CREDENTIALS POLICY

Ridgeview Medical Center
Ridgeview Le Sueur Medical Center
Ridgeview Sibley Medical Center

CREDENTIALS POLICY

TABLE OF CONTENTS

PAGE

1. GENERAL 1

1.A. DEFINITIONS 1

1.B. TIME LIMITS 4

1.C. DELEGATION OF FUNCTIONS 5

1.D. CONFIDENTIALITY AND PEER REVIEW PROTECTION 5

1.D.1. Confidentiality 5
1.D.2. Peer Review Protection 5

1.E. INDEMNIFICATION 6

2. QUALIFICATIONS, CONDITIONS, AND RESPONSIBILITIES 7

2.A. QUALIFICATIONS 7

2.A.1. Threshold Eligibility Criteria 7
2.A.2. Process for Waiver of Threshold Eligibility Criteria 10
2.A.3. Factors for Evaluation 11
2.A.4. Burden of Providing Information 11
2.A.5. No Entitlement to Appointment 13
2.A.6. Nondiscrimination 13

2.B. GENERAL CONDITIONS OF APPOINTMENT, REAPPOINTMENT, & CLINICAL PRIVILEGES 13

2.B.1. Basic Responsibilities and Requirements 13
2.B.2. Immunity and Authorization to Obtain and Release Information 15

3. PROCEDURE FOR INITIAL APPOINTMENT AND PRIVILEGES 19

3.A. APPLICATION 19

PAGE

3.A.1. Application Form 19
3.A.2. Misstatements and Omissions 19

3.B. PROCEDURE FOR INITIAL APPOINTMENT AND PRIVILEGES 20

3.B.1. Application Process 20
3.B.2. Initial Review of Application 20
3.B.3. Steps to Be Followed for Initial Applicants 20
3.B.4. Service Chairperson Procedure 21
3.B.5. Credentials Committee Procedure 21
3.B.6. Medical Executive Committee Recommendation 22
3.B.7. Board Action 23
3.B.8. Time Periods for Processing 24

4. CLINICAL PRIVILEGES 25

4.A. CLINICAL PRIVILEGES 25

4.A.1. General 25
4.A.2. Requests for Limited Privileges Within a Core or Specialty 26
4.A.3. Resignation of Limited Clinical Privileges 27
4.A.4. Resignation of Appointment and Clinical Privileges 27
4.A.5. Clinical Privileges for New Procedures 27
4.A.6. Clinical Privileges That Cross Specialty Lines 29
4.A.7. Physicians and Other Practitioners in Training 30
4.A.8. Focused Professional Practice Evaluation for Initial Privileges 31

4.B. TEMPORARY CLINICAL PRIVILEGES 31

4.B.1. Temporary Clinical Privileges for Initial Applicants 31
4.B.2. Temporary Clinical Privileges for an Important Patient Care Need 32
4.B.3. General Provisions Relating to Temporary Clinical Privileges 32

4.C. TELEMEDICINE PRIVILEGES 33

4.C.1. Processing Requests for Telemedicine Privileges 33
4.C.2. Review of Telemedicine Privileges 34

4.D. EMERGENCY AND DISASTER PRIVILEGES 34

4.D.1. Emergency Situations 34
4.D.2. Disaster Privileges 34

PAGE

4.E. CONTRACTS FOR SERVICES AND EMPLOYED MEDICAL STAFF MEMBERS 35

5. PROCEDURE FOR REAPPOINTMENT 38

5.A. PROCEDURE FOR REAPPOINTMENT 38

5.B. REAPPOINTMENT CRITERIA 38

5.B.1. Eligibility for Reappointment 38
5.B.2. Factors for Evaluation 38

5.C. REAPPOINTMENT PROCESS 39

5.C.1. Reappointment Application Form 39
5.C.2. Processing Applications for Reappointment 39
5.C.3. Conditional Reappointments 40
5.C.4. Potential Adverse Recommendation 41

6. MANAGING QUESTIONS ABOUT MEDICAL STAFF OR NON-PHYSICIAN PROVIDERS STAFF MEMBERS 42

6.A. INITIAL COLLEGIAL EFFORTS AND PROGRESSIVE STEPS 42

6.A.1. Options Available to Medical Staff Leaders and Hospital Administration 42
6.A.2. No Right to the Presence of Others 43
6.A.3. No Right to Counsel 43
6.A.4. Involvement of Supervising Physician in Matters Pertaining to Non-Physician Providers 44

6.B. OTHER OPTIONS 44

6.B.1. Mandatory Meeting 44
6.B.2. Fitness for Practice Evaluation 44
6.B.3. Competency Assessment 45

6.C. AUTOMATIC RELINQUISHMENT 45

6.C.1. Failure to Complete Medical Records 46
6.C.2. Failure to Satisfy Threshold Eligibility Criteria 46
6.C.3. Criminal Activity 46

PAGE

6.C.4. Failure to Provide Information....46
6.C.5. Failure to Attend a Mandatory Meeting....46
6.C.6. Failure to Complete or Comply with Training or Educational Requirements....47
6.C.7. Failure to Comply with Request for Fitness for Practice Evaluation....47
6.C.8. Failure to Comply with Request for Competency Assessment....47
6.C.9. Reinstatement from Automatic Relinquishment and Automatic Resignation....47

6.D. ACTIONS OCCURRING AT OTHER HOSPITALS AND FACILITIES WITHIN THE SYSTEM....48

6.E. LEAVES OF ABSENCE....49

6.E.1. Initiation....49
6.E.2. Duties of Member on Leave....50
6.E.3. Reinstatement....50

6.F. PRECAUTIONARY SUSPENSION OR RESTRICTION OF CLINICAL PRIVILEGES....51

6.F.1. Grounds for Precautionary Suspension or Restriction....51
6.F.2. Medical Staff Leadership Council Procedure....52

6.G. INVESTIGATIONS....52

6.G.1. Initial Review....52
6.G.2. Initiation of Investigation....53
6.G.3. Appointment of Investigating Committee....54
6.G.4. Investigative Procedures....54
6.G.5. Report of Investigating Committee....55
6.G.6. Recommendation....56

7. HEARING AND APPEAL PROCEDURES....57

7.A. INITIATION OF HEARING....57

7.A.1. Hearing Rights....57
7.A.2. Grounds for Hearing....57
7.A.3. Actions Not Grounds for Hearing....58
7.A.4. Notice of Recommendation....59
7.A.5. Request for Hearing....59

PAGE

7.A.6. Notice of Hearing and Statement of Reasons 60
7.A.7. Hearing Panel, Presiding Officer, and Hearing Officer 60
7.A.8. Counsel 63

7.B. PRE-HEARING PROCEDURES 63

7.B.1. General Procedures 63
7.B.2. Time Frames 63
7.B.3. Witness List 64
7.B.4. Provision of Relevant Information 64
7.B.5. Pre-Hearing Conference 65
7.B.6. Stipulations 65
7.B.7. Provision of Information to the Hearing Panel 65

7.C. THE HEARING 65

7.C.1. Time Allotted for Hearing 65
7.C.2. Rights of Both Sides and the Hearing Panel at the Hearing 66
7.C.3. Record of Hearing 66
7.C.4. Order of Presentation and Burden 66
7.C.5. Admissibility of Evidence 67
7.C.6. Persons to Be Present 67
7.C.7. Presence of Hearing Panel Members 67
7.C.8. Failure to Appear 67
7.C.9. Postponements and Extensions 67

7.D. HEARING CONCLUSION, DELIBERATIONS, AND RECOMMENDATIONS 67

7.D.1. Basis of Hearing Panel Recommendation 67
7.D.2. Deliberations and Recommendation of the Hearing Panel 68
7.D.3. Disposition of Hearing Panel Report 68

7.E. APPEAL PROCEDURE 68

7.E.1. Time for Appeal 68
7.E.2. Grounds for Appeal 68
7.E.3. Time, Place, and Notice 68
7.E.4. Nature of Appellate Review 69

7.F. BOARD ACTION 69

7.F.1. Final Decision of the Board 69
7.F.2. Right to One Hearing and One Appeal Only 70

PAGE

7.G. PROCEDURAL RIGHTS FOR DEPENDENT PRACTITIONERS 70

8. CONFLICTS OF INTEREST 71

9. MEDICAL STAFF ACCESS TO CREDENTIALS AND QUALITY FILES 73

10. AMENDMENTS AND ADOPTION 76

APPENDIX A - NON-PHYSICIAN PROVIDERS STAFF

APPENDIX B - CONFLICT OF INTEREST GUIDELINES

APPENDIX C - DELEGATED CREDENTIALING PROCEDURES

ARTICLE 1

GENERAL

1.A. DEFINITIONS

The following definitions apply to terms used in this Policy:

(1) "AFFILIATED ENTITY" means any entity that is part of Ridgeview Medical Center system or is directly or indirectly controlled by, or is under common control along with the Hospital.

(2) "APPLICANT" means an individual who has submitted an application for initial appointment or reappointment to the Medical Staff or the Non-Physician Provider Staff or has submitted an application for clinical privileges.

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

(4) "BOARD CERTIFICATION" is the designation conferred by one of the affiliated specialties of the American Board of Medical Specialties, the American Osteopathic Association, the American Board of Oral and Maxillofacial Surgery, or the American Board of Foot and Ankle Surgery, as applicable. For other members, the certifying body approved by the Hospital will be included in the delineation of clinical privileges.

(5) "CHIEF MEDICAL OFFICER" means the individual appointed by the President and Chief Executive Officer and ratified by the Board to provide overall administrative management of physician services and to serve as liaison between the Medical Staff and the Hospital Administration.

(6) "CLINICAL PRIVILEGES" or "PRIVILEGES" means the authorization granted by the Board to render specific clinical procedures and patient care services, subject to the provisions of this Policy. For purposes of this Policy, clinical privileges also mean the authorization granted by the Board for a scope of practice for a dependent practitioner.

(7) "CREDENTIALS POLICY" means the Hospital's Medical Staff Credentials Policy.

(8) "DAYS" means calendar days.

(9) "DENTIST" means a doctor of dental surgery or doctor of dental medicine.

(10) "EX OFFICIO" means service as a member of a body by virtue of an office or position held and, unless otherwise expressly provided, means without voting rights.

(11) "HOSPITAL" means Ridgeview Medical Center, Ridgeview Le Sueur Medical Center, or Ridgeview Sibley Medical Center.

(12) "HOSPITAL ADMINISTRATION" means the President and Chief Executive Officer or his or her designee, including the administrator on call.

(13) "MEDICAL EXECUTIVE COMMITTEE" means the Executive Committee of the Medical Staff as set forth in the Medical Staff Bylaws. For the purposes of this Policy, in the absence of a Credentials Committee, the Medical Executive Committee will perform the functions assigned to the Credentials Committee.

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

(15) "MEDICAL STAFF GOVERNANCE DOCUMENTS" means the Medical Staff Bylaws, Credentials Policy, Organization Manual, Medical Staff Rules and Regulations, and Medical Staff Policies and Procedures.

(16) "MEDICAL STAFF LEADER" means any Medical Staff officer, service chairperson, or committee chairperson.

(17) "MEDICAL STAFF POLICIES AND PROCEDURES" means those policies and procedures that have been approved by the Medical Executive Committee and the Board. Medical Staff Policies and Procedures will be maintained by the Medical Staff Office.

(18) "MEMBER" means a physician, dentist, podiatrist, or other practitioner who has been granted appointment to the Medical Staff or Non-Physician Provider Staff by the Board.

(19) "NON-PHYSICIAN PROVIDER (NPP) STAFF" consists of individuals other than members of the Medical Staff who are authorized by law and by the Hospital to provide patient care services. A listing of the categories of professionals who are practicing at the Hospital as members of the Non-Physician Provider Staff is included at Appendix A. The Non-Physician Provider Staff includes licensed independent practitioners, advanced practice clinicians, and dependent practitioners:

- "LICENSED INDEPENDENT PRACTITIONER" means an individual who is permitted by law and by the Hospital to provide patient care services without direction or supervision, within the scope of his or her license and consistent with the clinical privileges granted. A listing of the categories of

licensed independent practitioners practicing at the Hospital is included at Appendix A.

- "ADVANCED PRACTICE CLINICIAN" means an individual who provides a medical level of care or performs surgical tasks consistent with granted clinical privileges, but who is required by law and/or the Hospital to exercise some or all of those clinical privileges under the direction of, or in collaboration with, a Supervising Physician pursuant to a written supervision or collaborative agreement.

