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Medical Staff Credentials Policy

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Policy Type

- ☐ Entity Governance Policy
- ☒ Entity Policy
- ☐ Entity Departmental Policy
- ☐ Governance Policy
- ☐ Corporate Policy
- ☐ Corporate Departmental Policy

Policy Scope

- ☐ Summa Health (Corporate)
- ☐ Summa Health Network
- ☐ Summa Health Medical Group
- ☐ SummaCare
- ☒ Summa Health System (Hospitals)
- ☐ New Health Collaborative
- ☐ Department: _____

1.0 **Purpose:**

1.1 This policy provides a uniform method for the credentialing, appointment, and privileging of Practitioners to provide clinical services in the Hospital inpatient and outpatient departments.

2.0 **Scope:**

2.1 This policy applies to all Practitioners who desire appointment to the Medical Staff or to exercise Clinical Privileges in the Hospital.

3.0 **Definitions:**

3.1 The definitions set forth in the Medical Staff Bylaws shall apply to this Medical Staff Credentials Policy unless another definition is provided for herein.

4.0 **Policy:**

4.1 **NATURE OF MEDICAL STAFF APPOINTMENT AND DELINEATED CLINICAL PRIVILEGES**

4.1.1 Appointment to the Medical Staff is separate and distinct from a grant of Clinical Privileges. A Practitioner may be granted Medical Staff appointment with Privileges, Medical Staff appointment without Privileges, or Privileges without a Medical Staff appointment.

4.1.2 Medical Staff appointment and Privileges shall be extended only to professionally competent Practitioners who continuously meet the qualifications, standards, and requirements set forth in the Medical Staff Bylaws and this Credentials Policy.

4.1.3 No Practitioner, including those employed by or in a medical administrative position by virtue of a contract with the Hospital, shall admit or provide care, treatment, and/or services to patients in the Hospital unless he or she has been granted Clinical Privileges to do so in accordance with the procedures set forth in the Medical Staff Bylaws and/or this Credentials Policy.

4.1.4 A Practitioner who is granted appointment to the Medical Staff is entitled to such Prerogatives and is responsible for fulfilling such obligations as are set forth in the Medical Staff Bylaws and Policies and the Medical Staff category to which the Practitioner is appointed. Appointment to the Medical Staff shall confer on the Appointee only such delineated Clinical Privileges as have been granted in accordance with the Medical Staff Bylaws and this Credentials Policy.

4.1.5 A Practitioner who is granted Clinical Privileges is entitled to exercise such Privileges and is responsible for fulfilling such obligations as set forth in the Medical Staff Bylaws and Policies and the applicable Privilege set, and as otherwise required by the Department to which he/she is assigned.

4.2 **BURDEN OF PRODUCING INFORMATION**

In connection with all applications for appointment, reappointment, grant/regrant of Clinical Privileges, advancement, or transfer, the Practitioner shall have the burden of producing information for an adequate evaluation of his/her qualifications and suitability for the Clinical Privileges and Medical Staff category requested, of resolving any reasonable doubts about these matters, and of satisfying requests for information.

4.3 **DURATION OF APPOINTMENT & CLINICAL PRIVILEGES**

Initial appointment and/or grant of Clinical Privileges, modification of Medical Staff appointment and/or Clinical Privileges, and reappointment/regrant of Clinical Privileges shall be for a period of not more than two (2) years. An appointment or grant of Clinical Privileges of less than two (2) years shall not be deemed Adverse for purposes of the Medical Staff Bylaws or Credentials Policy.

4.4 **EFFECT OF OTHER AFFILIATIONS**

No Practitioner shall be entitled to appointment to the Medical Staff or to exercise particular Clinical Privileges at the Hospital merely by virtue of the fact that he or she holds a certain degree or is duly licensed to practice medicine, dentistry, podiatry or psychology in this or in any other state; is certified by any clinical board; is a member of any professional organization; had in the past, or presently has, medical staff appointment or privileges at this Hospital or at another hospital or healthcare facility; or, contracts with or is employed by the Hospital.

4.5 **ADDITIONAL CONSIDERATIONS**

4.5.1 In the case of initial applications for Medical Staff appointment and/or Clinical Privileges or applications for new Clinical Privileges during the course of an appointment/Privilege period, the requested appointment/Privileges must be compatible with any policies, plans, or objectives formulated by the Board concerning:

4.5.1.1 The Hospital's patient care needs including current and projected needs.

4.5.1.2 The Hospital's ability to provide the facilities, equipment, personnel, and financial resources that will be necessary if the application is approved.

4.5.1.3 The Hospital's decision to contract exclusively for the provision of certain medical/professional services with a Practitioner or group of Practitioners other than the affected Practitioner.

4.6 **APPLICATION FOR INITIAL APPOINTMENT/GRANT OF CLINICAL PRIVILEGES**

Unless otherwise provided in the Medical Staff Bylaws and/or this Policy:

4.6.1 Initial appointments to the Hospital Medical Staff and grants of delineated Privileges shall be approved and granted by the Board. A written, signed application for Medical Staff appointment and/or Privileges must be submitted to the Credentialing Office/the Credentials Verification Organization (CVO) on the application approved by the Board. If

the initial application is not returned by the requesting applicant within sixty (60) days after the date that the applicant is provided an application, the application will be deemed to have been voluntarily withdrawn. For any future consideration for Medical Staff appointment and/or Clinical Privileges, the applicant will need to submit a new, full application including application fee.

4.6.2 For initial appointment and/or grant of Clinical Privileges, the applicant is required to provide the following when submitting an application:

- Current Ohio License
- Current DEA Registration Certificate (if necessary for the Privileges requested)
- Evidence of Board Certification or Eligibility
- Current Certificate of Professional Liability Insurance
- Proof of Continuous Professional Liability Insurance for the prior five (5) years; or, for new graduates, for such shorter period of time as the Practitioner has practiced outside of a training program.
- Completed Delineation of Clinical Privileges Form, if requesting Clinical Privileges
- Completed HCFA Penalty Statement
- Signed Security Agreement
- Signed Code of Conduct Form
- Signed I'm 4 Safety Form
- Signed Appointment Form, if requesting appointment to the Medical Staff
- Signed Parking Permit
- Signed Pager Agreement, if requesting appointment to the active Medical Staff
- Signed Attestation Form
- Tuberculosis/Health Status Evaluation Form
- $200 Non-Refundable Application Processing Fee

4.6.3 The application shall require detailed information regarding the Practitioner's qualifications for Medical Staff appointment and/or Clinical Privileges which shall include, but not be limited to, information concerning:

4.6.3.1 The applicant's satisfaction of the required education and training.

4.6.3.2 The Practitioner's current ability to safely and competently exercise the Privileges requested with or without a reasonable accommodation.

4.6.3.3 A chronology and account of all professional practice since completion of an approved residency program, if required, and information concerning any period of more than two (2) months during which the applicant was not in practice.

4.6.3.4 All present and past Medical Staff appointments and/or clinical privileges at the Hospital or any other hospital/healthcare organization.

4.6.3.5 Any action taken by any hospital or health care organization concerning limiting of Medical Staff appointment and/or privileges or any action taken toward that end regardless of whether Medical Staff appointment and/or privileges were actually limited.

4.6.3.6 Any corrective action taken by any hospital or health care organization against the Practitioner.

4.6.3.7 Voluntary or involuntary relinquishment of professional license or DEA registration; termination, limitation, reduction, or loss of Medical Staff appointment and/or Clinical Privileges at Hospital or another hospital or health care organization.

4.6.3.8 Names and addresses of at least three (3) professionals/peers in the Practitioner's same professional discipline who have recently worked with the applicant, and directly observed his/her professional performance over a reasonable period of time, and who can and will provide reliable information regarding the applicant's: current professional competence; the applicant's documented experience in requested treatment areas or procedures, the results of treatment provided/procedures performed, and the conclusions drawn from quality assessment and improvement activities when available; his/her ethics; and, ability to work with others. At least one (1) reference shall be from the institution where the applicant has just finished training or the most recent institution where the applicant was/is practicing, and if possible, another shall be from an active member of the Hospital Medical Staff. Three (3) references are requested but two (2) are acceptable for processing the application. References should not be associates or partners of the applicant and may not be provided by the applicant's relatives. Peer recommendations shall include information regarding the applicant's medical/clinical knowledge, technical/clinical skills, clinical judgment, interpersonal skills, communication skills, and professionalism. Peer recommendations may be in the form of written documentation reflecting informed opinions on the applicant's scope and level of performance or a written peer evaluation of Practitioner-specific data collected from various sources for the purpose of validating current competence.

4.6.3.9 Number and expiration date of current license to practice in Ohio and number and expiration date of current license to practice in any other jurisdiction, if any.

4.6.3.10 Copy of current DEA registration (if necessary for the Privileges requested) verifying continued registration, certificate number, and expiration date as applicable.

4.6.3.11 Specialty board certification or eligibility for such certification

4.6.3.12 Information as to whether any of the following have ever been or are in the process of being denied, revoked/terminated, suspended, reduced, involuntarily relinquished, or relinquished while under investigation or to avoid investigation:

- Medical Staff appointment and/or privileges at any hospital or health care institution.
- Membership in, or association with, any local, State, or national professional organizations.
- Specialty or sub-specialty board certification(s) or eligibility.
- License or certificate to practice any health profession in any jurisdiction.

