) the Facility'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 Facility;

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

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

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

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

4.A.2. Waiver of Requirement that Privileges Be Granted by 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) In limited circumstances, the Facility may consider a waiver of the requirement that privileges are granted by core or specialty. If an individual wants to request such a waiver, the request must be submitted in writing to the Credentialing Verification Office. The request must indicate the specific privileges within the core or specialty that the individual does not wish to provide, state a good cause basis for the request, and include evidence that he or she does not provide the relevant patient care services in any health care facility. The department chairperson who will be significantly affected will review the request and submit a recommendation to the Medical Executive Committee, which will make a recommendation to the Medical Executive Committee. The Board will take final action on requests for a waiver.

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

(1) the Facility'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 Facility'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) an undue burden on other Medical Staff members who serve on the call roster in the relevant specialty; 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.

(d) If the Board grants a waiver related to privileges, it will specify the effective date.

(e) No one is entitled to a waiver under this Section or to a hearing or appeal if a waiver is not granted.

4.A.3. Relinquishment of Individual Privileges:

A request to relinquish individual clinical privileges in the core or specialty must include a good cause basis. All such requests will be processed in the same manner as a request for waiver, as described above.

4.A.4. Relinquishment of Appointment and Privileges:

A request to resign all clinical privileges must specify the desired date of resignation, at least 30 days from the date of the request, and must provide evidence that the individual has completed all medical records and will be able to appropriately discharge or transfer responsibility for the care of any patient. After consulting with the Medical Executive Committee, the Medical Director will act on the request.

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

(a) Requests for clinical privileges to perform either a procedure not currently being performed or a new technique to perform an existing procedure ("new procedure") will not be processed until a determination has been made that the procedure will be offered by the Facility and criteria for the privilege have been adopted.

(b) As an initial step, the relevant Medical Director will determine whether a procedure or technique is a new procedure or an extension of a procedure or technique already being offered. If the procedure or technique involves clinical privileges that affect members in multiple specialties, the Medical Director will work cooperatively to determine if the procedure or technique is a new procedure or an extension of a procedure or technique already being offered. If the Medical Director finds the procedure or technique is a new procedure, the Medical Director will prepare a report that addresses the new procedure and its recommended criteria to present to the Medical Executive Committee.

(c) The Medical Executive Committee will review this report, conduct additional research as necessary based on the following factors, as to whether the new procedure should be offered to the community and the criteria for the privilege:

(1) whether there are greater risks to the patient in performing the new procedure;

(2) whether different equipment is required and whether different skills are required;

(3) whether the new procedure requires additional training for the staff;

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

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

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

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

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

(9) whether other members of the Medical Staff are available to address complications outside of the scope of privileges granted to the individual seeking the new privilege and whether emergency call and alternative coverage is available; and

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

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

(e) Specific requests from eligible Medical Staff members who wish to perform the new procedure or service may not be processed until the foregoing steps are completed. The individual seeking to perform the new procedure has the burden to provide any and all information requested during this process.

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

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

(b) As an initial step, the individual seeking the privilege will submit a report to the relevant department chairpersons and the Medical Executive Committee that includes a statement explaining why the individual wishes to perform the requested privilege and demonstrates: (i) that he/she meets the minimum qualifications needed to perform the procedure safely and competently, if already identified, or, if not already identified, specifies the minimum qualifications needed to perform the procedure safely and competently, (ii) whether the individual's specialty is performing the privilege at other similar facilities, and (iii) the experiences of those other facilities in terms of patient care outcomes and quality of care.

(c) The Medical Executive Committee shall then conduct additional research and consult with experts, as necessary, including those on the Medical Staff (e.g., department chairpersons, individuals on the Medical Staff with special interest and/or expertise) and those outside the Facility (e.g., other facilities, residency training programs, specialty societies). All individuals on the Medical Staff who are involved in the process are expected to work cooperatively and make good faith efforts to reach an outcome that is in the best interest of the community served by the Facility.

(d) The Medical Executive 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 minimum education, training, and experience necessary to perform the clinical privileges in question;

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

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

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

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

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

(e) The Medical Executive Committee will review the matter and forward its recommendations to the Board for final action.

(f) Specific requests from eligible Medical Staff members who wish to exercise the privileges in question may not be processed until the foregoing steps are completed. The individual seeking to perform the new procedure has the burden to provide any and all information requested during this process.

(g) The requirements in this 4.A.6 will be applicable only to those requests for clinical privileges that cross specialty lines made after the adoption of this policy. Clinical privileges that cross specialty lines existing at the time of the adoption of this policy will continue to be recognized.

4.A.7. Training:

(a) Physicians, podiatrists, advanced practice providers, and licensed independent practitioners in training will not be granted appointment or clinical privileges. The program director, clinical faculty, or attending staff member will be responsible for the direction and supervision of the on-site or day-to-day patient care activities of each trainee, who will be permitted to perform only those clinical functions set out in curriculum requirements, affiliation agreements, or training protocols approved by the Medical Executive Committee and the Graduate Medical Education Committee of the Facility. The applicable program director will be responsible for verifying and evaluating the qualifications of each individual who is in training.

(b) Individuals who are in training who wish to moonlight (outside of the training program) will be granted specific privileges as set forth in this Policy. A resident who is moonlighting must comply with the institutional and program requirements of the ACGME and all applicable CMS requirements. Loss of employment by the Facility in 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:

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

(b) A qualified individual may be granted telemedicine privileges, but need not be appointed to the Medical Staff.

(c) Requests for initial or renewed telemedicine privileges shall be processed through one of the following options, as determined by the Medical Director:

(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 individual must satisfy all qualifications and requirements set forth in this Policy, except those relating to geographic location, coverage arrangements, and emergency call responsibilities.

(2) If the individual requesting telemedicine privileges is practicing at a distant Facility 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 alternative process that relies on the credentialing and privileging decisions made by the distant Facility or telemedicine entity after the Facility queries the National Practitioner Data Bank and conducts a criminal background check. In such cases, the Facility must ensure, through a written agreement, that the distant Facility or telemedicine entity complies with all applicable Medicare regulations and accreditation standards. The distant Facility or telemedicine entity must provide:

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

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

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

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

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

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

This information received about the individual requesting telemedicine privileges will be provided to the Medical Executive Committee for review and

recommendation for final action by the Board. Notwithstanding the process set forth in this subsection, the Facility may determine that an applicant for telemedicine privileges is ineligible for appointment or clinical privileges if the applicant fails to satisfy the threshold eligibility criteria set forth in this Policy.

