

Professional Staff Credentials Policy DAYTON CHILDREN'S HOSPITAL

A Professional Staff Document

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ARTICLE I DEFINITIONS

1.1 DEFINITIONS

The definitions set forth in the Professional Staff Bylaws shall apply to this Credentials Policy unless otherwise provided herein.

1.2 USE OF DESIGNEE

Wherever a position or title is used in the Professional Staff Bylaws or Policies, the designee or substitute of the person holding that position or title is included in the term.

ARTICLE II
APPLICATION FOR PROFESSIONAL STAFF APPOINTMENT/PRIVILEGES

2.1 GENERAL INFORMATION

2.1-1 REQUIREMENTS

Unless otherwise provided in the Professional Staff Bylaws or Policies, all Applicants will be required to document compliance with the baseline and other qualifications for Professional Staff appointment and/or Privileges set forth in the Professional Staff Bylaws in addition to the qualifications set forth in the applicable Professional Staff category and/or Privilege set.

2.1-2 PROCESSING FEE

All applications for Professional Staff appointment and/or Privileges must be submitted with the required application fee. The amount of the application fee, as such fee may change from time to time, will be established by the PSEC. The application fee is non-refundable regardless of action taken on the application.

2.1-3 FORM

All applications for appointment to the Professional Staff and/or Privileges shall be in writing, signed and dated by the Applicant, and submitted on a form recommended by the PSEC and approved by Hospital administration.

2.1-4 INFORMATION FOR APPLICANT

- (a) Each Applicant for Professional Staff appointment and/or Clinical Privileges shall be provided access to the Professional Staff Bylaws and Policies as well as applicable Hospital policies.
- (b) Upon receipt of the application and required application fee, a credentials file shall be created and maintained for the Applicant.

2.2 APPLICATION CONTENT

Each Applicant must furnish complete, truthful responses to questions asked (or an explanation of why answers are unavailable) and information requested. Unless otherwise provided in the Professional Staff Bylaws or Policies, the application shall include, but not be limited to, the following content:

2.2-1 EDUCATION/TRAINING

Information regarding undergraduate education, professional school(s), and postgraduate training (*e.g.*, internships, residencies, fellowships, *etc.*) including the name of each institution, degree(s) granted, program(s) completed, dates attended, and name(s) of Practitioners responsible for monitoring the Applicant's performance.

2.2-2 LICENSURE

- (a) Evidence of a current, valid Ohio professional license/certificate to practice.
 - (i) A commissioned officer of the United States uniformed services who (i) is a current active duty military physician; (ii) who has a current, valid unrestricted medical license from a State medical board; and (iii) who is the physician of record for a military-dependent Hospital patient is exempt from the requirement of having a current, valid Ohio medical license.
 - (ii) An Applicant for appointment to the consulting peer review Professional Staff shall satisfy the licensure requirement set forth in Section 5.6-1(a) of the Professional Staff Bylaws.
- (b) If necessary for the Privileges requested, evidence of a current, valid Drug Enforcement Administration (DEA) registration and attestation regarding Ohio OARRS registration.

2.2-3 CONTINUING EDUCATION

Evidence of participation in continuing education activities at the level required by the Applicant's licensing board. The Hospital, in its discretion, has the right to audit and verify the Applicant's participation in any such continuing education activities at any time.

2.2-4 BOARD CERTIFICATION

Documentation of satisfaction of the applicable board certification requirements as set forth in Article VII.

2.2-5 PROFESSIONAL STAFF CATEGORY / CLINICAL PRIVILEGES

Request for the Professional Staff category and/or Clinical Privileges for which the Applicant wishes to be considered.

2.2-6 PEER RECOMMENDATIONS

- (a) At least three (3) peer recommendations are obtained and evaluated for all new Applicants for Privileges. Peer recommendations are obtained from Practitioners in the same professional discipline (*e.g.*, M.D./D.O., D.P.M., *etc.*) as the Applicant with personal knowledge of the Applicant's ability to practice. Reasonable efforts will be made to obtain at least one (1) recommendation from a Practitioner in the same specialty as the Applicant.
- (b) Peer recommendations should be provided by professionals who have worked with the Applicant within the past three (3) years; who have directly observed the Applicant's professional performance over a reasonable period

of time; and, who can provide reliable information regarding the Applicant's current clinical competence, ethical character, and professional conduct. Peer recommendations may not be provided by the Applicant's relatives and only one (1) of the three (3) references may be a current partner or associate of the Applicant.

- (c) One reference should be received from the director of the Practitioner's training program or a medical staff leader (*e.g.*, chief of staff/medical staff president, department chair, section chief, *etc.*) at another hospital at which the Applicant holds clinical privileges and address the Practitioner's ability to safely and competently perform the Clinical Privileges requested at the Hospital, with or without a reasonable accommodation.
- (d) Peer recommendations include written information regarding the Applicant's current: medical/clinical knowledge; technical and clinical skills; clinical judgment; interpersonal skills; communication skills; and professionalism.
- (e) Peer recommendations may be in the form of written documentation reflecting informed opinions on each Applicant's scope and level of performance, or a written peer evaluation of Practitioner-specific data collected from various sources for the purpose of validating current competence.
- (f) Sources for peer recommendations may include the following:
 - (i) An organization performance improvement committee, the majority of whose members are the Applicant's peers.
 - (ii) A reference letter(s), written documentation, or documented telephone conversation(s) about the Applicant from peer(s) who is knowledgeable about the Applicant's professional performance and competence.
 - (iii) A department or major clinical service chair who is a peer.
 - (iv) A medical staff executive committee.
- (g) Upon regrant of Privileges, when insufficient Practitioner-specific data are available, the Professional Staff obtains and evaluates peer references.
- (h) References are not required for Applicants seeking appointment to Professional Staff categories without Privileges.

2.2-7 PROFESSIONAL SANCTIONS

The nature and specifics of any pending or completed action involving denial, revocation, termination, suspension, reduction, limitation, non-renewal, or

voluntary (while under investigation or to avoid investigation for conduct or clinical competency concerns) or involuntary relinquishment of:

- (a) License or certificate to practice any profession in any jurisdiction.
- (b) DEA registration or other required credentials with respect to prescriptive authority.
- (c) Membership or fellowship in local, state, or national professional organizations.
- (d) Specialty or sub-specialty board certification or eligibility.
- (e) Faculty membership at any medical or other professional school.
- (f) Medical staff appointment or clinical privileges at any other hospital, clinic, or health care institution.
- (g) The Practitioner's provider status with a Federal Healthcare Program or any third party payer including insurance companies, HMOs, PPOs, MSOs, and PHOs.

2.2-8 EVIDENCE OF ABILITY TO PERFORM

Affirmation and demonstrated evidence that the Practitioner is able to safely and competently exercise the Privileges requested with or without a reasonable accommodation.

2.2-9 BACK-UP COVERAGE

Except as otherwise provided in the Professional Staff Bylaws, all Practitioners who are granted Clinical Privileges must be able to provide continuous care to their hospitalized patients, emergency care to their patients when needed, and arrange for back-up coverage as required by Section 4.7.1(f) of the Professional Staff Bylaws. In case of emergency absence of a Practitioner, coverage arrangements may default to the Department Chair/Division Chief.

2.2-10 PROFESSIONAL LIABILITY

Evidence of adequate Professional Liability Insurance coverage, as required by the Board, and information for the last ten (10) years on professional liability claims history and experience (*e.g.*, suits filed, pending, and concluded; settlements made; *etc.*) including the names of present and past insurance carriers.

2.2-11 WORK HISTORY

Information regarding the Applicant's previous affiliations including: location of offices; names and addresses of current and prior professional practices with which

the Applicant is or was associated and inclusive dates of such associations; names and locations of all other hospitals, clinics, or health care institutions where the Applicant provides or provided clinical services with the inclusive dates of each affiliation, status held, and general scope of clinical privileges.

2.2-12 OTHER LEGAL ACTIONS

An explanation of any: lawsuits (in addition to the professional liability claims history provided pursuant to Section 2.2-10) in which the Applicant has been a party including the status or resolution of each such lawsuit; criminal charges (other than routine traffic tickets) of which the Applicant was found guilty or to which the Applicant plead guilty or no contest; pending criminal investigations; and, past criminal convictions including settlements.

2.2-13 REGULATORY ACTIONS

Information as to whether the Applicant is, or has been, the subject of investigation by a Federal Healthcare Program and, if so, the status/outcome of such investigation.