- Prescriptive authority/DEA number or any other controlled substances registrations.
- Faculty appointment at any professional school.
- Professional Liability Insurance.
- Participation in any Federal Healthcare Program.

4.6.3.13 Documentation of continuing education activities or attestation that the applicant meets all continuing education activities/requirements necessary to maintain Ohio licensure.

4.6.3.14 Documentation of required immunizations and/or health screenings.

4.6.3.15 Conviction(s), arrest(s), or charge(s) of a felony or misdemeanor (other than minor traffic offenses) including crimes related to children, adolescents, and/or adults.

4.6.3.16 Names and addresses of the applicant's present and past Professional Liability Insurance carriers and a current certification from the present carriers. The insurance carrier must be approved by the Board and have a current rating of A- or better by an A.M. Best insurance rated company carrying at least the minimum limits of coverage as mandated by the Board ($1 million/$3 million set by the Board 8/1998).

4.6.3.17 Completion of the Professional Liability Claim Form which will include information on any and all claims, judgments, and settlements against the applicant during the past five (5) years and information regarding any denial, limitation, or cancellation of liability insurance during the past five (5) years; or, for new graduates, for such shorter period of time as the Practitioner has practiced outside of a training program.

4.6.3.18 Names and addresses of affiliated Practitioners, if any, the nature of the affiliation, and the date on which the affiliation commenced.

4.6.3.19 Information concerning any and all legal action the applicant has commenced against any other health care facility and/or organization with respect to denial or loss of medical staff appointment and/or privileges, termination of medical staff appointment and/or privileges, termination of any contracted services, or any other legal action so commenced.

4.6.3.20 Information necessary to complete required background checks. Background checks/inquiries (to include criminal and civil reports) will be a part of all credentialing verifications.

4.6.3.21 Information required pursuant to the Hospital's conflict of interest policy, if any, as applicable.

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

4.6.3.23 Government-issued photo identification to verify that the applicant is, in fact, the individual requesting Privileges.

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

4.6.3.25 The applicant's signature.

4.6.4 Each application for Medical Staff appointment and/or Privileges shall be in writing, submitted on the prescribed form with all provisions completed (or accompanied by an explanation of why answers are unavailable), and signed and dated by the applicant.

4.6.5 When an applicant requests an application form, he/she shall be given a copy of, or access to, the Medical Staff Bylaws and Policies, Department specific rules and regulations, and information regarding appointment/reappointment and delineated Clinical Privileges.

4.7 EFFECT OF APPLICATION

By applying for Medical Staff appointment and/or Clinical Privileges at the Hospital each applicant:

4.7.1 Signifies his/her willingness to appear for interviews in support of his/her application.

4.7.2 Agrees to the provisions set forth in Article XII of the Medical Staff Bylaws regarding confidentiality of information, immunity for reviews and actions taken, and release of liability for obtaining and sharing information.

4.7.2.1 Authorizes Hospital/Medical Staff Representatives to consult with others who have been associated with the applicant regarding the applicant's clinical competency, professional qualifications, and performance. Applicant authorizes such individuals and organizations to candidly provide all such information to the Hospital/Medical Staff.

4.7.2.2 Consents to the inspection and copying of records and documents that may be material to an evaluation of the applicant's qualifications and ability to carry out the delineated Clinical Privileges requested, and authorizes all individuals and organizations who have custody of such records and documents to permit such inspection, copying, and transmittal.

4.7.2.3 Releases from any liability, to the fullest extent permitted by law, all Hospital/Medical Staff Representatives for their acts performed in connection with investigating and evaluating the applicant's qualifications for Medical Staff appointment and/or Clinical Privileges.

4.7.2.4 Releases from any liability, to the fullest extent permitted by law, all Third Parties who provide information regarding the applicant, including otherwise privileged and confidential information.

4.7.2.5 Consents to the disclosure to other hospitals, medical associations, licensing boards, the National Practitioner Data Bank, background check entities, and other similar organizations of any information regarding the Practitioner's professional conduct or clinical competence that the Hospital may have and releases Medical Staff, Hospital and all authorized agents and/or

Representatives of the Medical Staff and Hospital from liability for doing so to the fullest extent permitted by law.

4.7.3 Acknowledges that he/she has received access to, and has a responsibility to review, the Medical Staff Bylaws and Policies and applicable Hospital policies. The applicant agrees that during all times that he/she holds Medical Staff appointment and/or Clinical Privileges at the Hospital he/she will comply with the Medical Staff Bylaws and Policies, and applicable Hospital policies as they exist and as they may be modified from time to time.

4.7.4 Understands and agrees that if Medical Staff appointment and/or requested Privileges are denied based upon the Applicant's competence or conduct, the Applicant may be subject to reporting to the National Practitioner Date Bank and/or state authorities.

4.7.5 Acknowledges his/her obligation to satisfy the applicable Medical Staff responsibilities set forth in the Medical Staff Bylaws and the designated Medical Staff category including, but not limited to, practicing in an ethical manner and providing continuous care to patients.

4.7.6 Agrees to notify the Credentialing Office immediately if any information contained in the application changes. The foregoing obligation shall be a continuing obligation of the applicant so long as he/she is an Appointee to the Medical Staff and/or has Privileges at the Hospital.

4.7.7 Agrees that when an Adverse action or recommendation is made with respect to his/her Medical Staff appointment and/or Privileges, the applicant will exhaust the administrative remedies afforded by the Bylaws before resorting to formal legal action.

4.7.8 Acknowledges and attests that the application is correct and complete, and that any material misstatement or omission is grounds for a denial or revocation of Medical Staff appointment and/or Privileges.

4.8 APPLICATIONS FOR MEDICAL STAFF APPOINTMENT WITHOUT PRIVILEGES

4.8.1 Due to the limited nature of an appointment without Privileges, applicants requesting appointment to the consulting peer review Medical Staff category will only be required to complete such application and provide such information as required by the applicable Medical Staff category and as the Medical Executive Committee and Board otherwise deem necessary. Upon the written recommendation of the pertinent Department Chair and Medical Staff President, the Hospital President may grant a Practitioner appointment to the consulting peer review category for a specific peer review matter.

4.8.2 Applicants requesting appointment to the active Medical Staff category without Privileges must complete the same application as applicants requesting appointment to the active Medical Staff Category with Privileges. Applications for appointment to the active Medical Staff category without Privileges shall be processed in the same manner as applications for appointment to the active Medical Staff with Privileges.

4.8.3 Practitioners who wish to move to the retired Medical Staff shall submit a written request for change of Medical Staff category which shall be reviewed and acted upon in accordance with Section 4.12.

4.8.4 Denial of an application/request for, or suspension/termination of, appointment to the consulting peer review or retired Medical Staff shall not trigger procedural rights nor shall it create a reportable event for purposes of federal or state law.

4.9 ACTION UPON RECEIPT OF AN APPLICATION FOR MEDICAL STAFF APPOINTMENT AND/OR PRIVILEGES

Unless otherwise provided in the Medical Staff Bylaws or Credentials Policy, the procedure for acting upon applications for Medical Staff appointment and/or Privileges shall be as set forth below:

4.9.1 Collection & Verification of Information

4.9.1.1 The applicant shall deliver a completed application to the Credentialing Office along with a non-refundable application fee. For purposes of the Credentials Policy, a completed application is defined as containing all information requested on the application, any and all letters of recommendation as requested, and timely providing of any and all other information requested by the Medical Staff to evaluate the Practitioner's professional qualifications including, but not limited to, current clinical competence. Upon receipt of a completed application and required application fee, a credentials file will be created and maintained by the Hospital.

4.9.1.2 The Credentialing Office shall expeditiously seek to collect and verify the applicant's references, licensure status, and other evidence submitted in support of the application. The Credentialing Office shall query the National Practitioner Data Bank and shall also check the OIG Cumulative Sanction report, the General Services Administration List of Parties Excluded from Federal Procurement and Non-Procurement Programs, and any other appropriate sources to determine whether the applicant has been convicted of a health care related offence or debarred, excluded, or otherwise made ineligible for participation in a Federal Healthcare Program.

4.9.1.3 The applicant shall be notified of any problems in obtaining the information required and it shall be the applicant's obligation to obtain the required information in accordance with the specified time period. Failure to provide the requested documentation with the application or within thirty (30) days after a request therefore will result in the application being incomplete and may be deemed a voluntary withdrawal of the application.

4.9.1.4 When collection and verification are accomplished, the application and accompanying information shall be transmitted to the appropriate Department Chair and/or Division Chief.

4.9.2 Department Action

4.9.2.1 Upon completion of the collection and verification process, the credentials file will be presented to the Division Chief, where applicable, and then to the Department Chair for review. Upon receipt of the credentials file, the Department Chair shall review the application and accompanying documentation and may, when deemed appropriate, conduct a personal interview with the applicant.