- "DEPENDENT PRACTITIONER" means an individual who is permitted by law or the Hospital to function only under the direction of a Supervising Physician, pursuant to a written supervision agreement and consistent with the scope of practice granted.

(20) "NOTICE" means written communication by regular hand delivery, U.S. mail, e-mail, facsimile, or Hospital mail.

(21) "PATIENT CONTACTS" means any admission, consultation, procedure, physical response to emergency call, evaluation, treatment, or service performed in the Hospital, one of the Hospital's rural health clinics, or one of the Hospital's other outpatient facilities. Patient contacts include supervision of a member of the Non-Physician Provider Staff but not referrals for diagnostic or laboratory tests or x-rays.

(22) "PHYSICIAN" includes both doctors of medicine and doctors of osteopathy.

(23) "PODIATRIST" means a doctor of podiatric medicine.

(24) "PRESIDENT AND CHIEF EXECUTIVE OFFICER" means the individual appointed by the Board to act on its behalf in the overall management of the Hospital.

(25) "PROFESSIONAL PRACTICE EVALUATION" refers to the Hospital's routine and ongoing peer review, performance improvement, and professional practice evaluation processes. These processes include, but are not limited to, the review and assessment of an individual's clinical performance, professionalism, and ability to exercise clinical privileges safely and competently.

(26) "RESTRICTION" means a professional review action based on clinical competence or professional conduct which results in the inability of an individual to exercise his or her own independent judgment for a period longer than 30 days (for example, a mandatory concurring consultation, where the consultant must approve the proposed procedure or treatment before privileges may be exercised, or other requirement that another physician must agree before privileges can be exercised). Conditions built into a performance improvement plan are not considered a restriction.

(27) “SERVICE” means a patient-centered strategic business unit, co-led by administration and physician champion(s) engaged in (a) improving and enhancing clinical services; (b) building seamless delivery of care; (c) improving process, outcome, and operational performance; (d) growing the business-monitoring trends and proactively responding with strategic initiatives; and (e) assuring a commitment to outstanding quality, exceptional patient experience/service, and cost-effective care.

(28) “SERVICE CHAIRPERSON” is the physician leader of a clinical service. To the extent a service does not have a chairperson, all functions assigned to the chairperson will be carried out by the Chief of Staff.

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

(30) “SUPERVISING PHYSICIAN” means a member of the Medical Staff with clinical privileges, who has agreed in writing to supervise or collaborate with an Non-Physician Provider and to accept full medical responsibility for the actions of the Non-Physician Provider while he or she is practicing in the Hospital.

(31) “SUPERVISION” means the supervision of (or collaboration with) an Non-Physician Provider by a supervising physician, that may or may not require the actual presence of the supervising physician, but that does require, at a minimum, that the supervising physician be readily available for consultation. The requisite level of supervision will be determined at the time each Non-Physician Provider is credentialed and will be consistent with any applicable written supervision or collaboration agreement.

(32) “SYSTEM” means Ridgeview Medical Center, Ridgeview Le Sueur Medical Center, and Ridgeview Sibley Medical Center.

(33) “UNASSIGNED PATIENT” means any individual who comes to the Hospital for care and treatment who does not have an attending physician, or whose attending physician or designated alternate is unavailable to attend the patient, or who does not want the prior attending physician to provide him/her care while a patient at the Hospital.

1.B. TIME LIMITS

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

1.C. DELEGATION OF FUNCTIONS

(1) When a function is to be carried out by a Medical Staff Leader, or a Medical Staff committee, or a member of Hospital Administration, the individual, or the committee through its chairperson, may delegate performance of the function to one or more designees.

(2) When a member of the Medical Staff is unavailable or unable to perform an assigned function, one or more of the Medical Staff Leaders may perform the function personally or delegate it to another appropriate individual.

1.D. CONFIDENTIALITY AND PEER REVIEW PROTECTION

1.D.1. Confidentiality:

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

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

(b) as authorized by a policy; or

(c) as authorized by the President and Chief Executive Officer or by legal counsel to the Hospital.

Any breach of confidentiality may result in appropriate sanctions, including but not limited to a professional review action or appropriate legal action. Breaches of confidentiality will not constitute a waiver of any privilege. Any member of the Medical Staff or Non-Physician Provider Staff who becomes aware of a breach of confidentiality is encouraged to inform the President and Chief Executive Officer, the Chief Medical Officer, or the Chief of Staff.

1.D.2. Peer Review Protection:

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

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

(b) all services;

(c) hearing and appellate review panels;

(d) the Board and its committees; and

(e) any individual or body acting for or on behalf of a peer review committee, Medical Staff Leaders, and experts or consultants retained to assist in professional review activity.

All oral and written communications, reports, recommendations, actions, and minutes made or taken by peer review committees are confidential and covered by the provisions of applicable law and are deemed to be “professional review bodies” as that term is defined in the Health Care Quality Improvement Act of 1986 (“HCQIA”), 42 U.S.C. §11101 et seq.

1.E. INDEMNIFICATION

The Hospital will provide a legal defense for, and will indemnify, all Medical Staff Leaders, Medical Staff committees, members, and authorized representatives when engaged in those capacities, in accordance with applicable laws and the Hospital’s Bylaws.

ARTICLE 2

QUALIFICATIONS, CONDITIONS, AND RESPONSIBILITIES

2.A. QUALIFICATIONS

2.A.1. Threshold Eligibility Criteria:

(a) To be eligible to apply for initial appointment, reappointment, and clinical privileges, an individual must demonstrate satisfaction of all of the following threshold eligibility criteria, as applicable:

(1) have a current, unrestricted license to practice in Minnesota that is not subject to any restrictions, probationary terms, or conditions;

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

(3) have a current, unrestricted Minnesota DEA registration where applicable to a provider's clinical practice and have never had a DEA registration or state controlled substance license denied, revoked, restricted or suspended;

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

(5) have current, valid professional liability insurance coverage in amounts satisfactory to the Hospital;

(6) have current, government-issued photographic identification which verifies the individual's identity;

(7) have successfully completed the following professional training requirements[1]:

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

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[1] The residency training requirement will be applicable only to those individuals who apply for initial appointment after _______________; members appointed prior to this date will be governed by the residency requirement in effect at the time of their initial appointment.

(ii) a dental training program accredited by the Commission on Dental Accreditation of the American Dental Association;

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

(iv) for members of the Non-Physician Provider Staff, have satisfied the applicable training requirements as established by the Hospital;

(8) satisfy the following board certification requirements:

(i) are certified in their primary area of practice at the Hospital by an approved board as defined in this Policy; or

(ii) are eligible for examination and have been actively pursuing certification for no longer than five years from the date of eligibility or any different time period imposed by the applicable specialty board[2]; and

(iii) maintain board certification in their primary area of practice at the Hospital on a continuous basis, and satisfy all requirements of the relevant specialty/subspecialty board necessary to do so;

(9) satisfy the following professional practice and experience requirements:

(i) demonstrate recent clinical activity in their primary area of practice, in an acute care hospital, during the last three (3) years;

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

(iii) have never resigned staff appointment or relinquished privileges during an investigation or in exchange for not conducting such an investigation at any health care facility, including the Hospital;

(iv) have never had an application for appointment or clinical privileges not processed, nor had appointment or privileges automatically relinquished, at the Hospital or any of its affiliated entities, due to an omission or misrepresentation;

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[2] The board certification requirement will be applicable only to those individuals who apply for initial appointment after _______________; members appointed prior to this date will be governed by the board certification requirement in effect at the time of their initial appointment.

(v) have never been terminated from a post-graduate training program (residency or fellowship for physicians or a similarly equivalent program for other categories of practitioners), nor resigned from such a program during an investigation or in exchange for the program not conducting an investigation;

(vi) not currently be under any criminal investigation or indictment and have not been convicted of, or entered a plea of guilty or no contest to, any felony, or misdemeanor related to: (i) controlled substances; (ii) illegal drugs; (iii) Medicare, Medicaid, or other federal, state governmental or private third-party payer fraud; (iv) violent acts; (v) sexual misconduct; (vi) moral turpitude; (vii) child or elder abuse; (viii) the practitioner-patient relationship; and

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

(10) satisfy the following Hospital practice requirements:

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

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

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

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

(v) agree to fulfill all responsibilities regarding emergency call for their specialty;

(vi) document compliance with health screening requirements (i.e., TB testing, mandatory flu vaccines, and infectious agent exposures);

(vii) complete a conflict of interest questionnaire; and

(11) if seeking to practice as a physician assistant or another practitioner whose licensing board requires the applicant to have a written delegation agreement or similar supervision agreement with a physician, the applicant must provide the Hospital with a copy of such an agreement with a physician member of the Medical Staff and confirmation that the agreement has been filed with the applicable state licensing board (to the extent required by law).

(b) In order to be eligible for continued appointment and privileges, members must demonstrate satisfaction of the above threshold eligibility criteria, as applicable, on an ongoing basis.

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

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

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

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

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

(e) The Board's determination regarding whether to grant a waiver is final.

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

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

(h) A determination not to grant a waiver is not a "denial" of appointment or clinical privileges and the individual who requested the waiver is not entitled to a hearing. A determination to grant a waiver in a particular case is not intended to set a precedent.

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, a commitment to quality care and recognition that interpersonal skills and collegiality are essential to the provision of quality patient care.

2.A.4. Burden of Providing Information:

(a) All individuals 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. This includes information that may be needed to assist in an appropriate assessment of qualifications for appointment, reappointment, and clinical privileges, such as information from other hospitals, the individual's office practice, insurers or managed care organizations, and/or confidential evaluation forms.

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

(c) An application will be complete when all questions on the application form have been answered, all supporting documentation has been supplied, and all information has been verified from primary sources. An application will become incomplete if the need arises for new, additional, or clarifying information. Any application that continues to be incomplete sixty (60) 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 and all information requested from third parties for a proper evaluation. An incomplete application will not be processed.

(e) Applicants and members are responsible for notifying the Medical Staff Office of any change in status or any change in the information provided on the application form. This information is required to be provided with or without request, at the time the change occurs, and includes, but is not limited to:

(1) any information on the application form;

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

(3) any and all complaints, documents or other information known to the practitioner regarding, or changes in, licensure status or DEA controlled substance authorization or state-controlled substance license;

(4) changes in professional liability insurance coverage;

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

(6) arrest, charge, indictment, conviction, or a plea of guilty or no contest in any criminal matter;

(7) exclusion or preclusion from participation in Medicare, Medicaid or any other federal or state healthcare program or any sanctions imposed with respect to the same; and

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

2.A.5. No Entitlement to Appointment:

No one is entitled to receive an application, be appointed, reappointed or be granted or exercise 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, staff appointment or privileges at any hospital or health care facility;

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

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

2.A.6. Nondiscrimination:

No one will be denied appointment or clinical privileges or otherwise discriminated against on the basis of race, color, religion, sex, pregnancy, citizenship, national origin, age, disability, military service, veteran status, genetic information, union membership, creed, marital status, familial status, sexual orientation, gender identity, status with regards to public assistance, membership in local human rights commission, or any other category that may be protected by law.

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

2.B.1. Basic Responsibilities and Requirements:

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

(a) to provide continuous and timely care;

(b) to abide by the medical staff governance documents and the policies of the Hospital, and any revisions or amendments thereto;

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

(d) to provide emergency call coverage, consultations, and care for unassigned patients;

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

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

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

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

(i) to obtain, when requested, an evaluation of current clinical competence by a consultant or program selected by the Hospital;

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

(k) to use the Hospital sufficiently to allow continuing assessment of current competence;

(l) to seek consultation whenever necessary;

(m) to complete in a timely manner all medical and other required records;

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

(o) to satisfy continuing medical education requirements;

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

(q) to meet with Medical Staff Leaders and/or Hospital Administration, provide information regarding professional qualifications, and participate in collegial efforts as may be requested;

(r) to maintain and monitor a current e-mail address with the Medical Staff Office, which will be the primary mechanism used to communicate information to members of the Medical Staff and Non-Physician Provider Staff;

(s) to provide valid contact information in order to facilitate practitioner-to-practitioner communication (e.g., mobile phone number or valid answering service information);

(t) to cooperate with all care management activities;

(u) to participate in an Organized Health Care Arrangement with the Hospital and abide by the terms of the Hospital's Notice of Privacy Practices with respect to health care delivered in the Hospital; and

(v) to disclose conflicts of interest regarding relationships with pharmaceutical companies, device manufacturers, other vendors, or other persons or entities as may be required by Hospital or Medical Staff policies.

