CENTRACARE
CREDENTIALS POLICY

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ARTICLE 1

GENERAL

1.A. PREAMBLE

All Medical Staff, Advanced Practice Provider Staff, and Allied Health Professional Staff ("Medical Staff/APP/AHP"") members commit to working cooperatively and professionally with each other and Hospital 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. CLINICAL PRIVILEGES

Appointment or reappointment will not confer any clinical privileges or right to practice at the Hospital. Only those clinical privileges granted by the Board may be exercised. A request for privileges will be processed only when an applicant satisfies threshold eligibility criteria.

1.C. 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.D. DELEGATION OF FUNCTIONS

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

1.E. CONFIDENTIALITY AND PEER REVIEW PROTECTION

1.E.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 Administrator or by legal counsel to the Hospital.

Any breach of confidentiality will result in appropriate sanctions.

1.E.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 Hospital;

(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.F. INDEMNIFICATION

The Hospital 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 Hospital'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/AHP, 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 or prescriptive coverage agreement as applicable;

(c) be able to attend to a patient in the Hospital within 30 minutes response time unless a greater or lesser time is otherwise specified by the Medical Executive Committee, or unless exempted by the Board;

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

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

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

(g) have never had medical staff/APP/AHP 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;

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

(i) 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;

(j) agree to fulfill all assigned responsibilities regarding emergency call within the scope of their clinical privileges or obtain appropriate coverage by another member of the Medical Staff;

(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 the last two years;

(m) have successfully completed a residency training program approved by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association, or a residency training program certified through the Royal College of Physicians and Surgeons of Canada, 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 Hospital within five years from the date of completion of training unless an exception is made by the Medical Executive Committee;*

(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 and if required by state law or the Hospital's medical staff, have a written agreement with a member of the Medical Staff to provide the requisite supervision or collaboration and provide the Hospital with a copy of the agreement.

(q) if seeking to practice as a moonlighting resident, submit a letter of recommendation from their program director

*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 reviewing the request for a waiver, the Credentials Committee may consider supporting documentation submitted by the applicant, any relevant information from third parties, input from the relevant Medical Staff members or committee chairperson, and the best interests of the Hospital and the communities it serves. The Credentials Committee will forward its recommendation, including the basis for such, to the Hospital's Medical Executive Committee.

(d) The Medical Executive Committee will review the recommendation of the Credentials Committee and make a recommendation to the Board regarding whether to grant or deny the request for a waiver 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 Hospital 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/AHP, or be granted particular clinical privileges merely because he or she:

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

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

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

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

(e) has had in the past, or currently has, Medical Staff/APP/AHP or other related appointment, affiliation, or privileges at any hospital or health care facility;

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

(g) is affiliated with, or under contract to, any managed care plan, insurance plan, 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.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/AHP 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 Hospital 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, consultations, and, if the need arises, care for unassigned patients or arrange appropriate coverage;

(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; for applicants who are currently credentialed at another CentraCare Health entity, a drug screen completed for credentialing at that entity will be accepted as long as there has not been a break in medical staff membership at that entity since completion of the original drug test. This requirement is only applicable to those individuals who apply for initial staff appointment after the July 1, 2019;

(7) to immediately submit to a blood, hair or urine test, or to a complete physical or mental evaluation, if at least two Medical Staff leaders (or one Medical Staff leader and the Administrator or Vice President for Medical Affairs) 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 Staff leaders;

(8) to submit to a mandatory background study, fingerprinting and photo as required by the Minnesota Department of Human Services;

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

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

(11) to seek consultation whenever necessary;

(12) to complete all medical and other required records in accordance with Hospital policy;

(13) to perform all services for which they are privileged and to act in a cooperative and professional manner;

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

(15) to satisfy continuing medical education requirements;

(16) to maintain a current e-mail address with the Medical Staff Office, 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;

(17) 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 Hospital, including, but not limited to, those involving electronic medical records, patient safety, and infection control; and

(18) 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 Hospital.

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

(1) any privileges granted by the Board will be performed in the Hospital under the supervision of or in collaboration with a Supervising/Collaborating Physician as required by Hospital's Medical Staff;

(2) to give notice, within three days, to the Administrator or Vice President for Medical Affairs of any revisions or modifications that are made to the supervision/collaboration agreement if applicable to the Hospital as determined by Hospital's Medical Staff.

(c) Additional collaboration and supervision requirements for members of the Advanced Practice Provider Staff for individual hospitals are included in Appendix A.