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

(e) Individuals granted telemedicine privileges shall be subject to the Facility's peer review activities. The results of the peer review activities, including any adverse events and complaints filed about the practitioner providing telemedicine services from patients, other practitioners or staff, will be shared with the Facility or entity providing telemedicine services.

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

4.B. TEMPORARY CLINICAL PRIVILEGES

(1) Temporary privileges may be granted by the Director of the Facility, upon recommendation of the Medical Director, to:

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

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

(i) the care of a specific patient;

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

(iii) proctoring; or

(iv) when serving as a locum tenens for a member of the Medical Staff/APP/MAS.

(2) The following verified information will be considered prior to the granting of any temporary privileges:

(a) current licensure;

(b) relevant training and experience;

(c) current competence;

(d) professional liability coverage acceptable to the Facility;

(e) confirmation that the individual is not on the List of Excluded Individuals and Entities;

(f) the results of a query to the National Practitioner Data Bank; and

(g) in the case of advanced practice provider's confirmation from the individual's Supervising/Collaborating Physician.

(3) The grant of temporary clinical privileges will not exceed 190 days. For non-applicants the days need not be consecutive and may be renewed.

(4) 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 Facility.

(5) In the case of an individual serving as a locum tenens for a member of the Medical Staff/APP/MAS who is on vacation, attending an educational seminar, or ill and/or otherwise needs coverage assistance for a period of time to meet the needs of patients in the member's absence, failure to submit a complete application two weeks prior to his or her start date may result in a processing fee.

(6) The granting of temporary privileges is a courtesy. Temporary privileges may be withdrawn for any reason by the Director at any time, after consulting with the Medical Director, or the Medical Executive Committee. The individual may be afforded an opportunity to refrain from exercising privileges.

(7) The Medical Director will assign to another member of the Medical Staff responsibility for the care of patients until they are discharged. Whenever possible, consideration will 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 patient(s) and in which any delay in administering treatment would add to that harm.

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

(3) When the emergency situation no longer exists, the patient will be assigned by the Medical Director 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 Medical Director may use a modified credentialing process to grant disaster privileges to eligible volunteer licensed independent practitioners, APPs and MASs ("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 Facility picture ID card that clearly identifies the individual's professional designation; (ii) current license to practice; (iii) primary source verification of the license; (iv) identification indicating that the individual has been granted authority to render patient care in disaster circumstances or is a member of a Disaster Medical Assistance Team, the Medical Resource Corps, the Emergency System for Advance Registration of Volunteer Health Professionals, or other recognized state or federal organizations or groups; or (v) identification by a current Facility employee or member of the Medical Staff/APP/MAS who possesses personal knowledge regarding the individual's ability to act as a volunteer during a disaster.

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

(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 volunteers who are licensed independent practitioners, APPs and MASs. This oversight will be conducted through direct observation, mentoring, clinical record review, or other appropriate mechanism developed by the Medical Staff and Facility.

4.E. CONTRACTS FOR SERVICES

(1) From time to time, the Facility may enter into contracts for the performance of clinical and administrative services. All individuals functioning pursuant to such contracts will obtain and maintain clinical privileges, in accordance with the terms of this Policy.

(2) To the extent that a contract confers the exclusive right to perform specified services to one or more practitioners or the Board adopts a resolution that limits the practitioners who may exercise privileges in any clinical specialty to employees of the Facility or its affiliates, no other practitioner except those authorized by the exclusive contract or resolution may exercise clinical privileges to perform the specified services while the contract or resolution is in effect. Only practitioners authorized by the exclusive contract or Board resolution are eligible to apply for the clinical privileges in question at the time of initial appointment, during the term of an appointment, or at reappointment. No other applications will be processed.

(3) Prior to the Facility signing any exclusive contract and/or passing any Board resolution described above, the Board will consider input from the Medical Executive Committee pertaining to quality of care issues and service implications.

(4) After receiving the Medical Executive Committee's report, the Board will determine whether to proceed with the exclusive contract or Board resolution. If the Board determines to proceed, and if that determination would have the effect of preventing an existing member from exercising clinical privileges that had previously been granted, the following notice and review procedures apply:

(a) The affected member(s) will be given at least 30 days advance notice of the exclusive contract or Board resolution and have the right to meet with a committee designated by the Board to discuss the matter prior to the contract being signed by the Facility or the Board resolution becoming effective.

(b) At the meeting, the affected member(s) will be entitled to present any information relevant to the Facility's decision to enter into the exclusive contract or enact the Board resolution. If, following this meeting, the Board decides to enter into the exclusive contract, or enact the Board resolution, the affected member(s) will be ineligible to continue to exercise the clinical privileges covered by the exclusive contract, or resolution, unless a waiver has been granted. In that circumstance, the ineligibility begins as of the effective date of the exclusive contract or Board resolution and continues for as long as the contract or resolution is in effect.

(c) The affected member(s) will not be entitled to any other procedural rights beyond those outlined above with respect to the Board's decision or the effect of the decision on his or her clinical privileges.

(d) The inability of a physician to exercise clinical privileges because of an exclusive contract or Board resolution is not a matter that requires a report to the Minnesota licensure board or to the National Practitioner Data Bank.

ARTICLE 5

PROCEDURE FOR REAPPOINTMENT

AND RENEWAL OF CLINICAL PRIVILEGES

5.A. PROCEDURE FOR REAPPOINTMENT AND RENEWAL

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

5.B. ELIGIBILITY FOR REAPPOINTMENT AND RENEWAL

In addition, to be eligible to apply for reappointment and renewal of clinical privileges, a member must have:

(1) completed all medical records;

(2) completed all continuing medical education requirements;

(3) satisfied all Staff responsibilities, including payment of any dues, fines, and assessments;

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

(5) paid any applicable reappointment processing fee;

(6) documented compliance with all applicable training, educational and/or patient care protocols that may be adopted by the Medical Executive Committee and required by the Facility, including, but not limited to, those involving electronic medical records, patient safety, and infection control; and

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

5.C. FACTORS FOR EVALUATION

In considering an application for reappointment, the factors listed in Section 2.A.3 of this Policy will be considered, as will the following additional factors relevant to the member's previous term:

(1) compliance with the bylaws, rules and regulations, and policies of the Medical Staff and the Facility;

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

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

(4) any focused professional practice evaluations;

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

(6) other reasonable indicators of continuing qualifications as may be requested by the department chairperson or the Medical Director or the Medical Executive Committee.

