THE MEDICAL STAFF CREDENTIALS POLICY

Part of the Yakima Valley Memorial

Medical Staff Bylaws, Policies, & Rules & Regulations

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MEDICAL STAFF CREDENTIALS POLICY
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ARTICLE 1
GENERAL

1.A. DEFINITIONS

The following definitions apply to capitalized terms used in the Medical Staff Bylaws, the Credentials Policy, and the Organization Manual:

(1) "ADVANCED PRACTICE PROFESSIONALS" ("APPs") means individuals other than Members of the Medical Staff who are authorized by law and by the Hospital to provide a medical level of care or perform surgical tasks consistent with the Clinical Privileges granted to the APP, but who are required by law and/or the Hospital to exercise some or all of those Clinical Privileges pursuant to a written sponsorship/ Supervision/ collaborative agreement with a Supervising/ Collaborating Practitioner. Appendix A of this Policy includes a list of those categories of Advanced Practice Professionals that have been authorized by the Board to practice at the Hospital and the Appendix may be updated at any time to reflect new categories that are authorized to practice pursuant to this Policy, without the need to follow the process for amending the Policy.

(2) "AFFILIATED ENTITY" means any entity which directly or indirectly, through one or more intermediaries, controls, is controlled by, or is under common control with the Hospital.

(3) "APPLICANT" means an individual who has submitted an Application for Membership and/or Clinical Privileges (for example, a request for temporary Privileges).

(4) "APPLICATION" means a request for consideration for Membership or Clinical Privileges, which shall include a request for all information required by Washington law, amongst other things. The fact that an individual is provided an Application form, that an Application form is accepted from the individual, or the form is verified or processed in part does not imply a determination that the individual is eligible to apply or eligible for Membership or Clinical Privileges. Rather, eligibility determinations will be specifically made as described in the Medical Staff Bylaws and the Credentials Policy.

(5) "BOARD" or "BOARD OF DIRECTORS" means the governing body of the Hospital, which delegates specific authority and responsibility to the Medical Staff, in accordance with the Medical Staff Bylaws and other Medical Staff Rules and Regulations and policies.

(6) "BOARD CERTIFICATION" or "BOARD CERTIFIED" is the designation conferred by one of the affiliated specialties of the American Board of Medical Specialties, the American Osteopathic Association, the American Board of Oral

and Maxillofacial Surgery, the American Board of Podiatric Medicine, or the American Board of Foot and Ankle Surgery, upon a Physician, Dentist, or Podiatrist, as applicable, or, for an Advanced Practice Professional, the designation conferred by a certifying body approved by the Hospital, as set forth in Hospital policy and/or the relevant delineation of Clinical Privileges.

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

(8) "CHIEF MEDICAL OFFICER" means the individual appointed by the Hospital to act as the Chief Medical Officer of the Hospital, at the direction of the CEO and in cooperation with the President of the Medical Staff.

(9) "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.

(10) "COMPLETE" means, in the context of an Application for Membership or Clinical Privileges, that all questions presented to the individual have been answered, all supporting documentation (including adequate responses from references and all information in the possession of third parties that has been deemed necessary for full and appropriate evaluation of the Applicant's qualifications) has been supplied, and all information has been verified from primary sources. A Complete Application for Membership or Clinical Privileges will become incomplete (i.e., not "Complete") if the need arises for new, additional, or clarifying information at any time.

(11) "CORE PRIVILEGES" or "CORE" means a defined grouping of Clinical Privileges for a specialty or subspecialty that includes the fundamental patient care services that are routinely taught in residency or fellowship training for that specialty or subspecialty and that have been determined by the Medical Staff Leaders and Board to require closely related skills and experience.

(12) "DAYS" means calendar Days.

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

(14) "DEPENDENT PROFESSIONAL" means a health care professional 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. Dependent Professionals are not eligible for Clinical Privileges or Medical Staff Membership. All aspects of the clinical practice at the Hospital by Dependent Professionals shall be assessed and managed by Human Resources in accordance with Human Resources policies and

procedures, and the provisions of this Policy will not apply and any references in this Policy or any related Medical Staff Bylaws or policies to "Practitioner" will not be deemed to include Dependent Professionals.

(15) "GOOD STANDING" means a Practitioner who continues to meet all eligibility criteria and other qualifications for initial and renewed Medical Staff Membership and Clinical Privileges, as applicable, has continually satisfied the basic responsibilities of Medical Staff Membership and Clinical Privileges, is not delinquent with respect to his or her completion of medical records, and is not currently subject to a performance improvement plan, under Investigation, nor subject to a recommendation for adverse professional review action (e.g. a recommendation that would give rise to the right to request a hearing and appeal, as set forth in the Medical Staff Credentials Policy).

(16) "HOSPITAL" means Yakima Valley Memorial Hospital, Association, d/b/a Yakima Valley Memorial.

(17) "INELIGIBLE PERSON" means any individual who is (1) currently excluded, suspended, debarred, or otherwise ineligible to participate in federal health care programs; (2) has been convicted of a criminal offense related to the provision of health care items or services but has not yet been excluded, debarred, or otherwise declared ineligible; or (3) is currently excluded on a state exclusion list.

(18) "INVESTIGATION" means the process of gathering and reviewing information related to a concern involving a Practitioner, which begins after a formal resolution by the Medical Executive Committee or Board to commence an Investigation and is concluded after final action has been taken on the matter that was subject to Investigation, as set forth in this Policy.

(19) "MEDICAL EXECUTIVE COMMITTEE" or "MEC" means the Medical Executive Committee of the Medical Staff, as set forth in the Medical Staff Bylaws document.

(20) "MEDICAL STAFF" means the body comprised of all Physicians, Dentists, Podiatrists, and Licensed Clinical Psychologists who have been granted Membership in the Medical Staff by the Board.

(21) "MEDICAL STAFF LEADER" means any Medical Staff officer, department chairperson, or committee chairperson or any designee acting on their behalf or on behalf of a department or committee at its request. The term shall also include the Chief Medical Officer when acting on behalf of, in conjunction with, or as liaison to, the Medical Staff. In addition, the Hospital may employ or contract with other individuals or organizations to provide administrative services and support to Medical Staff Officers, departments, and committees and when any such individuals or organizations are performing any credentialing, peer review,

professional practice evaluation, patient safety, or other function by delegation of a Medical Staff Leader, they too will be deemed to be acting as a Medical Staff Leader.

(22) "MEDICAL STAFF YEAR" means the period from January 1 to December 31 each year.

(23) "MEMBER" means any Physician, Dentist, Podiatrist, or Licensed Clinical Psychologist who has been granted initial or renewed Membership in the Medical Staff by the Board.

(24) "MEMBERSHIP" means the designation of being a Member of the Medical Staff, following a grant of Membership in the Medical Staff by the Board.

(25) "NON-PRIVILEGED HEALTHCARE PRACTITIONER" means an individual who by Hospital Policy is allowed to order specific diagnostic tests and services, but who is not a Member of the Medical Staff and has not been granted Clinical Privileges to practice at the Hospital.

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

(27) "PATIENT CONTACT" includes any admission, consultation, procedure, response to emergency call, evaluation, treatment, or service performed in any facility operated by the Hospital, including outpatient facilities.

(28) "PEER" means a Practitioner with the same or similar level of education and/or Membership status with respect to the Medical Staff. The following are deemed to be Peers of each other: (a) any Physician, Podiatrist, Dentist, or Clinical Psychologist to another Physician, Podiatrist, Dentist, or Clinical Psychologist (b) any Physician Assistant or Advanced Practice Nurse to Physician Assistant another Advanced Practice Nurse. Practitioners may be Peers of each other regardless of specialty degree, licensure, or training.

(29) "PHYSICIAN" means a doctor of medicine ("M.D.") or a doctor of osteopathy ("D.O.").

(30) "PODIATRIST" means a doctor of podiatric medicine ("D.P.M.") or doctor of podiatric surgery ("D.P.S.").

(31) "PRACTITIONER" means any individual who has been granted Clinical Privileges and/or Membership by the Board, including, but not limited to, Members of the Medical Staff, and Advanced Practice Professionals.

(32) "PRESENT" and "PRESENCE" means in-person attendance or active participation by telephone or other electronic means in a meeting. The chairperson of a department or committee or other body that has called a meeting may specify whether in-person, telephonic, or electronic attendance is permitted with respect to a meeting. In the absence of specification, attendance via any of those methods shall constitute the individual's "Presence."

(33) "PROFESSIONAL PRACTICE EVALUATION" ("PPE") refers to the Hospital's routine and ongoing peer review and professional practice evaluation processes. These processes include, but are not limited to, the review and assessment of Practitioners' clinical performance, professionalism, and health status/ability to exercise Clinical Privileges safely and competently.

(34) "PROFESSIONAL REVIEW ACTION" and "PROFESSIONAL REVIEW ACTIVITY" have the meanings defined in the Health Care Quality Improvement Act of 1986 ("HCQIA").