2.2-14 CONFLICTS OF INTEREST

Such information, if any, as may be required by the Hospital's conflict of interest policy.

2.2-15 IDENTIFICATION

Current, valid government-issued photo identification to verify that the Applicant is, in fact, the individual requesting appointment and/or Privileges.

2.2-16 CRIMINAL BACKGROUND CHECK

Information necessary to complete criminal background checks on the

Applicant. 2.2-17 OTHER

Such other information as the PSEC may recommend and the Board may require from time to time.

2.3 EFFECT OF APPLICATION

2.3-1 By signing and submitting an application for Professional Staff appointment and/or Privileges, each Applicant:

- (a) Acknowledges receiving access to the Professional Staff Bylaws and Policies in addition to applicable Hospital policies and procedures; and, agrees to abide by the terms thereof if the Applicant is granted appointment and/or Clinical Privileges and in all matters relating to consideration of the

Applicant's application without regard to whether the Applicant is granted appointment and/or Clinical Privileges.

- (b) Attests that all information furnished is complete and correct and acknowledges that any significant misstatement in or omission from the application constitutes grounds for denial or termination of Professional Staff appointment and/or Privileges.
- (c) Signifies his or her willingness to appear for interviews in regard to the application.
- (d) Acknowledges and agrees to the scope and extent of the confidentiality, immunity, and release provisions set forth in Article XII of the Professional Staff Bylaws.
- (e) Understands and agrees that if Professional Staff appointment and/or Privileges are denied or terminated based upon the Practitioner's conduct or clinical competence, the Practitioner may be subject to reporting to the National Practitioner Data Bank and/or state authorities.
- (f) Acknowledges and agrees that if an Adverse recommendation is made or an Adverse action is taken with respect to his/her Professional Staff appointment and/or Privileges, the Practitioner will exhaust the administrative remedies provided for in the Fair Hearing Policy before resorting to formal legal action.
- (g) Agrees to uphold the responsibilities, as applicable, set forth in the Professional Staff Bylaws for Practitioners granted Professional Staff appointment and/or Privileges including, but not limited to:
 - (i) Maintaining an ethical practice and providing continuous care for his or her patients.
 - (ii) Discharging such Professional Staff, Department/Division, committee, and Hospital functions for which he or she is responsible.
- (h) Agrees to keep the Professional Staff Office up-to-date on any changes made or proposed regarding information contained in the Applicant's application including, but not limited to: changes in the status of his or her professional license to practice; prescriptive authority, DEA, or other controlled substances registrations; Professional Liability Insurance coverage; appointment and/or clinical privileges at other institutions; and the status of current or initiation of new claims or lawsuits in which Applicant is involved. The foregoing obligation shall be a continuing obligation of the Practitioner so long as he/she has Professional Staff appointment and/or Privileges at the Hospital.

- (i) Agrees to provide to the Professional Staff Office, upon receipt or submission, copies of all correspondence received from or submitted to any third party reviewing competency issues including, but not limited to, state licensing boards and third party payers based upon patient care, treatment, and/or services provided by the Practitioner at the Hospital.

**ARTICLE III
INITIAL APPOINTMENT AND PRIVILEGING PROCESS**

3.1 APPLICANT'S BURDEN

- 3.1-1 In connection with all applications for Professional Staff appointment, reappointment, advancement, transfer, and/or grant/regrant of Privileges, the Applicant shall have the burden of producing adequate information, within the allotted time, for proper evaluation of the Applicant's qualifications, for resolving reasonable doubts with respect to such qualifications, and for satisfying requests for information or clarification from appropriate Professional Staff or Hospital authorities. The Applicant's failure to sustain this burden shall be grounds for denial of the application.
- 3.1-2 If the application is not returned by the requesting Applicant within sixty (60) days, the application will be deemed to have been voluntarily withdrawn. For any future consideration for appointment and/or Privileges, the Applicant will need to submit a new, full application including application fee.

3.2 VERIFICATION OF INFORMATION

- 3.2-1 Applications for Professional Staff appointment and/or Privileges shall be submitted to the Professional Staff Office whose staff will organize and coordinate the collection and verification of information consistent with applicable laws and accreditation standards.
- 3.2-2 If a Practitioner is solely requesting Clinical Privileges in telemedicine, the Professional Staff Office may rely upon credentialing information from another TJC accredited hospital or distant site telemedicine entity as part of the verification process as long as there is a written agreement between the facilities in accordance with the requirements set forth in Section 5.9.
- 3.2-3 Action on the Applicant's application will not be taken until the required information is available and verified.
- 3.2-4 If problems are encountered in obtaining the required information, the Professional Staff Office shall notify the Applicant, in writing, indicating the nature of the problem and what additional information the Applicant must provide. Upon receipt of such notification, the Applicant then has thirty (30) days in which to secure the appropriate information needed for a completed application. Failure, without good cause, to respond to the notification in a satisfactory manner within thirty (30) days may be deemed a voluntary withdrawal of the application.
- 3.2-5 The credentials of all Applicants shall be checked through the National Practitioner Data Bank. The Professional Staff Office shall also query the Office of Inspector General's Cumulative Sanction report, the General Services Administration List of Parties Excluded from Federal Procurement and Non-Procurement Programs, and any other appropriate sources to determine whether the Applicant has been

convicted of a health care related offense, or debarred, excluded, or otherwise made ineligible for participation in a Federal Healthcare Program.

3.2-6 When the application is complete and collection and verification is accomplished, the Professional Staff Office shall notify the applicable Division Chief that the Applicant's file is available for review.

3.3 EXPEDITED APPOINTMENT & PRIVILEGING PROCEDURE

3.3-1 NO RIGHT TO EXPEDITED REVIEW

- (a) The decision to use the expedited appointment and privileging procedure is totally discretionary on the part of the Hospital.
- (b) No Applicant has any entitlement to have his/her application reviewed through an expedited appointment and privileging process.

3.3-2 CRITERIA

- (a) If the application is complete and provided the Applicant meets all of the following criteria, the Applicant is deemed a candidate for expedited appointment and privileging:
 - (i) The Applicant has successfully completed a residency or fellowship, as applicable, in the specialty for which Privileges are requested with no disciplinary action or conditions imposed during training.
 - (ii) The Applicant has not changed practice location more than four (4) times in the past ten (10) years. Practitioners serving on active duty with the Uniformed Services can be exempted from this criterion at the discretion of the Chief Medical Officer.
 - (iii) All references reflect recommendation without reservation.
 - (iv) No professional liability claims/settlements within the past five (5) years.
 - (v) There have been no involuntary terminations, limitations, reductions, denials, or loss of appointment or privileges at any other hospital or entity, including licensing bodies.
 - (vi) The Applicant has never been charged with, pleaded to, or been convicted of a crime (except for minor traffic violations).
 - (vii) The following reports fail to identify any problems: NPDB, AMA Masterfile, AOA, OSMB or ADA, and any other applicable board report.

- (viii) There exists no current or previously successful challenge to any license or registration.
 - (ix) If currently a Practitioner with Professional Staff appointment and/or Clinical Privileges at the Hospital, is not currently under an FPPE (other than one for an initial grant of Clinical Privileges) or otherwise subject to current oversight by the Practitioner/APP Wellness Committee or the MPRC.
- (b) In the event that an Applicant fails to meet any one or more of the standards in subsection (a) above; or, if at any time questions or concerns are raised or the reviewers are otherwise not all in agreement, the application shall be ineligible for the expedited process and subject to processing in accordance with the routine appointment and privileging procedure set forth in Section 3.4.

3.3-3 REVIEW BY DIVISION CHIEF

- (a) The applicable Division Chief will review the application and accompanying materials and provide his/her evaluation to the Credentials Committee chair.
- (b) In the event the Division Chief's evaluation is anything other than favorable, the request will not be forwarded to the Credentials Committee chair. Instead, the application will be forwarded back to the Professional Staff Office for review in accordance with the routine appointment and privileging procedure set forth in Section 3.4.