5.D. REAPPOINTMENT APPLICATION

(1) Reappointment will be for a period of not more than two years.

(2) An application for reappointment will be furnished to members at least 90 days prior to the expiration of their current appointment term. A completed reappointment application must be returned to the Credentialing Verification Office within 30 days.

(3) Failure to return a completed application within 30 days of receipt will result in the assessment of a reappointment processing fee. Failure to submit a complete application within 60 days of receipt may result in automatic expiration of appointment and clinical privileges at the end of the then current term of appointment.

(4) The application will be reviewed by the Credentialing Verification Office to determine that all questions have been answered and that the member satisfies all threshold eligibility criteria for reappointment and for the clinical privileges requested.

(5) The Credentialing Verification Office will oversee the process of gathering and verifying relevant information. The Credentialing Verification Office will also be responsible for confirming that all relevant information has been received.

(6) Applicants will be notified in writing within 30 days of the Board's decision regarding reappointment.

5.E. POTENTIAL ADVERSE RECOMMENDATION AND CONDITIONAL REAPPOINTMENTS

(1) If the Medical Executive Committee is considering a recommendation to deny reappointment or to reduce clinical privileges, the Medical Director will notify the member of the general tenor of the possible recommendation and may invite the member to meet prior to any final recommendation being made.

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

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

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

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

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

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

ARTICLE 6

PEER REVIEW PROCEDURES FOR QUESTIONS INVOLVING

MEDICAL STAFF, ADVANCED PRACTICE PROVIDERS

AND MEDICAL ASSOCIATE STAFF MEMBERS

6.A. COLLEGIAL INTERVENTION

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

(2) Collegial intervention is a part of the Facility's professional review activities and may include counseling, education, and related steps, such as the following:

(a) advising colleagues of applicable policies and standards, including policies and standards pertaining to appropriate behavior, emergency call obligations, conditions and responsibilities of staff members, and the timely and adequate completion of medical records;

(b) proctoring, monitoring, consultation, and letters of guidance; and

(c) sharing comparative quality, utilization, and other relevant information, including any variations from clinical protocols or guidelines, in order to assist individuals to conform their practices to appropriate norms.

(3) If an issue is raised pertaining to clinical competence or professional conduct of a member of the APP Staff, the Supervising/Collaborating Physician will be notified and may be invited to participate in the collegial intervention.

(4) The Medical Director may determine whether a matter should be handled in accordance with another policy (e.g., code of conduct policy, practitioner health policy, peer review policy) or should be referred to the Medical Executive Committee or the Medical Executive Committee for further action.

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

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

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

6.B. INVESTIGATIONS

6.B.1. Initial Review:

(a) Whenever a serious question has been raised, or where collegial efforts have not resolved an issue regarding the following, the question may be referred to the Medical Director, Director, or the chairperson of the Board:

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

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

(3) conduct that is considered lower than the standards of the Facility or disruptive to the orderly operation of the Facility or its Medical Staff/APP/MAS, including the inability of the member to work harmoniously with others.

(b) In addition, if the Board becomes aware of information that raises concerns about the qualifications of any member of the Medical Staff/APP/MAS, the matter will be referred to the Director or Medical Director.

(c) The person to whom the question is referred will make a sufficient inquiry to determine whether the question is credible and, if so, may forward it to the Medical Executive Committee. If the question pertains to a member of the APP Staff, the Supervising/Collaborating Physician may also be notified.

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

6.B.2. Initiation of Investigation:

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

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

(c) The Board may also determine to commence an investigation and may delegate the investigation to the Medical Executive Committee, a subcommittee of the Board, or an ad hoc committee.

6.B.3. Investigative Procedure:

(a) Once a determination has been made to begin an investigation, the Medical Executive Committee will investigate the matter itself or appoint an individual or committee ("Investigating Committee") to do so. In appointing the Investigating Committee, the Medical Executive Committee will not include partners, non-partner associates, relatives of the individual being investigated, or any other individual with a significant conflict of interest. The Medical Executive Committee may appoint individuals not on the Medical Staff/APP/MAS to serve on the Investigating Committee.

(b) The Investigating Committee may:

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

(2) conduct interviews;

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

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

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

(d) As part of the investigation, the individual will have an opportunity to meet with the Investigating Committee. Prior to this meeting, the individual will be informed of the questions being investigated and will be invited to discuss, explain, or refute the questions. If the individual who is the subject of the investigation is a member of the APP Staff, the Supervising/Collaborating Physician may also be invited to meet with the Investigating Committee. A summary of the interview will be made and included with the Investigating Committee's report. This meeting is not a hearing, and none of the procedural rules for hearings will apply. Lawyers will not be present at this meeting.

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

6.B.4. Recommendation:

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

(1) determine that no action is justified;

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

(3) impose conditions for continued appointment;

(4) require monitoring, proctoring or consultation;

(5) require additional training or education;

(6) recommend reduction of clinical privileges;

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

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

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

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

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

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

6.C. PRECAUTIONARY SUSPENSION OR RESTRICTION OF CLINICAL PRIVILEGES

6.C.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 Director, the Medical Director, the Medical Executive Committee, or the Board chairperson is authorized to (1) afford the individual an opportunity to voluntarily refrain from exercising privileges pending an investigation; or (2) suspend or restrict all or any portion of an individual's clinical privileges pending an investigation.

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

the individual and review the concerns that support the suspension and afford the individual an opportunity to respond.

(c) 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 Director and the Medical Director. A precautionary suspension will remain in effect unless it is modified by the Director or the Medical Executive Committee.

(e) Within three days of the imposition of a suspension, 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), will be provided to the individual.

6.C.2. Medical Executive Committee Procedure:

(a) Within a reasonable time, not to exceed 30 days of the imposition of the suspension, the Medical Executive Committee will review the reasons for the suspension.

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

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

(d) After considering the reasons for the suspension and the individual's response, if any, the Medical Executive Committee will determine whether the precautionary suspension

should be continued, modified, or lifted. The Medical Executive Committee will also determine whether to begin an investigation.

(e) If the Medical Executive Committee decides to continue the suspension, it will send the individual written notice of its decision, including the basis for it and that suspensions lasting longer than 30 days must be reported to the National Practitioner Data Bank.