(35) "PSYCHOLOGIST" means an individual with a Ph.D. or Psy. D. in clinical psychology.

(36) "QUORUM" means, unless specifically stated otherwise, those Medical Staff Members with the prerogative to vote and who are either (a) the voting members Present (but not fewer than two members) at any regular or special meeting of the Medical Staff, department, committee, or other body or (b) the voting members of the Medical Staff or any department, division, committee, or other body, as applicable, who return a response to a vote presented via mail, facsimile, e-mail, hand delivery, website posting, or telephone. Exceptions to this general definition of Quorum (e.g. those members Present or returning a vote) exists as follows:

(a) for meetings and votes of the Medical Executive Committee, the Credentials Committee, and the Committee on Professional Enhancement, where the Presence (or return of a response, in the case of voting via mail, facsimile, e-mail, hand delivery, website posting, or telephone) of at least 50% of the voting committee members will constitute a Quorum; and

(b) for amendments to the Medical Staff Bylaws that are presented to the Medical Staff via mail, facsimile, e-mail, hand delivery, website posting, or telephone (which require 10% of the voting members of the Medical Staff to return a response in order to satisfy the Quorum requirement).

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

mentoring or specification of a maximum number of patients, nor does it include a limitation on the exercise of Clinical Privileges resulting from an exclusive arrangement with another Practitioner or group of Practitioners or other action by the Board.

(38) "SPECIAL NOTICE" means email (in the case of a Practitioner who has been granted Membership or Privileges, to the email account provided by Yakima Valley Memorial; in the case of an individual who is not a current Member or does not currently maintain Membership, to the last email address provided by the individual to the Medical Staff Office), along with either hand delivery or U.S. mail. In all cases where hand delivery is made as part of Special Notice, the individual making the delivery must submit written confirmation of the delivery, to be included in the file.

(39) "SPECIAL CLINICAL PRIVILEGES" means Clinical Privileges that fall outside of the Core Privileges for a given specialty, which require additional education, training, or experience beyond that required for Core Privileges in order to demonstrate competence.

(40) "SUPERVISING/COLLABORATING PRACTITIONER" means a Practitioner with Clinical Privileges, who has agreed in writing and has been approved by the appropriate licensure board to supervise or collaborate with an Advanced Practice Professional and to accept full responsibility for the actions of the Advanced Practice Professional while he or she is practicing in the Hospital.

(41) "SUPERVISION" means the Supervision of (or collaboration with) an Advanced Practice Professional by a Supervising/Collaborating Practitioner, that may or may not require the actual presence of the Supervising/Collaborating Practitioner, but that does require, at a minimum, that the Supervising/Collaborating Practitioner be readily available for consultation. The requisite level of Supervision (general, direct, or personal) will be determined at the time each Advanced Practice Professional is credentialed and will be consistent with any applicable written supervision or collaboration agreement approved by the state.

1.B. DELEGATION OF ADMINISTRATIVE AND MEDICAL STAFF LEADERSHIP FUNCTIONS

(1) Except as follows, when a function is to be carried out by a member of Hospital administration, by a Medical Staff Leader or by a Medical Staff committee, the individual, or the committee through its chairperson, may delegate performance of the function to one or more designees. Delegation is not permitted in the following situations:

(a) When the Medical Executive Committee is making a recommendation directly to the Board to grant, deny, restrict, suspend, or revoke the Membership or Clinical Privileges of an individual; and

(b) When the Board is rendering its preliminary or final determination to grant, deny, restrict, suspend, or revoke the Membership or Clinical Privileges of an individual.

(2) When a Medical Staff Member or other Practitioner 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.C. CONFIDENTIALITY AND PEER REVIEW PROTECTION

1.C.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:

(1) to another authorized individual or body, whether internal or external to the Hospital, for the purpose of conducting Professional Review Activity;

(2) as authorized by Hospital or Medical Staff policy, including any policy governing the sharing of credentialing and peer review information among Affiliated Entities; or

(3) as authorized by the 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 shall not constitute a waiver of any legal privilege. Any Practitioner who becomes aware of a breach of confidentiality is encouraged to inform the Chief Executive Officer, the Chief Medical Officer, or the President of the Medical Staff (or the Vice-President of the Medical Staff if the President of the Medical Staff is the person committing the claimed breach).

1.C.2. Peer Review Protection:

All professional review activity is performed as part of the quality improvement and medical malpractice prevention program of the Hospital and all individuals and committees engaged in credentialing, professional practice evaluation, and other quality improvement activities are engaged in such activity, including, but not limited to:

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

(2) all departments and any service lines that may be created in the future;

(3) hearing and appellate review panels, hearing officers, presiding officers, and others involved in the conduct of a hearing or appeal;

(4) the Board and its committees; and

(5) any individual, organization, or other organized body acting for, or on behalf of, or at the request of: the Board, the Medical Executive Committee, the Committee on Professional Enhancement, the Credentials Committee, the Advanced Practice Professional Review Committee, any Medical Staff Leader, the Chief Executive Officer, Chief Medical Officer, or other Hospital Administrator, including any experts or consultants retained to assist in quality improvement and professional review activities.

All oral and written communications, reports, recommendations, actions, and minutes made or taken by the individuals and bodies listed above are confidential and covered by the provisions of applicable law and are deemed to be "Professional Review Activity" pursuant to the Health Care Quality Improvement Act of 1986.

ARTICLE 2
QUALIFICATIONS, CONDITIONS, AND RESPONSIBILITIES

2.A. QUALIFICATIONS

2.A.1. Threshold Eligibility Criteria:

To be eligible to apply for or maintain Membership or Clinical Privileges, an individual must submit an Application or other request for Clinical Privileges to the Medical Staff Office, on the forms provided, and, in addition, must continuously demonstrate satisfaction of all of the following threshold eligibility criteria, as applicable:

(1) have a current, unrestricted license to practice in this state that is not subject to any restrictions, probationary terms, or conditions not generally applicable to all licensees. For purposes of this section, educational stipulations by the state medical board do not constitute "restrictions," "probationary terms," or "conditions";

(2) for individuals applying for initial Membership or an initial grant of Clinical Privileges at the Hospital after the date of the adoption of this Policy, have never had a license to practice revoked, restricted or suspended by any professional licensing agency in any state or any jurisdiction (including Washington). This criterion will not apply to individuals already granted Medical Staff Membership or Clinical Privileges as of the date of adoption of this Policy, provided they continuously maintain Membership and/or Privileges;

(3) if the individual is an Advanced Practice Professional that falls within a category that is granted licensure and prescriptive authority separately (whether in this state or in any other state that the individual has ever been licensed or practiced), the individual must have never had his or her prescriptive authority revoked, restricted, or suspended by any professional licensing agency in any state or other jurisdiction;

(4) satisfy the following professional education requirements:

(a) for a Physician, have successfully graduated from a school of medicine accredited by the Association of American Medical Colleges or the American Association of Colleges of Osteopathic Medicine. If the Physician is a foreign medical graduate, he or she must have successfully graduated from a foreign medical school and have completed the Education Commission for Foreign Medical Graduate (ECFMG) or an accredited Fifth Pathway Program;

(b) for a Dentist or an oral and maxillofacial surgeon, have successfully graduated from a school of dentistry accredited by the Commission on Accreditation of the American Dental Association;

(c) for a Podiatrist, have successfully graduated from a school of podiatry accredited by the Council on Podiatric Medical Education of the American Podiatric Medical Association; or

(d) for Clinical Psychologists and Advanced Practice Professionals, have satisfied the applicable education requirements, as established by Hospital policy and the relevant delineation of Clinical Privileges;

(5) satisfy the following professional training requirements:

(a) for a Physician, have successfully completed a residency and, if applicable to the Physician's subspecialty, a fellowship training program, both of which must be approved by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association in all specialties in which the Physician seeks Clinical Privileges;

(b) for a Dentist or an oral and maxillofacial surgeon, have successfully completed a training program accredited by the Commission on Dental Accreditation of the American Dental Association;

(c) for a Podiatrist, have successfully completed a podiatric residency program accredited by the Council on Podiatric Medical Education of the American Podiatric Medical Association; or

(d) for Clinical Psychologists and Advanced Practice Professionals, have satisfied the applicable training requirements, as established by Hospital policy and the relevant delineation of Clinical Privileges;

(6) satisfy the following Board Certification requirements:

(a) to be eligible for Membership or Clinical Privileges:

(i) be Board Certified (as defined in this Policy) in their primary area of practice at the Hospital or become Board Certified within seven (7) years of appropriate residency and/or fellowship training completion or within the amount of time specified by the Physician's, Podiatrist's, or Oral Surgeon's specialty board, whichever is less. If a period of clinical practice is required prior to taking the certification examination, the seven (7) year interval shall begin at the completion of the practice period;

(ii) maintain Board Certification in their primary area of practice at the Hospital and, to the extent required by the applicable specialty/subspecialty board, satisfy recertification requirements.