2.B.2. Immunity and Authorization to Obtain and Release Information:

(a) Conditions Prerequisite to Application and Consideration:

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

(b) Scope of Conditions:

The terms set forth in this Section:

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

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

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

(c) Information Defined:

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

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

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

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

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

(d) Authorization for Criminal Background Check:

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

(e) Authorization to Share Information Among Affiliated Entities:

The individual authorizes Affiliated Entities to share with one another information pertaining to the individual's clinical competence, professional conduct, and health. This information and documentation may be shared at any time, including, but not limited to, any initial evaluation of an individual's qualifications, any periodic reassessment of those qualifications, or when a question is raised about the individual.

(f) Authorization to Obtain Information from Third Parties:

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

(g) Authorization to Disclose Information to Third Parties:

The individual authorizes the Hospital, Medical Staff Leaders, and their representatives to disclose information to other hospitals, health care facilities, managed care organizations, government regulatory and licensure boards or

agencies, and their representatives to assist them in evaluating the individual's qualifications.

(h) Access to Information by Individuals:

(1) Upon request, applicants will be informed of the status of their applications for appointment, or clinical privileges.

(2) Except during the hearing and appeal processes, which are governed by Article 7 of this Policy, an individual may review information obtained or maintained by the Hospital only upon request and only if the identity of the individual who provided the information will not be revealed.

(3) If an individual disputes any information obtained or maintained by the Hospital, the individual may submit, in writing, a correction or clarification of the relevant information which will be maintained in the individual's file.

(i) Hearing and Appeal Procedures:

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

(j) Immunity:

(1) To the fullest extent permitted by law, the individual releases from any and all liability, extends immunity to, and agrees not to sue the Hospital, the Board, and the Medical Staff, their authorized representatives, any members of the Medical Staff or the Non-Physician Provider Staff, or Board, and any third party who provides information.

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

(k) Legal Actions:

If, despite this Section, an individual institutes legal action challenging any credentialing, privileging, peer review, or other professional review action or activity and does not prevail, he or she will reimburse the Hospital, the Board, and the Medical Staff, their authorized representatives, any members of the Medical Staff, or Non-Physician Provider Staff, or Board, and any third party who provides

information involved in the action for all costs incurred in defending such legal action, including costs and attorneys' fees, and expert witness fees.

ARTICLE 3

PROCEDURE FOR INITIAL APPOINTMENT AND PRIVILEGES

3.A. APPLICATION

3.A.1. Application Form:

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

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

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

3.A.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 Chairperson of the Credentials Committee and the President and Chief Executive Officer will review the response and determine whether the application should be processed further.

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

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

3.B. PROCEDURE FOR INITIAL APPOINTMENT AND PRIVILEGES

3.B.1. Application Process:

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

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

(c) Applications may be provided to residents and fellows who are in the final six (6) months of their training. Final action will not be taken until all applicable threshold eligibility criteria are satisfied.

3.B.2. Initial Review of Application:

(a) As a preliminary step, the application will be reviewed by the Medical Staff 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 the hearing and appeal rights outlined in this Policy, and is not reportable to any state agency or to the National Practitioner Data Bank.

(b) The Medical Staff Office will oversee the process of gathering and verifying relevant information, and confirming that all references and other information deemed pertinent have been received. Verification of current and past practice settings for the previous ten (10) years will be obtained.

3.B.3. Steps to Be Followed for Initial Applicants:

(a) Evidence of the applicant's character, professional competence, qualifications, behavior, and ethical standing will be examined. This information may be contained in the application, and obtained from 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. The National Practitioner Data Bank will be queried, the Office of Inspector General's List of Excluded Individuals/Entities will be checked, and a criminal background check will be obtained.

(b) Follow-up telephone calls to solicit additional information from references and past practice settings may be made and documentation of such calls will be included in the applicant's credentials file.

(c) An interview with an applicant may be conducted. The purpose of the interview is to discuss and review any aspect of the applicant's application, qualifications, and requested clinical privileges. This interview may be conducted by any combination of the following: the service chairperson, the Credentials Committee chairperson, two (2) or more members of the Credentials Committee, the Medical Executive Committee, the Chief of Staff, the Chief Medical Officer, or the President and Chief Executive Officer. The interview may be clinical in nature or to solicit additional information from the applicant. A summary of the interview will be included in the applicant's credentials file.

(d) At the completion of the application and primary source verification process, each credentialing file is quality reviewed by the Medical Staff Office to ensure completeness, accuracy, appropriateness, and compliance with policies. The Medical Staff Office will transmit the complete application and all supporting materials to the chairperson of each service in which the applicant seeks clinical privileges.

3.B.4. Service Chairperson Procedure:

The service chairperson will prepare a written report regarding whether the applicant has satisfied the qualifications for appointment and the clinical privileges requested. The report will be on a form provided by the Medical Staff Office.

3.B.5. Credentials Committee Procedure:

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

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

(c) After determining that an applicant is otherwise qualified for appointment and privileges, if there is any question about the applicant's ability to perform the privileges requested and the responsibilities of appointment, the Credentials Committee may require a fitness for practice evaluation by a physician(s) satisfactory to the Credentials Committee. The results of this evaluation will be made available to the Credentials Committee. Failure of an applicant to undergo a fitness for practice evaluation within a reasonable time after being requested to do so in writing by the Credentials Committee will be considered a voluntary withdrawal of the application and all processing of the application shall cease.

(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 three (3) years in

order to permit closer monitoring of the applicant's compliance with any conditions.

(e) Nothing herein prohibits the chairperson of the Credentials Committee from acting on behalf of the Credentials Committee and performing the procedures outlined in this section if the following criteria are met, as applicable:

(1) the application is complete;

(2) the applicant has successfully completed a residency in the specialty in which the applicant is requesting clinical privileges;

(3) all reference evaluations are complete and contain only favorable evaluations, including unqualified recommendations for appointment and clinical privileges;

(4) the applicant's malpractice claims history is reasonable with respect to his or her specialty;

(5) the applicant was not subject to any disciplinary actions or conditions during residency training;

(6) there are no pending or past investigations or reports of disciplinary action from any hospital or licensing agency, including challenges to licensure;

(7) no member of the Medical Staff has raised a question about the applicant's qualifications for appointment or clinical privileges;

(8) no questions have been raised about the applicant by the service chairperson(s); and

(9) the service chairperson(s) recommends a review of the application by the chairperson of the Credentials Committee in lieu of review by the full Credentials Committee.

If the chairperson of the Credentials Committee performs the procedures outlined in this Section because the criteria listed above are met, all references to the Credentials Committee in the following sections shall be interpreted to mean the chairperson of the Credentials Committee.

<u>3.B.6. Medical Executive Committee Recommendation</u>:

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

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

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

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

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

3.B.7. Board Action:

(a) The Board may delegate to a committee, consisting of at least two (2) Board members, action on appointment, reappointment, and clinical privileges if there has been a favorable recommendation from the Credentials Committee and the Medical Executive Committee and there is no evidence of any of the following:

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

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

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

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

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

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

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

(3) modify the recommendation.

(c) If the Board disagrees with a favorable recommendation, it should first discuss the matter with the chairperson of the Credentials Committee and the chairperson of the Medical Executive Committee. The matter may also be submitted to the Joint Conference Committee. If the Board's determination remains unfavorable, the President and Chief Executive Officer will promptly send special notice that the applicant is entitled to request a hearing.

(d) A decision by the Board to grant appointment will be for a period not to exceed three (3) years.

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

3.B.8. Time Periods for Processing:

Once an application is deemed complete, it is expected to be processed within one hundred-eighty (180) 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. Individuals may only exercise those clinical privileges that have been granted by the Board, subject to the terms of this Policy.

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

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

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

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

(2) appropriateness of utilization patterns;

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

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

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

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

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

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

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

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

(11) morbidity and mortality data, when available;

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

(13) the Hospital's need, available resources, and personnel.

(e) An applicant has the burden of establishing qualifications and current competence for clinical privileges requested.

(f) The report of the relevant service chairperson will be processed as a part of the application for privileges. Clinical privileges will be granted for a period not to exceed three (3) years.

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

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

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

(b) In appropriate circumstances, the Board may grant limited clinical privileges within a core or specialty as requested by an individual on the application. The request must indicate the specific clinical privileges within the core or specialty that the individual does not wish to provide, state a basis for the request, and include evidence that the individual does **not** provide the patient care services in any health care facility in that area.

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

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

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

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

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

(4) fairness to the individual requesting the waiver;

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

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

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

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

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

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

A request to resign all clinical privileges should specify the desired date of resignation, at least thirty (30) days from the date of the request, and 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. The Medical Staff Office will notify the Chief of Staff of any resignation.

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

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

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

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

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

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

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

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

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

  (7) whether the new procedure is investigational and, if so, whether there has been Institutional Review Board (IRB) approval; and

  (8) whether the new procedure has received any regulatory approval (e.g., Food and Drug Administration (FDA)) and whether it has a favorable safety profile.

(c) The President and Chief Executive Officer will review this report and consult with the Medical Staff Office, the service chairperson, and the Credentials Committee (either of which may conduct additional research as may be necessary) and will make a preliminary determination as to whether the new procedure should be offered at the Hospital.

(d) If the preliminary determination is favorable, the Credentials Committee will consider whether the request constitutes a "new procedure" or if it is an extension of an existing privilege. If it is a "new procedure," the Credentials Committee will then develop threshold criteria. In developing the criteria, the Credentials Committee may conduct additional research and consult with experts, as necessary, and develop recommendations regarding:

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

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

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

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

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

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

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

(b) As an initial step in the process, the individual seeking the privilege will submit a request and report to the Medical Staff Office that specifies the qualifications needed to perform the procedure safely and competently, whether the individual's specialty is performing the clinical privilege at other similar hospitals, and the experiences of those other hospitals in terms of patient care outcomes and quality of care.

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

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

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

(2) the clinical indications for when the procedure is appropriate to be performed by individuals in a different clinical specialty;

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

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

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

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

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

4.A.7. Physicians and Other Practitioners in Training:

(a) Physicians and other practitioners in training, including but not limited to medical students, advanced practice nurses, and physician assistants in training programs ("Trainees"), will not be granted appointment to the Medical Staff or the Non-Physician Provider Staff 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. The applicable training program will be responsible for verifying and evaluating the qualifications of each physician in training.

(b) Notification will be provided to the Medical Staff Office prior to any trainee being a rotation. At a minimum, the following will be verified or attested to prior to the start of a rotation, as applicable: (1) liability insurance; (2) health status; (3) licensure; (4) DEA; (5) background check; and (6) signed application. Once the verification is complete, the Medical Staff Office will send notification to the appropriate services via electronic communication.

(c) Physicians who are in a residency training program and 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 training requirements. Failure to comply with these requirements or termination from the residency program will result in the automatic relinquishment of clinical privileges, without a right to the hearing and appeal procedures.

4.A.8. Focused Professional Practice Evaluation for Initial Privileges:

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

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

(c) If, based upon information obtained through the focused professional practice evaluation process, a recommendation is made to terminate, revoke, or restrict clinical privileges for reasons related to clinical competence or professional conduct, the member will be entitled to a hearing and appeal.

4.B. TEMPORARY CLINICAL PRIVILEGES

4.B.1. Temporary Clinical Privileges for Initial Applicants:

(a) Temporary privileges may be granted by the President and Chief Executive Officer, with the written concurrence of the service chairperson, to applicants for initial appointment whose complete application, following a favorable recommendation of the Credentials Committee, is pending review by the Medical Executive Committee and Board.

(b) Prior to granting temporary privileges to applicants, at a minimum, the following information will be verified: (1) current licensure; (2) relevant training and experience; (3) current competence; (4) current professional liability coverage acceptable to the Hospital; (5) an ability to perform the clinical privileges requested; (6) result from a query to the National Practitioner Data Bank; and (6) result from a query to the Office of Inspector General's List of Excluded Individuals/Entities. Additionally, an applicant must demonstrate there have been no current or previously successful challenges to licensure or registration and there have not have been any involuntary limitation, restriction, reduction, denial, loss or termination of appointment or clinical privileges at another health care facility.

(c) All information required of initial applicants will be verified prior to the granting of any temporary clinical privileges.

(d) The granting of temporary clinical privileges to an initial applicant will not exceed one hundred-twenty (120) days.

4.B.2. Temporary Clinical Privileges for an Important Patient Care Need:

(a) Temporary privileges may be granted by the President and Chief Executive Officer, with the written concurrence of the service chairperson, to non-applicants, when there is an important patient care, treatment, or service need, including the following: (1) the care of a specific patient; (2) when necessary to prevent a lack of services in a needed specialty area; (3) proctoring; or (4) when serving as a locum tenens for a member of the Medical Staff or Non-Physician Provider Staff.