(f) There is no right to a hearing based on the imposition or continuation of a precautionary suspension. The procedures outlined above are deemed to be fair under the circumstances.

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

6.D. AUTOMATIC RELINQUISHMENT

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

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

6.D.2. Action by Government Agency or Insurer and Failure to Satisfy Threshold Eligibility Criteria:

(a) Any action taken by any licensing board, professional liability insurance company, court or government agency regarding any of the matters set forth below, or failure to satisfy

any of the threshold eligibility criteria, must be promptly reported to the Medical Director.

(b) An individual's appointment and clinical privileges will be automatically relinquished, without right to hearing or appeal, if any of the following occur:

(1) Licensure: Revocation, probation, expiration, suspension, or the placement of conditions or restrictions on an individual's license.

(2) DEA Registration: Revocation, expiration, suspension, or the placement of conditions or restrictions on an individual's DEA registration.

(3) Insurance Coverage: Termination or lapse of an individual's professional liability insurance coverage, or other action causing the coverage to fall below the minimum required by the Facility.

(4) Medicare and Medicaid Participation: Termination, exclusion, or preclusion by government action from participation in the Medicare/Medicaid or other federal or state health care programs.

(5) Criminal Activity: Arrest, indictment, conviction, or a plea of guilty or no contest pertaining to any felony, or to any misdemeanor involving (i) controlled substances; (ii) illegal drugs; (iii) Medicare, Medicaid, or insurance or health care fraud or abuse; (iv) violence; (v) sexual misconduct; or (vi) moral turpitude.

(c) An individual's appointment and clinical privileges will be automatically relinquished, without entitlement to a hearing and appeal, if the individual fails to satisfy any of the threshold eligibility criteria or perform his or her responsibilities during the provisional period.

(d) Automatic relinquishment will take effect immediately upon notice to the Facility and continue until the matter is resolved and the individual is reinstated.

(e) If the underlying matter leading to automatic relinquishment is resolved or if the individual contends that there are exceptional circumstances which warrant an exception to an automatic relinquishment, the individual may request reinstatement. Failure to resolve the matter within 60 days of the date of relinquishment will result in an automatic resignation from the Medical Staff/APP/MAS.

(f) Requests for reinstatement will be reviewed by the Medical Executive Committee, the Medical Director and the Director. If all these individuals make a favorable recommendation on reinstatement, the individual may immediately resume clinical practice at the Facility. This determination will then be forwarded to the Medical Executive Committee and the Board for ratification. If, however, any of the individuals reviewing the request have any questions or concerns, those questions will be noted and the reinstatement request will be forwarded to the full Medical Executive Committee and Board for review and recommendation.

6.D.3. Failure to Provide Information:

Appointment and clinical privileges will be deemed to be automatically relinquished upon the occurrence of:

(a) failure to notify the Medical Director, or the Director of any change in any information provided on an application for initial appointment or reappointment, after review by the Medical Director and after considering any written or oral explanation provided by the individual;

(b) failure to provide information or to otherwise respond to requests pertaining to an individual's qualifications for appointment or clinical privileges in response to a written request specifying the time frame for response from the Medical Executive Committee or any other committee authorized to request such information, until the information is provided to the satisfaction of the requesting party; or

(c) failure to undergo a blood, hair or urine test or a complete physical or mental examination if at least two Medical Staff leaders (or one Medical Staff leader and the Director are concerned about the member's ability to safely and competently care for patients.

6.D.4. Failure to Attend Requested Meeting:

(a) Whenever there is a concern regarding an individual's clinical practice or professional conduct, the individual may be requested to attend a meeting with one or more Medical Staff leaders and/or a committee of the Medical Staff.

(b) Special notice will be given to inform the individual that attendance at the meeting is mandatory and that the individual must make himself or herself available in at least three days, or earlier if agreed upon by the parties.

(c) Failure of the individual to attend the meeting will be reported to the Medical Executive Committee. Unless excused by the Medical Executive Committee upon a showing of good cause, failure to attend will result in the automatic relinquishment of all or such portion of the individual's clinical privileges as the Medical Executive Committee may direct. Such relinquishment will remain in effect until the individual attends the requested meeting.

6.D.5. Failure to Complete or Comply with Training or Educational Requirements:

Failure to complete or comply with training, educational, and patient care protocol requirements that are adopted by the Medical Executive Committee and required by the Facility, including, but not limited to, those pertinent to electronic medical records, patient safety, and infection control, may result in the automatic relinquishment of all clinical privileges. Any relinquishment will continue in effect until documentation of compliance is provided to the satisfaction of the Medical Executive Committee. If the requested information is not provided within 30 days of the date of relinquishment, it may result in automatic resignation from the Medical Staff.

6.E. LEAVES OF ABSENCE

6.E.1. Initiation:

(a) Except for requests related to physical or mental health (as addressed in (d) below), any leave of absence that is expected to last for 90 days or more must be requested in writing and submitted to the Medical Director. The request must state the beginning and ending dates of the leave, the reasons for the leave, and the arrangement that has been made for patient coverage.

(b) Except in extraordinary circumstances, this request should be submitted at least 30 days prior to the anticipated start of the leave.

(c) The Medical Director will determine whether a request for a leave of absence will be granted. The granting of a leave of absence or reinstatement may be conditioned upon the individual's completion of all medical records.

(d) Members of the Medical Staff/APP/MAS must report to the Medical Director anytime they are away from the Facility or patient care responsibilities for longer than 30 days and the reason for the absence is related to their physical or mental health or otherwise to their ability to care for patients safely and competently. Under such circumstances, the Medical Director may trigger an automatic medical leave of absence.

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

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

During the leave of absence, the individual will not exercise any clinical privileges and will be excused from all Medical Staff/APP/MAS responsibilities (e.g., meeting attendance, committee

service, emergency service call obligations, and payment of dues). All medical records must be completed as soon as reasonably possible.

6.E.3. Reinstatement:

(a) Individuals requesting reinstatement will submit a written summary of their professional activities during the leave and any other information that may be requested by the Facility. Requests for reinstatement will then be reviewed by the Medical Director and the and in accordance with the practitioner health policy, if applicable.

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

(c) If any request for reinstatement is not granted for reasons related to clinical competence or professional conduct, and if a report to the National Practitioner Data Bank is determined to be required, the individual will be entitled to request a hearing and appeal.