Recertification will be assessed at the time of renewal of Membership or Clinical Privileges; and

These general Board Certification and maintenance of Board Certification requirements will be applicable only to those individuals who submit an Application for initial Membership or an initial grant of Clinical Privileges after the date of adoption of this Policy. Individuals already granted Medical Staff Membership or Clinical Privileges as of the date of adoption of this Policy will be governed by the Board Certification, recertification, and maintenance of certification requirements governing eligibility for Membership that were in effect at the time of their initial Membership or initial grant of Clinical Privileges, provided they have continuously maintained Membership and/or Privileges.

(b) to be eligible for specific Clinical Privileges, satisfy any Board Certification, recertification, and maintenance of certification requirements set forth in any applicable delineation of Clinical Privileges and other Hospital and Medical Staff policies;

This Privilege-specific Board Certification requirement will be applicable only to those individuals who submit an Application for Clinical Privileges that requests new or additional Clinical Privileges (Privileges not currently held by the individual) after the date of adoption of this Policy. Practitioners already granted Clinical Privileges as of the date of adoption of this Policy will be governed by the Board Certification, recertification, and maintenance of Certification requirements governing eligibility for Clinical Privileges that were in effect at the time those Privileges were initially granted to those Practitioners.

(7) so long as the prescribing or administering of controlled substances is any part of the customary exercise of the Clinical Privileges sought by the Practitioner, have a current, unrestricted DEA registration that is linked to an address in the state of Washington;

(8) be lawfully authorized to work in the United States of America, whether through citizenship, permanent resident status, possession of a valid visa, or otherwise;

(9) have current, government-issued photographic identification which is either written in English or has been translated by a professional translation service and which, on its face, verifies the individual’s identity;

(10) have current valid professional liability insurance coverage in a form and in amounts, as determined by the Hospital;

(11) meet any privileging eligibility requirements that are applicable to the Clinical Privileges being sought including, but not limited to, any relating to Board Certification and/or maintenance of Board Certification, as outlined above;

(12) if applying for Clinical Privileges in an area that is covered by an exclusive contract or arrangement, meet the specific requirements set forth in the contract or Board resolution setting forth the decision to proceed with that arrangement;

(13) agree to, and fulfill, all responsibilities regarding emergency call for their specialty, including any requirements for response within a specific timeframe;

(14) demonstrate recent clinical activity in an acute care hospital, sufficient to support an evaluation of current clinical competence, during the last two years;

(15) when on-call for the ED or when responsible for responding to patients in the hospital (e.g. when covering for a practice), agree to, and routinely be, close enough to fulfill Hospital and Medical Staff responsibilities, including responding to call as required, and to provide timely and continuous care for his or her patients in the Hospital (close enough to respond in person within 30 minutes, on average);

(16) have an appropriate coverage arrangement, as determined by the Credentials Committee, with other Practitioners who are qualified and have the appropriate Clinical Privileges, for those times when the individual will be unavailable;

(17) if seeking to practice as an Advanced Practice Professional, have a written agreement with a Supervising/Collaborating Practitioner, which agreement must meet all applicable requirements of state law and Hospital policy;

(18) have never had Membership or Clinical Privileges, or status as a participating provider denied, revoked, or terminated by any health care facility, including this Hospital, or health plan for reasons related to clinical competence or professional conduct;

(19) have never resigned Membership or relinquished Clinical Privileges during an Investigation or in exchange for not conducting an Investigation at any health care facility, including this Hospital;

(20) have never had a request or Application for Clinical Privileges or Medical Staff Membership deemed ineligible for continued processing by the Hospital or any Affiliated Entity due to a finding of material omission or misrepresentation nor has had his or her Medical Staff Membership or Clinical Privileges automatically relinquished due to such a finding;

(21) have never been expelled from a post-graduate training program (residency or fellowship or equivalent program for an Advanced Practice Professional), nor

resigned from such a program during an investigation or in exchange for the program not conducting an investigation;

(22) since the start of medical or professional education, have not been convicted of, or entered a plea of guilty or no contest to, any felony or misdemeanor related to controlled substances, illegal drugs, violent acts, sexual misconduct, moral turpitude, domestic, child or elder abuse, or Medicare, Medicaid, or other federal or state governmental or private third-party payer fraud or program abuse, nor have been required to pay a civil money penalty for any such fraud or program abuse; and

(23) have never been, and not currently be, excluded or precluded from participation in Medicare, Medicaid, or other federal or state governmental health care program and is not otherwise an Ineligible Person.

2.A.2. Determination of Eligibility to Apply:

(1) Once an application for Medical Staff appointment and/or Clinical Privileges has been received by the Medical Staff Office, it will begin to review the application, conduct primary source verification and other fact-gathering, and process the application as set forth in this Policy. No individual is entitled to have these procedures conducted within any specific timeframe.

(2) If it is not clear whether the applicant is eligible, the Medical Staff Office may consult with the CMO, who will have the final authority to determine whether particular threshold eligibility criteria apply to an individual and whether the individual has satisfied all criteria

(3) If it is determined that the applicant does not satisfy one or more of the threshold eligibility criteria set forth in this Policy, he or she will be informed of the threshold eligibility criteria not satisfied.

(4) As a general rule, the application will not be processed if the individual fails to satisfy one or more threshold criteria. Two exceptions to this general rule exist:

(a) where a determination to process has been made pursuant to Section 2.A.3. of this Policy; and

(b) where a waiver has been granted pursuant to Section 2.A.4. of this Policy.

2.A.3. Processing Pending Resolution of Ineligibility

(1) An applicant may request that the application be processed pending resolution of a matter that led to ineligibility. The individual bears the burden of supplying information indicating the matter is not only capable of being resolved, but also that

resolution is likely to be automatic and therefore, for the sake of efficiency, it makes sense to continue with the credentialing process while awaiting resolution of the matter.

(2) Situations that may warrant processing pending resolution of ineligibility include, but are not limited to:

(a) individuals who are in their final six months of residency training and who provide evidence that they are expected to successfully complete the program on time and without incident (e.g. no leaves of absence, probationary terms);

(b) individuals who have an executed employment agreement with the Hospital or another health care practice in the geographic service area of the Hospital, who expect to receive professional liability coverage as a benefit of employment but will not have "current" coverage until the employment start date;

(c) individuals who are relocating to the Hospital's geographic service area and have submitted an application for licensure to the applicable state medical board, but have not yet received a license to practice; and

(d) individuals who have an executed employment agreement with the Hospital or another health care practice in the geographic service area of the Hospital, and who are not currently located (office and residence) close enough to fulfill Hospital and Medical Staff responsibilities, but expect to satisfy the location requirement on the employment start date;

(3) Situations that would likely <u>not</u> warrant processing pending resolution of ineligibility include, but are not limited to:

(a) individuals who have been the subject of a licensure action by a state health care professions board or agency or been the subject of an adverse professional review recommendation (such as revocation of appointment or Clinical Privileges) and who have a hearing, appeal, or lawsuit challenging the action pending at the time of the application;

(b) individuals who fail to satisfy the board certification requirements set forth in this Policy, unless the individual has already satisfied all of the conditions for certification, as defined by the applicable board (e.g., completed and passed all examinations, completed all education, and completed and submitted all clinical logs) and is merely awaiting formal confirmation that board certification has been attained.

(4) After reviewing the information provided by the individual and any other relevant information that is available, the CMO will determine whether application will be processed pending resolution of the individual's ineligibility.

(5) If the CMO determines that the application will be processed pending resolution of the matter that led to ineligibility, any Board action to grant appointment and/or Clinical Privileges will be conditional and will not be final and effective until such time as documentation indicating the individual satisfies the threshold criteria has been received and deemed sufficient by the CMO.

(6) The burden is on the applicant to supply all documentation as the CMO requests in order to verify that he or she has satisfied the threshold criteria previously at issue. If any of the supplied documentation, or any other relevant information, raises new concerns about the applicant, the conditional appointment and/or conditional grant of Privileges will not take effect. Rather, the CMO will send the application back to Medical Staff Services, which shall refer the application to be fully processed through the department chair, Credentials Committee, Medical Executive Committee, and Board, even if it had previously been considered and acted upon by these individuals/bodies at any time during the credentialing process.

(7) The individual will be notified of the CMO's determination regarding processing. If the CMO determines that the application will not be granted an exception to allow processing pending resolution of the matter that led to ineligibility, that determination is not subject to the hearing and appeal processes set forth in this Policy. The decision will be final and no further processing of the application will occur until such time as the individual submits documentation evidencing satisfaction or waiver of all threshold criteria.

2.A.4. Waivers of Threshold Eligibility Criteria:

(1) Any individual wishing to request a waiver may submit a written request, along with evidence of exceptional circumstances, to the Hospital's Medical Staff Office. Because waivers are intended to be used rarely and are an "exception to the rule," the Hospital and Medical Staff Leaders have no obligation to inform an individual of the right to request a waiver, nor to contact an individual to ask whether he or she wishes to request a waiver.