2.B.2. Burden of Providing Information:

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

(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 Chief of Staff, Vice President for Medical Affairs, or the Administrator. 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 a suspension of privileges for 30 days. After 30 days, 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 Credentials Reviewer or Credentials 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 Chief of Staff and Vice President for Medical Affairs or Administrator 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 Hospital or the Board, any member of the Medical Staff/APP/AHP 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 Hospital, any member of the Medical Staff/APP/AHP, 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 Hospital, 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 Hospital 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 Hospital.

(c) Authorization to Release Information to Third Parties:

The applicant also authorizes Hospital representatives to release information to other hospitals, 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 Hospital's policies will be the sole and exclusive remedy with respect to any professional review action taken by the Hospital.

(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 Hospital and any member of the Medical Staff/APP/AHP, 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 Hospital 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 Hospital's professional review activities; and

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

ARTICLE 3

PROCEDURE FOR INITIAL APPOINTMENT AND PRIVILEGES

3.A. PROCEDURE FOR INITIAL APPOINTMENT AND PRIVILEGES

3.A.1. Application:

(a) Applications for appointment and clinical privileges will be submitted via forms approved by the Board, upon recommendation by the Medical Executive Committee.

(b) 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.

(c) Applications may be provided to residents. Final action will not be taken until all applicable threshold eligibility criteria are satisfied. However, residents may be approved to moonlight in response to a request by the applicable department and upon approval of the Medical Executive Committee. Such approval may be revoked at any time. The requirement to obtain Medical Executive Committee approval will be applicable only to those departments who wish to utilize moonlighting residents after the date of adoption of this policy.

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 being sent to the applicant. Application fees associated with processing the application will be charged at the discretion of the Hospital.

(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,

background study, 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 at any time during the review of an initial application to discuss and review any aspect of the applicant's application, qualifications, and requested clinical privileges. This interview(s) may be conducted by one of or a combination of any of the following: the applicable committee/department chairperson, the Credentials Reviewer, Credentials Committee, Chief of Staff, the Vice President for Medical Affairs, the Chief Nursing Officer (where applicable for Advanced Practice Providers), or the Administrator. Every attempt will be made to conduct this interview in-person.

(f) For those Hospitals requiring nursing review for Advanced Practice Registered Nurses the Chief Nursing Officer will review and report on applications for appointment to the Advanced Practice Provider staff.

3.A.3. Credentials Reviewer Procedure:

(a) The Credentials Reviewer will review the application and all supporting materials and prepare a report.

(b) For Hospitals that are departmentalized, the Credentials Reviewer report will be forwarded to the Department Chair for review and then forwarded to the Hospital's Medical Executive Committee for review and recommendation for approval to the Board. For Hospitals that are not departmentalized, applications that are complete will be forwarded with recommendation for approval directly to each Hospital's Medical Executive Committee or Medical Staff, as applicable, for additional review and recommendation for approval to the Board.

(c) The Credentials Committee will set the criteria that requires a Credentials Committee review. If the Credentials Reviewer identifies information meeting this criteria, the applicant's application will be forwarded to the Credentials Committee.

3.A.4. Department Chairperson and Chief Nursing Officer Procedure:

(a) For those Hospitals that are departmentalized, the chairperson in each department in which the applicant has requested Medical Staff appointment will review the application and all supporting materials and prepare a report.

(b) Before preparing the report, the department chairperson may request that the vice chairperson or division chief provide input on the application.

(c) Once reviewed and approved, applications will be forwarded with recommendation for approval to the Hospital's Medical Executive Committee.

(d) For those Hospitals requiring a nursing review for Advanced Practice Registered Nurses, the Chief Nursing Officer will prepare a report for all applicants seeking appointment to the APP Staff as advanced practice registered nurses.

3.A.5. Credentials Committee Procedure:

The following process will apply to those applications that a Credentials Reviewer or Department Chairperson, as applicable, have referred for Credentials Committee review.

(a) The Credentials Committee will consider any report from the Chief Nursing Officer and department chairperson, as applicable, and any report prepared by the Credentials Reviewer, and will make a recommendation.

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

(c) If there is any question about the applicant's ability to perform the responsibilities of appointment, the Credentials Committee may require a physical or mental examination by a physician(s) satisfactory to the Credentials Committee. The results of this examination will be made available to the Credentials Committee for its consideration. Failure to undergo an examination within a reasonable time after a written request from the Credentials Committee will be considered a withdrawal of the application.

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

(e) If the recommendation of the Credentials Committee is delayed longer than 60 days after the receipt of a completed application, the Chairperson of the Credentials Committee will send a letter to the applicant, with a copy to the Vice President of Medical Affairs/Chief Medical Officer, explaining the reasons for the delay.