(d) If an individual's current appointment is due to expire during the leave, the individual's appointment and clinical privileges will expire at the end of the appointment period, and the individual will be required to apply for reappointment simultaneously with the request for reinstatement.

ARTICLE 7

HEARING AND APPEAL PROCEDURES

7.A. INITIATION OF HEARING

7.A.1. Grounds for Hearing:

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

(1) denial of initial appointment, reappointment or requested clinical privileges;

(2) revocation of appointment to the Medical Staff/APP/MAS or clinical privileges;

(3) suspension of clinical privileges for more than 30 days (other than precautionary suspension);

(4) restriction of clinical privileges, meaning a mandatory concurring consultation requirement, in which the consultant must approve the course of treatment in advance; or

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

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

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

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

None of the following actions constitute grounds for a hearing. These actions take effect without hearing or appeal. The individual is entitled to submit a written statement regarding these actions for inclusion in his or her file:

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

(b) conditions, monitoring, proctoring, or a general consultation requirement;

(c) a lapse or decision not to grant or not to renew temporary privileges;

(d) automatic relinquishment of appointment or privileges;

(e) a requirement for additional training or continuing education;

(f) precautionary suspension;

(g) denial of a request for leave of absence or for an extension of a leave;

(h) determination that an application is incomplete;

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

(j) determination of ineligibility based on a failure to meet threshold eligibility criteria, a lack of need or resources, or because of an exclusive contract; or

(k) a recommendation for or commencement of a focused professional practice evaluation.

7.A.3. Notice of Recommendation:

The Director will promptly give special notice of a recommendation which entitles an individual to request a hearing. This notice will 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.A.4. Request for Hearing:

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

7.A.5. Notice of Hearing and Statement of Reasons:

(a) The Director will schedule the hearing and provide, by special notice, the following:

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

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

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

(4) a statement of the specific reasons for the recommendation, including a list of patient records (if applicable), and information supporting the recommendation. This statement may be revised or amended at any time, even during the hearing, so long as the additional material is relevant to the recommendation or the individual's qualifications and the individual has had a sufficient opportunity, up to 30 days, to review and respond with additional information.

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

7.A.6. Witness List:

(a) At least 15 days before the pre-hearing conference, the individual requesting the hearing will provide the Director with a written list of the names of witnesses expected to offer testimony on his or her behalf.

(b) The witness list will 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.A.7. Hearing Panel, Presiding Officer, and Hearing Officer:

(a) Hearing Panel:

The Director, after consulting with the Medical Director, will appoint a Hearing Panel in accordance with the following guidelines:

(1) The Hearing Panel will consist of at least three members, one of whom will be designated as chairperson.

(2) The Hearing Panel may include any combination of:

(i) any member of the Medical Staff/APP/MAS; or

(ii) physicians or laypersons not connected with the Facility (i.e., physicians, advanced practice providers, or licensed independent practitioners not on the Medical Staff/APP/MAS or laypersons not affiliated with the Facility).

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

(4) Employment by, or other contractual arrangement with, the Facility or an affiliate will not preclude an individual from serving on the Panel.

(5) The Panel will not include any individual who:

(i) is in direct economic competition with the individual requesting the hearing;

(ii) is professionally associated with, related to, or involved in a formal referral relationship with, the individual requesting the hearing;

(iii) is demonstrated to have an actual bias, prejudice, or conflict of interest that would prevent the individual from fairly and impartially considering the matter; or

(iv) actively participated in the matter at any previous level.

(b) Presiding Officer:

(1) The Director will appoint a Presiding Officer who may be an attorney. The Presiding Officer will not act as an advocate for either side at the hearing.

(2) The Presiding Officer will:

(i) schedule and conduct a pre-hearing conference;

(ii) 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;

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

(iv) maintain decorum throughout the hearing;

(v) determine the order of procedure;

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

(vii) conduct argument by counsel on procedural points outside the presence of the Hearing Panel unless the Panel wishes to be present.

(3) The Presiding Officer may participate in the private deliberations of the Hearing Panel, may be a legal advisor to it, and may draft the report of the Hearing Panel's decision based upon the findings and discussions of the Panel, but will not vote on its recommendations.

(c) Hearing Officer:

(1) As an alternative to a Hearing Panel, the Director, after consulting with the Medical Director, may appoint a Hearing Officer, preferably an attorney, to perform the functions of a Hearing Panel. The Hearing Officer may not be, or represent clients, in direct economic competition with the individual requesting the hearing.

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

(d) Objections:

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

7.A.8. 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.B. PRE-HEARING PROCEDURES

7.B.1. General Procedures:

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

7.B.2. Provision of Relevant Information:

(a) Prior to receiving any confidential documents, the individual requesting the hearing must agree, in writing, that all documents and information will be maintained as confidential and will not be disclosed or used for any purpose outside of the hearing. The individual must also provide a written representation that his/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 will be provided with 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 Medical Executive Committee;

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

(4) copies of any other documents relied upon by the Medical Executive Committee.

The provision of this information is not intended to waive any privilege.

(c) The individual will have no right to discovery beyond the above information. No information will be provided regarding other members. In addition, there is no right to depose, interrogate, or interview witnesses or other individuals prior to the hearing.

(d) Ten days prior to the pre-hearing conference, or on dates set by the Presiding Officer or agreed upon by both sides, each party will provide the other party with its proposed exhibits.

(e) Neither the individual nor any other person acting on behalf of the individual may contact Facility employees or members whose names appear on the Medical Executive Committee's witness list or in documents provided pursuant to this section concerning the subject matter of the hearing, until the Facility has been notified and has contacted the individuals about their willingness to be interviewed. The Facility will advise the individual who requested the hearing once it has contacted such employees or members and confirmed their willingness to meet. Any employee or member of the Medical Staff /APP/MAS may agree or decline to be interviewed by or on behalf of the individual who requested a hearing.

7.B.3. Pre-Hearing Conference:

(a) The Presiding Officer may require the individual or a representative (who may be counsel) for the individual, and for the Medical Executive Committee, to participate in a pre-hearing conference.

(b) All objections to documents and witnesses will be submitted in writing five days in advance of the pre-hearing conference. The Presiding Officer will not entertain subsequent objections unless the party offering the objection demonstrates good cause.