(2) Waivers of threshold eligibility criteria will not be granted routinely and will be considered only if the individual requesting waiver demonstrates that exceptional circumstances exist and that he or she is otherwise qualified. As a general rule, "exceptional" circumstances are those that are outside the norm (e.g. there is a demonstrated community or coverage need for the services provided by the individual and that need cannot reasonably be met by other practitioners, there has been a delay in the individual satisfying the relevant criterion due to a serious illness or injury affecting the individual or an immediate family member, or the individual

has provided evidence of mitigating circumstances and/or remediation activities that are above and beyond the norm). Exceptional circumstances generally do not include situations where a waiver is sought for the convenience of the requesting individual (e.g. failure to achieve board certification or recertification due to being busy or forgetful).

(3) Requests for waiver will be considered by the Credentials Committee. In reviewing the request for a waiver, the Credentials Committee may consider input from the relevant department chairperson and the best interests of the Hospital and the communities it serves. Additionally, the Credentials Committee may, in its discretion, consider any aspect of the Practitioner's qualifications, including information from the Application or other information supplied by the individual (for example, a re-entry plan submitted by the practitioner to document his or her plan to reestablish current clinical competence following a period away from the active practice of medicine in the specialty in which he or she is seeking Clinical Privileges or in the acute care hospital setting).

The Credentials Committee will forward a recommendation to the Medical Executive Committee. The Credentials Committee's recommendation must articulate the basis for the waiver recommendation (e.g. if the Committee recommends that waiver be granted, the recommendation should articulate the exceptional circumstances supporting waiver; if it recommends that waiver not be granted, the recommendation should articulate why the request was not considered exceptional enough to support waiver).

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. As with the Credentials Committee, the Medical Executive Committee must articulate the basis for its recommendation.

The Board will consider the recommendation of the Medical Executive Committee and make a determination regarding whether to grant a waiver. The Board's determination is final.

(4) The individual who requested the waiver and will be given Notice of the Board's determination.

(i) If the Board has granted a waiver, the individual will be deemed eligible and, in turn, processing of the Application will proceed as set forth in this Policy, in the same manner that other eligible individuals are credentialed.

(iii) If the Board has not granted the waiver, the individual who requested the waiver will remain ineligible and the Application will not be processed.

(5) A determination to grant a waiver does not mean that Membership or Clinical Privileges will be granted; only that the individual's Application can be processed further.

(6) A determination to grant a waiver in a particular case is not intended to set a precedent for others seeking waivers, nor does it guarantee that a waiver will be permanent. To that end, there is no guarantee that:

(a) waiver of the criterion will be available to request in the future (i.e., the Hospital and Medical Staff may, at a future date, determine to no longer consider or grant waivers of any criteria or, alternatively, to no longer consider or grant waivers of the particular criterion in question);

(b) the individual will be granted the same waiver if he or she requests it again at a future date (e.g. at the time an Application to renew Membership and/or Clinical Privileges is made, there is no guarantee that the same waiver will be granted); or

(c) that the criteria for Membership or Clinical Privileges will remain unchanged and the individual will remain eligible indefinitely.

(7) A recommendation of the Medical Executive Committee or a determination of the Board not to grant a waiver of the threshold eligibility criteria is not a "denial" of Membership or Clinical Privileges, nor is it a Professional Review Action.

(8) An individual who requests a waiver is not entitled to a hearing or appeal or any other due process pursuant to the Medical Staff Bylaws, Credentials Policy, or other rules, regulations, policies or procedures of the Medical Staff or Hospital for any matter related to the request, the Hospital and Medical Staff Leaders' consideration of the request, and/or the determination to grant a waiver or not to grant a waiver.

2.A.5. Burden of Providing Information:

(1) All Applicants, Members, and other Practitioners 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 participating in personal or phone interviews in regard to an Application.

(2) All Applicants, Members, and other Practitioners have the burden of providing evidence that all the statements made and all information provided by them in support of the Application are accurate and Complete.

(3) Each Applicant is responsible for providing a Complete Application. An Application that is not Complete will not be processed. Any Application that

continues to not be Complete 30 Days after the Applicant has been notified of the additional information required will be deemed to be withdrawn.

(4) During the credentialing process and throughout the term of any Membership and/or Clinical Privileges, Applicants and Practitioners are responsible for immediately (and in no event later than one business day after being provided notice of the change) notifying the Medical Staff Office of any change in status or any change in the information provided as part of a request for Clinical Privileges or Application including, but not limited to, the following:

(a) any investigation commenced by another health care organization, state licensure agency, the federal DEA or a state drug control agency, or a specialty certification board;

(b) any payer contract termination;

(c) any criminal investigation commenced regarding the individual; or

(d) any investigation commenced or sanction imposed or recommended by any subdivision or office of the Department of Health and Human Services or any other federal or state health oversight entity.

2.A.6. Factors for Evaluation:

The following factors will be evaluated as part of the processes of considering individuals for Membership and Clinical Privileges:

(1) 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;

(2) 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;

(3) good reputation and character;

(4) ability, with or without reasonable accommodation, to safely and competently perform the Clinical Privileges requested and any other essential functions of Medical Staff Membership and/or the exercise of Clinical Privileges;

(5) ability to communicate in an understandable manner in English and maintain all medical record entries legibly and in English, sufficient for the safe delivery of patient care;

(6) 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

(7) 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.7. No Entitlement to Membership:

No one is entitled to receive an Application form, to be granted Membership in the Medical Staff, or to exercise or be granted particular Clinical Privileges merely because he or she:

(1) is employed by this Hospital or Affiliated Entities or has a contract with this Hospital;

(2) is or is not a member or employee of any particular Physician group;

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

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

(5) has had in the past, or currently has, Medical Staff Membership or Clinical Privileges at any hospital or health care facility;

(6) resides in the geographic service area of the Hospital;

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

(8) is certified by any specialty certification board.

2.A.8. Nondiscrimination:

No one will be denied Membership or Clinical Privileges on the basis of race, color, sex, gender identity, marital status, sexual orientation, creed/religion, national origin, or disability.

2.B. GENERAL CONDITIONS OF MEMBERSHIP

2.B.1. Basic Responsibilities and Requirements:

As a condition of having an Application accepted, verified, and/or processed, of being granted initial or renewed Membership or Clinical Privileges, and of ongoing Membership or Clinical Privileges, every individual specifically agrees to the following:

(1) to provide continuous and timely care at the generally recognized level of quality and efficiency and refrain from delegating responsibility for Hospital patients to any individual who is not appropriately licensed, qualified, supervised and, as applicable, granted the Clinical Privileges or scope of practice necessary to perform the delegated responsibility;

(2) that he or she is subject to and shall abide by the Bylaws, policies, guidelines, and Rules and Regulations of the Hospital and Medical Staff, all local, state, and federal laws and regulations applicable to the Hospital or to the Practitioner's professional practice; and the applicable Joint Commission and other accreditation standards currently in existence or as may be adopted or amended in the future;

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

(4) to provide emergency call coverage (in accordance with the call plan established by the department and approved by the Medical Executive Committee and Board), consultations, and care for unassigned patients;

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

(6) to comply with or document the clinical reasons for variance from clinical practice or evidence-based protocols that have been adopted by the Hospital as part of its performance improvement program or for compliance with or reporting to regulatory or accrediting agencies or patient safety organizations, including those related to national patient safety initiatives, core measures, and other performance measures;

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

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

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

(10) to seek consultation whenever necessary;

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

(12) to utilize the Hospital's applications and systems, including the electronic medical record, in accordance with all policies, procedures, rules and regulations, and protocols that have been adopted by the Hospital;

(13) to abide by all terms of the Confidentiality and Security Agreement (CSA), which includes exercising due diligence in following appropriate access, safeguarding confidential information, and protecting the individual's sole ability to access the Hospital's applications, including the electronic medical record, and systems;

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

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

(16) to satisfy continuing medical education requirements;

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

(18) to comply with all applicable training and educational protocols that may be adopted by the Medical Executive Committee or required by the Hospital, including, but not limited to, those involving electronic medical records, computerized physician order entry ("CPOE"), the privacy and security of protected health information, patient safety, and EMTALA;

(19) prior to becoming eligible to begin exercising Clinical Privileges and engaging in any patient care at the Hospital, to comply with all health screening and immunization requirements set forth by Hospital policy;

(20) to cooperate with the Hospital in matters involving its fiscal responsibilities and policies, including those relating to payment or reimbursement by governmental and third-party payors;

(21) to agree that the Yakima Valley Memorial email system will be designated as the primary mechanism for communicating all information relevant to the individual's Membership status or Clinical Privileges and that the individual shall be responsible for checking his or her email account with sufficient frequency to timely receive any Notice, Special Notice, and other relevant communication sent to that account;

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

(23) to disclose relationships with pharmaceutical companies, device manufacturers, other vendors or other persons or entities as may be required by Hospital or Medical Staff policies, including, but not limited to, disclosure of financial interests in any product, service, or medical device that a Practitioner may request the Hospital to purchase or approve for use;

(24) if the individual is a Member of the Medical Staff who serves or plans to serve as a Supervising/Collaborating Practitioner to an Advanced Practice Professional, the Member of the Medical Staff will abide by the Supervision requirements and conditions of practice set forth in Article 8; and

(25) if the individual is an Advanced Practice Professional, the individual will also abide by the conditions of practice set forth in Article 8.