3.A.6. Medical Executive Committee Recommendation:

(a) After receipt of the written report and recommendation of the Credentials Reviewer or Credentials Committee, the Medical Executive Committee at each Hospital will:

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

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

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

(b) If the recommendation of the Medical Executive Committee is to appoint, the recommendation will be forwarded to the 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 Administrator, who will promptly send special notice to the applicant. The Administrator will then hold the application until after the applicant has completed or waived a hearing and appeal.

3.A.7. Board Action:

(a) The Board may delegate to a subcommittee, consisting of at least two Board members, action on appointment, reappointment and clinical privileges if there has been a favorable recommendation from the Medical Executive Committee and there is no evidence of any of the following:

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

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

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

Any decision reached by the subcommittee to appoint will be effective immediately and will be forwarded to the Board for information at its next meeting.

(b) When there has been no delegation to a subcommittee, 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 or ratify the appointment and clinical privileges granted by the Board, as appropriate; or

(2) refer the matter back to the Medical Executive Committee or to another source inside or outside the Hospital 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 or Chief of Staff. If the Board's determination remains unfavorable, the Administrator 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.8. Time Periods for Processing:

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

ARTICLE 4

CLINICAL PRIVILEGES

4.A. CLINICAL PRIVILEGES

4.A.1. General:

(a) Appointment or reappointment will not confer any clinical privileges or right to practice at the Hospital. Only those clinical privileges granted by the 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 Hospital's available resources and personnel;

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

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

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

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

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

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

4.A.2. Relinquishment of Appointment and Privileges:

A request to relinquish 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 hospitalized patient. After consulting with the Chief of Staff, the Administrator or Vice President for Medical Affairs will act on the request.

4.A.3. Medical Students and Residents:

(a) Physicians, podiatrists, advanced practice providers and allied health professionals enrolled in the Hospital's training program or rotating at Hospital from another Hospital's training program 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 Hospital, as applicable. 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 at the Hospital 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 Hospital in the training program will result in the automatic relinquishment of clinical privileges, without a right to the hearing and appeal procedures.

(c) Individuals who are in a residency program outside of Hospital, who want to moonlight at Hospital may do so upon request of the applicable department and upon approval of the Medical Executive Committee. Such approval may be revoked at any time.

4.A.4. 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 Administrator/Vice President for Medical Affairs in consultation with the Chief of Staff:

(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 hospital that participates in Medicare or a telemedicine entity (as that term is defined by Medicare), and the hospital or telemedicine entity is accredited by an organization approved for "deemed" status 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 hospital or telemedicine entity after the Hospital queries the National Practitioner Data Bank and conducts a background study. In such cases, the Hospital must ensure, through a written agreement, that the distant hospital or telemedicine entity complies with all applicable Medicare regulations and accreditation standards. The distant hospital or telemedicine entity must provide:

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

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

(iii) information indicating that the applicant has actively exercised the relevant privileges in a competent manner during the previous 12 months, or if within the first year of practice, competency is being actively monitored through a process by the distant site;

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

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

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

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

(d) 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 Hospital's peer review activities. The results of the peer review activities, including any adverse events and complaints filed about the practitioner providing telemedicine services from patients, other practitioners or staff, will be shared with the hospital or entity providing telemedicine services.

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

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:

(a) completed all medical records;

(b) completed all continuing medical education requirements;

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

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

(e) paid any applicable reappointment processing fee;

(f) 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 Hospital, including, but not limited to, those involving electronic medical records, patient safety, and infection control; and

(g) had sufficient patient contacts to enable the assessment of current clinical judgment and competence for the privileges requested. Any member seeking reappointment who has minimal activity at the Hospital may be requested to submit information to the department chairperson, Credentials Reviewer or to the Credentials Committee, as applicable, (such as a copy of his or her confidential quality profile from his or her primary hospital, clinical information from his or her private office practice, or a quality profile from a managed care organization or

insurer), before the application will be considered complete and processed further.

5.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:

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

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

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

(d) any focused or ongoing professional practice evaluations;

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

(f) other reasonable indicators of continuing qualifications as may be requested by the Credentials Reviewer, department chairperson, Credentials Committee or the Medical Executive Committee.

5.D. REAPPOINTMENT APPLICATION

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

(b) 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 14 days.

(c) Failure to return a completed application within 14 days of receipt may result in the assessment of a reappointment processing fee. Failure to submit a complete application within 60 days prior to expiration of the then current appointment term may result in automatic expiration of appointment and clinical privileges at the end of the then current term of appointment.

(d) 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.

(e) 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.