(c) At the pre-hearing conference, the Presiding Officer will resolve all procedural questions, including any objections to exhibits or witnesses.

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

(e) The Presiding Officer will establish the time to be allotted to each witness's testimony and cross-examination.

(f) It is expected that the hearing will last no more than 15 hours, with each side being afforded approximately seven and a half hours to present its case, in terms of both direct and cross-examination of witnesses. Both parties are required to prepare their case so that a hearing will 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.B.4. Stipulations:

The parties will use their best efforts to develop and agree upon stipulations to provide for a more efficient hearing.

7.B.5. Provision of Information to the Hearing Panel:

The following documents will 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) stipulations agreed to by the parties.

7.B.6. Time Frames:

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

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

(b) the parties will 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. THE HEARING

7.C.1. Failure to Appear:

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

7.C.2. Record of Hearing:

A stenographic reporter will be present to make a record of the hearing. The cost of the reporter will be borne by the Facility. Copies of the transcript will be available at the individual's expense. Oral evidence will be taken on oath or affirmation administered by any authorized person.

7.C.3. Rights of Both Sides and the Hearing Panel at the Hearing:

(a) At a hearing, both sides will 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;

(4) to have representation by counsel who may be present but not call, examine, and cross-examine witnesses and present the case;

(5) to submit a written statement at the close of the hearing; and

(6) to submit proposed findings, conclusions and recommendations to the Hearing Panel.

(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, or request documentary evidence.

7.C.4. Order of Presentation:

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

7.C.5. Admissibility of Evidence:

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

7.C.6. Persons to Be Present:

The hearing will be restricted to those individuals involved in the proceeding. Administrative personnel may be present as requested by the Director or the Medical Director.

7.C.7. Postponements and Extensions:

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

7.C.8. Presence of Hearing Panel Members:

A majority of the Hearing Panel will 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 will read the entire transcript of the portion of the hearing from which he or she was absent.

7.D. HEARING CONCLUSION, DELIBERATIONS, AND RECOMMENDATIONS

7.D.1. 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 will recommend in favor of the Medical Executive Committee unless it finds that the individual who requested the hearing has proved, by clear and convincing evidence, that the recommendation that prompted the hearing was arbitrary, capricious, or not supported by credible evidence.

7.D.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 will conduct its deliberations outside the presence of any other person except the Presiding Officer. The Hearing Panel will render a recommendation, accompanied by a report, which will contain a statement of the basis for its recommendation.

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

The Hearing Panel will deliver its report to the Director. The Director will send by special notice a copy of the report to the individual who requested the hearing. The Director will also provide a copy of the report to the Medical Director.

7.E. APPEAL PROCEDURE

7.E.1. Time for Appeal:

(a) Within ten days after notice of the Hearing Panel's recommendation, either party may request an appeal. The request will be in writing, delivered to the Director either in person or by certified mail, return receipt requested, and will 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 ten days, an appeal is deemed to be waived and the Hearing Panel's report and recommendation will be forwarded to the Board for final action.

7.E.2. Grounds for Appeal:

The grounds for appeal will be limited to the following:

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

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

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

Whenever an appeal is requested, the chairperson of the Board will schedule and arrange for an appeal. The individual will be given special notice of the time, place, and date of the appeal. The appeal will be held as soon as arrangements can reasonably be made, taking into account the schedules of all the individuals involved.

7.E.4. Nature of Appellate Review:

(a) The Board may serve as the Review Panel or the chair of the Board may appoint a Review Panel, composed of members of the Board or others, including but not limited to reputable persons outside the Facility.

(b) The Review Panel may consider the record upon which the recommendation was made, including the hearing transcripts and exhibits, post-hearing statements, the findings and recommendations of the Medical Executive Committee and Hearing Panel and any other information that it deems relevant, and recommend final action to the Board.

(c) Each party will have the right to present a written statement in support of its position on appeal. The party requesting the appeal will submit a statement first and the other party will 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.

(d) 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. Additional evidence will be accepted only if the Review Panel determines that the party seeking to admit it can demonstrate that it is new, relevant evidence or that any opportunity to admit it at the hearing was improperly denied.

7.F. BOARD ACTION

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

(a) The Board will take final action within 30 days after it (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 when no appeal has been requested.

(b) Consistent with its ultimate legal authority for the operation of the Facility and the quality of care provided, the Board may adopt, modify, or reverse any recommendation that it receives or refer the matter for further review.

(c) The Board will render its final decision in writing, including the basis for its decision, and will send special notice to the individual. A copy will also be provided to the Medical Director.

(d) Except where the matter is referred by the Board for further review, the final decision of the Board will be effective immediately and will not be subject to further review.

7.F.2. Right to One Hearing and One Appeal Only:

No individual will be entitled to more than one hearing and one appeal on any matter. If the Board denies initial appointment or reappointment or revokes appointment or clinical privileges, that individual may not apply for appointment or clinical privileges for a period of five years, from the date of the Board's final action, unless the Board provides otherwise.

ARTICLE 8

CONFLICTS OF INTEREST

(a) When performing a function outlined in this Policy, the bylaws, or the rules and regulations, if any member has or reasonably could be perceived as having a conflict of interest or a bias, that member will not participate in the final discussion or voting on the matter, and will be excused from any meeting during that time. However, the member may provide relevant information and may answer any questions concerning the matter before leaving.

(b) Any member with knowledge of the existence of a 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 Director (or the Medical Executive Committee if the Medica Director is the person with the potential conflict). The Medical Director or the Medical Executive Committeewill make a final determination as to whether the provisions in this Article should be triggered.

(c) The fact that a department chairperson or a member is in the same specialty as a member whose performance is being reviewed does not automatically create a conflict. In addition, the 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. No member has a right to compel disqualification of another member based on an allegation of conflict of interest.

(d) The fact that a department 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 actual conflict.

ARTICLE 9

FACILITY EMPLOYEES

(a) Except as provided below, the employment of an individual by the Facility will be governed by the Facility's employment policies and manuals and the terms of the individual's employment relationship or written contract. To the extent that the Facilityies employment policies or manuals, or the terms of any applicable employment contract, conflict with this Policy, the employment policies, manuals and descriptions and terms of the individual's employment relationship or written contract will apply.

(b) It is expected that all members, including members who are employed or otherwise have a contract with the Facility, will, at a minimum, satisfy the threshold eligibility criteria for appointment and the privileges requested and will fulfill the basic responsibilities and requirements set forth in this Policy and the Medical Staff Bylaws.