3.3-4 REVIEW BY CREDENTIALS COMMITTEE CHAIR

- (a) Upon receipt of the Division Chief's evaluation, the chair of the Credentials Committee, acting on behalf of the Credentials Committee, shall review the application and accompanying materials and consider the Division Chief's evaluation. The Credentials Committee chair will then prepare a report containing his/her evaluation regarding appointment, Clinical Privileges, and Department/Division assignment. This report is forwarded to the Chief Medical Officer.
- (b) In the event the evaluation of the Credentials Committee chair is anything other than favorable, the request will not be forwarded to the Chief Medical Officer. Instead, the application will be forwarded back to the Professional Staff Office for review in accordance with the routine appointment and privileging procedure set forth in Section 3.4.

3.3-5 REVIEW BY CMO

- (a) Upon receipt of the evaluation of the Division Chief and Credentials Committee chair, the Chief Medical Officer shall review the application and

accompanying materials and consider the evaluations of the Division Chief and Credentials Committee chair. The Chief Medical Officer will then prepare a report containing his/her evaluation regarding appointment, Clinical Privileges, and Department/Division assignment. This report is forwarded to the PSEC.

- (b) In the event the evaluation of the Chief Medical Officer is anything other than favorable, the request will not be forwarded to the PSEC. Instead, the application will be forwarded back to the Professional Staff Office for review in accordance with the routine appointment and privileging procedure set forth in Section 3.4.

3.3-6 RECOMMENDATION BY THE PSEC

- (a) The PSEC shall consider the evaluations of the Division Chief, Credentials Committee chair, and Chief Medical Officer and such other documentation as the PSEC deems appropriate. The PSEC shall make a recommendation regarding appointment, Clinical Privileges, and Department/Division assignment to a designated committee of the Board (composed of at least two voting Board members).
- (b) In the event the PSEC's recommendation is anything other than favorable, the request will not be forwarded to the designated Board committee. Instead, the application will be forwarded back to the Professional Staff Office for review in accordance with the routine appointment and privileging procedure set forth in Section 3.4.

3.3-7 ACTION BY DESIGNATED BOARD COMMITTEE

- (a) The designated Board committee (consisting of the Hospital CEO, the Chief Medical Officer, and the Department Chair of Pediatrics of the Boonshoft School of Medicine at Wright State University) shall review the application and act upon the request for Professional Staff appointment and/or Privileges.
- (b) All Applicants who are granted appointment and/or Privileges through this expedited process shall be forwarded to the Board for information at their next meeting.
- (c) In the event the determination of the Board committee is anything other than favorable, the Board committee will not take action. Instead, the application will be forwarded back to the Professional Staff Office for review in accordance with the routine appointment and privileging procedure set forth in Section 3.4.

3.4 ROUTINE APPOINTMENT & PRIVILEGING PROCEDURE

3.4-1 REVIEW BY DIVISION CHIEF, DEPARTMENT CHAIR, AND CHIEF MEDICAL OFFICER

- (a) The applicable Division Chief, Department Chair, and the Chief Medical Officer will review the application and accompanying materials and provide their evaluations to the Credentials Committee.
- (b) The Division Chief, Department Chair, and Chief Medical Officer may request an interview with the Applicant.

3.4-2 REVIEW BY CREDENTIALS COMMITTEE

- (a) Upon receipt of the evaluations of the Division Chief, Department Chair, and Chief Medical Officer, the completed application and accompanying materials shall be reviewed by the Credentials Committee. This review shall include evaluation of the Applicant's qualifications and a determination as to whether the Applicant meets all of the necessary qualifications for, as applicable, the category of Professional Staff appointment and/or the Clinical Privileges requested by the Applicant. In the course of this evaluation the Credentials Committee may consult with the applicable Division Chief, Department Chair, or Chief Medical Officer.
- (b) The Credentials Committee may elect to interview the Applicant or seek additional information. If additional information is requested, the Credentials Committee may defer transmitting its report to the PSEC and note in the Credentials Committee minutes the deferral and the grounds therefore.
- (c) If the Applicant is to provide additional information or a specific release/authorization to allow Hospital representatives to obtain information, the Professional Staff Office shall notify the Applicant, in writing, indicating the request for additional information or release/authorization required and the time frame for response.
- (d) Failure by the Applicant, without good cause, to respond within thirty (30) days to a request from the Credentials Committee for an interview, additional information, or a release/authorization may be deemed a voluntary withdrawal of the application.
- (e) Upon completion of its review, the Credentials Committee shall provide the PSEC with a written report/recommendation (which may be set forth in Credentials Committee minutes) as to approval or denial of the Applicant's application for Professional Staff appointment and/or Privileges.

3.4-3 PSEC RECOMMENDATION

- (a) Consideration. The PSEC shall consider the evaluations of the Division Chief, Department Chair, and Chief Medical Officer, the Credentials Committee's report/recommendation, and such other documentation as the PSEC deems appropriate.
 - (i) The PSEC may elect to interview the Applicant. Failure by the Applicant, without good cause, to respond to a request for an interview within thirty (30) days may be deemed a voluntary withdrawal of the application.
 - (ii) The PSEC may seek additional information. If additional information is requested, the PSEC shall refer the application back to the Credentials Committee, defer transmitting its recommendation to the Board, and note in the PSEC minutes the deferral and the grounds therefore.
- (b) Action. Upon completion of its review, the PSEC may take any of the following actions which may be set forth in the PSEC minutes:
 - (i) Deferral. A decision by the PSEC to defer the application for further consideration must be revisited at the next regularly scheduled meeting, except for good cause, at which point the PSEC shall issue its recommendation as to approval or denial of Professional Staff appointment and/or Privileges.
 - (ii) Favorable Recommendation. When the recommendation of the PSEC is favorable to the Applicant, the Professional Staff Chair shall forward the recommendation and accompanying documentation to the Board.
 - (iii) Adverse Recommendation. When the recommendation of the PSEC is Adverse to the Applicant, the Professional Staff Chair shall promptly provide the Applicant Special Notice of this Adverse recommendation and the Applicant shall be entitled, if applicable, to the procedural rights set forth in the Fair Hearing Policy. No such Adverse recommendation shall be forwarded to the Board until after the Applicant has exercised or has been deemed to have waived his or her right to a hearing, if any, as provided for in the Fair Hearing Policy.

3.4-4 BOARD ACTION

- (a) Without Benefit of PSEC Recommendation. If the PSEC fails to make a recommendation within ninety (90) days of receipt of the Credentials Committee's report, the Board may, after informing the PSEC of the Board's intent and allowing a reasonable period of time for response by the PSEC, make its own determination using the same type of criteria considered by the PSEC.

- (i) If the Board's decision is favorable to the Applicant, the Board action shall be effective as its final decision.
 - (ii) If the Board's decision is Adverse to the Applicant, the Hospital CEO shall so notify the Applicant, by Special Notice, and the Applicant shall be entitled, if applicable, to the procedural rights provided for in the Fair Hearing Policy. Such Adverse decision shall be held in abeyance until the Practitioner has exercised or been deemed to have waived his/her procedural rights, if any, under the Fair Hearing Policy. The fact that the Adverse decision is held in abeyance shall not be deemed to confer Professional Staff appointment and/or Privileges where none existed before.
- (b) After Favorable PSEC Recommendation. The Board may adopt or reject any portion of the PSEC's recommendation that was favorable to the Applicant; or, refer the recommendation back to the PSEC for additional consideration but must state the reason(s) for the requested reconsideration and set a time limit within which a subsequent PSEC recommendation must be made.
 - (i) If the Board's decision is favorable to the Applicant, the action shall be effective as its final decision.
 - (ii) If the Board's decision is Adverse to the Applicant, the Hospital CEO shall so notify the Applicant, by Special Notice, and the Applicant shall be entitled, if applicable, to the procedural rights provided for in the Fair Hearing Policy. Such Adverse decision shall be held in abeyance until the Practitioner has exercised or been deemed to have waived his/her procedural rights, if any, under the Fair Hearing Policy. The fact that the Adverse decision is held in abeyance shall not be deemed to confer Professional Staff appointment and/or Privileges where none existed before.
- (c) After Adverse Recommendation. If the Board is to receive an Adverse PSEC recommendation, the Professional Staff Chair shall withhold the recommendation and not forward it to the Board until after the Applicant either exercises or waives his/her right, if any, to the procedural rights set forth in the Fair Hearing Policy. The Board shall thereafter take final action in the matter as provided for in the Fair Hearing Policy.
- (d) Decision By Board Contrary to PSEC. Whenever the Board's proposed decision is contrary to the PSEC's recommendation, the Board shall submit the matter to the Joint Conference Committee for review and recommendation before the Board makes its final decision. The Joint Conference Committee shall have access to all recommendations and documentation in connection with the application.