(b) Prior to granting temporary privileges to non-applicants, at a minimum, the following information will be verified: (1) current licensure; (2) relevant training and experience; (3) current competence; (4) current professional liability coverage acceptable to the Hospital; (5) result from a query to the National Practitioner Data Bank; and (6) result from a query to the Office of Inspector General's List of Excluded Individuals/Entities.

(c) Prior to any temporary clinical privileges being granted, the individual must agree in writing to be bound by the Medical Staff Governance Documents and Hospital policies, and any revisions or amendments thereto.

(d) For non-applicants, who are granted temporary privileges, the individual may exercise temporary privileges for a maximum of one hundred-twenty (120) days, consecutive or not, anytime during the thirty-six (36)-month period following the grant of privileges, subject to the following conditions:

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

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

4.B.3. General Provisions Relating to Temporary Clinical Privileges:

(a) The granting of temporary clinical privileges is a courtesy that may be withdrawn by the President and Chief Executive Officer at any time, after consulting with the Chief of Staff, the chairperson of the Credentials Committee or the service chairperson.

(b) The service chairperson or the Chief of Staff will assign to another member of the Medical Staff responsibility for the care of patients until they are discharged. Whenever possible, consideration will be given to the wishes of the patient in the selection of a substitute physician.

4.C. TELEMEDICINE PRIVILEGES

4.C.1. Processing Requests for Telemedicine Privileges:

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

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

(1) A request for telemedicine privileges may be processed through the same process for Medical Staff and Non-Physician Provider 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, a request for telemedicine privileges may be processed using an alternative process that relies on the credentialing and privileging decisions made by the distant hospital or telemedicine entity. In such cases, the Hospital must ensure, through a written agreement, that the distant hospital or telemedicine entity complies with all applicable Medicare regulations and accreditation standards. The distant hospital or telemedicine entity must provide:

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

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

(iii) a signed attestation by the chief medical officer or the president of the medical staff that the applicant satisfies all of the distant hospital or telemedicine entity's qualifications for the clinical privileges granted;

(iv) a signed attestation by the chief medical officer or the president of the medical staff that all information provided by the distant hospital or telemedicine entity is complete, accurate, and up-to-date; and

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

Prior to granting telemedicine privileges, the National Practitioner Data Bank will be queried, and the Office of Inspector General's List of Excluded Individuals/Entities will be checked.

This information received about the individual requesting telemedicine privileges will be provided to the Medical Executive Committee for review and recommendation and to the Board for final action. Notwithstanding the process set forth in this section, 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.

(c) Telemedicine privileges, if granted, will be for a period of not more than three (3) years.

(d) Telemedicine privileges granted in conjunction with an agreement will automatically expire with the expiration or termination of the agreement.

4.C.2. Review of Telemedicine Privileges:

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

4.D. EMERGENCY AND DISASTER PRIVILEGES

4.D.1. Emergency Situations:

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

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

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

4.D.2. Disaster Privileges:

(a) When the disaster plan has been implemented and the immediate needs of patients in the facility cannot be met, the President and Chief Executive Officer or the Chief

of Staff may use a modified credentialing process to grant disaster privileges to eligible volunteer licensed independent practitioners ("volunteers"). Safeguards must be in place to verify that volunteers are competent to provide safe and adequate care.

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

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

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

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

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

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

4.E. CONTRACTS FOR SERVICES AND EMPLOYED MEDICAL STAFF MEMBERS

(1) From time to time, the Hospital may enter into contracts with practitioners or groups of practitioners for the performance of clinical and administrative services

at the Hospital. All individuals providing clinical services pursuant to such contracts will obtain and maintain clinical privileges at the Hospital, in accordance with the terms of this Policy.

(2) To the extent that:

(a) any such contract confers the exclusive right to perform specified services to one or more practitioners or groups of practitioners, or

(b) the Board by resolution limits the practitioners who may exercise clinical privileges in any clinical specialty to employees of the Hospital or its affiliates,

no other practitioners except those authorized by or pursuant to the contract or arrangement may exercise clinical privileges to perform the specified services while the contract or resolution is in effect. This means that only practitioners so authorized are eligible to apply for appointment or reappointment to the Medical Staff and for the clinical privileges in question. No other applications will be processed.

(3) If the Board determines to proceed with an exclusive contract or Board resolution, and if that determination would have the effect of preventing an existing member of the Medical Staff from exercising clinical privileges that had previously been granted, the affected member is entitled to the following notice and hearing procedures:

(a) The affected member will be given at least sixty (60) days' advance notice of the exclusive contract or Board resolution. The notice will inform the member of the right to request a hearing as outlined in this Section prior to the contract being signed by the Hospital or the Board resolution becoming effective.

(b) The affected member must request the hearing within fourteen (14) days of receiving the notice, and the hearing must then be commenced and concluded within thirty (30) days of the member's request unless the individual and the Board agree upon a different time frame. A report and recommendation must be prepared by the hearing committee within this thirty (30)-day period and copies sent to the affected member, the Board, and the Medical Executive Committee.

(c) The affected member may be represented by counsel at the hearing, but must notify the Hospital of that fact at the time that the hearing is requested. If the affected member chooses to be accompanied by counsel, the Board may also be represented by legal counsel at the hearing.

(d) The hearing will be held before a committee appointed by the Board, which will include representatives from the Medical Executive Committee. At the hearing, the affected member will be entitled to present any information and documentation that he or she deems relevant to the Board's decision to enter into the exclusive contract or enact the resolution, as well as to present witnesses in support of his or her position.

(e) Following receipt of the hearing committee's report and recommendation, the Board will make a final decision in the matter. If the Board confirms its initial determination to enter into the exclusive contract or enact the resolution, the affected member will be notified that he or she is ineligible to continue to exercise the clinical privileges covered by the exclusive contract or resolution. In that circumstance, the ineligibility begins as of the effective date of the exclusive contract or resolution and continues for as long as the contract or resolution is in effect.

(f) The affected member will only be entitled to any procedural rights outlined above with respect to the Board's decision or the effect of the decision on his or her clinical privileges. The provisions in Article 7 of this Policy are not applicable to the Board decision to enter into an exclusive contract or enact a resolution even when the effect of such is that a member is ineligible to continue to exercise the clinical privileges covered by the exclusive contract or resolution.

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

(4) Except as provided in paragraph (1), in the event of any conflict between this Policy and the terms of any contract, the terms of the contract will control. In particular, nothing in this Section will preclude or limit a Medical Staff member's right to waive, in writing, his or her right to request a hearing upon being granted the exclusive right to provide particular services at the Hospital, either individually or as a member of a group. If any exclusive contract is signed by a representative of a group of physicians, any waiver that is contained in the contract shall apply to all members of the group unless stated otherwise in the contract.

ARTICLE 5

PROCEDURE FOR REAPPOINTMENT

5.A. PROCEDURE FOR REAPPOINTMENT

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

5.B. REAPPOINTMENT CRITERIA

5.B.1. Eligibility for Reappointment:

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

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

(b) completed all continuing medical education requirements;

(c) satisfied all Medical Staff and Non-Physician Provider 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; and

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

5.B.2. Factors for Evaluation:

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

(a) compliance with the Medical Staff Governance Documents and the policies of the Hospital;

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

(c) the results of the Hospital's performance improvement activities, including ongoing and focused professional practice evaluation, 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) feedback received from patients and their families, visitors, or staff; and

(e) other reasonable indicators of continuing qualifications.

5.C. REAPPOINTMENT PROCESS

5.C.1. Reappointment Application Form:

(a) Appointment terms will not extend beyond three (3) years.

(b) An application for reappointment will be furnished to members at least three (3) months prior to the expiration of their current appointment term. A completed reappointment application must be returned to the Medical Staff Office within thirty (30) days.

(c) Failure to return a completed application within thirty (30) days will result in the assessment of a reappointment late fee, which must be paid prior to the application being processed. In addition, failure to return a complete application within sixty (60) days of receipt may result in the automatic expiration of appointment and clinical privileges at the end of the then current term of appointment unless the application can still be processed in the normal course, without extraordinary effort.

(d) The application will be reviewed by the Medical Staff 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 Medical Staff Office will oversee the process of gathering and verifying relevant information. The Medical Staff Office will also be responsible for confirming that all relevant information has been received.

5.C.2. Processing Applications for Reappointment:

(a) At the completion of the application and primary source verification process, each credentialing file is quality reviewed by the Medical Staff Office to ensure completeness, accuracy, appropriateness and compliance with policies. The Medical Staff Office will forward the application to the relevant service chairperson

and the application for reappointment will be processed in a manner consistent with applications for initial appointment.

(b) As with the procedure for initial appointment, nothing herein prohibits the chairperson of the Credentials Committee from acting on behalf of the Credentials Committee and performing the procedures assigned to the Credentials Committee in the reappointment process if the following criteria are met:

(1) the application is complete;

(2) all reference evaluations are complete and contain only favorable evaluations, including unqualified recommendations for appointment and clinical privileges;

(3) the applicant's malpractice claims history is reasonable with respect to his or her specialty;

(4) the applicant was not subject to any licensure disciplinary actions, conditions, or challenges during the previous three (3) years;

(5) there are no pending or past investigations or reports of disciplinary action from any hospital or licensing agency in the previous three (3) years;

(6) no questions have been raised about the applicant by the service chairperson(s); and

(7) the service chairperson(s) recommends a review of the application by the chairperson of the Credentials Committee in lieu of review by the full Credentials Committee.

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

5.C.3. Conditional Reappointments:

(a) Recommendations for reappointment may be subject to an applicant's compliance with specific conditions. These conditions may relate to behavior (e.g., professional code of conduct) or to clinical issues (e.g., general consultation requirements, proctoring, completion of CME requirements). Reappointments may be recommended for periods of less than three (3) years in order to permit closer monitoring of a member's clinical performance, professional conduct, and ongoing qualifications for appointment and privileges.

(b) A recommendation of a conditional reappointment or for reappointment for a period of less than three (3) years does not, in and of itself, entitle a member to request a hearing or appeal.

(c) Additionally, if questions or concerns are being addressed at reappointment or 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 three (3) years may be granted pending the completion of that process.

5.C.4. Potential Adverse Recommendation:

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

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

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

(d) This meeting is not a hearing, and none of the procedural rules for hearings will apply. The member will not have the right to be represented by legal counsel at this meeting and no recording (audio or video) of the meeting will be permitted or made.

ARTICLE 6

MANAGING QUESTIONS ABOUT MEDICAL STAFF OR NON-PHYSICIAN PROVIDER STAFF MEMBERS

6.A. INITIAL COLLEGIAL EFFORTS AND PROGRESSIVE STEPS

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

(a) This Policy encourages the use of collegial efforts and progressive steps to address and resolve questions that may be raised about a member's competence, health, or behavior.

(b) Initial collegial efforts include activities such as:

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

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

These efforts are not required to be documented, though documentation may be created in the discretion of the Medical Staff Leader and maintained in the individual's confidential file.

(c) Progressive steps include, but are not limited to, the following actions:

(1) addressing minor performance issues through an informational letter;

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

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

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

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

All progressive steps are to be documented and included in a member's confidential file. The written response by the member to any of these progressive steps will also be included in the member's confidential file.

(d) These efforts are fundamental and integral components of the Hospital's professional practice evaluation activities, and are confidential and protected in accordance with state law.

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

(1) address it pursuant to the initial collegial efforts and progressive steps provisions of this Section;

(2) refer the matter for review in accordance with a relevant Hospital or Medical Staff policy; or

(3) refer it to the Medical Executive Committee for its review and action.

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

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

Credentialing and peer review activities, including all activities set forth in this Article, are confidential and privileged to the fullest extent permitted by law. Accordingly, the individual may not be accompanied by friends, relatives, or colleagues when attending a meeting that takes place pursuant to this Article.

6.A.3. No Right to Counsel:

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

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

6.A.4. Involvement of Supervising Physician in Matters Pertaining to Non-Physician Providers:

If any peer review activity pertains to the clinical competence or professional conduct of a member of the Non-Physician Provider Staff, the Supervising Physician (if any) will be notified and may be invited to participate.

6.B. OTHER OPTIONS

6.B.1. Mandatory Meeting:

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

(b) Special notice will be given at least three (3) days prior to the meeting and will inform the individual that attendance at the meeting is mandatory.