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

5.E. POTENTIAL ADVERSE RECOMMENDATION AND CONDITIONAL REAPPOINTMENTS

(a) If the Credentials Committee or the Medical Executive Committee is considering a recommendation to deny reappointment or to reduce clinical privileges, the Chief of Staff or committee chairperson 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.

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

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

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

(e) 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.

(f) 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.

(g) 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

CONFLICTS OF INTEREST

6.A. General Principles:

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

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

(c) The steps outlined in this Article are intended to be guidelines only, with the intent that all credentialing and professional practice evaluation activities be carried out in a reasonable and fair manner. However, nothing within this Article is intended to prevent the Medical Staff from carrying out its duties as they relate to credentialing and peer review.

6.B. Immediate Family Members:

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

6.C. Employment or Contractual Relationship with the Hospital:

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

6.D. Actual or Potential Conflict Situations:

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

(a) membership in the same group practice;

(b) having a direct or indirect financial relationship;

(c) being a direct competitor;

(d) close friendship;

(e) a history of personal conflict;

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

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

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

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

6.E. Guidelines for Participation in Credentialing and Professional Practice Evaluation Activities:

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

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

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

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

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

(c) Ad Hoc Investigating Committee. Once a formal investigation has been initiated, additional precautions are required. Therefore, an Interested Member, with the exception of an Interested Member as a result of 6.D(a), may not be appointed as a member of an ad hoc investigating committee but may be interviewed and provide information to the ad hoc investigating committee if necessary for the committee to conduct a full and thorough investigation.

(d) Medical Executive Committee. An Interested Member, with the exception of an Interested Member as a result of 6.D(a), may be recused and not participate as a member of the Medical Executive Committee when the Medical Executive Committee is considering a recommendation that could adversely affect the clinical privileges of a practitioner, subject to the rules for recusal outlined below.

(e) Board. An Interested Member, with the exception of an Interested Member as a result of 6.D(a), will be recused and may not participate as a member of the Board when the Board is considering a recommendation that could adversely

affect the clinical privileges of a practitioner, subject to the rules for recusal outlined below.

6.F. Rules for Recusal:

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

(b) Any recusal will be documented in the committee's minutes.

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

6.G. Other Considerations:

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

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

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

ARTICLE 7

HOSPITAL EMPLOYEES

(a) Except as provided below, the employment of an individual by the Hospital will be governed by the Hospital's employment policies and manuals and the terms of the individual's employment relationship or written contract. To the extent that the Hospital's 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 Hospital, 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 Hospital, will be processed in accordance with the terms of this Policy. A report regarding each practitioner's qualifications may be made to Administration or Human Resources (as appropriate) to assist the Hospital 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 8

AMENDMENTS

This Policy may be amended in accordance with the requirements outlined in the Hospital's Medical Staff Bylaws.

ARTICLE 9

ADOPTION

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

Adopted by the Medical Staff on:

Date: September 13, 2022

Jacob Eiler, MD, Chief of Staff

Approved by the Board:

Date: September 14, 2022

Renee Frauendienst, Chair, Board of Directors

GLOSSARY

The following definitions apply to terms used in this Policy:

1. "ADMINISTRATOR" means the individual appointed by the Board to act on its behalf in the overall management of the Hospital.

2. "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 may be required by law and/or the Hospital 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.

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

4. "ADVANCED PRACTICE REGISTERED NURSE" ("APRN") means an individual licensed as an advanced practice registered nurse by the Minnesota Board of Nursing including clinical nurse specialist, nurse midwife, nurse practitioner, and nurse anesthetist.

5. "ALLIED HEALTH PROFESSIONAL" ("AHP") means licensed patient care providers other than physicians, oral surgeons, podiatrists and Advanced Practice Providers. AHPs include: Licensed Clinical Social Workers, Licensed Psychologists, Genetic Counselors, Dentists that provide inpatient consultations, care providers who alter tissue such as: Athletic trainers, Certified Surgical Techs, Surgical Assistants, and Certified First Assistants.

6. "ALLIED HEALTH PROFESSIONAL STAFF" means individuals other than Medical Staff members and Advanced Practice Provider staff who are authorized by law and by the Hospital to provide patient care services within the Hospital.

7. "BOARD" means the body having the overall responsibility for the Hospital, or its designated committee.

8. "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, the American Board of Physician Specialties, the American Board of Podiatric Surgery, or the American Board of Podiatric Orthopedics and Primary Podiatric 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.

9. "CHIEF NURSING OFFICER" means the nursing professional responsible for oversight of the provision of nursing services for the Hospital.

10. "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.

11. "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.

12. "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.

13. "CORE PRIVILEGES" or "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.

14. "CREDENTIALING" means the process for determining eligibility for appointment to the Medical Staff/APP/AHP and clinical privileges.