4.9.2.2 The Department Chair shall review all matters deemed relevant to an evaluation regarding Medical Staff appointment and/or Privileges including, but not limited to, information concerning the applicant's current clinical competence within the scope of Privileges requested. The Department Chair shall transmit to the MEC Credentials Committee a written evaluation as to approval or denial of Medical Staff appointment and/or Clinical Privileges and any special conditions to be attached.

4.9.3 MEC Credentials Committee Action

4.9.3.1 The MEC Credentials Committee is responsible for reviewing the Department Chair's evaluation, the application, and accompanying documentation upon receipt.

4.9.3.2 The MEC Credentials Committee is then responsible for preparing and submitting a written report to the Medical Executive Committee with its evaluation as to approval or denial of Medical Staff appointment and/or Clinical Privileges and any special conditions to be attached.

4.9.4 Medical Executive Committee Action

4.9.4.1 The Medical Executive Committee ("MEC") shall review the application and accompanying documentation in addition to the evaluations from the Department Chair and MEC Credentials Committee at the MEC's next regularly scheduled meeting following receipt thereof.

4.9.4.2 The Medical Executive Committee shall vote on the pending application and, on the basis thereof, may take any of the following actions:

4.9.4.2.1 **Defer Action**: A decision by the MEC to defer action on the application must be revisited, except for good cause, within thirty (30) days with a subsequent recommendation as to approval or denial of, and any special conditions on, Medical Staff appointment and/or Privileges, Medical Staff category, and Department affiliation.

4.9.4.2.2 **Favorable Action**: If the MEC makes a favorable recommendation regarding the application, the MEC shall

promptly forward its recommendation, together with all accompanying documentation, to the Board.

4.9.4.2.3 **Adverse Recommendation**: If the MEC's recommendation is Adverse to the applicant, the Medical Staff President shall inform the applicant of the recommendation, by Special Notice, and the applicant shall then be entitled, if applicable, to the procedural rights set forth in the Medical Staff Bylaws. No such Adverse recommendation shall be required to be forwarded to the Board until after the applicant has exercised, or has been deemed to have waived, his/her right, if any, to a hearing as provided for in the Medical Staff Bylaws.

4.9.5 Board Action

4.9.5.1 The Board may take any of the following actions with regard to an application for Medical Staff appointment and/or Privileges:

4.9.5.1.1 **Favorable MEC Recommendation**: The Board may adopt or reject any portion of the MEC's recommendation that was favorable to an applicant or refer the recommendation back to the MEC for additional consideration but must state the reason(s) for the requested reconsideration and set a time limit within which a subsequent recommendation must be made.

4.9.5.1.1.1 If the Board's action is favorable, the action shall be effective as its final decision.

4.9.5.1.1.2 If the Board's decision is Adverse to the applicant, the Hospital President shall notify the applicant, by Special Notice, and the applicant shall be entitled, if applicable, to the procedural rights provided for in the Medical Staff Bylaws.

4.9.5.1.2 **Without Benefit of MEC Recommendation**: If the MEC fails to make a recommendation within the time required, the Board may, after informing the MEC of the Board's intent and allowing a reasonable period of time for response by the MEC, make its own determination using the same type of criteria considered by the MEC.

4.9.5.1.2.1 If the Board's action is favorable, the action shall be effective as its final decision.

4.9.5.1.2.2 If the Board's decision is Adverse to the applicant, the Hospital President shall notify the applicant, by Special Notice, and the applicant shall be

entitled, if applicable, to the procedural rights provided for in the Medical Staff Bylaws.

4.9.5.1.3 **Adverse MEC Recommendation**: If the Board is to receive an Adverse Medical Executive Committee recommendation, the Medical Staff President shall withhold the recommendation and not forward it to the Board until after the applicant is notified, by Special Notice, of the Adverse recommendation and the applicant's right, if any, to the procedural rights provided for in the Medical Staff Bylaws, and the Applicant either exercises or waives such rights.

4.9.6 Joint Conference Committee Review

4.9.6.1 Whenever the Board's proposed decision is contrary to the recommendation of the MEC, there shall be further review of the recommendation by an *ad hoc* Joint Conference Committee to the extent such a referral has not previously been made (*e.g.,* pursuant to the hearing/appeal process). This committee shall, after due consideration, make its written recommendation to the Board within ten (10) days after referral to the committee.

4.9.6.2 Thereafter, the Board may act. Such action by the Board may include accepting, rejecting, or modifying, in whole or part, the recommendation of the Joint Conference Committee.

4.9.7 Time Guidelines

4.9.7.1 The following time periods are considered guidelines and do not create any rights for an applicant to have his/her application processed within these precise periods; provided, however, that this provision shall not apply to the time periods contained in Article VII (Hearing and Appeal Procedure) of the Medical Staff Bylaws.

4.9.7.2 When Article VII of the Medical Staff Bylaws is activated by an Adverse recommendation or action as provided herein, the time requirements set forth in Article VII of the Medical Staff Bylaws shall govern the continued processing of the application.

Individual	Time
Credentialing Office	30 Days
Department Chair	30 Days
MEC Credentials Committee	Next regular meeting
Medical Executive Committee	Next regular meeting
Board of Directors	Next regular meeting

4.10 NOTICE OF FINAL DECISION

4.10.1 The Board, through the Hospital President, shall give notice of its final decision to the applicant, by Special Notice, and to the Medical Staff President. The Medical Staff President shall, in turn, communicate the decision to the appropriate Medical Staff leaders and committees.

4.10.2 A decision and notice to appoint and/or grant Clinical Privileges shall include, if applicable:

4.10.2.1 The Medical Staff category to which the applicant is appointed.

4.10.2.2 The Department(s) to which he/she is assigned.

4.10.2.3 The delineated Clinical Privileges granted.

4.10.2.4 Any special condition(s) attached to the appointment and/or Clinical Privileges.

4.11 MEDICAL STAFF REAPPOINTMENT AND/OR REGRANT OF PRIVILEGES

4.11.1 Every Medical Staff appointment and/or grant of Clinical Privileges shall be reviewed at least every twenty-four (24) months. Reappointment/regrant of Privileges shall be for a period of not more than twenty-four (24) months.

4.11.2 Basis

4.11.2.1 Reappointment and/or regrant of Privileges shall be based on all factors bearing upon the Practitioner's:

4.11.2.1.1 Ongoing satisfaction of the qualifications for Medical Staff appointment and/or Privileges set forth in the Medical Staff Bylaws and this Policy.

4.11.2.1.2 Fulfillment of the Medical Staff and Department responsibilities identified in the Medical Staff Bylaws and Policies.

4.11.2.1.3 Compliance with the Medical Staff Bylaws and Policies and applicable Hospital policies and procedures.

4.11.2.1.4 Compliance with Department policies, procedures, and rules and regulations.

4.11.2.1.5 Completion of required continuing education including Hospital mandated education (*e.g.*, I'm 4 Safety, *etc*.) and education required by the applicable State board to maintain current licensure.

4.11.2.1.6 Any other criteria as may be recommended by the MEC and approved by the Board that bears upon the ability of the Practitioner to continue, as applicable, to carry out the duties and responsibilities of Medical Staff appointment and/or to competently exercise the delineated Clinical Privileges.

4.11.2.2 Professional practice evaluation data from focused and ongoing professional practice evaluation activities, including morbidity and mortality information if available, shall be reviewed and considered as part of the reappointment/regrant of Privileges process.

4.11.2.3 Upon regrant of Privileges, when insufficient Practitioner-specific data is available at the Hospital for the Practitioner requesting reappointment/regrant of Privileges, the Medical Staff shall obtain and evaluate additional peer recommendations.

4.11.2.4 If, during the preceding appointment/Privileges period, a Practitioner has not had enough Patient Encounters at the Hospital from which sufficient professional practice evaluation data has been generated to provide a basis for evaluation of the Practitioner's current clinical competence, supplemental performance data may be requested from the hospital at which the Practitioner has his/her primary affiliation for consideration.

4.11.3 Process

4.11.3.1 Prior to the end of the Practitioner's current appointment/Privilege term, he/she will be sent an application for reappointment/regrant of Privileges, as applicable, from the Credentialing Office of the Hospital. There is no application fee associated with reappointment/regrant of Privileges.

4.11.3.2 Completed applications for Medical Staff reappointment and/or regrant of Privileges shall be submitted to the Credentialing Office.

4.11.4 Application for Reappointment/Regrant of Privileges

4.11.4.1 The application for reappointment/regrant of Privileges shall be sufficient in scope to update the information required by Section 4.6 of this Policy necessary to bring the Practitioner's credentials file current **since the last submission of such information** including:

4.11.4.1.1 Present category of Medical Staff appointment and Department affiliation and any request for a change in Medical Staff category with the basis therefore.

4.11.4.1.2 Present delineated Clinical Privileges granted and any request for a change in Clinical Privileges with the basis therefore. A request for new Privileges shall require documentation of additional

education, training, and experience in support of the new Privileges requested and will be subject to focused professional practice evaluation, to assess clinical competency, if granted.

4.11.4.1.3 Number and expiration date of any professional state license and current Drug Enforcement Administration registration (if necessary for the Privileges requested).