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

6.B.2. Fitness for Practice Evaluation:

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

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

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

(2) of a member during an investigation; and

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

(c) A request for an immediate evaluation may also be made when two (2) Medical Staff Leaders (or one (1) Medical Staff Leader and one (1) member of the Hospital Administration) are concerned with the individual's ability to safely and competently care for patients.

(d) The Medical Staff Leaders, Hospital Administration, or committee that requests the evaluation will: (i) identify the health care professional(s) to perform the evaluation; (ii) inform the individual of the time period within which the evaluation must occur; and (iii) provide the individual with all appropriate releases and/or

authorizations to allow the Medical Staff Leaders, or relevant committee, to discuss with the health care professional(s) the reasons for the evaluation and to allow the health care professional to discuss and report the results to the Medical Staff Leaders or relevant committee.

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

6.B.3. Competency Assessment:

(a) An individual may be requested to participate in a competency assessment to determine his or her ability to safely and competently practice.

(b) A request for a competency assessment may be made of a member during the reappointment process, as part of the collegial intervention process, or during an investigation. The request may be made by Medical Staff Leaders, the Credentials Committee, the Medical Executive Committee, an Investigating Committee, or the Medical Staff Quality Improvement (QI) Committee, where applicable.

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

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

6.C. AUTOMATIC RELINQUISHMENT

(1) Any of the occurrences described in this Section may constitute grounds for the automatic relinquishment of an individual's appointment and clinical privileges. An automatic relinquishment is considered an administrative action and, as such, it generally does not trigger an obligation on the part of the Hospital to file a report with the National Practitioner Data Bank.

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

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

Failure of an individual to complete medical records, after notification by the medical records department of the delinquency in accordance with applicable policies and rules and regulations, may result in automatic relinquishment of all clinical privileges.

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

Failure of an individual to continuously evidence satisfaction of any of the threshold eligibility criteria set forth in this Policy will result in automatic relinquishment of appointment and clinical privileges.

6.C.3. Criminal Activity:

The occurrence of specific criminal actions may, as recommended by the Medical Executive Committee and confirmed by the President and Chief Executive Officer, result in the automatic relinquishment of appointment and clinical privileges. Specifically, an arrest, charge, indictment, conviction, plea of guilty or plea of no contest pertaining to any felony or any misdemeanor involving the following may result in an automatic relinquishment: (a) Medicare, Medicaid, or other federal or state governmental or private third-party payer fraud or program abuse; (b) controlled substances; (c) illegal drugs; (d) violent act; (e) sexual misconduct; (f) moral turpitude; or (g) child or elder abuse.

6.C.4. Failure to Provide Information:

(a) Failure of an individual to notify the Chief of Staff or President and Chief Executive Officer of any change in any information provided on an application for initial appointment or reappointment may, as recommended by the Medical Executive Committee and confirmed by the President and Chief Executive Officer, result in the automatic relinquishment of appointment and clinical privileges.

(b) Failure of an individual to provide information pertaining to an individual's qualifications for appointment or clinical privileges in response to a written request from the Medical Staff Leadership Council, Credentials Committee, Medical Executive Committee, or any other authorized committee may, as recommended by the Medical Executive Committee and confirmed by the President and Chief Executive Officer, result in the automatic relinquishment of appointment and clinical privileges until the information is provided to the satisfaction of the requesting party.

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

Failure to attend a mandatory meeting requested by the Medical Staff Leaders or Hospital Administration, after appropriate notice has been given, may, as recommended by the Medical Executive Committee and confirmed by the President and Chief Executive Officer, result in the automatic relinquishment of appointment and clinical privileges. The

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

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

Failure of an individual to complete or comply with training and educational requirements that are adopted by the Medical Executive Committee and/or required by the Board, including, but not limited to, those pertinent to electronic medical records or patient safety, may, as recommended by the Medical Executive Committee and confirmed by the President and Chief Executive Officer, result in the automatic relinquishment of appointment and clinical privileges.

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

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

(b) Failure of a member to undergo a requested fitness for practice evaluation or to execute any of the required releases (i.e., to allow the Medical Staff Leaders, or the relevant committee, to discuss with the health care professional(s) the reasons for the evaluation and to allow the health care professional to report the results to the Medical Staff Leaders or relevant committee) may, as recommended by the Medical Executive Committee and confirmed by the President and Chief Executive Officer, result in the automatic relinquishment of appointment and privileges.

6.C.8. Failure to Comply with Request for Competency Assessment:

Failure of a member to undergo a requested competency assessment or to execute any of the required releases (i.e., to allow the Medical Staff Leaders, or the relevant committee, to discuss with the health care professional(s) the reasons for the assessment and to allow the health care professional to report the results of the assessment to the Medical Staff Leaders or relevant committee) may, as recommended by the Medical Executive Committee and confirmed by the President and Chief Executive Officer, result in the automatic relinquishment of appointment and privileges.

6.C.9. Reinstatement from Automatic Relinquishment and Automatic Resignation:

(a) If an individual believes that the matter leading to the automatic relinquishment of appointment and privileges has been resolved within ninety (90) days of the relinquishment, the individual may request to be reinstated.

(b) A request for reinstatement from an automatic relinquishment following completion of all delinquent records will be processed in accordance with applicable policies and rules and regulations. Failure to complete the medical records that caused relinquishment within the time required will result in automatic resignation from the Medical Staff or Non-Physician Provider Staff.

(c) Requests for reinstatement from an automatic relinquishment following the expiration or lapse of a license, board certification, controlled substance authorization, or insurance coverage will be processed by the Medical Staff Office. If any questions or concerns are noted, the Medical Staff Office will refer the matter for further review in accordance with (d) below.

(d) All other requests for reinstatement from an automatic relinquishment will be reviewed by the relevant service chairperson, the chairperson of the Credentials Committee, the Chief of Staff, and the President and Chief Executive Officer. If these individuals make a favorable recommendation on reinstatement, the individual may immediately resume clinical practice at the Hospital. This determination will then be forwarded to the Credentials Committee, the Medical Executive Committee, and the Board for ratification. If, however, any of the individuals reviewing the request have any questions or concerns, those questions will be noted and the reinstatement request will be forwarded to the full Credentials Committee, Medical Executive Committee and Board for review and recommendation.

(e) Failure to resolve a matter leading to an automatic relinquishment within ninety (90) days of the relinquishment, and to be reinstated as set forth above, will result in an automatic resignation from the Medical Staff or Non-Physician Provider Staff.

6.D. ACTIONS OCCURRING AT OTHER HOSPITALS AND FACILITIES WITHIN THE SYSTEM

(1) Each hospital and health care facility within the Ridgeview Medical Center system will share information regarding the implementation or occurrence of any of the following actions with all other hospitals and facilities within the system at which an individual maintains medical staff appointment, clinical privileges, or any other permission to care for patients:

(a) automatic relinquishment or resignation of appointment or clinical privileges;

(b) agreement to modify clinical privileges or refrain from exercising clinical privileges;

(c) grant of a leave of absence;

(d) participation in a performance improvement plan;

(e) grant of conditional appointment, reappointment or clinical privileges; and

(f) denial, suspension, revocation, or termination of appointment or clinical privileges.

(2) Upon receipt of notice that any of the actions set forth above have occurred at, or been implemented by, any hospital or facility within the system, that action will automatically and immediately take effect at the Hospital. In the alternative, a determination may be made that the individual no longer satisfies the threshold eligibility criteria set forth in this Policy which may trigger the automatic relinquishment of appointment and privileges.

(3) The automatic effectiveness of an action at the Hospital, as set forth above, may be waived by the Board after consideration of a recommendation of the Medical Executive Committee. The automatic effectiveness of the action, will continue unless a waiver has been granted and the practitioner has been notified in writing. Waivers are within the discretion of the Board and are final. A waiver may be granted only as follows:

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

(b) after a full review of the specific circumstances and any relevant documents (including peer review documents) from the hospital or other facility where the action first occurred. The burden is on the practitioner to provide evidence showing that a waiver is appropriate.

(4) Neither the automatic effectiveness of any action set forth above at the Hospital, nor the denial of a waiver, will entitle any individual to any procedural rights, formal investigation, hearing, or appeal.

6.E. LEAVES OF ABSENCE

6.E.1. Initiation:

(a) Individuals who will be away from practice at the Hospital for more than forty-five (45) days are expected to notify the Medical Staff Office, in writing. When possible, the notice should include the expected beginning and ending dates and the reasons for the leave. The notice should be submitted to the Medical Staff Office at least thirty (30) days prior to the anticipated leave.

(b) Except for maternity leaves, members must report to the President and Chief Executive Officer any time they are away from patient care responsibilities for longer than forty-five (45) days and the reason for such absence is related to their physical or mental health or otherwise to their ability to care for patients safely and

competently. Upon becoming aware of such circumstances, the President and Chief Executive Officer, in consultation with the Chief of Staff, may trigger an automatic medical leave of absence at any point after becoming aware of the member's absence from patient care. The member will be sent special notice that a medical leave has been triggered.

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

During a leave of absence, the member may not exercise any clinical privileges and will be excused from staff responsibilities (e.g., meeting attendance, committee service, emergency service call obligations). The obligation to pay dues will continue during a leave of absence except that a member granted a leave of absence for U.S. military service will be exempt from this obligation. An individual must submit proof of professional liability insurance or a claims made tail policy covering the duration of the leave of absence.

6.E.3. Reinstatement:

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

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

(c) If the leave of absence was for health reasons (except for maternity leave), the request for reinstatement must be accompanied by a report from the individual's physician indicating that the individual is capable of resuming a hospital practice and safely exercising the clinical privileges requested. The Medical Staff Leadership Council may also require that the individual submit a comprehensive fitness for practice evaluation by a physician(s) satisfactory to it. Additionally, the recommendation for reinstatement from the leave of absence may be subject to specific conditions such as proctoring or monitoring in order to allow for a closer assessment of the individual's competence.

(d) If an individual's current appointment expires during a leave of absence, the individual will be permitted to request reappointment at the same time reinstatement is sought. However, an individual whose appointment expired during a leave may not be reinstated prior to final action on his or her reappointment application.

(e) Failure to request reinstatement from a leave of absence in a timely manner will be deemed a voluntary resignation of appointment and clinical privileges unless an extension is granted by the President and Chief Executive Officer. Extensions will be considered only in extraordinary cases where the extension of a leave is in the best interest of the Hospital.

6.F. PRECAUTIONARY SUSPENSION OR RESTRICTION OF CLINICAL PRIVILEGES

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

(a) Whenever failure to take action may result in imminent danger to the health and/or safety of any individual, the President and Chief Executive Officer, the Chief of Staff, the relevant service chairperson, the Chief Medical Officer, the Medical Executive Committee, or the Board chairperson is authorized to (1) suspend or restrict all or any portion of an individual's clinical privileges; or (2) afford the individual an opportunity to voluntarily refrain from exercising clinical privileges while the matter is being reviewed.

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

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

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

(e) Within three (3) days of the imposition of a suspension, the individual will be provided with a brief written description of the reason(s) for the action, including the names and medical record numbers of the patient(s) involved (if any). The relevant Supervising Physician will be notified when the affected individual is a member of the Non-Physician Provider Staff.

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

6.F.2. System Medical Staff Leadership Committee Procedure:

(a) Within a reasonable time, not to exceed fourteen (14) days of the imposition of the suspension or restriction, the System Medical Staff Leadership Committee will review the reasons for the action.

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

(c) This meeting with the System Medical Staff Leadership Committee is not a hearing, and none of the procedural rules for hearings will apply. Lawyers will not be present at the meeting.

(d) At the meeting, the individual may provide information to the System Medical Staff Leadership Committee and must respond to questions raised by committee members. The individual may also propose ways, other than precautionary suspension or restriction, to protect patients, employees, or others while the matter is being reviewed.

(e) After considering the reasons for the suspension, and the individual's response, if any, the System Medical Staff Leadership Committee will recommend whether the precautionary suspension should be continued, modified, or lifted. The System Medical Staff Leadership Committee may also determine whether to begin an investigation or whether to refer the matter for further review consistent with this or another policy.

(f) If the System Medical Staff Leadership Committee recommends that the suspension be continued, it will send the individual written notice of its recommendation, including the basis for it. If the System Medical Staff Leadership Committee recommends that the suspension be modified, or lifted, this recommendation will be forwarded to the President and Chief Executive Officer for final action.