15. "CREDENTIALS POLICY" or "POLICY" means the Hospital's Medical Staff Credentials Policy.

16. "CREDENTIALS COMMITTEE" means the Credentials Reviewers meeting as a whole when necessary to review applications for Medical Staff/APP/AHP membership and privileges to formulate a recommendation regarding membership and privileges to the Hospital's Medical Staff and Board.

17. "CREDENTIALS REVIEWER" means an individual trained in the process of reviewing credentials applications who makes a recommendation to the Hospital related to appointment to the Medical Staff/APP/AHP and privileges.

18. "CREDENTIALS VERIFICATION OFFICE" means the group providing primary verification on all applicants.

19. "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.

20. "DENTIST" means a Doctor of Dental Surgery ("D.D.S.") or Doctor of Dental Medicine ("D.M.D.").

21. "DIRECT SUPERVISION" means the overseeing or participation in the work of a non-licensed provider by a Supervising Physician. The Supervising Physician must be either in the Operating Room or immediately available if assistance should be needed. See individual privileges for further delineation.

22. "HOSPITAL" means hospital, including provider-based clinical of that Hospital, where the Medical Staff member is practicing, to include:

i. CentraCare - Rice Memorial Hospital
ii. CentraCare - Redwood
iii. CentraCare - Long Prairie
iv. CentraCare - Monticello
v. CentraCare - Melrose
vi. CentraCare - Paynesville
vii. CentraCare - Sauk Centre
viii. The Saint Cloud Hospital

23. "LICENSED INDEPENDENT PRACTITIONER" means a practitioner who is permitted by law and by the Hospital 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 Hospital ("moonlighting").

24. "MEDICAL EXECUTIVE COMMITTEE" means the executive committee of the Medical Staff at the site where the Medical Staff member is practicing. If the Hospital's Medical Staff does not have a Medical Executive Committee then the Medical Staff as a whole will function as the Medical Executive Committee for the rights and responsibilities outlined in this Credentials Policy.

25. "MEDICAL STAFF" means all physicians, dentists and podiatrists who have been appointed to the Medical Staff by the individual Hospital's Board.

26. "MEDICAL STAFF LEADER" means any Medical Staff officer, department chairperson, division chief, or committee chairperson.

27. "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 AHP Staff, by the Board to practice at the Hospital.

28. "NOTICE" means written communication by regular U.S. mail, e-mail, facsimile, or Hospital mail.

29. "PATIENT CONTACTS" includes an admission, consultation, procedure, evaluation, treatment, or service performed attending a patient for purposes of diagnosis or treatment as evidenced by a notation in the patient's medical record, a pre-op physical that is used in the Hospital, a significant elective surgical or other procedure, or a consultation in a specialty area required by the patient's condition or by Medical Staff or Hospital rules.

30. "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.

31. "PHYSICIAN" includes both Doctors of Medicine ("M.D.s") and Doctors of Osteopathy ("D.O.s") or their equivalent.

32. “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.

33. “PODIATRIST” means a Doctor of Podiatric Medicine (“D.P.M.”).

34. “PRIVILEGING” means the process of granting and monitoring clinical privileges.

35. “PROFESSIONAL REVIEW ACTION” has the meaning defined in the HCQIA.

36. “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.

37. “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.

38. “SPECIAL NOTICE” means hand delivery, certified mail (return receipt requested), or overnight delivery service providing receipt.

39. “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.

40. “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, as required by state law or the Hospital’s Medical Staff.

41. “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.

42. “VICE PRESIDENT FOR MEDICAL AFFAIRS” means the individual appointed by the Board to act as the Vice President for Medical Affairs, Chief Medical Officer or other such position, working in cooperation with the Chief of Staff, related to the medical affairs of the Hospital.

APPENDIX A

ST. CLOUD HOSPITAL

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 Hospital 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 Hospital, 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 Hospital:

      (1) Admitting Privileges. Advanced practice providers may be granted admitting/privileges and therefore may admit patients on behalf of their Attending Physician**.** It will then be documented in the medical record that review has taken place. Each inpatient admission will be supervised medically by a physician with privileges on the Hospital's Medical Staff. This supervising physician will regularly review the patient care provided by the advanced practice provider both in direct care situations and through regular medical record chart reviews. The supervising physician will also be available to the advanced practice provider for patient consultations, education, and patient referrals.

      (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 Hospital 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 Hospital policy, advanced practice providers must provide the Hospital with notice of any revisions or modifications that are made to their supervision/collaboration agreement. This notice must be provided to the Vice President for Medical Affairs 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 Hospital 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 Hospital. 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.