2.C. CONDITIONS OF APPLICATION AND CONSIDERATION

2.C.1. Scope:

The authorizations, immunities, and other terms set forth in this Section 2.C.1. are expressly accepted by every individual as a condition of requesting an Application, requesting Medical Staff Membership or Clinical Privileges, submitting an Application for initial or renewed Membership or Clinical Privileges, having an Application processed or considered, and/or being granted Medical Staff Membership or Clinical Privileges and are applicable to all of the following situations and to all of the following activities:

(1) whether or not a request to apply for, or receive an Application form to apply for, medical staff Membership or clinical privileges is provided to the individual by the Hospital,

(2) whether or not the individual executes any authorization or release language included in an Application, authorization, or other form,

(3) whether or not an Application or request for Membership or Clinical Privileges, once submitted, is verified or processed by the Medical Staff or Hospital,

(4) whether or not Membership or Clinical Privileges are recommended or granted,

(5) throughout the term of any Membership or Clinical Privileges, and at all times thereafter, even after an individual's relationship with the Hospital has ceased;

(6) even if Membership or Clinical Privileges are denied, revoked, reduced, restricted, suspended, and/or otherwise affected as part of the Hospital and/or Medical Staff's professional review activities or otherwise (for example, pursuant to a decision of the Hospital to terminate a clinical service or enter into an exclusive contract or pursuant to an employment or other contract that calls for coterminous appointment and privileges),

(7) with respect to any response to a third-party inquiry received about the individual, even after the individual has departed the Medical Staff or no longer maintains clinical privileges,

(8) with respect to any disclosure, at any time, about the individual regarding his or her credentials, clinical performance, professional conduct, or health,

(9) with respect to any reports made to government regulatory and licensing boards or agencies, as well as with respect to any disclosures about the individual made in response to subpoenas or other lawful requests for information,

(10) even if prior Notice of an activity is not made to the individual, and

(11) even if hearing and/or appeal rights are not available and/or afforded to the individual pursuant to the terms of the Bylaws or the terms of any Hospital or Medical Staff policy.

2.C.2. Misstatements and Omissions:

(1) Consequences of Misrepresentation and/or Omission

(a) Applicants and Practitioners are expected at all times to be forthcoming and truthful with respect to their initial and ongoing qualifications for Medical Staff Membership and Clinical Privileges and any concerns that have been raised regarding the same. The Hospital and Medical Staff agree that complete information is of the utmost importance to the credentialing and professional practice evaluation processes and, in turn, to patient safety. To that end, when in doubt about whether disclosure is required, Applicants and Practitioners are expected to err on the side of making full disclosure to the Hospital and/or Medical Staff leadership (through notification to the Medical Staff Office, Chief of Staff, or Chief Executive Officer).

(b) Any misstatement in, or omission from, an Application or privilege request form, or with respect to any other information submitted as part of the credentialing and/or privileging processes, including information given verbally, is grounds to stop processing the Application or request.

(c) If Membership or Clinical Privileges have been granted and/or renewed with respect to a Practitioner prior to the discovery of a misstatement or omission, the Practitioner's Membership and Clinical Privileges may be deemed automatically relinquished, pursuant to this Policy, upon Notice to the Practitioner. In addition, any subsequent Applications and/or requests for Privileges that have been submitted by the individual, but have not yet processed may be declared ineligible for continued processing.

(d) Once a determination has been made to not process an Application or request for Privileges from a Practitioner, or to automatically relinquish a Member's Membership and Privileges, due to a misrepresentation or omission, that Practitioner will become permanently ineligible to apply for Membership or Privileges at the Hospital unless a waiver is specifically granted by the Board pursuant to the process set forth in this Policy for waivers of threshold eligibility criteria.

(2) If, at any time (whether during credentialing or after a final decision has been made regarding Membership or Privileges), a possible misrepresentation or omission on an Application or during the credentialing process is identified, the Hospital will provide Notice to the Practitioner in writing of the nature of the misstatement or omission and permit the Practitioner the opportunity to provide a written response within the timeframe set forth in the Notice.

(3) The President of the Medical Staff and Chief Executive Officer will review the Practitioner's response, if any, and determine whether to process the Practitioner's Application further or deem the Practitioner's Membership and Privileges to be automatically relinquished (as applicable).

(4) The correction of, or supplementation to, an Application or related materials, after notification of a potential misstatement or omission, does not preclude consequences related to the misstatement or omission from being implemented.

(5) The implementation of the consequences of a misrepresentation or omission, pursuant to this Section, will not entitle an Applicant or Practitioner to a hearing or appeal or any other process.

2.C.3. Immunity:

With respect to all activities and situations that fall within the scope of this Section, the individual releases from any and all liability, extends immunity to, and agrees not to sue the Hospital and its Board, any Practitioner, any Affiliated Entity and its Board and Medical Staff, or any of their authorized representatives, as well as any third party who provides information for any matter relating to Membership or Clinical Privileges or the individual's qualifications to be granted or to renew or maintain the same.

2.C.4. Authorization to Obtain Information from Third Parties:

(1) The individual authorizes the Hospital, its Medical Staff leaders, and their authorized representatives (1) to consult with any third party who may have information bearing on the individual's professional qualifications, credentials, clinical competence, character, ability to perform safely and competently, ethics, behavior, or any other matter reasonably having a bearing on his or her qualifications for initial and continued Membership to the Medical Staff, and (2) to obtain any and all communications, reports, records, statements, documents, recommendations or disclosures of third parties that may be relevant to such questions.

(2) The individual also specifically authorizes third parties to release this information to the Hospital, the Medical Staff, and their authorized representatives.

2.C.5. Authorization to Release Information to Third Parties:

The individual authorizes the Hospital and Medical Staff and any of their representatives to release information to:

(1) other hospitals, health care facilities, managed care organizations, and their authorized representatives, if the Practitioner has (or is believed to have) medical staff membership, clinical privileges, or other permission to practice at the hospital, facility, or organization, or if the hospital, facility, or organization has requested the information as part of its evaluation of the individual's professional qualifications for medical staff membership, privileges, permission to practice, and/or participation at the requesting organization/facility, and

(2) federal and state agencies, boards, and authorities, pursuant to federal or state law.

2.C.6. Authorization to Share Information Among Entities Affiliated with and Providing Services within the Yakima Valley Healthcare System:

The individual authorizes the Hospital and its Affiliated Entities to share credentialing, professional practice evaluation, peer review, and other information and documentation pertaining to the individual's clinical competence, professional conduct, and/or health, including, but not limited to: reported concerns, peer references, fitness for practice evaluation results, and clinical competency evaluation results.

This information and documentation may be shared at any time, including, but not limited to, at the time of any initial evaluation of an individual's qualifications, at the time of any periodic reassessment of those qualifications, or when a question is raised about the individual.

2.C.7. Redisclosure of Drug/Alcohol Treatment Information:

In the course of performing credentialing or peer review functions, the Hospital may receive written or verbal information about the treatment of a Practitioner from a federally-assisted drug or alcohol abuse program, as defined by 42 C.F.R. Part 2. The Hospital will not redisclose such information without a signed authorization from the Practitioner except as otherwise required or permitted by law. The Practitioner Health Policy includes additional guidance on the maintenance and disclosure of information obtained from a federally-assisted drug or alcohol abuse program.

2.C.8. Procedures Fair Under Circumstances:

The individual agrees that the credentialing, quality improvement, and professional practice evaluation procedures set forth in the Medical Staff Bylaws, this Policy, and the other Hospital and Medical Staff policies, which address, amongst other things, procedures for processing requests and applications for Membership and Privileges, procedures for credentialing and Privileging, and procedures for addressing concerns regarding clinical performance, professional conduct, and Practitioner health, including the hearing and appeal procedures set forth herein, constitute procedures that are fair under the circumstances and those procedures are the sole and exclusive remedy to challenge any matter that falls within the scope of this Section. The individual agrees and understands that some credentialing, quality improvement, and professional practice evaluation procedures are not associated with due process (e.g. automatic relinquishment of Clinical Privileges) and the fact that no procedures for challenging a particular activity are provided in the Bylaws and related policies does not imply that the Practitioner may seek recourse through legal action. Rather, every individual agrees not to sue for any matter that falls within the scope of this Section (as outlined in 2.C.1.) and affirmatively and explicitly waives legal action as a method of disputing the outcome of any such matter.