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

6.G. INVESTIGATIONS

6.G.1. Initial Review:

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

Medical Officer, the President and Chief Executive Officer, or the chairperson of the Board:

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

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

(3) the known or suspected violation of ethical standards, the medical staff governance documents or any policy of the Hospital; or

(4) conduct that is considered lower than the standards of the Hospital, undermines the Hospital's culture of safety, or is disruptive to the orderly operation of the Hospital, its Medical or Non-Physician Provider Staff, including the inability of the member to work harmoniously with others.

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

(c) No action taken pursuant to this Section will constitute an investigation.

6.G.2. Initiation of Investigation:

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

(b) The Medical Executive Committee will inform the individual that an investigation has begun. The notification shall include:

(1) the date the investigation was commenced;

(2) the composition of the committee that will be conducting the investigation, if already identified;

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

(4) a copy of this Section of the Policy, which outlines the process for investigations.

(c) Notification may be delayed if, in the judgment of the Medical Executive Committee, informing the individual immediately might compromise the investigation or disrupt the operation of the Hospital, Medical Staff, or Non-Physician Provider Staff.

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

6.G.3. Appointment of Investigating Committee:

(a) Once a determination has been made to begin an investigation, the Medical Executive Committee will decide whether to investigate the matter itself or appoint an individual or committee ("Investigating Committee") to do so. The Investigating Committee may include individuals not on the Medical Staff or Non-Physician Provider Staff. The Investigating Committee will not include any individual who:

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

(2) is a relative of the individual being investigated;

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

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

(b) Whenever the questions raised concern the clinical competence of the individual under review, the Investigating Committee will include a peer of the individual (e.g., physician, dentist, podiatrist, advanced practice nurse, or physician assistant).

6.G.4. Investigative Procedures:

(a) The Investigating Committee has the authority to:

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

(2) conduct interviews and prepare a summary of each interview, which each interviewee will be asked to review, revise, and sign;

(3) use external review; or

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

professional(s) the reasons for the examination or assessment and allowing the health care professional to discuss and report the results to the Investigating Committee.

(b) If a decision is made to obtain an external review, the individual under investigation will be notified of that decision and the nature of the external review. Upon completion of the external review, the individual will be provided a copy of the reviewer's report.

(c) The individual will have an opportunity to meet with the Investigating Committee before it prepares its report. Prior to this meeting, the individual will be informed of the questions being investigated. The Investigating Committee may also ask the individual to provide written responses to specific questions related to the investigation.

(d) At the meeting, the individual shall be invited to discuss, explain, or refute the questions that gave rise to the investigation or that have been identified by the investigating committee during its review. A summary of the interview with the individual will be made and will be included with the Investigating Committee's report. The interview summary will be shared with the individual prior to the investigating committee finalizing its report. The individual may review the interview summary and recommend suggested changes.

(e) This meeting is not a hearing, and none of the procedural rules for hearings will apply. Lawyers will not be present at this meeting.

(f) The Investigating Committee will make a reasonable effort to complete the investigation and issue its report within forty-five (45) days, provided that an external review is not necessary. When an external review is used, the Investigating Committee will make a reasonable effort to complete the investigation and issue its report within thirty (30) days of receiving the results of the external review. These time frames are intended to serve as guidelines and, as such, will not be deemed to create any right for an individual to have an investigation completed within such time periods.

6.G.5. Report of Investigating Committee:

(a) At the conclusion of the investigation, the Investigating Committee will prepare a report. The report will include a summary of the investigation process, including a list of documents that were reviewed and individuals who were interviewed, along with witness summaries that were prepared. The report will also include specific findings and conclusions regarding the concerns that were under review and the recommendations of the Investigating Committee.

(b) The report of the Investigating Committee will be forwarded to the Medical Executive Committee.

6.G.6. Recommendation:

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

(1) determine that no action is justified;

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

(3) impose conditions for continued appointment;

(4) require monitoring, proctoring, or consultation;

(5) require additional training or education;

(6) recommend reduction or restriction of clinical privileges;

(7) recommend suspension of clinical privileges for a specific period of time or until specified conditions have been met;

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

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

(b) A recommendation by the Medical Executive Committee that does not entitle the individual to request a hearing, will be forwarded to the Board for review and action.

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

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

ARTICLE 7

HEARING AND APPEAL PROCEDURES

7.A. INITIATION OF HEARING

7.A.1. Hearing Rights:

(a) The hearing and appeal process outlined in Sections 7.A through 7.F of this Policy apply to the following:

(1) an applicant for appointment to the Medical Staff;

(2) a member of the Medical Staff;

(3) an applicant for appointment to the Non-Physician Provider Staff who is a licensed independent practitioner or advanced practice clinician; and

(4) a member of the Non-Physician Provider Staff who is a licensed independent practitioner or advanced practice clinician.

(b) The hearing process available to a dependent practitioner who is applying to, or is a member of, the Non-Physician Provider Staff is outlined in Section 7.G of this Policy.

7.A.2. Grounds for Hearing:

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

(1) denial of initial appointment;

(2) denial of reappointment;

(3) revocation of appointment;

(4) denial of requested clinical privileges;

(5) revocation of clinical privileges;

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

(7) restriction of clinical privileges for more than thirty (30) days, including a mandatory concurring consultation requirement, in which the consultant must approve the course of treatment in advance; or

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

(b) No other recommendation or action will entitle the individual to a hearing.

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

7.A.3. Actions Not Grounds for Hearing:

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

(a) determination that an individual is ineligible for appointment or clinical privileges and that the individual's application will not be processed because he or she fails to meet threshold eligibility criteria;

(b) determination that an individual is ineligible to request appointment or privileges, or to continue appointment or the exercise of privileges because a specialty is closed under a staff development plan or is covered by an exclusive contract;

(c) determination that an application will not be processed because it is incomplete or untimely;

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

(e) expiration of appointment and clinical privileges due to a failure to timely submit an application for reappointment;

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

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

(h) imposition of conditions, monitoring, supervision, proctoring, or a general consultation requirement (i.e., the individual must obtain a consult, but need not get prior approval for the treatment);

(i) imposition of a requirement for additional training or continuing education;

(j) acceptance of a performance improvement plan;

(k) a requirement that an individual complete a fitness for practice evaluation;

(l) the grant of conditional appointment or reappointment or the grant of appointment or reappointment for a period of less than three (3) years;

(m) imposition of a precautionary suspension;

(n) automatic relinquishment of appointment or privileges;

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

(p) activation of automatic medical leave of absence;

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

(r) decision not to grant, or the withdrawal of, temporary privileges;

(s) requirement to appear for a special meeting; and

(t) termination of any contract with or employment by the Hospital.

7.A.4. Notice of Recommendation:

The President and Chief Executive Officer will promptly give special notice of a recommendation which entitles an individual to request a hearing. This notice will contain:

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

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

(c) a copy of this Article.

7.A.5. Request for Hearing:

An individual has thirty (30) days following receipt of the notice to request a hearing. The request must be in writing, to the President and Chief Executive Officer, and must include the name, address, and telephone number of the individual's counsel, if any. Failure to

request a hearing will constitute waiver of the right to a hearing, and the recommendation will be transmitted to the Board for final action.

7.A.6. Notice of Hearing and Statement of Reasons:

(a) The President and Chief Executive Officer will schedule the hearing and provide, by special notice to the individual requesting the hearing, the following:

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

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

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

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

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

7.A.7. Hearing Panel, Presiding Officer, and Hearing Officer:

(a) Hearing Panel:

The President and Chief Executive Officer, after consulting with the Chief of Staff, will appoint a Hearing Panel in accordance with the following guidelines:

(1) The Hearing Panel will consist of at least three (3) members, one of whom will be designated as chairperson.

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

(i) member(s) of the Medical Staff or Non-Physician Provider Staff;

(ii) physicians not connected with the Hospital (i.e., practitioners not on the Medical Staff or Non-Physician Provider Staff); or

(iii) layperson(s) who may, or may not, be connected with the Hospital.

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

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

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

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

(ii) is a relative of the individual requesting the hearing;

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

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

(b) Presiding Officer:

(1) The President and Chief Executive Officer, after consulting with the Chief of Staff, will appoint an attorney to serve as the Presiding Officer. The Presiding Officer may not be, or represent clients who are, in direct economic competition with the individual requesting the hearing. The Presiding Officer will not act as an advocate for either side at the hearing.

(2) The Presiding Officer will:

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

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

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

(iv) maintain decorum throughout the hearing;

(v) determine the order of procedure;

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

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

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

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

(c) Hearing Officer:

(1) As an alternative to a Hearing Panel, in matters in which the underlying recommendation is based upon concerns involving behavior, sexual harassment, or failure to comply with rules, regulations or policies, the President and Chief Executive Officer, after consulting with the Chief of Staff, may appoint a Hearing Officer.

(2) The Hearing Officer, who should be an attorney, will perform the functions of a Hearing Panel. The Hearing Officer may not be, or represent clients, in direct economic competition with the individual requesting the hearing.

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

(d) Objections:

An objection to any member of the Hearing Panel, the Presiding Officer, or the Hearing Officer will be made in writing, within ten days of receipt of notice, to the President and Chief Executive Officer. The objection, which must include reasons to support it, must also be provided to the Chief of Staff. The Chief of Staff will be given a reasonable opportunity to comment on the objections. The President and Chief Executive Officer will rule on the objection and give notice to the parties. The President and Chief Executive Officer may request that the Presiding Officer make a recommendation as to the validity of the objection.

(e) Compensation:

Members of the Hearing Panel and the Presiding Officer may be compensated for their service by the Hospital. The individual requesting the hearing will be offered the opportunity to contribute to the compensation paid.

7.A.8. Counsel:

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

7.B. PRE-HEARING PROCEDURES

7.B.1. General Procedures:

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

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

(c) Neither the individual who requested the hearing, nor any other person acting on behalf of the individual, may contact Hospital employees or Medical Staff or Non-Physician Provider Staff members whose names appear on the Medical Executive Committee's witness list or in documents provided pursuant to this Article concerning the subject matter of the hearing, until the Hospital has been notified and has contacted the individuals about their willingness to be interviewed. The Hospital will advise the individual who requested the hearing once it has contacted the employees or members and confirmed their willingness to meet. Any employee or member may agree or decline to be interviewed by or on behalf of the individual who requested the hearing. If an employee or member who is on the Medical Executive Committee's witness list agrees to be interviewed pursuant to this provision, counsel for the Medical Executive Committee may be present for the interview.

7.B.2. Time Frames:

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

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

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

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

7.B.3. Witness List:

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

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

(c) The witness list of either party may, in the discretion of the Presiding Officer, be amended at any time during the course of the hearing, provided that notice of the change is given to the other party. If the witness list is amended, the other party may request a postponement if additional time is needed to prepare for the new witness.

7.B.4. Provision of Relevant Information:

(a) Prior to receiving any confidential documents, the individual requesting the hearing must agree, in writing, that all documents and information will be maintained as confidential and will not be disclosed or used for any purpose outside of the hearing. The individual must also provide a written representation that his or her counsel and any expert(s) have executed Business Associate agreements in connection with any patient Protected Health Information contained in any documents provided.

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

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

(2) reports of experts relied upon by the Medical Executive Committee;

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

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

The provision of this information shall not waive any privilege.

(c) The individual will have no right to discovery beyond the above information. No information will be provided regarding other practitioners on the Medical Staff or Non-Physician Provider Staff.

7.B.5. Pre-Hearing Conference:

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

(b) All objections to exhibits or witnesses will be submitted, in writing, five (5) days in advance of the pre-hearing conference. The Presiding Officer will not entertain subsequent objections unless the party offering the objection demonstrates good cause.

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

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

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

7.B.6. Stipulations:

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

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

The following documents will be provided to the Hearing Panel in advance of the hearing:

(a) a pre-hearing statement that either party may choose to submit;

(b) exhibits offered by the parties following the pre-hearing conference (without the need for authentication); and

(c) stipulations agreed to by the parties.

7.C. THE HEARING

7.C.1. Time Allotted for Hearing:

The Presiding Officer will determine the length of the hearing at the pre-hearing conference. As a general rule, it is expected that the hearing will last no more than fifteen (15) hours, with each side being afforded approximately seven and a half (7.5) hours to present its case, in terms of both direct and cross-examination of witnesses. Both parties are required to prepare their case so that a hearing will be concluded after a maximum of fifteen (15) hours. The Presiding Officer may, after considering any objections, grant

limited extensions upon a demonstration of good cause and to the extent compelled by fundamental fairness.