- (e) Final Decision. The Practitioner shall be notified of the Board’s final decision by Special Notice.

3.4-5 CONTENTS OF NOTICE TO APPOINT AND/OR GRANT PRIVILEGES

A decision and notice to appoint and/or grant Privileges shall include, as applicable: (a) the Professional Staff category to which the Applicant is appointed; (b) the Department/Division to which the Applicant is assigned; (c) the Clinical Privileges granted; (d) any special conditions attached to the appointment or the Clinical Privileges granted; and (e) the duration of the appointment and/or Privilege period.

3.4-6 TIME PERIODS FOR THE APPLICATION PROCESSING

All individuals and groups required to act on an application for Professional Staff appointment and/or Privileges must do so in a timely and good faith manner. The burden of providing all necessary information in a timely manner remains at all times with the Applicant.

Except for obtaining required additional information, or for other good cause, each application should be processed within the following time periods:

<u>INDIVIDUAL/GROUP</u>	<u>TIME</u>
Professional Staff Office Verification	Within ninety (90) days of submission of the completed application. If additional information is needed from the Applicant, the time awaiting a response from the Applicant shall not count towards the verification time period.
Division Chief Department Chair Chief Medical Officer Credentials Committee Chair Evaluation	Within fourteen (14) days of notice by the Professional Staff Office of application availability (with respect to the Division Chief); or upon receipt of the applicable evaluation(s) (with respect to the Department Chair, CMO, or Credentials Committee chair, as applicable).

Credentials Committee
Evaluation

At the next scheduled meeting.
Credentials
Committee evaluations may be deferred
beyond such meeting but will generally be
completed not later than the next regularly
scheduled meeting.

Professional Staff Executive
Committee Recommendation

At the next scheduled meeting. PSEC
recommendations may be deferred beyond
such meeting but will generally be completed
not later than the next regularly scheduled
meeting.

Board of Directors
Action

At the next scheduled meeting. Board
action
may be deferred beyond such meeting but
will generally be completed not later than the
next regularly scheduled meeting.

The time periods set forth herein are guidelines and are not directives such as to create any right for an Applicant to have an application processed within these precise periods; provided, however, that this provision shall not apply to the time periods contained in the Fair Hearing Policy. When the Fair Hearing Policy is activated by an Adverse recommendation or action of the PSEC or Board, the time requirements set forth therein shall govern the continued processing of the application.

3.4-7 No Practitioner may submit or have in process at any given time more than one application for Professional Staff appointment and/or the same Clinical Privileges.

3.5 REAPPLICATION WAITING PERIOD

3.5-1 Except as otherwise provided in the Professional Staff Bylaws or this Policy, or as otherwise determined by the Board upon recommendation of the PSEC in light of exceptional circumstances, a Practitioner:

- (a) whose Professional Staff appointment and Privileges are automatically terminated pursuant to §6.5.1(a)(1), (2), or (4) of the Professional Staff Bylaws shall not be eligible to reapply for Professional Staff appointment and/or Privileges for a period of at least one (1) year from the effective date of the automatic termination.
- (b) who has received a final Adverse decision regarding appointment/reappointment and/or Privileges/regrant of Privileges shall not be eligible to reapply for Professional Staff appointment and/or Privileges

for a period of at least one (1) year from the latter of the date of the notice of the final Adverse decision or final court decision.

- (c) who has resigned his/her Professional Staff appointment and/or Privileges or withdrawn an application for appointment/reappointment and/or Privileges/regrant of Privileges while under investigation or to avoid an investigation for professional conduct or clinical competency concerns shall not be eligible to reapply for Professional Staff appointment and/or Privileges for a period of at least one (1) year from the effective date of the resignation or application withdrawal.

3.5-2 Any such reapplication shall be processed as an initial application, in accordance with the applicable procedures set forth in this Credentials Policy, and the Practitioner must submit such additional information as may be reasonably required to demonstrate that the basis of the automatic termination, Adverse decision, or resignation/withdrawal has been resolved or no longer exists. If such information is not provided, the reapplication will be considered incomplete and voluntarily withdrawn and will not be further processed.

3.6 PROCESSING APPLICATIONS FOR PROFESSIONAL STAFF APPOINTMENT WITHOUT PRIVILEGES

3.6-1 APPLICATION CONTENT

The content of an application for Professional Staff appointment without Privileges shall include information necessary to satisfy the qualifications set forth in the applicable Professional Staff category.

3.6-2 PROCEDURE

- (a) Due to the limited nature of an appointment without Privileges:
 - (i) An application for appointment to the consulting peer review Professional Staff category may be acted upon by the Hospital CEO upon recommendation of the PSEC chair if time constraints so require.
 - (ii) Appointment to the honorary Professional Staff shall require recommendation of the Credentials Committee and PSEC and approval of the Board.
 - (iii) An application for appointment to the active Professional Staff without Privileges or to the community Professional Staff shall be reviewed and acted upon in accordance with the procedure set forth in Section 3.3 or Section 3.4, as applicable, with the exception that such Applicants shall only be required to satisfy the qualifications set forth in Section 5.3-1(a) or Section 5.5.1(a) of the Professional Staff Bylaws.

- (b) Denial of an application/request for, or suspension/termination of, appointment to the community, consulting peer review, or honorary Professional Staff shall not trigger procedural rights nor shall it create a reportable event for purposes of federal or state law.

3.7 RESIGNATION OF PROFESSIONAL STAFF APPOINTMENT AND/OR PRIVILEGES

- 3.7-1 Resignation from the Professional Staff, the effective date, and the reason for such resignation shall be submitted in writing to the Professional Staff Office. Upon receipt, notification of the resignation shall be forwarded to the Hospital CEO, the Professional Staff Chair, the Practitioner's Department Chair/Division Chief, and the Board for information.
- 3.7-2 A Practitioner who resigns his/her Professional Staff appointment and/or Privileges is obligated to complete all medical records for which he/she is responsible prior to the effective date of the resignation. In the event a Practitioner fails to do so, consideration may be given by the Hospital to contacting the applicable State licensing board regarding the Practitioner's actions.
- 3.7-3 Provided a resignation pursuant to this Section 3.7 is determined by the Board to be voluntary, such resignation or termination shall not give rise to any procedural rights set forth in the Fair Hearing Policy.

**ARTICLE IV
PROCEDURE FOR PROFESSIONAL STAFF REAPPOINTMENT
AND REGRANT OF PRIVILEGES**

4.1 REAPPOINTMENT/REGRANT PROCESS

Professional Staff reappointments and regrants of Privileges shall occur at least once every two (2) years.

4.2 REAPPOINTMENT/REGRANT APPLICATION AND INFORMATION COLLECTION AND VERIFICATION

4.2-1 REAPPOINTMENT/REGRANT APPLICATION AND FEE

- (a) Prior to the expiration date of a Practitioner's current Professional Staff appointment and/or Privilege period, a reapplication form recommended by the PSEC and approved by Hospital administration shall be provided to the Practitioner.
- (b) Applicants for reappointment/regrant of Privileges may be assessed a reappointment/regrant application fee. The amount will be established by the PSEC. This reappointment/regrant fee must be remitted with the submission of the reappointment/regrant application.

4.2-2 CONTENT OF THE REAPPOINTMENT/REGRANT APPLICATION

- (a) The application for reappointment/regrant of Privileges shall include:
 - (i) All information required by Section 2.2 necessary to bring the Practitioner's credentials file current since the last submission of such information.
 - (ii) Attestation of continuing training and education activities external to the Hospital during the preceding appointment/Privilege period.
 - (iii) A request for additions to or deletions from the Clinical Privileges presently held with the basis for any such changes.
 - (iv) A request for a change, if any, in Professional Staff category with the basis therefore.

4.2-3 SUBMISSION OF THE REAPPOINTMENT/REGRANT APPLICATION

Applications for Professional Staff reappointment and/or regrant of Privileges shall be submitted to the Professional Staff Office.

4.2-4 VERIFICATION

Information with respect to applications for Professional Staff reappointment and/or regrant of Privileges shall be collected and verified by the Professional Staff Office in accordance with the procedure set forth in Section 3.2 to the extent applicable.