(c) A request for appointment, reappointment or clinical privileges, submitted by an applicant or member who is employed by the Facility, will be processed in accordance with the terms of this Policy. A report regarding each practitioner's qualifications will be made to Administration or Human Resources (as appropriate) to assist the Facility in making employment decisions.

(d) If a concern about an employed member's clinical conduct or competence originates with the Medical Staff, the concern will be reviewed and addressed in accordance with this Policy, after which a report will be provided to Human Resources.

ARTICLE 10

ADOPTION

This Policy is adopted and made effective upon approval of the Board, superseding and replacing any and all other bylaws, rules and regulations of the Medical Staff or Facility policies pertaining to the subject matter thereof.

Adopted by the Medical Staff on:

Date: _____

_____

Medical Director

Approved by the Board:

Date: _____

_____

Chairperson, Board of Directors

GLOSSARY

The following definitions apply to terms used in this Policy:

(1) "ADVANCED PRACTICE PROVIDER" means a type of provider who provides a medical level of care or performs surgical tasks consistent with granted clinical privileges, but who is required by law and/or the Facility to exercise some or all of those clinical privileges under the direction of, or in collaboration with, a Supervising/Collaborating Physician pursuant to a written supervisory or, as permitted by statute, collaborative agreement. This category includes advanced practice registered nurses and physician assistants.

(2) "ADVANCED PRACTICE PROVIDER STAFF" ("APP Staff") means advanced practice registered nurses and physician assistants who have been appointed to this Staff by the Board.

(3) "ADVANCED PRACTICE REGISTERED NURSE" means an individual licensed as a registered nurse and certified by a national nurse certification organization acceptable to the state board and the Board of the Facility, including clinical nurse specialist, nurse midwife, nurse practitioner, and nurse anesthetist.

(4) "BOARD" means the Board of Directors of the Facility, which has the overall responsibility for the Facility, or its designated committee.

(5) "BOARD CERTIFICATION" is the designation conferred by one of the affiliated specialties of the American Board of Medical Specialties, the American Osteopathic Association, the American Board of Oral and Maxillofacial Surgery, or the American Board of Podiatric Surgery, or the American Board of Podiatric Orthopedics and Primary Medicine, upon an individual, as applicable, who has successfully completed an approved educational training program and an evaluation process, including passing an examination, in the individual's area of clinical practice. The approved boards for

certification for members of the Advanced Practice Provider Staff are included in Appendix C.

(6) "CLINICAL PRIVILEGES" or "PRIVILEGES" means the authorization granted by the Board to render specific patient care services, for which the Medical Executive Committee and Board have developed eligibility and other credentialing criteria and focused and ongoing professional practice evaluation standards.

(7) "COLLABORATE" means the process by which an advanced practice registered nurse practices cooperatively with a Collaborating Physician to deliver health care services consistent with a mutually agreed upon plan between an advanced practice registered nurse and one or more physicians that designates the scope of collaboration necessary to manage the care of patients.

(8) "COMPLETED APPLICATION" means that all questions on the application form have been answered, all supporting documentation has been supplied, and all information has been verified from primary sources. An application will become incomplete if the need arises for new, additional, or clarifying information at any time.

(9) "CORE PRIVILEGES" or "CORE" means a defined grouping of privileges for a specialty or subspecialty that includes the fundamental patient care services that are routinely taught in residency or fellowship training, or through educational preparation for that specialty or subspecialty and that have been determined by the Medical Executive Committee and Board to require closely related skills and experience.

(10) "CREDENTIALING" means the process for determining eligibility for appointment to the Medical Staff/APP/MAS and clinical privileges.

(11) "CREDENTIALS POLICY" or "POLICY" means the Facility's Medical Staff Credentials Policy.

(12) "CREDENTIALS VERIFICATION OFFICE" means the group providing primary verification on all applicants.

(13) "DAYS" means calendar days except for time periods identified in this Policy as 10 days or less, which will be calculated using business days, meaning any day from Monday through Friday, except holidays.

(14) "DENTIST" means a doctor of dental surgery ("D.D.S.") or doctor of dental medicine ("D.M.D.").

(15) "DEPENDENT PRACTITIONER" means a practitioner who is permitted by law or the Facility to function only under the direction of a Supervising/Collaborating Physician, pursuant to a written supervisory/collaborative agreement and consistent with the scope of practice granted. All aspects of the clinical practice of a Facility-employed Dependent Practitioner at the Facility shall be assessed and managed by Human Resources in accordance with Human Resources policies and procedures, and the provisions of this Policy shall specifically **not** apply. Applications for permission to practice by Dependent Practitioners who are not employed by the Facility will be submitted and processed in the same manner as outlined for Medical Staff/APP/MAS members in this Policy. For ease of use, when applicable to Dependent Practitioners, any reference in this Policy to "appointment" or "reappointment" shall be interpreted as a reference to initial or continued permission to practice, and any reference to "clinical privileges" shall be interpreted as a reference to a "scope of practice."

(16) "FACILITY" means CentraCare Surgery Center.

(17) "LICENSED INDEPENDENT PRACTITIONER" means a practitioner who is permitted by law and by the Facility to provide patient care services within the scope of his or her license and consistent with the clinical privileges granted and without the direction of or collaboration with a Supervising/Collaborating Physician. Licensed independent practitioners include those physicians not appointed to the Medical Staff who seek to exercise certain limited clinical privileges at the Facility ("moonlighting").

(18) "MEDICAL ASSOCIATE STAFF" ("MAS") means licensed independent practitioners other than members of the Medical Staff (e.g., psychologist, licensed social workers) who are authorized by law and by the Facility to provide patient care services within the Facility.

(19) “MEDICAL EXECUTIVE COMMITTEE” means the Medical Executive Committee of the Medical Staff.

(20) “MEDICAL STAFF” means all physicians, dentists and podiatrists who have been appointed to the Medical Staff by the Board.

(21) “MEDICAL STAFF LEADER” means any Medical Staff officer, department chairperson, division chief, or committee chairperson.

(22) “MEMBER” means any physician, dentist or podiatrist who has been appointed to the Medical Staff, any advanced practice provider who has been appointed to the APP Staff, and any licensed independent practitioner who has been appointed to the MAS Staff, by the Board to practice at the Facility.