7.C.2. Rights of Both Sides and the Hearing Panel at the Hearing:

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

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

(2) to introduce exhibits;

(3) to cross-examine any witness;

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

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

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

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

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

7.C.3. Record of Hearing:

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

7.C.4. Order of Presentation and Burden:

The Medical Executive Committee will first present evidence in support of its recommendation. Thereafter, the burden will shift to the individual who requested the hearing to present clear and convincing evidence that the recommendation that prompted the hearing was arbitrary, capricious, or not supported by credible evidence.

7.C.5. Admissibility of Evidence:

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

7.C.6. Persons to Be Present:

The hearing will be restricted to those individuals involved in the proceeding. Administrative personnel may be present as requested by the President and Chief Executive Officer or the Chief of Staff.

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

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

7.C.8. Failure to Appear:

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

7.C.9. Postponements and Extensions:

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

7.D. HEARING CONCLUSION, DELIBERATIONS, AND RECOMMENDATIONS

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

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

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

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

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

The Hearing Panel will deliver its report to the President and Chief Executive Officer. The President and Chief Executive Officer will send by special notice a copy of the report to the individual who requested the hearing. The President and Chief Executive Officer will also provide a copy of the report to the Chief of Staff.

7.E. APPEAL PROCEDURE

7.E.1. Time for Appeal:

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

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

7.E.2. Grounds for Appeal:

The grounds for appeal will be limited to the following:

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

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

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

Whenever an appeal is requested, the Board chairperson will schedule and arrange for an appeal. The individual will be given special notice of the time, place, and date of the

appeal. The appeal will be held as soon as arrangements can reasonably be made, taking into account the schedules of all the individuals involved.

7.E.4. Nature of Appellate Review:

(a) The Board may serve as the Review Panel or the Board chairperson may appoint a Review Panel, composed of not less than three persons, either members of the Board or others, including but not limited to persons outside the Hospital.

(b) Each party will have the right to present a written statement in support of its position on appeal. The party requesting the appeal will submit a statement first and the other party will then have ten (10) days to respond.

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

(d) In its sole discretion, the Review Panel may allow each party or its representative to appear personally and make oral argument not to exceed thirty (30) minutes.

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

(f) The Review Panel will prepare a report recommending final action to the Board.

7.F. BOARD ACTION

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

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

(b) The Board may review any information that it deems relevant, including, but not limited to, the findings and recommendations of the Medical Executive Committee, Hearing Panel, and Review Panel (if applicable).

(c) The Board may adopt, modify, or reverse any recommendation it receives or refer the matter for further review and recommendation to any individual or committee.

Consistent with its ultimate legal authority for the operation of the Hospital and the quality of care provided, the Board may also make its own decision.

(d) The Board will render its final decision in writing, including the basis for its decision. The final decision will be sent by special notice to the individual. A copy will also be provided to the Chief of Staff.

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

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

No individual will be entitled to more than one (1) hearing and one (1) appeal on any matter.

7.G. PROCEDURAL RIGHTS FOR DEPENDENT PRACTITIONERS

(1) In the event a recommendation is made by the Medical Executive Committee that a dependent practitioner not be granted a scope of practice or that the scope of practice previously granted be restricted for a period of more than thirty (30) days, terminated, or not renewed, the individual will receive special notice of the recommendation. The notice will include a general statement of the reasons for the recommendation and will advise the individual that he or she may request a meeting with the Medical Executive Committee.

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

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

ARTICLE 8

CONFLICTS OF INTEREST

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

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

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

(d) Any member with knowledge of the existence of a potential conflict of interest or bias on the part of any other member may call the conflict of interest to the attention of the Chief of Staff (or the Chief of Staff-Elect if the Chief of Staff is the person with the potential conflict), the President and Chief Executive Officer, or the applicable service or committee chairperson.

(e) Additionally, the subject member is obligated to notify the Chief of Staff, the President and Chief Executive Officer, or the applicable service or committee chairperson of any known or suspected conflicts of interest who are involved in reviewing the member's request or performance. Any potential conflict of interest that is not timely raised will be deemed to be waived.

(f) The Chief of Staff, or the applicable service or committee chairperson, will make a final determination as to whether the provisions in this Article should be triggered or may submit the issue of whether there is a conflict of interest to a vote of the entire committee or service.

(g) The fact that a chairperson or a member is in the same specialty as a member whose request is being considered or performance is being reviewed does not automatically create a conflict. In addition, an assessment of whether a conflict of interest exists will be interpreted reasonably by the persons involved, taking into consideration common sense and objective principles of fairness. No member has

a right to compel disqualification of another member based on an allegation of conflict of interest.

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

(i) Conflict of Interest Guidelines, which are attached as Appendix B, may be used to provide guidance in addressing potential conflict of interest situations.

ARTICLE 9

MEDICAL STAFF ACCESS TO CREDENTIALS AND QUALITY FILES

Practitioners are notified of their rights to review, correct, or receive a status update on their file at the time of the initial or re-credentialing application process via the application portal/web.

(a) Applicants have the right to be informed of the status of their credentialing and recredentialing applications upon request. Requests for information on the status of an application will be made in writing to the Medical Staff Office. The Medical Staff Office will provide a written response to a request for application status within fourteen (14) days and specify the status of the application.

(b) Practitioners will be given an opportunity to review and to respond in writing to any written communication concerning the individual's practice and included in the individual's credentials and/or quality file.

Each practitioner will be notified of the right, and offered a reasonable opportunity, to inspect his/her file and to make notes regarding it, in the presence of the Medical Staff Manager, Medical Staff Leader, or President and Chief Executive Officer. In no case shall a practitioner remove the file or portions thereof from the Medical Staff Office or make copies of it, without the express permission of the President and Chief Executive Officer or other authorized designee.

(c) Practitioners have the right to correct erroneous information in their file. Ridgeview will notify the practitioner immediately in writing in the event that credentialing information obtained from other sources varies substantially from that provided by the practitioner.The notification sent to the practitioner will detail the information in question and will include instruction to the practitioner indicating:

a. The requirement to submit a written response within fourteen (14) calendar days of receiving notification from Ridgeview.

b. In the response, the practitioner must explain the discrepancy, may correct any erroneous information, and may provide proof that is available.

c. The practitioner's response must be sent to the Ridgeview Medical Staff Office. Upon receipt of notification from the practitioner, Ridgeview will document the receipt of the information in the practitioners credentials file.

(d) The Medical Staff Manager, Medical Staff Specialist, Medical Staff Leader, or President and Chief Executive Officer will correct or delete materials contained in a practitioner's file only after the individual has submitted a written request demonstrating good cause for the correction or deletion and the request has been approved by the Medical Executive

Committee and the President and Chief Executive Officer.

a. The credentialing system will automatically track and date any changes in the practitioners electronic file. The reason for the change will be documented in the practitioner file.

b. If a new primary source verification is obtained, it will be added to the practitioners file. It will not replace the previous verification. However, corrected data will override any previously entered information.

CONFIDENTIALITY:
Ridgeview will ensure all information obtained in the credentialing process is confidential, except as otherwise provided by law. This process includes but is not limited to: secure software system which requires password access and role based security, locked computer when unattended, badge access to office suite. Annual review of job roles and current user access to ensure system is still appropriate for the role requirements and review of user activity logs including modifications made to credentialing data to confirm accuracy and appropriateness using the electronic system.

As well as the following process noted below:

(e) A practitioner will routinely be permitted access to the following information, provided appropriate notice is given to the Medical Staff Office:

(1) Applications for appointment, reappointment, and requested changes in staff status or clinical privileges, with all attachments.

(2) All information gathered in the course of verifying, evaluating, or otherwise investigating applications for appointment, reappointment, or changes in staff status or clinical privileges (except for confidential reference information obtained from third parties).

(3) Results of queries to the National Practitioner Data Bank.

(4) Any performance improvement trend sheets, and reports concerning the individual's practice at the Hospital, including quality profiles.

(5) Any routine correspondence between the Hospital and the practitioner.

(6) Information concerning the practitioner's meeting attendance record and compliance with other requirements.

(f) A practitioner may review the documents listed below while in the presence of an appropriate Medical Staff Leader or President and Chief Executive Officer. At this meeting, the practitioner will be shown the document or an appropriate summary of it (but will not be told the identity of any individuals who provided the information). The

practitioner shall be given the right to submit a written explanation for inclusion in the file.

(1) Any and all incident reports concerning the practitioner which are placed into the file, along with any written explanations submitted by the individual.

(2) Any confidential correspondence and/or memos to the file, prepared pursuant to collegial intervention efforts or other progressive disciplinary steps with the individual, along with any responses from the individual. Any periodic review and appraisal forms completed by the appropriate service chairperson, including those completed at the time of appointment or reappointment.

(3) Any routine peer review evaluation forms completed.

(4) Any evaluation or reports from proctors, monitors, and/or external clinical reviewers, and any written explanations submitted by the individual.

(5) Confidential reports and/or minutes of peer review committees pertaining to the practitioner.

(6) Any correspondence setting forth formal Medical Executive Committee action, including, but not limited to, letters of guidance, warning, or reprimand, terms of probation, or consultation requirements, or final adverse actions following completion or waiver of a hearing and appeal, accompanied by any written explanation the individual submits.

(g) Because of the expectations of confidentiality on the part of individuals who submit documents, a practitioner may not have access to these documents, unless the individual providing such information consents to the disclosure, or the information is the basis for an adverse professional review action that entitles the individual to a hearing pursuant to the Credentials Policy. These documents are as follows:

(1) Any and all confidential correspondence from references and other third parties, including, but not limited to, letters of reference, confidential evaluation forms, and other documents concerning the practitioner's training, clinical practice, professional competence, or conduct at any other health care facility or medical school.

(2) Notations of telephone conversations concerning the practitioner's qualifications with references and other third parties, including date of conversation, identification of parties, and information received and/or discussed.

ARTICLE 10

AMENDMENTS AND ADOPTION

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

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

Adopted by the Medical Staff: 12/08/2023______________________

Approved by the Board: 12/18/2023______________________

APPENDIX A

NON-PHYSICIAN PROVIDER STAFF

Licensed independent practitioners include the following:

- Psychologists;
- Clinical Counselors;
- Clinical Social Workers;
- Licensed Alcohol and Drug Counselors;
- Licensed Marriage and Family Therapists; and
- Moonlighting residents.

Advanced practice clinicians include the following:

- Advanced Practice Registered Nurses, including certified nurse practitioners and certified clinical nurse specialists;
- Certified Nurse Midwives;
- Certified Registered Nurse Anesthetists;
- Physician Assistants.

Dependent practitioners include the following:

- Registered Dental Assistants;
- Registered Nurses who round with a member of the Medical Staff;
- Certified Surgical Techs;
- Surgical Assistants; and
- Licensed Practical Nurses.

APPENDIX B

CONFLICT OF INTEREST GUIDELINES

Potential Conflicts	Levels of Participation						
	Provide Information	Individual Reviewer	Committee Member				Hearing Panel
			Medical Staff Leadership Council	QI	MEC	Ad Hoc Investigating	
Employment/contract relationship with Hospital	Y	Y	Y	Y	Y	Y	Y
Self or family member	Y	N	N	N	N	N	N
Relevant treatment relationship	Y	N	N	N	N	N	N
Significant financial relationship	Y	M	M	M	M	N	N
Direct competitor	Y	M	M	M	M	N	N
Close friends	Y	M	M	M	M	N	N
History of conflict	Y	M	M	M	M	N	N
Personally involved in care of patient (but not subject of review)	Y	M	M	M	M	N	N
Other than Medical Staff Leadership Council, MEC, or service chairperson, reviewed at prior level	Y	M	M	M	M	N	N
Raised the concern	Y	M	M	M	N	N	N

Y – means the individual may serve in the indicated role, no extra precautions are necessary.

N – means the individual may not serve in the indicated role and should be recused in accordance with the rules for recusal ***(see next page)***. If the facts and circumstances are contentious or otherwise unclear, the Chairperson of the Medical Staff Leadership Council, Medical Staff QI Committee, or MEC may submit the issue to a vote of the entire committee.

M – means the Interested Member may have a conflict of interest. The Chief of Staff or the chairperson of the committee should consider the facts and circumstances and determine whether the conflict would make it difficult for the individual to be fair and objective in performing a review, whether the individual's service might inhibit the full and fair discussion of the issue, skew the recommendation of the committee, or otherwise be unfair to the practitioner under review. In considering the facts and circumstances, the Chief of Staff or the applicable chairperson may determine that a potential conflict is not significant enough to prohibit the person from serving in the designated role because of the check and balance provided by the multiple levels of review and the fact that the committee at issue has no disciplinary authority. The Chief of Staff or the chairperson of the applicable committee may submit the issue of whether there is a conflict of interest to a vote of the entire committee. No Medical Staff member has the right to demand the recusal of another member.