4.2-5 REVIEW AND ACTION

- (a) Applications for Professional Staff reappointment and/or regrant of Privileges shall be reviewed and acted upon in accordance with the procedure set forth in Section 3.3 or Section 3.4 of this Policy.
- (b) For purposes of reappointment and/or regrant of Privileges, the terms "Applicant" and "appointment" and "Privileges" as used in Section 3.3 and Section 3.4 of this Policy shall be read, as "Practitioner" and "reappointment" and "regrant of Privileges," respectively.

4.2-6 BASIS FOR RECOMMENDATIONS AND ACTION REGARDING PROFESSIONAL STAFF REAPPOINTMENT AND/OR REGRA NT OF PRIVILEGES

- (a) Professional Staff reappointments and/or regrant of Privileges shall be based upon:
 - (i) Ongoing satisfaction of the baseline and other qualifications for Professional Staff appointment and/or Privileges set forth in the Professional Staff Bylaws and this Policy.
 - (ii) Review of the Practitioner's performance within the Hospital as demonstrated by professional practice evaluation data from focused and ongoing professional practice evaluation activities including morbidity and mortality information if available.
 - (iii) Continued satisfaction of the Practitioner's Professional Staff and Department/Division responsibilities as set forth in the Professional Staff Bylaws and Policies.
 - (iv) Such other criteria as may be recommended by the PSEC and approved by the Board.
- (b) Upon regrant of Privileges, when insufficient Practitioner-specific data is available at the Hospital for the Practitioner requesting reappointment/regrant of Privileges, the Professional Staff shall obtain and evaluate additional peer recommendations.
- (c) If, during the preceding appointment/Privilege period, a Practitioner has not had enough Patient Encounters at the Hospital from which sufficient

professional practice evaluation data has been generated to provide a basis for evaluation of the Practitioner's current professional competence, clinical judgment, and ability to safely and competently exercise the Privileges requested, supplemental performance data may also be requested from the hospital at which the Practitioner has his/her primary affiliation for consideration.

4.2-7 TIME PERIODS FOR PROCESSING

- (a) All individuals and groups required to act on an application for Professional Staff reappointment and/or regrant of Privileges must do so in a timely and good faith manner.
- (b) If an application for reappointment/regrant of Privileges has not been fully processed by the expiration date of the Practitioner's current appointment and/or Privilege period, the Practitioner's appointment and Privileges shall terminate as of the last date of his/her current appointment/Privilege period. A Practitioner whose appointment and Privileges are so terminated shall not be entitled to the procedural rights provided in the Fair Hearing Policy. If the Practitioner qualifies, he/she may be granted temporary Privileges to meet an important patient care need pursuant to Section 5.6 of this Policy

4.3 REQUESTS FOR MODIFICATION OF APPOINTMENT STATUS OR CLINICAL PRIVILEGES

A Practitioner may, either in connection with reappointment/regrant of Privileges or at any other time, request modification of his/her Professional Staff category or Clinical Privileges by submitting a written request to the Professional Staff Office. A modification request shall be processed in substantially the same manner as an application for reappointment and/or regrant of Privileges. Requests for new Privileges during a current appointment/Privilege period will require evidence of appropriate education, training, and experience supportive of the request and will be subject to focused professional practice evaluation if granted.

**ARTICLE V
PROCEDURES FOR DELINEATING CLINICAL PRIVILEGES**

5.1 IN GENERAL

5.1-1 BASIS

- (a) Any Practitioner seeking to provide care, treatment, or services at the Hospital may exercise only those Clinical Privileges specifically granted to him or her by the Board in conjunction with Professional Staff appointment; or, as otherwise provided in this Policy.
- (b) Unless otherwise provided in the Professional Staff Bylaws or this Policy, Practitioners requesting Privileges must satisfy the baseline and other qualifications set forth in the Professional Staff Bylaws and this Policy and such additional qualifications as may be required by the applicable Privilege set.

5.1-2 REQUESTS

- (a) Each application for appointment and reappointment to the Professional Staff must contain a request for the specific Clinical Privileges desired, if any.
- (b) Specific requests must also be submitted, in writing, for Privileges without Professional Staff appointment including for temporary, disaster, and telemedicine Privileges, as well as for moonlighting Privileges.
- (c) Requests for modification of Clinical Privileges in the interim between reappraisals may be submitted in accordance with Section 4.3 of this Policy.

5.1-3 PROCESSING REQUESTS

- (a) All requests for Clinical Privileges shall be processed according to the procedures outlined in Section 3.3 or Section 3.4 of this Policy, as applicable, with the exception that:
 - (i) Requests for temporary Clinical Privileges shall be processed according to the procedure set forth in Section 5.6 of this Policy.
 - (ii) Requests for disaster Clinical Privileges shall be processed according to the procedure set forth in Section 5.8 of this Policy.
 - (iii) Requests for telemedicine Clinical Privileges shall be processed according to the procedure set forth in Section 5.9 of this Policy.

- (iv) Requests for Clinical Privileges for moonlighting residents shall be processed according to the procedure set forth in Section 5.10 of this Policy.
- (b) Requests for new Clinical Privileges will be subject to the focused professional practice evaluation requirements as provided in Section 5.4.

5.2 PRIVILEGE SETS

Privilege sets may be adopted and amended following review by the applicable Department Chair/Division Chief and Credentials Committee, recommendation of the PSEC, and approval by the Board.

5.3 RECOGNITION OF A NEW SERVICE OR PROCEDURE

5.3-1 CONSIDERATIONS

- (a) The Board shall determine the Hospital's scope of patient care services based upon recommendation from the PSEC. Overall considerations for establishing new services and procedures include, but are not limited to:
 - (i) The Hospital's available resources and staff.
 - (ii) The Hospital's ability to appropriately monitor and review the competence of the performing Practitioner(s).
 - (iii) The availability of another qualified Practitioner(s) with Privileges at the Hospital to provide coverage for the procedure when needed.
 - (iv) The quality and availability of training programs.
 - (v) Whether such service or procedure currently, or in the future, would be more appropriately provided through a contractual arrangement with the Hospital.
 - (vi) Whether there is a community need for the service or procedure.

5.3-2 PRIVILEGE REQUESTS FOR NEW SERVICES OR PROCEDURES

- (a) Requests for Privileges for a service or procedure that has not yet been recognized by the Board shall be processed as follows:
 - (i) The Practitioner must submit a written request for Privileges to the Professional Staff Office. The request should include a description of the Privileges being requested, the reason why the Practitioner believes the Hospital should recognize such Privileges, and any additional information that the Practitioner believes may be of

assistance in evaluating the request. The Professional Staff Office will notify the Credentials Committee chair of such request.

- (1) If the Credentials Committee determines that the service or procedure can or should be included in an existing Privilege set, the Credentials Committee will provide the basis for its determination.
 - (2) If the Credentials Committee decides to recommend that the new Privileges be recognized at the Hospital, the Credentials Committee shall develop privileging criteria based upon: a determination as to what specialties are likely to request the Privileges; the positions of specialty societies, certifying boards, *etc.*; the available training programs; and criteria required by other hospitals with similar resources and staffing. The Credentials Committee must provide in its report the recommended standards to be met with respect to the following: education; training; fellowship/board status; experience; whether proctoring/monitoring should be required; and, if so, the number of cases/procedures that should be performed during an appointment/Privilege period to establish current competency.
- (ii) Upon receipt of a recommendation from the Credentials Committee, the PSEC will act.
 - (iii) The recommendation of the PSEC, whether favorable or not favorable, will be forwarded to the Board for review and action.
 - (1) If the Board approves the new service or procedure, the Practitioner(s) request for Privileges for such service/procedure may be acted upon consistent with the Professional Staff Bylaws and this Policy.
 - (2) If the Board does not approve the new service/procedure, the requesting Practitioner(s) will be so notified. A decision by the Board not to recognize a new service or procedure does not constitute an appealable event for purposes of the Fair Hearing Policy.

5.4 PROFESSIONAL PRACTICE EVALUATION

5.4-1 The Hospital's focused professional practice evaluation (FPPE) process is set forth, in detail, in the Professional Staff Peer Review Policy and shall be implemented for all: (i) Practitioners requesting initial Privileges; (ii) existing Practitioners requesting new Privileges during the course of an appointment/Privilege period; and, (iii) in response to concerns regarding a Practitioner's ability to provide safe, high quality patient care. The FPPE period shall be used to determine the

Practitioner's current clinical competence and ability to perform the requested Privileges.