2.C.9. Legal Actions:

If, despite the terms set forth in this Section 2.C., an individual institutes legal action (including making any request for arbitration or review by any judicial, quasi-judicial, or governmental agency) challenging any activity that falls within the scope of this Section, and does not prevail, he or she will reimburse the Hospital, its Medical Staff, any Practitioner, and the Board, any of the Hospital's Affiliated Entities, any of the Affiliated Entities' Medical Staffs, Practitioners, and/or Boards, and any of their representatives, as well as any other defendant (including external reviewers and third parties) involved in the action for all costs incurred in defending the legal action, including court and litigation costs and attorney's fees, expert witness fees, and lost revenues.

ARTICLE 3
PROCEDURE FOR GRANTING MEMBERSHIP AND CLINICAL PRIVILEGES

3.A. PROCEDURE FOR GRANTING MEMBERSHIP AND CLINICAL PRIVILEGES

3.A.1. Initial Review of Application:

(1) 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 individual satisfies all threshold eligibility criteria, as set forth in this Policy. Incomplete Applications will not be processed. Unless a waiver has been granted, or a determination has been made to process an Application pending resolution of eligibility, in accordance with the terms of this Policy, individuals who fail to meet 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.

(2) The Medical Staff Office will conduct and oversee the process of gathering additional information, if any, relating to the Applicant's character, professional competence, qualifications, behavior, and ethical standing, or any concerns identified during the verification process. This information may be contained in the Application, and obtained from references and other sources, including the Applicant's past or current department chairperson at other health care entities, residency training director, and others, including lay persons, who may have knowledge about the Applicant's education, training, experience, ability to work with others, and other qualifications.

(3) With respect to each Application, the following background checks will be obtained:

(a) a query of the National Practitioner Data Bank;

(b) review of the Office of Inspector General List of Excluded Individuals/Entities or the General Services Administration's Excluded Parties List System (EPLS) and System for Award Management; and

(c) a criminal background check.

(3) An interview(s) with the Applicant may be conducted at any stage of the processing of the Application. The purpose of the interview is to discuss and review any aspect of the individual's Application, qualifications, and requested Clinical Privileges. This interview may be conducted by one or any combination of any of the following: a department chairperson, the Credentials Committee, a Credentials Committee representative, the Medical Executive Committee, the President of the

Medical Staff, the Chief Medical Officer, the Chief Executive Officer, or the Chair of the Board, or any of their designees.

(4) The Medical Staff Office will transmit the Complete Application and all supporting materials to the chairperson of each department in which the Applicant seeks Clinical Privileges.

3.A.2. Department Chairperson Procedure:

The department chairperson will prepare a written report regarding whether the Applicant has satisfied all of the qualifications for Membership and the Clinical Privileges requested. The report will be on a form provided by the Medical Staff Office.

3.A.3. Credentials Committee Procedure:

(1) The Credentials Committee shall review and consider the qualifications of each Applicant to determine whether the Applicant is "otherwise qualified" for Membership and Clinical Privileges, taking into consideration all aspects of the Applicant's credentials except for information related to disability. The Credentials Committee may rely on any reasonably reliable information in making its evaluation of the Applicant, including the Application form and other materials gathered as part of the Application verification, as well as the report prepared by the department chairperson(s).

(2) If the Credentials Committee believes additional information regarding the Applicant's qualifications is necessary or would be helpful in its evaluation of the Application, the Application will be deemed incomplete until such time as the Credentials Committee is satisfied that sufficient information has been supplied to resolve the question or concern. The Credentials Committee may request information from the Applicant or others, request the opinion and/or expertise of the department chairperson(s) or any other member of the department, request an external review, request the opinion of an outside consultant, or request an interview with the Applicant, amongst other things.

(3) Once the Application is complete, the Credentials Committee will reach its preliminary determination regarding whether the Applicant is "otherwise qualified" for Membership and Clinical Privileges. An Applicant is "otherwise qualified" if he or she is deemed to be qualified for Medical Staff Membership and/or the Clinical Privileges requested, despite the fact that any information about the Applicant's disability, if any, has not yet been gathered or considered.

(4) If the preliminary determination of the Credentials Committee is that an Applicant is "otherwise qualified" for Membership and Clinical Privileges, the Medical Staff Office will provide Notice to the Applicant, along with a copy of the Fitness for Practice Form, and inform the Applicant that the form must be submitted to the

Medical Staff Office within 30 days. The Application will not be processed further, until receipt of the Fitness for Practice form.

(5) The Chief Medical Officer, department chair, or Leadership Council will review the Fitness for Practice Evaluation form and make a determination regarding whether the Applicant may be suffering from a disability that could affect the Applicant's ability, with or without accommodation, to perform the Clinical Privileges requested or the responsibilities of Membership. If the determination is that a disability may affect the Applicant's ability to perform the Clinical Privileges requested or the responsibilities of Membership, or may require accommodation, the matter will be referred to the Leadership Council, to be considered further in accordance with the Medical Staff Policy on Practitioner Health (which may include a request that the practitioner submit to a fitness for practice evaluation and authorize the results of that evaluation to be released to the Hospital and Medical Staff leadership). A copy of the Fitness for Practice form will be retained in the Credentials file, in the portion of the file dedicated to health information. The Application will not be processed further, until the Credentials Committee receives the recommendation of the Leadership Council regarding the Application.

(6) After resolving all concerns regarding the Applicant's qualifications, including, where applicable, receiving the report of the Leadership Council, the Credentials Committee will make its final recommendation regarding the Application to the Medical Executive Committee.

3.A.4. Medical Executive Committee Recommendation:

(1) After receipt of the written report and recommendation of the Credentials Committee, the Medical Executive Committee will:

(a) make a recommendation regarding Membership and/or Clinical Privileges, and, if applicable, adopt the report and recommendation of the Credentials Committee as its own; or

(b) make a recommendation regarding Membership and/or Clinical Privileges, and, if applicable, state its reasons for disagreement with the report and recommendation of the Credentials Committee; or

(c) deem the Application incomplete and refer the matter back to the Credentials Committee for further consideration of specific questions or further inquiry into specified concerns.

(2) If the recommendation of the Medical Executive Committee is to grant Membership and/or Clinical Privileges, that recommendation will be forwarded to the Board.

(3) If the recommendation of the Medical Executive Committee would entitle the Applicant to request a hearing pursuant to this Policy, that recommendation will be forwarded to the Chief Executive Officer, who will promptly send Special Notice to the Applicant in accordance with this Policy.

(4) If the recommendation of the Medical Executive Committee is to grant some, but not all, of the Clinical Privileges requested by the Applicant, or is a recommendation to grant Clinical Privileges subject to a restriction that entitles the Applicant to request a hearing or appeal pursuant to this Policy, the portion of the recommendation that is to grant Membership and/or Privileges shall be forwarded to the Board for consideration and, if applicable, final action even while the hearing and appeal procedures set forth in this Policy are conducted.

3.A.5. Board Action:

(1) Upon receipt of a recommendation that an Applicant be granted Medical Staff Membership and/or Clinical Privileges, the Board may:

(a) grant or deny Membership and/or Clinical Privileges, adopting the report and recommendation of the Medical Executive Committee as its own; or

(b) grant or deny Membership and/or Clinical Privileges, stating its reasons for disagreement with the report and recommendation of the Medical Executive Committee (in such cases, the Board should, when reasonably practicable, first discuss the matter with the Chair of the Medical Executive Committee and Chair of the Credentials Committee); or

(c) deem the Application incomplete and refer the matter back to the Medical Executive Committee for further consideration of specific questions or further inquiry into specified concerns.

(2) If the recommendation from the Medical Executive Committee regarding Membership or Privileges is partially favorable (e.g., because hearing or appeal procedures are underway with respect to the Medical Executive Committee's recommendation not to grant some of the Clinical Privileges requested or to grant Privileges subject to restriction), the Board will render a decision only regarding that portion of the recommendation that is in favor of granting Membership and/or Privileges and will not, at this phase, take action with respect to the portion of Application/recommendation that is subject to pending hearing and appeal procedures.

(3) If the Board's determination would entitle the Applicant to request a hearing pursuant to this Policy, that determination will be forwarded to the Chief Executive Officer, who will promptly send Special Notice to the Applicant in accordance with this Policy. If the Board's adverse determination concerns a recommendation that

was forwarded from the Medical Executive Committee in partial form (e.g., because hearing or appeal procedures are underway with respect to the Medical Executive Committee's recommendation not to grant some of the Clinical Privileges requested or to grant Privileges subject to restriction), the hearing and appeal procedures already underway may be amended at the discretion of the Chief Executive Officer so that all pending adverse professional review recommendations and actions with respect to the Application are considered at the same hearing and/or appeal. In that case, a revised Special Notice

(4) Following the completion or waiver of any applicable hearing or appeal procedures, the Board will render its final decision.