CONFLICT OF INTEREST GUIDELINES *(cont'd.)*

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

[3] "Interested Member" refers to the individual with a potential conflict of interest.

APPENDIX C

DELEGATED CREDENTIALING PROCEDURES

The procedures outlined in this Appendix will apply when this Policy is used for delegated credentialing for third-party payors.

SCOPE

The types of practitioners that will be subject to delegated credentialing include both Medical Staff and Non-Physician Provider Staff members.

SUB-DELEGATION

Sub-delegation to an entity outside the System of the functions described in this Policy and this Appendix will not occur.

REVIEW OF POLICY

The Credentials Committee will review the effectiveness of this Policy and recommend revisions or modifications on a yearly basis.

OVERSIGHT OF DELEGATED CREDENTIALING PROGRAM

The Chief Medical Officer will serve as the medical director of the delegated credentialing program. The Chief Medical Officer will be responsible for the program's compliance with relevant laws, regulations, and accreditation standards. The Chief Medical Officer will also oversee the delegated credentialing, recredentialing, and ongoing monitoring processes.

NONDISCRIMINATION

(1) Credentialing decisions shall not be based on an individual's gender, race, creed, color, ethnic/national identity, age, disability, sexual orientation or the patient type (e.g., Medicaid or high-risk populations) in which the individual specializes. Monitoring and preventing such discrimination shall be done by completing audits, at least annually, of the files of individuals who are denied membership or have their membership revoked or suspended.

(2) All Credentials Committee members will be required to sign an annual affirmative statement that any decisions or recommendations that they make will be done in a nondiscriminatory manner.

APPLICATION

(1) The application will specifically seek, among other things, information pertaining to the following:

  (A) reasons for inability to perform the essential functions of the position, if applicable;

  (B) lack of present illegal drug use;

  (C) history of loss of license and felony convictions;

  (D) history of loss or limitation of privileges or disciplinary actions;

  (E) current malpractice insurance coverage or, if no current malpractice insurance coverage, eligibility for malpractice insurance coverage on the effective date of membership; and

  (F) clinical privileges, or evidence of an admitting arrangement, for admitting patients to the Hospital.

(2) The application will also include a requirement for the applicant to attest, via signature, to the correctness and completeness of the application.

(3) As a preliminary step, an application will be reviewed by the Medical Staff Office to determine that all questions have been answered and are accurate (including a review for conflicting information), and that the applicant satisfies the threshold eligibility criteria. Individuals who fail to meet these criteria will be notified in writing that they are ineligible to apply and the reasons for ineligibility. A complete application for an individual eligible for an unrestricted DEA license, in which the Applicant's DEA license is in active-pending status, may still be presented to the Credentials Committee provided that the individual has confirmed that a practitioner with appropriate clinical privileges with a current, unrestricted DEA license is willing to write all prescriptions requiring a DEA Number for the individual until his or her DEA license is granted. Final action will not be taken until all applicable threshold eligibility criteria are satisfied. There is no right to a hearing on a determination of ineligibility.

TIME PERIODS FOR PROCESSING

(1) Once an application is deemed complete, it will be processed in accordance with state time requirements, and not to exceed National Committee for Quality Assurance (NCQA) time frames, unless it becomes incomplete. Notification of credentialing decisions will be made in accordance with any accreditation and/or regulatory requirements, not to exceed sixty (60) days.

(2) The verifications to be performed and the relevant NCQA time limits are as follows:

(A) Current, valid license and any sanctions or restrictions on licensure or limitations on scope of practice - must be reviewed within one-hundred eighty (180) calendar days of verification;

(B) Valid DEA or CDS certificate - for non-pending DEA or CDS certificates, must be reviewed within one-hundred eighty (180) calendar days of verification;

(C) Education and training - must be reviewed prior to the credentialing decision;

(D) Board certification status if practitioner states on application that he or she is board certified - must be reviewed within one-hundred eighty (180) calendar days of verification;

(E) Work history (five (5) years) - must be reviewed within one-hundred eighty (180) calendar days of verification;

(F) Malpractice history - must be reviewed within one-hundred eighty (180) calendar days of verification;

(G) Medicare and Medicaid sanctions - must be reviewed within one-hundred eighty (180) calendar days of verification; and

(H) Attestation on application - must be reviewed within one-hundred eighty (180) calendar days of the date the attestation is made.

The NCQA time limits set forth above are current as of the adoption date of this Policy. If these time limits are shortened before this Appendix can be amended, the shorter time limits will be used until this Appendix can be amended.

VERIFICATION SOURCES

(1) Verification of information required for credentialing and recredentialing (verification of education and training and work history are not applicable for recredentialing) can be received/obtained via various methods including but not limited to: e-mail, fax, hard copy (mail), verbally, electronically via website, or database webcrawl and will be performed as follows:

(A) Licensure and limitations or restrictions on licensure or limitations on scope of practice – directly from state licensing or certification agency and/or the National Practitioner Data Bank.

(B) DEA or CDS certification – DEA or CDS agency; DEA or CDS certification, documented visual inspection of the original DEA or CDS certificate, confirmation

from the National Technical Information Service database, or confirmation from the American Medical Association ("AMA") Masterfile (DEA only).

(C) Education and training – primary source, the state licensing agency or specialty board if the state agency and specialty board, respectively, perform primary source verification, or sealed transcripts if there is written documentation that the transcript was inspected and confirmation that the practitioner completed the appropriate training program. For physicians, other acceptable verification sources include (when appropriate for the degree) AMA Physician Masterfile, American Osteopathic Association ("AOA") Official Osteopathic Physician Profile Report or Physician Masterfile, and the Educational Commission for Foreign Medical Graduates for international medical graduates licensed after 1996.

(D) Board certification status – primary source (appropriate specialty board) and the state licensing agency. For physicians, other acceptable verification sources include the ABMS or its member boards, or an official ABMS Display Agent, where a dated certificate of primary source authenticity has been provided, AMA Physician Masterfile, AOA Official Osteopathic Physician Profile Report or Physician Masterfile, and boards in the United States that are not members of the ABMS or AOA if the organization documents within its policies and procedures which specialty boards it accepts and obtains annual written confirmation from the board that the board performs primary source verification of completion of education and training.

(E) Work history – application or CV.

(F) Gaps in work history – application or CV (A review of work history and any gaps will be documented. If a gap in employment exceeds six (6) months, the practitioner will be required to clarify the reasons for the gap verbally or in writing. If a gap in employment exceeds one (1) year, the practitioner will be required to clarify the reasons for the gap in writing).

(G) Malpractice history – the malpractice carrier or the National Practitioner Data Bank.

(H) Medicare and Medicaid sanctions – National Practitioner Data Bank or other NCQA-approved source.

(2) During initial credentialing and recredentialing, the Centers for Medicare & Medicaid Services' ("CMS") Opt-Out Affidavit List will be reviewed to determine if an applicant has elected to opt out of Medicare, and a CMS-approved sanctions list (e.g., Office of Inspector General List of Excluded Individuals/Entities) to determine if an applicant is eligible for participation in Medicare. The MN Medicaid Sanctions will also be reviewed to verify eligibility.

<u>DOCUMENTATION OF INFORMATION AND ACTIVITIES IN CREDENTIALS FILES</u>

The Medical Staff Office may use an electronic checklist to document verification of information for practitioner credentials files. The electronic checklist and/or document includes, among other things, the source used for verification purposes, the date that the verification was conducted, the electronic signature of the individual conducting the verification, and, where applicable, the report date. Primary source verification will be documented/stored electronically within the practitioners credentialing file.

SITE ASSESSMENTS

(1) Site assessments will be conducted to ensure that the offices of all practitioners meet office site standards.

(2) The quality, safety, and accessibility of practitioners' offices will be assessed based on the following factors:

(A) Physical accessibility;

(B) Physical appearance;

(C) Adequacy of waiting and examining room space; and

(D) Adequacy of medical/treatment record keeping.

Patient complaints for practitioner office sites will also be monitored.

(3) The results of the assessments will be scored on a 0 to 100% compliance scale.

(A) For sites demonstrating 80% or greater compliance, no follow-up is required.

(B) For sites demonstrating less than 80% compliance, an action plan will be developed and monitored. Follow-up to the site assessment action plan will occur at least every six months until the deficiency is resolved.

(4) A site assessment will be completed as follows:

(A) At initial credentialing of a practitioner at a site which has not been assessed;

(B) Every three (3) years after the initial site assessment;

(C) When patient complaints for a site exceed the threshold established (under such circumstances, site visits will be conducted within sixty (60) days of the threshold being met and communicated to the Chief Medical Officer); and

(D) As part of the follow-up when a site demonstrates less than 80% compliance.

ONGOING MONITORING

(1) The following will be reviewed as part of the ongoing monitoring process (i.e., during the credentialing cycle/period): (Sanctions will be verified through primary source that includes but is not limited to: SAM; OIG; LEIE; state licenses)

(A) Medicare and Medicaid sanctions; (reviewed monthly)

(B) sanctions or limitations on licensure; (reviewed monthly)

(C) grievances from patients or complaints from staff, including any history of such grievances or complaints (grievances will be reviewed upon their receipt and any history of grievances will be evaluated at least every six (6) months); and

(D) information from identified adverse events (will be reviewed upon their receipt and any history of adverse events will be evaluated at least every six (6) months).

(E) Ridgeview will not employ or contract with practitioners that are excluded from participation under Medicare. Practitioner Medicare "opt-out" status will be verified prior to initial credentialing, re-credentialing and on a quarterly basis. Verification will be obtained electronically through the credentialing software system. Documentation will be maintained in the practitioners file.

(2) Sanctions information will also be reviewed within thirty (30) days of its release by the reporting entity. If the reporting entity does not publish sanctions information on a set schedule, it will be documented that the reporting entity does not release information on a set schedule, and a query of the reporting entity for the necessary information will occur at least every six (6) months. If there is a subscription to a sanctions alert service, the information provided through the service as a part of an alert will be reviewed within thirty (30) days of a new alert being issued.

(3) Documentation of monitoring and review will be documented on an Ongoing Monitoring Log (Attachment A).

(4) Any findings will be forwarded to the appropriate Medical Staff Committee/Chair for review.

REPORTING TO AUTHORITIES

(1) Reporting to the National Practitioner Data Bank (NPDB):

(A) A report will be submitted to the National Practitioner Data Bank after a physician or dentist has exercised or waived his or her hearing rights and the Board takes one of the following reportable professional review actions:

(1) denial of request for initial or renewed Medical Staff membership or clinical privileges;

(2) revocation of Medical Staff membership or clinical privileges; or

(3) suspension of Medical Staff membership or clinical privileges for more than thirty (30) days.

(B) A report will also be submitted to the National Practitioner Data Bank if the Hospital accepts the surrender, restriction, or resignation of a physician's or dentist's Medical Staff membership or clinical privileges while under an investigation, or in return for not conducting an investigation, or in return for not taking an adverse professional review action. Under such circumstances, the physician or dentist will be informed that a report will be made to the National Practitioner Data Bank.

(C) Reports to the National Practitioner Data Bank of adverse actions and surrender involving practitioners other than physicians and dentists are **not** mandatory under federal law and will not be made.

(D) Reports to the National Practitioner Data Bank and query results received by the National Practitioner Data Bank are confidential and will not be shared with third-party payors who have delegated credentialing. However, the fact that a query was conducted may be disclosed to third-party payors. Copies of all information obtained through queries to the National Data Bank shall be maintained as part of the individual's permanent confidential credentials file.

(2) State law reporting requirements

The state law reporting requirements are not identical to the National Practitioner Data Bank requirements. On a case-by-case basis, legal counsel will be consulted to determine if there is an obligation to file a report under the state reporting requirements when a practitioner has his or her request for membership or clinical privileges denied or current membership or clinical privileges are revoked, denied, restricted, or suspended, or surrenders or relinquishes membership or clinical privileges for any period of time. Reports will be made consistent with applicable state law.

MISCELLANEOUS

(1) When a practitioner requests a hearing for one of the recommendations enumerated in the Credentials Policy that are grounds for a hearing, the Hearing Officer option will not be

used when the recommendation would affect the individual's credentialing with third-party payors.

(2) For purposes of delegated credentialing and reporting practitioner effective dates to third-party payors, the date that the Credentials Committee, or chairperson of the Credentials Committee (for applications that meet the criteria outlined in the Credentials Policy), approves the practitioner's credentialing will be used as the practitioner's effective date.