4.11.4.1.4 Name of Professional Liability Insurance carrier, manual number, amount of coverage, and assurance that a continuum of insurance is maintained.

4.11.4.1.5 Continuing education activities for which the Practitioner has received credit which relate to the scope of the Practitioner's clinical practice and/or as required by the applicable State board to maintain current licensure.

4.11.4.1.6 A list of all hospitals at which the Practitioner has appointment and/or privileges at the time of reappointment/regrant of Privileges including identification of the category of appointment and type of clinical privileges. Designation of primary affiliation must be confirmed or stated.

4.11.4.1.7 Any change in affiliations with other Practitioners. Any suspension, revocation, or denial of a license to practice taken in any jurisdiction, or any action taken toward that end now pending.

4.11.4.1.8 Any change in or challenge to medical staff appointment or delineated clinical privileges taken by any other facility, hospital, or health care organization.

4.11.4.1.9 Any change in or challenge to any membership or fellowship in any professional associations, affiliations, or organizations.

4.11.4.1.10 Voluntary (while under investigation or to avoid investigation for conduct or clinical competency concerns) or involuntary relinquishment of license or registration; or denial, termination, suspension, or limitation of medical staff appointment and/or delineated clinical privileges at another hospital.

4.11.4.1.11 Any change in or challenge to board certification.

4.11.4.1.12 Any denial or cancellation of Professional Liability Insurance, any and all professional liability actions in which the Practitioner has been named as a party, and any and all claims, judgments, demands, and settlements against him/her.

4.11.4.1.13 Compliance with required immunizations and/or health screenings.

4.11.4.1.14 The Practitioner's continuing ability to safely and competently exercise the Privileges requested with or without a reasonable accommodation.

4.11.4.1.15 Conviction(s), arrest(s), or charge(s) of a felony or misdemeanor (other than minor traffic offenses) including crimes related to children, adolescents, and/or adults.

4.11.4.1.16 Completion of Hospital mandated refresher education (*e.g.,* I'm 4 Safety, *etc.*) as applicable.

4.11.4.1.17 Any additional information required to be reported to the Credentialing Office pursuant to Section 4.7-6.

4.11.5 Collection and Verification

4.11.5.1 Information with respect to applications for Medical Staff reappointment and/or regrant of Privileges shall be collected and verified in accordance with the procedure set forth in Section 4.9-1 of this Policy to the extent applicable.

4.11.6 Review and Action on the Application for Reappointment/Regrant of Clinical Privileges

4.11.6.1 Application for Medical Staff reappointment and/or regrant of Privileges shall be reviewed and acted upon in accordance with the procedure set forth in Section 4.9.2 through Section 4.9.6 of this Policy.

4.11.6.2 For purposes of reappointment and/or regrant of Privileges, the terms "applicant" and "appointment" and "Privileges" as used in Sections 4.9.2 through Section 4.9.6, shall be read as "Practitioner" and "reappointment" and "regrant of Privileges" respectively.

4.11.7 Time Period of Processing Application for Reappointment/Regrant of Clinical Privileges

4.11.7.1 All individuals and groups required to act on an application for Medical Staff reappointment and/or regrant of Privileges must do so in a timely and good faith manner.

4.11.7.2 If an application for reappointment/regrant of Privileges is not submitted or has not been fully processed by the expiration date of the Practitioner's current appointment/Privilege period, the Practitioner's appointment and Privileges shall terminate as of the last date of his/her current appointment/Privilege period. A Practitioner whose appointment and Privileges are so terminated shall not be entitled to the procedural rights

provided in Article VII, Hearing and Appeal Procedures, of the Medical Staff Bylaws.

4.11.7.3 If the Practitioner qualifies, he/she may be granted temporary Privileges to meet an important patient care need pursuant to Section 4.19.2.2 of this Policy.

4.12 REQUESTS FOR MODIFICATIONS OF MEDICAL STAFF APPOINTMENT AND/OR DELINEATED CLINICAL PRIVILEGES

4.12.1 A Practitioner who seeks a change in Medical Staff appointment category and/or modification of delineated Privileges may submit such a request in connection with reappointment/regrant of Privileges, or at any other time, by submitting a written request to the Credentialing Office. A request for modification of Privileges shall include the applicable Delineation of Clinical Privileges form. Such request may not be filed within one (1) year of the time a similar request has been denied.

4.12.2 Requests for new Clinical Privileges during a current appointment/Privilege period must be accompanied by appropriate documentation of training/education supportive of the request and will be subject to focused professional practice evaluation if granted.

4.12.3 A request for modification of Medical Staff appointment and/or Privileges shall be processed in the same manner as an application for Medical Staff reappointment and/or regrant of Privileges.

4.13 REAPPLICATION

4.13.1 Except as otherwise provided in the Medical Staff Bylaws or this Policy, or as otherwise determined by the Board upon recommendation of the MEC in light of exceptional circumstances, a Practitioner:

4.13.1.1 Whose Medical Staff appointment and Privileges are automatically terminated pursuant to Section 6.4.1 (a), (c) or (d) of the Medical Staff Bylaws shall not be eligible to reapply for Medical Staff appointment and/or Privileges for a period of one (1) year from the effective date of the automatic termination.

4.13.1.2 Who has received a final Adverse decision regarding Medical Staff appointment/reappointment and/or Privileges/regrant of Privileges shall not be eligible to reapply for Medical Staff appointment and/or Privileges for a period of one (1) year from the latter of the date of the notice of final Adverse decision or final court decision.

4.13.1.3 Who has resigned his/her Medical Staff appointment and/or Privileges, or withdrawn an application for appointment/reappointment and/or grant/regrant of Privileges while under investigation or to avoid an investigation for professional conduct or clinical competency concerns may

not reapply for Medical Staff appointment and/or Privileges for a period of one (1) year from the effective date of the resignation or application withdrawal.

4.13.1.4 Any such reapplication shall be processed as an initial application, in accordance with the applicable procedure set forth in this Credentials Policy, and the applicant shall submit such additional information as may be required to demonstrate that the basis for the earlier automatic termination, final Adverse decision, or resignation/withdrawal no longer exists or has been corrected. If such information is not provided, the reapplication will be considered incomplete and voluntarily withdrawn and will not be further processed.

4.14 LEAVE OF ABSENCE

4.14.1 Leave Status Requests

4.14.1.1 At the discretion of the Board, upon recommendation of the Medical Executive Committee and Department Chair, a Medical Staff Appointee may for good cause (which may include, but not be limited to, medical reasons, military duty, or educational sabbatical) obtain a voluntary leave of absence. A voluntary leave of absence may be requested by submitting a written request to the Credentialing Office stating the reason for the leave and the approximate period of leave desired. Leaves may not exceed twenty-four (24) months. In the event that a leave of absence extends beyond the final date of the Appointee's current appointment/Privilege period, the Appointee may apply for and be granted Medical Staff reappointment; provided, however, that regranting of his/her Privileges shall be held in abeyance until such time as the Appointee applies for reinstatement of his/her Medical Staff appointment.

4.14.1.2 Prior to a leave of absence being granted, the Appointee shall have made arrangements acceptable to the Medical Executive Committee and Board for the care of his/her patients during the leave.

4.14.1.3 During the period of the leave, the Appointee shall not exercise Clinical Privileges at the Hospital, appointment Prerogatives and responsibilities shall be inactive, and the obligation to pay dues shall be waived.

4.14.1.4 In order to qualify for reinstatement of Medical Staff appointment and, as applicable, reinstatement or regrant of Privileges following a leave of absence, the Appointee must maintain Professional Liability Insurance coverage during the leave or purchase tail coverage for all periods during which the Appointee held Privileges at the Hospital. The Appointee shall provide information to demonstrate satisfaction of continuing Professional Liability Insurance coverage or tail coverage as required by this provision upon request for reinstatement/regrant of Privileges.

4.14.2 Termination of Leave

4.14.2.1 The Medical Staff Appointee may request reinstatement of his/her Medical Staff appointment and, as applicable, reinstatement or regrant of Privileges by submitting a written notice to that effect to the Credentialing Office. A request for reinstatement of Medical Staff appointment and, as applicable, reinstatement or regrant of Privileges shall be submitted not less than thirty (30) days prior to the end of the leave of absence.

4.14.2.2 A summary shall be submitted by the Appointee outlining his/her activities during the leave. The Appointee shall submit such additional information as is necessary to reflect that the Appointee is qualified for reinstatement of Medical Staff appointment and, as applicable, reinstatement or regrant of Privileges.

4.14.2.3 Reinstatement or regrant of Privileges following a leave of absence may be subject to a focused professional practice evaluation period to assess the Practitioner's current clinical competency.

4.14.2.4 When the Appointee's request for reinstatement of Medical Staff appointment and, as applicable, reinstatement or regrant of Privileges is deemed complete, the procedure for reappointment/regrant of Privileges set forth in Section 4.11 of this Policy shall be followed.

4.14.3 Failure to Request Reinstatement/Regrant

4.14.3.1 If an Appointee fails to request reinstatement of Medical Staff appointment and, as applicable, reinstatement or regrant of Privileges upon the termination of a leave of absence, the Medical Executive Committee shall make a recommendation to the Board as to how the failure to request reinstatement/regrant should be construed.