5.4-2 Upon conclusion of the FPPE period, ongoing professional practice evaluation ("OPPE") shall be conducted on all Practitioners with Privileges. The Hospital's OPPE process is set forth, in detail, in the Professional Staff Peer Review Policy and requires the Hospital to gather, maintain, and review data on the performance of all Practitioners with Privileges on an ongoing basis.

5.5 SPECIAL CONDITIONS

5.5-1 DENTISTS AND ORAL SURGEONS

- (a) Dentists and Oral Surgeons may admit patients to the Hospital if granted Privileges by the Hospital to do so.
- (b) A qualified Oral Surgeon may perform the complete medical history and physical examination for his or her patients if granted Privileges by the Hospital to do so.
- (c) Dentist Responsibilities:
 - (i) A detailed dental history justifying Hospital admission/registration.
 - (ii) A detailed description of the examination of the oral cavity and a preoperative diagnosis.
 - (iii) A complete operative report to the extent applicable. In cases of extraction of teeth the Dentist shall clearly state the number of teeth and fragments removed. All tissue except teeth and fragments shall be sent to the Hospital pathologist for examination.
 - (iv) Progress notes as are pertinent to the oral condition.
 - (v) Discharge summary.
 - (vi) Completion of medical records such as relates to his/her dental care of the patient.
 - (vii) Arrange for a Physician Appointee with appropriate Privileges to complete the medical history and physical examination for patients admitted to the Hospital by the Dentist (other than admission of a patient by an Oral Surgeon).
 - (viii) Obtain medical consultation from a Physician-Appointee with appropriate Privileges for the care and treatment of any medical condition that is present at the time of admission/registration of the Dentist's patient or that may arise during hospitalization that is

outside the scope of practice of the Dentist. If there is a medical problem, the consulting Physician shall participate in the discharge of the Dentist's patient and the completion of medical records such as relates to the Physician's care of the patient

5.5-2 PODIATRISTS

- (a) Podiatrists may admit patients to the Hospital if granted Privileges by the Hospital to do so.
- (b) A qualified Podiatrist may perform the medical history and physical examination for his or her patients if granted Privileges by the Hospital to do so.
- (c) Podiatrist Responsibilities:
 - (i) A detailed history of the podiatric problem justifying Hospital admission/registration.
 - (ii) A detailed description of the examination of the pedal member(s) and a preoperative diagnosis.
 - (iii) A complete operative report to the extent applicable. All tissue removed shall be sent to the Hospital pathologist for examination.
 - (iv) Progress notes as are pertinent to the pedal condition.
 - (v) Discharge summary.
 - (vi) Completion of medical records such as relates to his/her podiatric care of the patient.
 - (vii) Arrange for a Physician Appointee with appropriate Privileges to complete the medical history and physical examination for patients admitted to the Hospital by the Podiatrist if the Podiatrist does not otherwise have the Privileges to do so.
 - (viii) Obtain medical consultation from a Physician-Appointee with appropriate Privileges for the care and treatment of any medical condition that is present at the time of admission/registration of the Podiatrist's patient or that may arise during hospitalization that is outside the scope of practice of the Podiatrist. If there is a medical problem, the consulting Physician shall participate in the discharge of the Podiatrist's patient and the completion of medical records such as relates to the Physician's care of the patient.

5.5-3 PSYCHOLOGISTS

Psychologists shall not be authorized to admit or co-admit patients to the Hospital. Psychologists shall be authorized to treat only those patients who have been admitted by a Physician Appointee with admitting Privileges and must maintain a consultative relationship with the attending Physician during the course of treatment of the patient.

5.6 TEMPORARY CLINICAL PRIVILEGES

5.6-1 CONDITIONS

Temporary Clinical Privileges may be granted only in the circumstances and under the conditions described in Section 5.6.2 below. Special requirements of consultation and reporting may be imposed by the Professional Staff Chair or the Department Chair/Division Chief responsible for supervision as applicable. Under all circumstances, the Practitioner requesting temporary Clinical Privileges must agree in writing to abide by the Professional Staff Bylaws and Policies and applicable Hospital policies and procedures in all matters relating to his or her activities in the Hospital.

5.6-2 CIRCUMSTANCES

Upon written recommendation of the Professional Staff Chair, the Hospital CEO or Chief Medical Officer may grant temporary Clinical Privileges on a case-by-case basis in the following circumstances:

- (a) Pendency of a Completed Application: Temporary Privileges may be granted to Applicants for new Privileges awaiting application review and action by the PSEC and Board upon request by the Applicant for such Privileges and satisfaction of the following:
 - (i) Receipt of a complete application that raises no concerns.
 - (ii) Review and verification of the information set forth in Section 4.2.1 of the Professional Bylaws and Section 2.2 of this Policy.
 - (iii) Completion of a query and evaluation of the National Practitioner Data Bank information and such other queries as required by Section 3.2 of this Policy.
 - (iv) Confirmation that the Applicant has no current or previously successful challenges to his/her licensure or registration.
 - (v) Confirmation that the Applicant has not been subject to the involuntary termination of his/her medical staff appointment at another organization.

- (vi) Confirmation that the Applicant has not been subject to the involuntary limitation, reduction, denial, or loss of his/her clinical privileges.

Applicants for new Privileges include a Practitioner applying for Privileges at the Hospital for the first time; a Practitioner currently holding Privileges who is requesting one or more additional Privileges during his/her current appointment/Privilege period; and a Practitioner who is in the reappointment/regrant process and is requesting one or more additional Privileges.

Temporary Privileges may be granted in this circumstance for a period not to exceed the pendency of the application (*i.e.*, completion of review and action on the application by the PSEC and Board) or one hundred twenty (120) days, whichever is less.

Under no circumstances may temporary Clinical Privileges be initially granted or renewed if the application is still pending because the Applicant has not responded in a satisfactory manner to a request for clarification of a matter or for additional information.

(b) Important Patient Care Need:

- (i) Temporary Privileges may be granted to a Practitioner to meet an important patient care, treatment, or service need (*e.g.*, care of a specific patient(s); when necessary to prevent a lack or lapse of services in a needed specialty area; for a Practitioner who temporarily comes to the Hospital to learn (be proctored on) or to teach (proctor) a procedure; *etc.*) upon receipt of a written request for the specific Clinical Privileges desired and verification of the Practitioner's:
 - (1) current licensure
 - (2) current competence relative to the Privileges being requested (*e.g.*, a fully positive written or documented oral reference specific to the Practitioner's current competence regarding the Clinical Privileges being requested from a responsible medical staff authority at the Practitioner's current hospital affiliation).
 - (3) DEA registration and attestation of Ohio OARSS registration, if applicable to the Privileges requested.
 - (4) Professional Liability Insurance
 - (5) Query of the National Practitioner Data Bank and applicable OIG data banks

Temporary Clinical Privileges may be granted in this circumstance for an initial period of up to thirty (30) days and may be renewed for additional periods of up to thirty (30) days as necessary not to exceed a period of 120 days.

5.7 EMERGENCY PRIVILEGES

5.7-1 In the case of an emergency, any Practitioner, to the degree permitted by his or her license and regardless of Professional Staff appointment/Privileges at the Hospital, shall be permitted to do everything possible to save the life of a patient using every facility of the Hospital necessary including calling for any consultation(s) necessary or desirable. When an emergency situation no longer exists, such Practitioner must request the Clinical Privileges necessary to continue to treat the patient if the Practitioner is not already granted such. In the event such Clinical Privileges are denied or the Practitioner does not desire to request such Clinical Privileges, the patient shall be assigned to an Appointee of the Professional Staff with appropriate Privileges.

5.7-2 For the purpose of this section, an “emergency” is defined as a condition in which the life of a patient is in immediate danger and any delay in administering treatment would add to that danger.

5.7-3 Emergency Privileges shall automatically terminate upon alleviation of the emergency situation. A Practitioner who exercises emergency Privileges shall not be entitled to the procedural rights set forth in the Fair Hearing Policy.

5.8 DISASTER PRIVILEGES

5.8-1 Disaster Privileges are granted only when the following two conditions are present: (a) the Hospital’s emergency management plan has been activated, and (b) the Hospital is unable to meet immediate patient needs.

5.8-2 In circumstances of a disaster, disaster Privileges may be granted to volunteer Practitioners to assist with victims for up to thirty (30) days.