(5) Any final decision by the Board to grant, deny, modify, or revoke Membership or Clinical Privileges will be communicated to the Applicant or Member within 15 business days and will be disseminated, both internally and externally, as appropriate and/or required by law (e.g., reports to the National Practitioner Data Bank pursuant to the Health Care Quality Improvement Act and its implementing regulations and reports to the appropriate Washington state agencies pursuant to RCW §§70.41.210 and 18.130.070 and Washington Admin. Code §246-853-150).

3.A.6. Prerequisites to Commencing Medical Staff Membership Activities and Exercise of Clinical Privileges:

Prior to an individual commencing Medical Staff Membership activities or exercising any Clinical Privileges that have been granted to the individual, the individual must complete the orientation process, if applicable (e.g., new Members), submit evidence of compliance with all Hospital vaccination and fitness for practice requirements (e.g., tuberculosis testing), and document compliance with all mandatory training and educational protocols that are applicable to the Practitioner and have been adopted by the Medical Executive Committee or Hospital, including, but not limited to, those involving electronic medical records, computerized physician order entry (CPOE), the privacy and security of protected health information, patient safety, and EMTALA.

3.A.7. Conditions on Membership and Clinical Privileges:

(1) At any time during the process of credentialing, the department chairperson, Credentials Committee, Medical Executive Committee, or Board may recommend/impose specific conditions on the Practitioner's Membership and/or Clinical Privileges. Those conditions may be related to behavior, health, or clinical issues. Those individuals and bodies may also recommend that Membership or Clinical Privileges be granted to a Practitioner for a period of less than two years in order to permit closer monitoring of a Practitioner's clinical performance, professional conduct, and ongoing qualifications for Membership and Clinical Privileges.

(2) In the case of a Practitioner seeking renewal of Membership or Clinical Privileges, if he or she is the subject of an Investigation or a hearing at the time of credentialing, Membership or Clinical Privileges may be granted for a specific period of less than two years (e.g. three months, six months) or for an event-dependent period of time (e.g. until the completion of the Investigation or until the conclusion of the Medical Staff hearing process).

(3) At the conclusion of any term of Membership or Clinical Privileges that was conditional or that was for a period shorter than two years, the individual must be recredentialed in accordance with the terms of this Policy unless otherwise specified with particularity in the original grant of the conditional or short term Membership or Privileges.

(4) The imposition of conditions on Membership or Clinical Privileges or the grant of Membership or Clinical Privileges for a term shorter than two years, as described in this Section, does not, in and of itself, entitle a Practitioner to the right to request a hearing or appeal or any other due process.

3.A.8. Time Periods for Processing:

Once an Application is deemed Complete, it is expected to be processed within 120 Days, unless it becomes not Complete. An individual who has submitted an Application will be provided Notice of the final action on the application within 15 days. These time periods are intended to be guidelines only and will not create any right for an Applicant to have an Application processed or to receive Notice of the outcome of the Application within these precise time periods.

ARTICLE 4
CLINICAL PRIVILEGES

4.A. CLINICAL PRIVILEGES

4.A.1. General:

(1) Membership will not confer any Clinical Privileges or right to practice at the Hospital. Only those Clinical Privileges granted by the Board may be exercised, subject to the terms of this Policy.

(2) Except as specifically set forth in this Policy, requests for Clinical Privileges will be processed only when an individual satisfies the threshold eligibility criteria for Medical Staff Membership and Clinical Privileges set forth in Article 2 of this Policy. An individual who does not satisfy the threshold eligibility criteria for Clinical Privileges may request that the threshold eligibility criteria be waived as set forth in this Policy.

(3) Requests for Clinical Privileges that are subject to an exclusive contract or arrangement will not be processed except as consistent with the applicable contract or Board resolution.

(4) Requests for Clinical Privileges that are not part of the established delineation of privileges will only be considered if the Board has determined that the Hospital has the resources to offer or support the Clinical Privileges. If such a determination has not been made by the Board, no Practitioner will be considered eligible to request such Clinical Privileges.

(5) Recommendations for Clinical Privileges will be based on consideration of the following:

(a) 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;

(b) appropriateness of utilization patterns;

(c) information concerning the individual's ability to perform the Clinical Privileges requested competently and safely;

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

(e) availability of coverage in case of the individual's illness or unavailability;

(f) having current valid professional liability insurance coverage for the Clinical Privileges requested in a form and in amounts as determined by the Hospital;

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

(h) any information concerning Professional Review Actions or voluntary or involuntary termination, limitation, reduction, or loss of staff membership or Clinical Privileges at another hospital or healthcare entity;

(i) Practitioner-specific data as compared to aggregate data, when available;

(j) morbidity and mortality data, when available;

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

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

(6) Requests for new or additional Privileges must be in writing and state the additional Clinical Privileges requested and provide information sufficient to establish eligibility. If the Practitioner is eligible and the request is Complete, it will be processed in the same manner as an Application for initial Clinical Privileges (and in all such cases, the Medical Staff Office shall not only verify current professional liability coverage, but also that such coverage specifically applies to the new or increased Clinical Privileges). If the request for new or additional Privileges is made at or near the time of renewal of Membership or Clinical Privileges, it may be processed along with the Application for renewal of Membership or Clinical Privileges.

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

4.A.2. Privilege Waivers:

(1) In limited circumstances, the Hospital may consider a waiver of the requirement that Clinical Privileges be granted by Core or specialty. If an individual wants to request such a waiver, the request must be submitted in writing to the Medical Staff Office. The request must indicate the specific Clinical Privileges within the Core or specialty that the individual does not wish to provide, state a good cause basis for the request, and include evidence that he or she does not provide the relevant patient care services in any health care facility.

(2) Requests for waivers related to Clinical Privileges will be processed in the same manner as requests for waivers of threshold eligibility criteria.

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

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

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

(c) the expectations of Practitioners who rely on the specialty;

(d) the interests of the individual requesting the waiver;

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

(f) 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.

(4) If the Board grants a waiver related to Clinical Privileges, it will specify the effective date.

(5) No one is entitled to a waiver or to a hearing or appeal if a waiver is not granted.

<u>4.A.3. Relinquishment of Individual Clinical Privilege:</u>

A request to relinquish any individual Clinical Privilege, whether or not part of the Core, must provide a good cause basis for the modification of Clinical Privileges. All such requests will be processed in the same manner as a request for waiver, as described above.

<u>4.A.4. Resignation of Membership and Clinical Privileges:</u>

A request to resign all Clinical Privileges must (a) specify the desired date of resignation, at least 30 Days after the date of the request, and (b) provide evidence that the individual has completed all medical records and will be able to appropriately discharge or transfer responsibility for the care of any hospitalized patient. After consulting with the President of the Medical Staff, the Chief Executive Officer will act on the request. Failure to follow this process will be reflected in any future reference responses provided for the Practitioner.

4.A.5. Clinical Privileges for New Treatments, Procedures, or Therapies:

(1) Requests for Clinical Privileges to perform either a treatment, procedure, or therapy not currently being performed at the Hospital or a new technique to perform an existing treatment, procedure, or therapy ("New Procedure") will not be processed until a determination has been made that the New Procedure will be offered by the Hospital and criteria for the associated Clinical Privilege(s) have been adopted.

(2) As an initial step in the process, any individual proposing that the New Procedure be offered at the Hospital will prepare and submit information to the department chairperson and the Credentials Committee addressing at least the following:

(a) clinical indications for when the New Procedure is appropriate;

(b) whether there is empirical evidence of improved patient outcomes with the New Procedure or other clinical benefits to patients;

(c) whether the New Procedure is being performed at other similar hospitals and the experiences of those institutions;

(d) whether the New Procedure is investigational and, if so, whether there has been IRB approval; and

(e) whether the New Procedure has received any regulatory approval (e.g., FDA) and whether it has a favorable safety profile.

(3) The department chairperson and the Credentials Committee will review and, as necessary, verify this information and conduct additional research, including at least the following:

(a) whether proficiency for the New Procedure is volume-sensitive and if the requisite volume would be available;

(b) whether the Hospital currently has the resources, including space, equipment, personnel, and other support services, to safely and effectively perform the New Procedure; and

(c) Yakima Valley's and/or other Affiliated Entities' experience with, or information regarding, the New Procedure;

Based on this information, the department chairperson will make a recommendation to the Credentials Committee, which will make a preliminary recommendation as to whether the New Procedure should be offered at the Hospital.

(4) The Credentials Committee will forward its recommendations regarding whether the New Procedure should be offered at the Hospital to the Medical Executive Committee, which will review the matter and forward its recommendations to the Board for final action.