4.14.3.2 If such failure is determined to be a voluntary resignation, it shall not give rise to any rights pursuant to Article VII, Hearing and Appeal Procedures, of the Medical Staff Bylaws.

4.15 DELINEATED CLINICAL PRIVILEGES

4.15.1 A Practitioner who seeks to provide clinical care, treatment, and/or services at the Hospital shall be entitled to exercise only those delineated Clinical Privileges specifically granted.

4.15.2 Practitioners granted Clinical Privileges shall exercise such Privileges in accordance with the applicable Delineation of Clinical Privileges, applicable laws, rules, regulations, and accreditation standards; the Medical Staff governing documents; Department policies and rules and regulation; and applicable Hospital policies.

4.15.3 Delineation of Privileges may be adopted and amended following review by the applicable Department Chair and the MEC Credentials Committee, recommendation of the Medical Executive Committee, and approval by the Board. Privilege sets shall be developed consistent with applicable laws, rules, regulations, and accreditation/professional practice standards.

4.16 **Recognition of a New Service/Procedure**

4.16.1 The Board shall determine the Hospital's scope of patient care services based upon recommendation from the Medical Executive Committee. Overall considerations for establishing new services and procedures include, but are not limited to:

4.16.1.1 The Hospital's available resources and staff.

4.16.1.2 The Hospital's ability to appropriately monitor and review the competence of the performing Practitioner(s).

4.16.1.3 The availability of another qualified Practitioner(s) with Privileges at the Hospital to provide coverage for the service or procedure when needed.

4.16.1.4 The quality and availability of training programs.

4.16.1.5 Whether such service or procedure currently, or in the future, would be more appropriately provided through a contractual arrangement with the Hospital.

4.16.1.6 Whether there is a community need for the service or procedure.

4.16.2 Requests for Privileges for a new service or procedure that has not yet been recognized by the Board shall be processed as follows:

4.16.2.1 The Practitioner must submit a written Privilege request for a new service or procedure to the Credentialing Office. The request should include a description of the Privileges being requested, the reason why the Practitioner believes the Hospital should recognize such Privileges, and any additional information that the Practitioner believes may be of assistance in evaluating the request.

4.16.2.2 The Credentialing Office will notify the Credentials Committee chair of such a request.

4.16.2.2.1 If the Credentials Committee determines that the service or procedure should not be recognized at the Hospital, the MEC Credentials Committee will provide the basis for its recommendation to the MEC.

4.16.2.2.2 If the MEC Credentials Committee determines that the service or procedure can or should be included in an existing Privilege set, the MEC Credentials Committee shall request that the applicable

Department submit to the committee a revised Privilege set for review. The MEC Credentials Committee will provide the basis for its recommendation to the MEC along with proposed revisions to the existing Privilege set.

4.16.2.2.3 If the MEC Credentials Committee decides to recommend that the new Privileges be recognized at the Hospital, the MEC Credentials Committee shall request that the applicable Department develop and submit to the MEC Credentials Committee a new Privilege set based upon:

4.16.2.2.3.1 A determination as to what specialties are likely to request the Privileges.

4.16.2.2.3.2 The positions of specialty societies, certifying boards, etc.

4.16.2.2.3.3 The available training programs.

4.16.2.2.3.4 Recommended standards to be met with respect to the following: education; training; fellowship/board status; experience; and, focused professional practice evaluation requirements to establish current competency.

4.16.2.2.3.5 Criteria required by other hospitals with similar resources and staffing.

4.16.2.3 Upon receipt of a recommendation from the MEC Credentials Committee, the MEC will act. The recommendation of the MEC whether favorable or not favorable, will be forwarded to the Board for review and action.

4.16.2.4 The Board will act on the recommendation from MEC by either:

4.16.2.4.1 Approving the new service or procedure. The Practitioner(s) request for Privileges fur such service/procedure may then be acted upon consistent with the Medical Staff Bylaws and this Policy.

4.16.2.4.2 Denying the request for the new service or procedure in which case the Practitioner(s) will be so notified. A decision by the Board not to recognize a new service or procedure does not constitute an appealable event.

4.16.3 Requests for Clinical Privileges

4.16.3.1 Each application for appointment and reappointment to the Medical Staff must contain a request for the specific delineated Clinical Privileges desired by the Practitioner or applicant, if any.

4.16.3.2 A request by a Practitioner for a modification of delineated Clinical Privileges may be made at any time in accordance with Section 4.12.

4.16.3.3 Requests for temporary, disaster, moonlighting, or telemedicine Privileges, without Medical Staff appointment, shall be submitted in writing in accordance with the applicable respective procedure set forth in this Policy.

4.16.4 Documentation for Review and Evaluation

4.16.4.1 Applicants requesting Clinical Privileges or regrant of Clinical Privileges at the Hospital shall provide such information for review and evaluation as set forth in Section 3.3.1 and Section 3.3.2 of the Medical Staff Bylaws and, as applicable, Sections 4.6 and 4.11 of this Credentials Policy with the exception that applicants requesting temporary, disaster, moonlighting, or telemedicine Privileges shall provide such information as set forth in the applicable respective section set forth in this Policy.

4.16.5 Procedures for Processing Requests for Delineated Privileges

4.16.5.1 Requests for Clinical Privileges and regrant of Clinical Privileges shall be processed in accordance with the procedures outlined, as applicable, in Section 4.9 or 4.11 of this Credentials Policy with the exception that:

4.16.5.1.1 Requests for temporary Privileges shall be processed according to the procedure set forth in Section 4.19.

4.16.5.1.2 Requests for disaster Privileges shall be processed according to the procedure set forth in Section 4.21.

4.16.5.1.3 Requests for telemedicine Privileges shall be processed according to the procedure set forth in Section 4.22.

4.16.5.1.4 Requests for moonlighting Privileges shall be processed according to the procedure set forth in Section 4.23.

4.16.6 Focused and Ongoing Professional Practice Evaluation

4.16.6.1 The Hospital's focused professional practice evaluation ("FPPE") process is set forth in detail, in the Medical Staff Professional Practice Evaluation and Peer Review Policy (#1.29) and shall be implemented for all: (i) Practitioners requesting initial Privileges; (ii) existing Practitioners requesting new Privileges during the course of an appointment/Privilege period; and, (iii) in

response to concerns regarding a Practitioner's ability to provide safe, high quality patient care. The FPPE period shall be used to determine the Practitioner's current clinical competence and ability to perform the requested Privileges. If a Practitioner resigns while under an FPPE for quality of care/clinical competency concerns, the Practitioner will be subject to reporting to the National Practitioner Data Bank.

4.16.6.2 Upon conclusion of the FPPE period, ongoing professional practice evaluation ("OPPE") shall be conducted on all Practitioners with Privileges. The Hospital's OPPE process is set forth, in detail, in the Medical Staff Professional Practice Evaluation and Peer Review Policy (#1.29) and requires the Hospital to gather, maintain, and review data on the performance of all Practitioners with Privileges on an ongoing basis.

4.16.7 Conditions for Dental, Podiatry, and Psychology Privileges

4.16.7.1 Division of Dentistry

4.16.7.1.1 Dentists and Oral-maxillofacial Surgeons shall be members of the Department of Surgery and may admit patients to the Hospital if granted admitting Privileges. All patients admitted for dental care shall receive the same basic medical appraisal as patients admitted for other surgical services.

4.16.7.1.2 A Physician Appointee with appropriate delineated Clinical Privileges shall be designated by the Dentist to be responsible for the evaluation and care of any medical problems that may be present at the time of admission or that may arise during hospitalization outside the scope of practice of the Dentist and shall determine the risk and effect of the proposed procedure on the total health status of the patient. The Physician shall be designated by the Dentist to perform an admission medical history and physical examination (H&P), except in cases where the Oral-maxillofacial Surgeon has been granted Clinical Privileges to perform such H&P.

4.16.7.1.3 Oral-maxillofacial Surgeons may be granted the Clinical Privilege of performing H&Ps on patients they admit to the Hospital. Minimum qualifications for consideration of such Privileges will be board certification and/or eligibility, consistent with the requirements set forth in the Medical Staff Bylaws, and the completion of a minimum of four years postgraduate training in an approved hospital-based program for Oral-maxillofacial Surgeons.

4.16.7.1.4 This section does not relieve a Dentist of the responsibility for: the dental diagnosis; completion of the dental portion of the

H&P; performing the procedure and any and all complications arising from his/her treatment of the patient; and, completion of the medical record such as it relates to his/her dental care of the patient including, but not limited to, documentation of a complete operative report, progress notes, and the discharge summary.

4.16.7.2 Division of Podiatry

4.16.7.2.1 Podiatrists shall be members of the Department of Orthopaedics and may admit patients to the Hospital if granted admitting Privileges. All patients admitted for podiatric care shall receive the same basic medical care appraisal as patients admitted for other orthopaedic procedures.