5.8-3 The Hospital CEO, Chief Medical Officer, or the Professional Staff Chair may grant such disaster Privileges on a case-by-case basis after verification of a valid government-issued photo identification issued by a state or federal agency (*e.g.*, driver’s license or passport) and at least one of the following: (i) a current license to practice, (ii) primary source verification of the license, (iii) a current hospital photo identification card that clearly identifies professional designation; (iv) identification indicating the individual is a member of a Disaster Medical Assistance Team (“DMAT”), the Medical Reserve Corps. (MRC), the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP) or other recognized state or federal response organization or group; (v) identification indicating the individual has been granted authority to render patient care, treatment, or services in disaster circumstances by a government agency; or,

(vi) confirmation of the identity of the volunteer Practitioner and his/her qualifications by a Hospital employee or Practitioner with Privileges at the Hospital.

5.8-4 Primary source verification of licensure will begin as soon as the immediate situation is under control or within 72 hours from the time the volunteer Practitioner presents to the Hospital, whichever comes first. Under extraordinary circumstances where primary source verification cannot be completed in 72 hours (due to, for example, no means of communication or lack of resources), the Professional Staff Office shall document the following: why primary source verification could not be performed in the required time frame; evidence of the volunteer Practitioner's demonstrated ability to provide adequate care, treatment, and services; and, an attempt to rectify the situation as soon as possible. Primary source verification shall thereafter be completed as soon as possible. Primary source verification of licensure is not required if the volunteer Practitioner has not provided care, treatment, or services under the disaster Privileges.

5.8-5 The Hospital will make a decision within 72 hours of the volunteer Practitioner's arrival at the Hospital, based upon information obtained regarding the professional practice of the volunteer Practitioner, as to whether to authorize continued exercise of the disaster Privileges initially granted.

5.8-6 It is anticipated that disaster Privileges may be granted to state-wide and out-of-state Practitioners as necessary.

5.8-7 All Practitioners at the Hospital who receive disaster Privileges must, at all time while at the Hospital, wear an identification badge, with photograph, from the facility at which they otherwise hold Privileges. If the Practitioner does not have such identification, he or she will be issued a badge identifying him or her and designating the Practitioner as a volunteer Practitioner disaster care provider.

5.8-8 The professional performance of Practitioners who receive disaster Privileges shall be managed by and under the direct observation of the Professional Staff Chair or an appropriate Department Chair/Division Chief.

5.8-9 Disaster Privileges shall cease upon alleviation of the circumstances of disaster as determined by the Hospital CEO.

5.9 TELEMEDICINE PRIVILEGES

5.9-1 Practitioners who are responsible for the patient's care, treatment, and services via a telemedicine link shall be credentialed and privileged to do so by the Hospital in accordance with the Bylaws, this Policy, accreditation requirements, and applicable laws. If the Hospital has a pressing clinical need and the Practitioner can supply that service through a telemedicine link, the Practitioner may be evaluated for temporary Privileges in accordance with the procedures set forth in §5.6-2 (b). Practitioners providing telemedicine services to Hospital patients shall be credentialed and privileged to do so through one of the following mechanisms:

- (a) The Practitioner is credentialed and privileged by the Hospital in accordance with the procedure set forth in Section 3.3 or Section 3.4 of this Policy, as applicable.
- (b) The Practitioner is credentialed and privileged by the Hospital in accordance with the procedure set forth in Section 3.3 or Section 3.4 of this Policy, as applicable, with the exception that the credentialing information and/or privileging decision from the distant site may be relied upon by the Professional Staff and Board in making its recommendations/decision provided that the Hospital has entered into a written agreement with the distant site and all of the following requirements are met:
 - (i) The distant site is a Medicare participating hospital or a facility that qualifies as a “distant site telemedicine entity.” A “distant site telemedicine entity” is defined as an entity that (1) provides telemedicine services, (2) is not a Medicare participating hospital, and (3) provides contracted services in a manner that enables hospitals using its services to meet all applicable conditions of participation, particularly those requirements related to the credentialing and privileging of practitioners providing telemedicine services to the patients of the hospital.
 - (1) When the distant site is a Medicare participating hospital, the written agreement shall specify that it is the responsibility of the distant site hospital to meet the credentialing requirements of 42 C.F.R. 482.12 (a)(1)-(a)(7), as that provision may be amended from time to time, with regard to the distant site hospital Practitioners providing telemedicine services.
 - (2) When the distant site is a “distant site telemedicine entity” the written agreement shall specify that the distant site telemedicine entity is a contractor of services to the Hospital and, as such, furnishes the contracted services in a manner that permits the Hospital to comply with all applicable conditions of participation for the contracted services including, but not limited to, 42 C.F.R. 482.12 (a)(1)-(a)(7), with regard to the distant site telemedicine entity Practitioners providing telemedicine services. The written agreement shall further specify that the distant site telemedicine entity’s medical staff credentialing and privileging process and standards will, at minimum, meet the standards at 42 C.F.R. 482.12 (a)(1)-(a)(7) and at 42 C.F.R. 482.22 (a)(1)-(a)(2), as those provisions may be amended from time to time.
 - (ii) The distant site is TJC accredited.

- (iii) The individual distant site Practitioner is privileged at the distant site for those services to be provided to Hospital patients via telemedicine link and the Hospital is provided with a current list of his/her privileges at the distant site.
- (iv) The individual distant site Practitioner holds an appropriate license or certificate issued by the State Medical Board of Ohio or other appropriate licensing entity in addition to an appropriate license in the State in which the Practitioner is located, if other than Ohio.
- (v) The Hospital maintains documentation of its internal review of the performance of each distant site Practitioner and sends the distant site such performance information for use in the distant site's periodic appraisal of the distant site Practitioner. At a minimum, this information must include:
 - (1) All adverse events that result from the telemedicine services provided by the distant site Practitioner to Hospital patients; and,
 - (2) All complaints the Hospital receives about the distant site Practitioner.

5.10 MOONLIGHTING PRIVILEGES

5.10-1 QUALIFICATIONS

- (a) Moonlighting Privileges may be granted to residents or fellows who:
 - (i) Satisfy applicable education requirements.
 - (ii) Have and maintain a current, valid, license/certificate to practice medicine (not a training certificate).
 - (iii) Have and maintain, if necessary for the Privileges requested, a current, valid Drug Enforcement Administration ("DEA") registration and attestation of Ohio OARRS registration.
 - (iv) Are requesting Privileges to provide care, treatment, and/or services to patients at the Hospital outside their Graduate Medical Education program.
 - (v) Have completed at least two (2) years of post-graduate training in an ACGME or AOA approved residency program.
 - (vi) Satisfy the baseline and other qualifications, to the extent applicable, set forth in Section 4.2.1 of the Professional Staff Bylaws as recommended by the PSEC and approved by the Board.

5.10-2 CONDITIONS

- (a) A moonlighting resident/fellow must request and be granted Privileges prior to providing any care, treatment, or services to patients at the Hospital.
- (b) Special requirements of consultation and reporting may be imposed by the Division Chief responsible for supervision of the moonlighting resident/fellow as applicable. A moonlighting resident/fellow shall work under the direction of an assigned Practitioner(s) with Professional Staff appointment and Privileges at the Hospital who is responsible for assuring that the moonlighting resident's/fellow's practice does not exceed the Privileges granted and for the quality of care provided.
- (c) A moonlighting resident/fellow must agree, in writing, to abide by the Professional Staff Bylaws and Policies and the policies of the Hospital in all matters relating to his/her activities at the Hospital.

5.10-3 PROCESSING A REQUEST FOR MOONLIGHTING PRIVILEGES

- (a) A resident or fellow seeking moonlighting Privileges shall submit an application, the content of which shall be determined by Hospital Administration upon recommendation of the PSEC, and shall have such application processed in accordance with the routine credentialing and privileging process, to the extent applicable, set forth in Section 3.3 or Section 3.4 of this Credentials Policy.
- (b) Moonlighting Privileges may be granted/regranted for a period of up to two (2) years as recommended by the PSEC and approved by the Board.

5.11 DENIAL, TERMINATION, ETC. OF TEMPORARY, DISASTER, TELEMEDICINE, AND MOONLIGHTING PRIVILEGES

5.11-1 The Hospital CEO, Chief Medical Officer, or Professional Staff Chair may, at any time, terminate any or all of a Practitioner's temporary, disaster, or telemedicine Privileges, or a resident's or fellow's moonlighting Privileges. Where the life or well-being of a patient is determined to be endangered, the Practitioner's or moonlighting resident's/fellow's Privileges may be terminated by any person entitled to impose a summary suspension pursuant to the Professional Staff Bylaws.