(23) “NOTICE” means written communication by regular U.S. mail, e-mail, facsimile, or Facility mail.

(24) “PATIENT CONTACTS” includes any admission, consultation, procedure, response to emergency call, evaluation, treatment, or service performed in any facility operated by the Facility or affiliate, including outpatient facilities.

(25) “PEER REVIEW COMMITTEES” includes professional review bodies, as defined in the HCQIA, that is, a health care entity and the governing body or any committee of a health care entity which conducts professional review activity, and includes any committee of the Medical Staff of such an entity when assisting the governing body in a professional review activity.

(26) “PHYSICIAN” includes both doctors of medicine (“M.D.s”) and doctors of osteopathy (“D.O.s”).

(27) "PHYSICIAN ASSISTANT" means an individual who is a graduate of a physician assistant program approved by the Accreditation Review Commission on Education for Physician Assistants or one of its predecessor agencies, and/or has been certified by the National Commission on Certification of Physician Assistants and who is licensed to practice medicine with physician supervision.

(28) "PODIATRIST" means a doctor of podiatric medicine ("D.P.M.").

(29) "DIRECTOR" means the individual appointed by the Board to act on its behalf in the overall management of the Facility.

(30) "PRIVILEGING" means the process of granting and monitoring clinical privileges.

(31) "PROFESSIONAL REVIEW ACTION" has the meaning defined in the HCQIA.

(32) "PROFESSIONAL REVIEW ACTIVITY" has the meaning defined in the HCQIA, that is, activity to determine whether an individual may be granted, to determine the scope or conditions of, or to change or modify, appointment or clinical privileges. All such activity is also intended to be encompassed within the scope of any applicable federal or state privilege, and includes but is not limited to credentialing, privileging, reappointment, ongoing and focused professional practice evaluations, collegial intervention, performance improvement plans, investigations and hearings.

(33) "RESTRICTION" means a mandatory concurring consultation, where the consultant must approve the proposed procedure or treatment before privileges may be exercised. It does not include conditions for performance improvement placed upon the exercise of privileges, such as general consultation, second opinions, proctoring, monitoring, education, training, mentoring or specification of a maximum number of patients.

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

(35) "SUPERVISE" means the overseeing of or participation in the work of a physician assistant by a Supervising Physician consistent with any applicable written supervision agreement.

(36) "SUPERVISING/COLLABORATING PHYSICIAN" means a member of the Medical Staff with clinical privileges, who has agreed to supervise a physician assistant or collaborate with an advanced practice registered nurse.

(37) "SUPERVISION/COLLABORATION" means the supervision of a physician assistant, or collaboration with an advanced practice registered nurse, by a Supervising/Collaborating Physician, that may or may not require the actual presence of the Supervising/Collaborating Physician, but that does require, at a minimum, that the physician be readily available for consultation. The requisite level of supervision/collaboration will be determined at the time of credentialing and privileging and will be consistent with any applicable written supervisory or collaborative agreement.

(38) "MEDICAL DIRECTOR" means the individual appointed by the Board to act as the Medical Director.

APPENDIX A

Those individuals currently practicing as **Advanced Practice Providers** at the Facility are as follows:

- Advanced Practice Registered Nurses
- Physician Assistants

Those individuals currently practicing as **Dependent Practitioners** at the Facility are as follows:

- Dental Assistants
- Practical Nurses
- Scrub Techs

APPENDIX B

CONDITIONS OF PRACTICE APPLICABLE TO

ADVANCED PRACTICE PROVIDERS

1. Standards of Practice for Advanced Practice Providers:

(a) Advanced practice providers are not permitted to function independently in the inpatient Facility setting. As a condition of being granted privileges, advanced practice providers specifically agree to abide by the standards of practice set forth in this Section. In addition, as a condition of being permitted to utilize the services of advanced practice providers in the Facility, Medical Staff members who serve as Supervising/Collaborating Physicians also specifically agree to abide by the standards set forth in this Section.

(b) The following standards of practice are applicable to advanced practice providers in the Facility:

(1) Admitting Privileges. Advanced practice providers are not granted admitting privileges and therefore may not admit patients independent of their Supervising/Collaborating Physician.

(2) Consultations. Advanced practice providers may gather data and order tests. Advanced practice providers must review every consult with the Supervising/Collaborating Physician and document in the medical record that this review has taken place.

(3) Emergency On-Call Coverage. Advanced practice providers may not independently participate in the emergency on-call roster in lieu of their Supervising/Collaborating Physician.

(4) Daily Inpatient Rounds. Advanced practice providers may perform daily inpatient rounds in collaboration with the Supervising/Collaborating Physician.

2. Oversight by Supervising/Collaborating Physician:

(a) Any activities permitted to be performed at the Facility by an advanced practice provider may be required to be performed only under the oversight of the Supervising/Collaborating Physician.

(b) If the Medical Staff appointment or clinical privileges of the Supervising/Collaborating Physician are resigned, revoked or terminated, or the advanced practice provider fails, for any reason, to maintain an appropriate supervision/collaboration relationship as required, the advanced practice provider's clinical privileges will be automatically relinquished, unless another Supervising/Collaborating Physician is approved as part of the credentialing process.

(c) As required by law and Facility policy, advanced practice providers must provide the Facility with notice of any revisions or modifications that are made to their supervision/collaboration agreement. This notice must be provided to the Medical Director within three days of any such change.

3. Responsibilities of Supervising/Collaborating Physicians:

(a) Physicians who wish to utilize the services of an advanced practice provider in their clinical practice at the Facility must notify the Credentialing Verification Office of this fact in advance and must ensure that the individual has been appropriately credentialed and privileged in accordance with this Policy.

(b) The number of advanced practice providers acting under the supervision of, or in collaboration with, a Medical Staff member, as well as the care they may provide, will be consistent with applicable state statutes and regulations and any other policies adopted

by the Facility. The Supervising/Collaborating Physician will make all appropriate filings with the state regarding the supervision/collaboration and responsibilities of the advanced practice provider, to the extent that such filings are required.

APPENDIX C

The following are boards that have been approved for certification of members of the Advanced Practice Provider Staff:

- American Nurses Credentialing Center
- American Association of Nurse Practitioners
- National Commission on Certification of Physician Assistants
- American Association of Nurse Anesthetists
- American Registry of Radiologic Technologists
- American Midwifery Certification Board
- National Certification Corporation
- Oncology Nursing Certification Corporation