4.16.7.2.2 A patient admitted solely for the purpose of receiving podiatric services must be under the supervision of the admitting Podiatrist. Podiatrists may be granted the Clinical Privilege of performing H&Ps on patients that they admit to the Hospital. The Podiatrist shall arrange for a Physician Appointee with appropriate Privileges to complete the H&P for patients admitted to the Hospital by the Podiatrist if the Podiatrist is not otherwise granted the Privilege of performing the H&P.

4.16.7.2.3 A podiatric patient requiring care, treatment, and/or services beyond the scope of practice of the Podiatrist at the time of admission, or during hospitalization, must receive such non-podiatric medical care, treatment, and/or services from a Physician who is an Appointee of the Medical Staff with appropriate Clinical Privileges.

4.16.7.2.4 The admitting Podiatrist must make arrangements through appropriate consultation for necessary non-podiatric medical care required during the patient's stay.

4.16.7.3 Division of Psychology

4.16.7.3.1 Psychologists shall be members of the Department of Psychiatry.

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

4.16.7.3.3 A Psychologist shall be responsible for completion of the medical record such as it relates to his/her psychiatric care of the patient

including, but not limited to documentation of the psychiatric diagnosis, the psychiatric portion of the H&P, progress notes, and the discharge summary.

4.16.8 Scientific Medical Staff

4.16.8.1 Practitioners appointed to the scientific Medical Staff shall be assigned to an appropriate Medical Staff Department. They shall not have admitting Privileges.

4.17 CONFIDENTIALITY & PEER REVIEW PROTECTION

4.17.1 The purpose of this section is to maintain the confidentiality of the following in compliance with Ohio Revised Code Section 2305.25 *et seq.*

4.17.1.1 All peer review files and other records, documentation, and information generated by or on behalf of a peer review committee

4.17.1.2 Peer review discussions

4.17.1.3 Deliberations relating to Practitioner/APP credentialing, appointment, privileging, conduct, and clinical competence (*e.g.,* collegial intervention, informal remediation, corrective action, summary suspension, hearings/appeals)

4.17.1.4 Peer quality review

4.17.1.5 Quality improvement activities

4.17.2 Disclosure of the aforementioned information shall be permitted only as directed in this section.

4.17.3 Location and Security

4.17.3.1 The Credentialing Office/CVO, Hospital Quality Department, and file cabinets where peer review files/records are stored shall be kept locked, except when an authorized Hospital representative supervises access.

4.17.3.2 Peer review files/records stored electronically shall be protected by passwords and read/write control.

4.17.4 Access to Records

4.17.4.1 All requests for access to peer review files/records must be presented to the Hospital President, Medical Staff President, Vice President of Medical Affairs, or Vice President of Surgical Affairs who is authorized to grant or deny such access.

4.17.4.2 A record of requests made and granted/denied shall be retained by the Credentialing Office/CVO or Hospital Quality Department, as applicable.

4.17.4.3 The following individuals may access peer review records/files to the extent described subject to completion of a Confidentiality Agreement as determined necessary by Hospital legal counsel. Such confidentiality agreements will be maintained by the Hospital.

4.17.4.3.1 Authorized Hospital representatives as needed to fulfill their responsibilities.

4.17.4.3.2 Consultants or attorneys engaged by the Hospital and whom the Hospital President has determined has a need to know information contained within such peer review files/records.

4.17.4.3.3 Representatives of regulatory or accreditation agencies upon proper request.

4.17.4.3.4 Authorized representatives from organizations for whom the Hospital performs delegated credentialing services relating to records pertaining to their applicants or participating providers, provided that each applicant or participating provider has completed a satisfactory authorization and release form.

4.17.4.3.5 An individual Practitioner/APP may review his or her credentials file under the following circumstances:

4.17.4.3.5.1 The request is approved pursuant to Section 4.17.4.1.

4.17.4.3.5.2 Review of the file is accomplished in the presence of the Vice President of Medical Affairs or Vice President of Surgical Affairs, or his/her designee.

4.17.4.3.5.3 A Practitioner/APP may have access to review peer review information that the Practitioner/APP submitted to the Hospital, that is addressed to the Practitioner/APP, or that was provided by the Hospital to the Practitioner/APP initially.

4.17.4.3.5.4 The Practitioner/APP understands that he or she may not remove any items from the credentials file.

4.17.4.3.5.5 The Practitioner/APP understands that he or she may add an explanatory note or other

documentation to the file to further explain any questioned information.

4.17.4.3.5.6 The Practitioner/APP understands that he or she may not review confidential letters of reference received.

4.17.4.3.5.7 If an individual has submitted peer review information and has been guaranteed anonymity pursuant to an applicable Hospital/Medical Staff policy or an appropriately authorized Hospital/Medical Staff leader, such document(s) must either be redacted; or, if redaction fails to properly protect the individual's identity, the document(s) must be removed from the Practitioner's/APP's peer review file prior to review. The document will be replaced in the peer review file following the Practitioner's/APP's review.

4.17.4.3.5.8 No items may be photocopied without the express written permission of the Vice President of Medical Affairs or the Vice President of Surgical Affairs.

4.17.4.4 All subpoenas pertaining to Medical Staff files/records (peer review – credentials/quality files) shall be referred to the authorized Hospital representative who shall first consult with Hospital legal counsel regarding the appropriate response.

4.17.4.5 Records that are requested by persons or organizations outside of the Hospital shall be provided upon approval pursuant to Section 4.17.4.1.

4.17.4.6 All information in a Practitioner's/APP's peer review files must be treated as confidential and cannot be released without approval pursuant to Section 4.17.4.1.

4.18 VISITING PRACTITIONER– OBSERVATION ONLY

4.18.1 Practitioners who are not current Medical Staff Appointees with Privileges at the Hospital and who may or may not be licensed in the State of Ohio may come to the Hospital to observe a procedure either in the surgical suite or in any Hospital department where procedures are performed.

4.18.2 At least one week prior to the Practitioner coming to the Hospital, the sponsoring Department and/or Appointee must send a letter to the Credentialing Office with the following information regarding the visiting Practitioner:

4.18.2.1 Procedure that will be observed. This information should include the date, time, and Medical Staff Appointee to be observed.

4.18.2.2 Name of visiting Practitioner.

4.18.2.3 Office address.

4.18.2.4 Specialty.

4.18.2.5 Hospital where the visiting Practitioner holds current medical staff appointment and privileges.

4.18.2.6 Copy of visiting Practitioner's license.

4.18.3 The Credentialing Office will forward this information to the Department Chair for approval.

4.18.4 The Credentialing Office will send notification to the Hospital department where the procedure will be observed (e.g., surgery, radiology, cardiac cath lab, etc.).

4.18.5 The Credentialing Office will keep the information regarding the visiting Practitioner on file.

4.18.6 The Medical Staff Appointee with Privileges at the Hospital who will be performing the procedure will obtain consent from the patient, or the patient's authorized representative, for observation of the surgery/procedure by the visiting Practitioner.

4.19 TEMPORARY PRIVILEGES

4.19.1 Conditions

4.19.1.1 Temporary Privileges may be granted only in the circumstances and under the conditions described below.

4.19.1.2 Special requirements of consultation and reporting may be imposed by the Department Chair responsible for the supervision of the Practitioner exercising temporary Privileges as applicable.

4.19.1.3 Under all circumstances, the Practitioner requesting temporary Privileges must agree in writing to abide by the Medical Staff Bylaws and policies of the Medical Staff and those of the Hospital in all matters relating to his/her activities in the Hospital.

4.19.2 Circumstances

Upon written recommendation of the Department Chair and Medical Staff President, the Hospital President may grant temporary Privileges on a case-by-case basis in the following circumstances:

4.19.2.1 Pendency of a Completed Application

To an applicant for new Privileges with a complete application that raises no concerns who is awaiting review and approval by the Medical Executive Committee and Board but only after:

4.19.2.1.1 Receipt of a completed application including a request for specific temporary Privileges.

4.19.2.1.2 Verification of the following:

4.19.2.1.2.1 Current licensure

4.19.2.1.2.2 Relevant training/experience

4.19.2.1.2.3 Current competence

4.19.2.1.2.4 Ability to perform the Clinical Privileges requested

4.19.2.1.2.5 Other criteria required by the Medical Staff Bylaws and Policies for a completed application

4.19.2.1.3 A query and evaluation of the National Practitioner Data Bank Information.

4.19.2.1.4 Along with the completed application, the record must establish that the applicant has no current or previously successful challenges to his/her licensure or registration; has not been subject to involuntary termination from a medical staff appointment at any other organization; has not been subject to any involuntary limitation, reduction, denial or loss of clinical privileges; and has not been suspended or terminated from any Federal Healthcare Program.

4.19.2.1.5 For purposes of this section, an “applicant for new Privileges” includes: a Practitioner applying for Clinical Privileges at the Hospital for the first time; a Practitioner currently holding Clinical Privileges who is requesting one or more additional Privileges; and a Practitioner who is in the reappointment/regrant of Privileges process and is requesting one or more additional Privileges.