5.11-2 A Practitioner who has been granted temporary, disaster, or telemedicine Privileges, or a resident/fellow who has been granted moonlighting Privileges is not an Appointee to the Professional Staff and is not entitled to the procedural due process rights afforded to Appointees. A Practitioner or moonlighting resident/fellow shall not be entitled to the procedural due process rights set forth in the Fair Hearing Policy because the Practitioner's request for temporary, disaster, or telemedicine Privileges, or a resident's/fellow's request for moonlighting Privileges are refused, in whole or in part, or because all or any portion of such

Privileges are terminated, not renewed, restricted, suspended, or otherwise limited, modified, or monitored in any way.

- 5.11-3 In the event a Practitioner's or moonlighting resident's/fellow's Privileges are revoked, the Practitioner's or moonlighting resident's/fellow's patients then in the Hospital shall be assigned to another Practitioner by the Professional Staff Chair. The wishes of the patient will be considered, where feasible, in choosing a substitute Practitioner.

ARTICLE VI
LEAVE OF ABSENCE

6.1 LEAVE OF ABSENCE

6.1-1 STATUS

- (a) At the discretion of the PSEC and subject to the approval of the Board, a Professional Staff Appointee may, for good cause (which may include, but not be limited to, illness, injury, military duty, or educational sabbatical), obtain a voluntary leave of absence by giving written notice to the Professional Staff Office who shall notify the Professional Staff Chair and the chair/chief of the Department/Division in which the Practitioner has his or her principal affiliation stating the approximate period of time of the leave which may not exceed one (1) year or the ending date of the current appointment/Privilege period, whichever occurs first.
- (b) Prior to a leave of absence being granted, the Appointee shall have made arrangements acceptable to the PSEC and Board for the care of his/her patients during the leave.
- (c) During the period of the leave, the Professional Staff Appointee's Clinical Privileges, Prerogatives, and responsibilities shall be inactive with the exception that the Appointee must continue to pay Professional Staff dues unless otherwise waived by the PSEC.
- (d) In order to qualify for reinstatement following a leave of absence, the Appointee must maintain Professional Liability Insurance coverage during the leave or purchase tail coverage for all periods during which the Appointee held Privileges. The Appointee shall provide information to demonstrate satisfaction of continuing Professional Liability Insurance coverage or tail coverage as required by this provision upon request for reinstatement.

6.1-2 TERMINATION OF LEAVE OF ABSENCE STATUS

- (a) At least thirty (30) days prior to the termination of the leave of absence, the Professional Staff Appointee may request reinstatement of his/her Professional Staff appointment and Privileges by sending a written notice to the Professional Staff Office who shall notify the Professional Staff Chair and the chair/chief of the applicable Department/Division.
- (b) The Appointee must submit a written summary of relevant activities during the leave as well as such additional information as is reasonably necessary to reflect that the Appointee is qualified for reinstatement of Professional Staff appointment and/or Privileges.

- (c) Once the Appointee's request for reinstatement is deemed complete, the procedures for reappointment/regrant of Privileges set forth in Article IV of this Policy shall, as applicable, be followed in evaluating and acting on the reinstatement request.

6.1-3 FAILURE TO REQUEST REINSTATEMENT

If an Appointee fails to request reinstatement of Professional Staff appointment and Privileges upon the termination of a leave of absence, the PSEC shall make a recommendation to the Board as to how the failure to request reinstatement should be construed. If such failure is determined to be a voluntary resignation, it shall not give rise to any rights pursuant to the Fair Hearing Policy.

ARTICLE VII BOARD CERTIFICATION

7.1 GENERAL REQUIREMENTS

7.1-1 Unless otherwise provided herein, all Practitioners shall at the time of initial application for Professional Staff appointment and/or Privileges be board-eligible or board certified as follows:

- (a) Physicians: By the American Board of Medical Specialties or American Osteopathic Association board applicable to their specialty/sub-specialty.
- (b) Dentists: By the American Board of General Dentistry; American Board of Oral & Maxillofacial Surgery; or American Board of Pediatric Dentistry.
- (c) Podiatrists: By the American Board of Podiatric Medicine or American Board of Foot and Ankle Surgery.
- (d) Psychologists: By the American Board of Clinical Neuropsychology; American Board of Child & Adolescent Psychology; or American Board of Professional Psychology.

7.2 BOARD ELIGIBILITY

A Practitioner who is a qualified candidate for board certification at the time of initial application for Professional Staff appointment and/or Privileges shall have seven (7) years (or such other time period as set by the applicable certifying board) from the date board eligibility was first attained to become board certified unless a waiver is otherwise granted.

7.3 GRANDFATHERED PRACTITIONERS

Practitioners who were granted Professional Staff appointment and Privileges at the Hospital prior to January 1, 1990, and who have continuously held appointment and Privileges at the Hospital since the time such appointment and Privileges were initially granted, are not required to be board certified.

7.4 MAINTAINING BOARD CERTIFICATION

Practitioners for whom board certification is required shall continuously maintain board certification as specified by the applicable specialty/subspecialty board.

7.5 GROUNDS FOR GRANTING WAIVER

7.5-1 A waiver of the board certification requirements may be requested by a Practitioner in the following instances:

- (a) Any Practitioner who is required to be board certified and who fails the initial board certification examination may request a temporary waiver in

order to retake the examination up to three (3) additional times (or such other shorter number of times as permitted by the applicable board) at the earliest available time the examination is offered.

- (b) Any Practitioner who is required to be board certified and who fails to attain board certification, but possesses equivalent qualifications, may request that the board certification requirement be waived. The Practitioner requesting the waiver bears the burden of demonstrating exceptional circumstances and that his or her qualifications are equivalent.
- (c) Any Practitioner who is required to maintain board certification and fails the recertification examination may request a temporary waiver in order to retake the examination up to two (2) additional times (or such other shorter number of times as permitted by the applicable board) at the earliest available time the examination is offered.
- (d) Any Practitioner who is required to be board certified and who fails to maintain board certification may request a waiver of the Board certification requirement. The Practitioner requesting the waiver bears the burden of demonstrating exceptional circumstances and that the waiver is in the best interest of the Hospital and patient care.

7.6 WAIVER PROCEDURE

7.6-1 A written request for a waiver may be submitted to the Credentials Committee for consideration. The Practitioner must supply all information as requested by the Credentials Committee. The Credentials Committee may, in its discretion, consider the specific qualifications of the Practitioner in question, input from the relevant Division Chief/Department Chair, the best interests of the Hospital and the patients and families it serves, the application form, and other information supplied by the Practitioner. The Practitioner's specialized expertise to meet a patient care need may also be considered.

7.6-2 The Credentials Committee's recommendation will be forwarded to the PSEC. Any recommendation to grant a waiver must include the basis and criteria relied upon for such recommendation.

7.6-3 The PSEC will review the recommendation of the Credentials Committee and make a recommendation to the Board regarding whether to grant or deny the request for a waiver. Any recommendation to grant a waiver must include the basis and criteria relied upon for such recommendation.

7.6-4 Once a waiver is granted, it shall remain in effect from the time it is granted for a period of time as recommended by the PSEC and approved by the Board.

7.6-5 No Practitioner is entitled to a waiver. A determination by the Board not to grant a Practitioner's request for a waiver; or, the Hospital's inability to process an application; or termination of a Practitioner's appointment and Privileges based

upon failure to satisfy the board certification requirements does not create any procedural rights nor does it create a reportable event for purposes of federal or state law.

7.7 FAILURE TO MEET BOARD CERTIFICATION REQUIREMENTS

7.7-1 Unless a waiver is requested and subsequently granted, a Practitioner's failure to:

- (a) Satisfy the requirement of board certification (or board eligibility, as applicable) at the time of initial application shall result in the Hospital's inability to process the application as a result of the Practitioner's failure to meet baseline qualifications.
- (b) Continuously satisfy the requirement of board certification (or board eligibility, as applicable) following attainment of Professional Staff appointment and/or Privileges shall result in an automatic termination of Professional Staff appointment and Privileges for failure to meet baseline qualifications.

CERTIFICATION OF ADOPTION AND APPROVAL

Adopted by the Professional Staff Executive Committee:

Professional Staff Chair

Date

Approved by the Board:

Board Chair

Date