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

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

4.19.2.2 Important Patient Care, Treatment and/or Service Need

To a Practitioner to meet an important patient care, treatment, and/or service need but only after:

4.19.2.2.1 Receipt of a written request for the specific temporary Privileges desired.

4.19.2.2.2 Telephonic confirmation (or receipt of a copy) of current, valid licensure, DEA/controlled substances registration (if necessary for the Privileges requested), and adequate Professional Liability Insurance.

4.19.2.2.3 A fully positive written or oral reference specific to the Practitioner's current competence relative to the Privileges being requested from a responsible medical staff authority at the Practitioner's current hospital affiliation.

4.19.2.2.4 NPDB and OIG database queries must be completed and reviewed before granting temporary Privileges in this instance.

4.19.2.2.5 Temporary Privileges may be granted in this circumstance for an initial period of up to thirty (30) days and may be renewed for additional periods of up to thirty (30) days as necessary for an important patient care, treatment, and or service need. In no event may temporary Privileges exceed one hundred twenty (120) days.

4.19.2.3 Termination of Temporary Privileges

4.19.2.3.1 The Hospital President, Vice President of Medical Affairs, Vice President of Surgical Affairs, or Medical Staff President shall terminate a Practitioner's temporary Privileges:

4.19.2.3.1.1 For failure to abide by the Medical Staff Bylaws or policies of the Hospital or Medical Staff.

4.19.2.3.1.2 Upon the discovery of any information or the occurrence of any event that raises a question about a Practitioner's professional qualifications or ability to exercise any or all of the Privileges granted.

4.19.2.3.2 The Hospital President, Vice President of Medical Affairs, Vice President of Surgical Affairs, or Medical Staff President may at any time revoke any or all of a Practitioner's temporary Privileges.

4.19.2.3.3 Where the life or well-being of a patient is determined to be endangered, the Practitioner's temporary Privileges may be terminated by any person entitled to impose a summary suspension pursuant to the Medical Staff Bylaws.

4.19.2.3.4 A Practitioner who has been granted temporary Privileges is not an Appointee to the Medical Staff and is not entitled to the procedural due process rights afforded to Appointees. A Practitioner shall not be entitled to the procedural due process rights set forth in the Medical Staff Bylaws because the Practitioner's request for temporary Privileges is refused, in whole or in part, or because all or any portion of such Privileges are terminated, not renewed, restricted, suspended, or otherwise limited, modified, or monitored in any way. Refusal to grant a Practitioner temporary Privileges or termination of a Practitioner's temporary Privileges is not a reportable event for purposes of federal or state law.

4.19.2.3.5 In the event a Practitioner's temporary Privileges are restricted, suspended, or terminated, the Practitioner's patients then in the Hospital shall be assigned to another Practitioner by the appropriate Department Chair. The wishes of the patient will be considered, where feasible, in choosing a substitute Practitioner.

4.20 EMERGENCY PRIVILEGES

4.20.1 In the case of an emergency, any Medical Staff Appointee with Privileges is permitted to provide any type of patient care, treatment, and/or services necessary as a life-saving measure or to prevent serious harm regardless of his/her Medical Staff status or Privileges provided that the care, treatment, and services provided are within the scope of the Practitioner's license. An Appointee exercising emergency Privileges may use every facility of the Hospital necessary including calling for any consultation(s) necessary or desirable. When an emergency situation no longer exists, such Practitioner must request the Clinical Privileges necessary to continue to treat the patient if the Practitioner is not already granted such. In the event such Clinical Privileges are denied or the Practitioner does not desire to request such Clinical Privileges, the patient shall be assigned to an Appointee of the Medical Staff with appropriate Privileges.

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

4.20.3 Emergency Privileges shall automatically terminate upon alleviation of the emergency situation. A Practitioner who exercises emergency Privileges shall not be entitled to the procedural rights set forth in the Medical Staff Bylaws.

4.21 DISASTER PRIVILEGES

4.21.1 Volunteer Practitioners who do not possess Clinical Privileges at the Hospital may be granted disaster Privileges when the Hospital's Emergency Operations Plan has been activated in response to an externally officially declared disaster, whether it is local, state or national, and the Hospital is unable to meet immediate patient needs.

4.21.2 The Hospital President, Vice President of Medical Affairs, Vice President of Surgical Affairs, or the Administrator-on-Call may grant disaster Privileges on a case-by-case basis after verification of a current, valid government-issued photo identification issued by a state or federal agency (e.g., driver's license or passport) and at least one of the following: (i) a current picture identification card from a health care organization that clearly identifies professional designation; (ii) a current license to practice, (iii) primary source verification of licensure, (iv) identification indicating that the individual is a member of a Disaster Medical Assistance Team ("DMAT"), the Medical Reserve Corps. ("MRC"), the Emergency System for Advance Registration of Volunteer Health Professionals ("ESAR-VHP") or other state or federal response organization or group; (v) identification indicating the individual has been granted authority to render patient care, treatment, or services in disaster circumstances by a government agency; or, (vi) confirmation by a Practitioner currently privileged by the Hospital or by a Hospital staff member with personal knowledge of the volunteer Practitioner and his/her professional qualifications.

4.21.3 The volunteer Practitioner must present himself/herself to the Credentialing Office where the above information will be collected by credentials staff. If the above items are available, the Hospital President, Vice President of Medical Affairs, Vice President of Surgical Affaires, or the Administrator-on-Call may grant disaster Privileges.

4.21.4 The volunteer Practitioner will be referred to Protective Services for a temporary ID badge according to Protective Services procedure.

4.21.5 The volunteer Practitioner may act only under the supervision of an assigned Hospital Medical Staff Appointee with appropriate Clinical Privileges.

4.21.6 Primary source verification of licensure occurs as soon as the disaster is under control or within 72 hours from the time the volunteer Practitioner presents himself/herself to the Hospital, whichever comes first. If primary source verification of a volunteer Practitioner's licensure cannot be completed within 72 hours of the Practitioner's arrival due to extraordinary circumstances, the Hospital documents all of the following: reasons primary source verification of licensure could not be performed within 72 hours of the Practitioner's arrival; evidence of the Practitioner's demonstrated ability to continue to provide adequate care, treatment, and services; and evidence of the Hospital's attempt to perform primary source verification as soon as possible. If, due to extraordinary circumstances, primary source verification of licensure of the volunteer Practitioner

cannot be completed within 72 hours of the Practitioner's arrival, it is performed as soon as possible. Based on its oversight of each volunteer Practitioner, the Hospital determines within 72 hours of the Practitioner's arrival if granted disaster Privileges should continue.

4.21.7 The credentialing staff may also request a report from the National Practitioner Data Bank that will become a part of the volunteer Practitioner's credentials file. A record of all information regarding the volunteer Practitioner will be retained in the Credentialing Office.

4.21.8 The volunteer Practitioner's disaster Privileges will continue for the duration of the disaster only (unless sooner terminated by the volunteer Practitioner or authorized Hospital representative) and will automatically terminate at the end of the disaster as determined by the Hospital President or Administrator-on-Call.

4.21.9 A Practitioner's disaster Privileges will be immediately terminated in the event any information received through the verification process indicates any adverse information or suggests the volunteer Practitioner is not capable of competently rendering care, treatment, and/or services in a disaster. The Hospital President, Vice President of Medical Affairs, Vice President of Surgical Affairs, or Medical Staff President may, at any time, revoke any or all of a volunteer Practitioner's disaster Privileges. Where the life or well-being of a patient is determined to be endangered, a volunteer Practitioner's disaster Privileges may be terminated by any person entitled to impose a summary suspension pursuant to the Medical Staff Bylaws.

4.21.10 A volunteer Practitioner who has been granted disaster Privileges is not an Appointee to the Medical Staff and is not entitled to the procedural due process rights afforded to Appointees. A volunteer Practitioner shall not be entitled to the procedural due process rights set forth in the Medical Staff Bylaws because the volunteer Practitioner's request for disaster Privileges is refused, in whole or in part, or because all or any portion of such disaster Privileges are terminated, not renewed, restricted, suspended, or otherwise limited, modified, or monitored in any way. Refusal to grant a volunteer Practitioner disaster Privileges or termination of a volunteer Practitioner's disaster Privileges is not a reportable event for purposes of federal or state law.

4.22 TELEMEDICINE PRIVILEGES

4.22.1 The Board will determine the clinical services to be provided through telemedicine after considering the recommendations of the appropriate Department Chair and appropriate Medical Staff committees.

4.22.2 Individuals providing telemedicine services shall be credentialed and granted telemedicine Privileges in accordance with this section, and applicable laws, rules, regulations, and accreditation standards, but will not be appointed to the Medical Staff. The contractual arrangement that authorizes Practitioners to provide telemedicine services at the Hospital will address quality review and assessment mechanisms that are designed to promote the provision of safe and competent services.

4.22.3 If the Hospital has a pressing clinical need and the Practitioner can supply that service through a telemedicine link, the Practitioner may be evaluated for temporary Privileges in accordance with the procedure set forth in Section 4.19 of this Policy.

4.22.4 In processing a request for telemedicine Privileges pursuant to this section:

4.22.4.1 Practitioners may be credentialed and privileged by the Hospital in accordance with the routine procedure set forth, as applicable, in Section 4.9 or 4.11 of this Policy; or

4.22.4.2 Practitioners may be credentialed and privileged by the Hospital in accordance with the routine procedure set forth, as applicable, in Section 4.9 or 4.11 of this Policy with the exception that the credentialing information and/or privileging decision from the distant site may be relied upon by the Medical Staff and Board in making its recommendation/decision provided that the Hospital has entered into a written agreement with the distant site and all of the following requirements are met:

4.22.4.2.1 The distant site is a Medicare participating hospital or a facility that qualifies as a "distant site telemedicine entity." A "distant site telemedicine entity" is defined as an entity that (1) provides telemedicine services, (2) is not a Medicare participating hospital, and (3) provides contracted services in a manner that enables hospitals using its services to meet all applicable conditions of participation, particularly those requirements related to the credentialing and privileging of practitioners providing telemedicine services to the patients of the hospital.

4.22.4.2.2 When the distant site is a Medicare participating hospital, the written agreement shall specify that it is the responsibility of the distant site hospital to meet the credentialing requirements of 42 C.F.R. 482.12 (a)(1)-(a)(7), as that provision may be amended from time to time, with regard to the distant site hospital Practitioners providing telemedicine services.

4.22.4.2.3 When the distant site is a "distant site telemedicine entity" the written agreement shall specify that the distant site telemedicine entity is a contractor of services to the Hospital and, as such, furnishes the contracted services in a manner that permits the Hospital to comply with all applicable conditions of participation for the contracted services including, but not limited to, 42 C.F.R. 482.12(a)(1)-(a)(7), with regard to the distant site telemedicine entity Practitioners providing telemedicine services. The written agreement shall further specify that the distant site telemedicine entity's medical staff credentialing and privilege process and standards will, at minimum, meet the standards of 42 C.F.R

482.12(a)(1)-(a)(7) and at 42 C.F.R. 482.22(a)(1)-(a)(2), as those provisions may be amended from time to time.

4.22.4.2.4 Each individual distant site Practitioner is privileged at the distant site for those services to be provided to Hospital patients via telemedicine link and the Hospital is provided with a current list of his/her privileges at the distant site.

4.22.4.2.5 Each individual distant site Practitioner holds an appropriate license or telemedicine certificate issued by the State Medical Board of Ohio or other appropriate licensing entity in addition to an appropriate license in the State in which the Practitioner is located, if other than Ohio.

4.22.4.2.6 The distant site must be accredited by The Joint Commission.

4.22.4.2.7 The Hospital must query the National Practitioner Data Bank with respect to each distant site Practitioner.

4.22.4.2.8 The Hospital maintains documentation of its internal review of the performance of each distant site Practitioner and sends the distant site such performance information for use in the distant site's periodic appraisal of the distant site Practitioner. At a minimum, this information must include:

4.22.4.2.8.1 All adverse events that result from the telemedicine services provided by the distant site Practitioner to Hospital patients; and

4.22.4.2.8.2 All complaints the Hospital receives about the distant site Practitioner.

4.22.4.2.9 Telemedicine Practitioners shall be subject to the Hospital's performance improvement, professional practice evaluation, and peer review activities as applicable.

4.22.5 The Hospital President, Vice President of Medical Affairs, Vice President of Surgical Affairs, or Medical Staff President may at any time revoke any or all of a Practitioner's telemedicine Privileges. Where the life or well-being of a patient is determined to be endangered, the Practitioner's telemedicine Privileges may be terminated by any person entitled to impose a summary suspension pursuant to the Medical Staff Bylaws. A Practitioner who has been granted telemedicine Privileges is not an Appointee to the Medical Staff and is not entitled to the procedural due process rights afforded to Appointees. A Practitioner shall not be entitled to the procedural due process rights set forth in the Medical Staff Bylaws because the Practitioner's request for telemedicine Privileges is refused, in whole or in part, or because all or any portion of such Privileges

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

4.23 MOONLIGHTING PRIVILEGES

4.23.1 Moonlighting Privileges may be granted to fellows or residents who:

4.23.1.1 Have and maintain a current, valid medical license (not a training certificate) from the State Medical Board of Ohio and satisfy such other qualifications set forth in Sections 3.3-1 and 3.3-2 of the Medical Staff Bylaws as determined by the MEC to be applicable to a moonlighting resident or fellow.

4.23.1.2 Have satisfactorily completed at least two (2) years of postgraduate training in an approved and accredited residency program.

4.23.1.3 Obtain prior written approval of the director of the applicable fellowship or residency program.

4.23.1.4 Are in good standing in his/her fellowship or residency program as verified by the director of such program.

4.23.1.5 Are requesting Privileges to provide clinical care, treatment, and/or services to patients at the Hospital outside their fellowship or residency program.

4.23.2 Fellows and residents on J-1 visas are not permitted to request moonlighting Privileges.

4.23.3 A moonlighting fellow or resident must request and be granted Privileges prior to providing any clinical care, treatment, and/or services to patients at the Hospital outside his/her fellowship or residency program.

4.23.4 Special requirements of consultation and reporting may be imposed at such time as moonlighting Privileges are granted.

4.23.5 A moonlighting fellow or resident must agree, in writing, to abide by the Medical Staff Bylaws and Policies and the policies of the Hospital in all matters relating to his/her activities at the Hospital.

4.23.6 Moonlighting must not interfere with the ability of the fellow or resident to otherwise achieve the goals and objectives of his/her fellowship or residency education/training program.

4.23.7 The moonlighting fellow or resident will be subject to FPPE and OPPE with respect to the moonlighting Privileges granted in accordance with the procedures set forth in applicable Medical Staff policies.

4.23.8 Permission for moonlighting may be withdrawn if the moonlighting fellow's or resident's program director believes the fellow's or resident's education/training is negatively impacted as a result of his/her moonlighting activities.

4.23.9 A request for moonlighting Privileges shall be processed in accordance with the routine credentialing and privileging process set forth in Section 4.9 or Section 4.11, as applicable.

4.23.10 Moonlighting Privileges may be granted/regranted for a period of up to two (2) years as recommended by the MEC and approved by the Board.

4.23.11 The Hospital President, Vice President of Medical Affairs, Vice President of Surgical Affairs, or Medical Staff President may at any time revoke any or all of a resident's or fellow's moonlighting Privileges. Where the life or well-being of a patient is determined to be endangered, the resident's or fellow's moonlighting Privileges may be terminated by any person entitled to impose a summary suspension pursuant to the Medical Staff Bylaws. A resident or fellow who has been granted moonlighting Privileges is not an Appointee to the Medical Staff and is not entitled to the procedural due process rights afforded to Appointees. A resident or fellow shall not be entitled to the procedural due process rights set forth in the Medical Staff Bylaws because the resident's or fellow's request for moonlighting Privileges is refused, in whole or in part, or because all or any portion of such Privileges are terminated, not renewed, restricted, suspended, or otherwise limited, modified, or monitored in any way.

4.23.12 In the event a Practitioner's or fellow's/resident's Privileges are revoked, the Practitioner's or fellow's/resident's patients then in the Hospital shall be assigned to another Practitioner by the applicable Department Chair/Section Head. The wishes of the patient will be considered, where feasible, in choosing a substitute Practitioner.

4.24 VOLUNTARY RESIGNATION OF MEDICAL STAFF APPOINTMENT AND/OR PRIVILEGES RESIGNATION

4.24.1 Resignation of Medical Staff appointment and/or Privileges, and the reason for such resignation, shall be submitted in writing to the Credentialing Office. Notification of the resignation shall be forwarded to the appropriate Medical Staff committees and Hospital personnel for information. The Practitioner will be notified of the Board's receipt and acceptance of his/her resignation.

4.24.2 A Practitioner who resigns his/her Medical Staff appointment and/or Privileges is obligated to complete all medical records for which he/she is responsible prior to the effective date of the resignation. In the event a Practitioner fails to do so, consideration may be given by the Hospital to contacting the applicable State licensing board regarding the Practitioner's actions.

4.24.3 Provided that resignation of Medical Staff appointment and/or Privileges pursuant to this section is determined by the Board to be voluntary, such resignation shall not give rise to any procedural due process rights set forth in the Medical Staff Bylaws.

4.24.4 A request for appointment and/or Privileges subsequently received from a Practitioner who resigns his/her Medical Staff appointment/Privileges pursuant to this section be submitted and processed in the manner specified for applications for initial Medical Staff appointment and/or Privileges.

5.0 **Procedure**

5.1 Not applicable.

6.0 **Responsibilities and Authorities**

6.1 The Credentials Policy is a Medical Staff Policy and shall be the responsibility of the Medical Staff. Adoption and amendment of the Credentials Policy requires the approval of the Medical Executive Committee and the Hospital Board in accordance with the applicable procedure set forth in the Medical Staff Bylaws.

7.0 **Records**

7.1 The current copy of the Medical Staff Credentials Policy will be maintained by the Credentialing Office on behalf of the Medical Staff.

8.0 **References**

8.1 Summa Health System Medical Staff Bylaws

8.2 The Joint Commission Medical Staff Standards

8.3 Medicare Hospital Conditions of Participation

9.0 **Key Words or Aliases (Optional)**

9.1 Not applicable.

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