(5) The Credentials Committee will develop eligibility criteria for requesting the Clinical Privileges required to perform any New Procedure approved for the Hospital. In developing the criteria, the Credentials Committee may conduct additional research and consult with experts, as necessary, and develop recommendations regarding:

(a) the minimum education, training, licensure, experience and, as applicable, additional eligibility criteria (such as an affiliation agreement with a Supervising/Collaborating Practitioner) necessary to perform the New Procedure;

(b) the clinical indications for when the New Procedure is appropriate; and

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

(6) The Credentials Committee will forward its recommendations regarding the eligibility criteria for Clinical Privileges to perform the New Procedure 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 or Practitioner Category Lines:

(1) Requests for Clinical Privileges that previously have been exercised only by Physicians in another specialty or individuals in another Practitioner category (e.g., Podiatrists vs. advanced practice registered nurses vs. Physicians) will not be processed until the steps outlined in this Section have been completed and a determination has been made regarding the individual's eligibility to request the Clinical Privilege(s) in question.

(2) As an initial step in the process, any individual proposing that Clinical Privileges be available for members of a new specialty or Practitioner category will prepare

and submit information to the Credentials Committee addressing at least the following:

(a) clinical indications for when the Clinical Privileges can be safely exercised by members of a new clinical specialty or category of practitioners; and

(b) whether individuals in the same specialty or category of practice are performing the Clinical Privilege at other similar hospitals and the experiences of those institutions.

(3) The Credentials Committee will then conduct additional research and consult with experts, as necessary, including those on the Medical Staff (e.g., department chairpersons and Practitioners with special interest and/or expertise) and those outside the Hospital (e.g., other hospitals, residency training programs, allied health training and certification programs, specialty societies). If the individual requesting Clinical Privileges is an Advanced Practice Professional, the Credentials Committee will consult with and obtain the recommendation of the Advanced Practice Professional Review Committee before making its recommendation.

(4) The Credentials Committee may or may not recommend that individuals from different specialties or Practitioner categories be permitted to request the Clinical Privileges at issue. If it does, the Committee may develop recommendations regarding:

(a) the minimum education, training, experience and, as applicable, additional eligibility criteria (such as an affiliation agreement with a Supervising/ Collaborating Practitioner) necessary to perform the Clinical Privileges in question;

(b) the clinical indications for when the procedure is appropriate to be performed by individuals in the new clinical specialty or practitioner category;

(c) 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;

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

(e) 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

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

(5) 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. Individuals in Training Programs:

(1) Individuals will not, by virtue of participation in training programs, be granted Membership in the Medical Staff or Clinical Privileges. Rather, individuals in training programs will be granted permission to perform clinical functions in the Hospital only as set forth in the curriculum requirements, affiliation agreements, and/or training protocols that have been approved by the Medical Executive Committee (or its designee). Those documents will, at a minimum, require the applicable program director to verify and evaluate the qualifications of each individual in the training program and require the program director or applicable clinical faculty or attending staff Members to direct and supervise the on-site or day-to-day patient care activities of trainees.

(2) Individuals in training programs who are seeking to practice outside of their training program must apply for Clinical Privileges as set forth in this Policy.

4.A.8. Telemedicine Clinical Privileges:

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

(2) A qualified individual may be granted telemedicine Clinical Privileges, but need not be granted Membership on the Medical Staff.

(3) Applications for initial or renewed telemedicine Privileges will be processed through one of the following options, as determined in the sole discretion of the CEO, after consultation with the President of the Medical Staff:

(a) Full Processing. An Application for telemedicine Privileges may be processed through the same process for Medical Staff Applications, as set forth in this Policy. In such case, the individual must satisfy all qualifications and requirements set forth in this Policy, except those relating to geographic location, coverage arrangements, and emergency call responsibilities. Any Applicant seeking Medical Staff Membership in addition to telemedicine Privileges (e.g. a local Applicant seeking to

exercise some of his or her Privileges through telemedicine) must be processed through the "full processing" option.

(b) Abbreviated Processing. If the individual requesting telemedicine Privileges is practicing at a "qualified entity," then the request for telemedicine Privileges may be processed using the following, abbreviated process that relies on the credentialing and privileging information and decisions made by the qualified entity. For purposes of this section, a qualified entity means a hospital or other entity that (i) participates in Medicare or is a telemedicine entity (as that term is defined by Medicare) (ii) is a hospital or ambulatory care organization accredited by the Joint Commission, and (iii) has entered into a written agreement with the Hospital, pursuant to which the qualified entity has agreed that it will comply with all applicable Medicare regulations and accreditation standards.

(i) Before an Application for telemedicine Privileges will be deemed Complete, the Applicant must ensure that the qualified entity has provided to the Medical Staff Office:

(A) confirmation that the Applicant is licensed in Washington;

(B) a current list of Privileges granted to the Applicant at the qualified entity's distant site;

(C) information indicating that the Applicant has actively exercised the relevant Privileges during the previous 12 months and has done so in a competent manner;

(D) a signed attestation that the Applicant satisfies all of the qualified entity's qualifications for the Clinical Privileges granted;

(E) a signed attestation that all information provided by the qualified entity is complete, accurate, and up-to-date; and

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

(ii) This information will be forwarded to the Medical Executive Committee for consideration. The Medical Executive Committee will make a recommendation regarding Clinical Privileges to the Board, which will be responsible for final action to grant or deny telemedicine Clinical Privileges.

(iii) Notwithstanding the abbreviated process set forth in this subsection, the Hospital may determine that an Applicant for telemedicine Privileges is ineligible for telemedicine Clinical Privileges if the Applicant fails at any time to satisfy any of the threshold eligibility criteria set forth in this Policy.

(4) Telemedicine Clinical Privileges, if granted, will be for a period of not more than two years.

(5) Practitioners granted telemedicine Clinical Privileges will be subject to the Hospital's professional practice evaluation activities. The results of these 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 entity providing telemedicine services.

(6) Telemedicine Clinical Privileges granted in conjunction with a contractual agreement will be incident to, coterminous with, and subject to the provisions of the agreement.

4.A.9. Focused Professional Practice Evaluation for Initial Clinical Privileges:

(1) All initial grants of Clinical Privileges, at any time, will be subject to focused professional practice evaluation by the department chairperson or by a Practitioner(s) designated by the Credentials Committee.

(2) 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.

(3) The newly-granted Clinical Privileges will expire if a Practitioner fails to fulfill the applicable focused professional practice evaluation clinical activity requirements within the time frame recommended by the Credentials Committee, which may include reasonable extensions, within the Credentials Committee's discretion. In such case, the individual may not reapply for those same Clinical Privileges for two years.

(4) When, 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 Practitioner will be entitled to a hearing and appeal.

4.B. TEMPORARY PRIVILEGES

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

(1) Temporary Privileges may be granted to Applicants for initial Membership or initial Clinical Privileges whose Complete Application is pending review by the Medical Executive Committee and Board.

(2) To be eligible for temporary Privileges, the Applicant must satisfy all qualifications and requirements set forth in this Policy. In addition, Applicants must demonstrate satisfaction of these additional criteria in order to be eligible for temporary Privileges for initial Applicants:

(a) a demonstrated ability to perform the Clinical Privileges requested; and

(b) that the Applicant has had no (i) current or previously successful challenges to licensure or registration or (ii) involuntary Restriction, reduction, denial or termination of Membership or Clinical Privileges at another health care facility.

(3) Requests for temporary Privileges for Applicants will initially be processed in the same manner as all other Applications for Membership and Clinical Privileges, as set forth in this Policy. Once the Applicant has a Complete Application, has been deemed eligible for temporary Privileges, and has received a favorable recommendation of the Credentials Committee during the course of the credentialing process, the President of the Medical Staff may recommend that the Applicant be granted temporary Privileges and, after receiving that recommendation, the Chief Executive Officer, acting on behalf of the Board, may grant temporary Privileges to the Applicant. Temporary Privileges shall be effective immediately upon Notice to the Practitioner.

(4) Temporary Privileges for initial Applicants will be granted until final action by the Board on the Application, not to exceed a term of 120 Days. Temporary Privileges for new Applicants are not subject to renewal.

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

(1) Temporary Privileges may be granted to individuals who are not requesting consideration for Medical Staff Membership or ongoing Clinical Privileges when there is an important patient care, treatment, or service need. This includes, but is not limited to, the following situations:

(a) for the care of a specific patient;

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

(c) for proctoring or teaching; or

(d) when serving in a locum tenens capacity for another Practitioner.

(3) Applications for temporary Privileges for an important patient care need will be processed through the following, alternative credentialing process:

(a) The Application will be verified through the same process as other Applications for Membership and Clinical Privileges, as set forth in this Policy.

(b) Following the full verification of the individual's Application by the Medical Staff Office, the matter will be referred to the President of the Medical Staff, for recommendation regarding whether the Applicant should be granted temporary Privileges. After receiving the recommendation of the President of the Medical Staff, the Chief Executive Officer, acting on behalf of the Board, may grant temporary Privileges to the Applicant. The grant of temporary Privileges will be based on:

(i) the individual's satisfaction of all applicable threshold eligibility criteria, except those relating to geographic location, coverage arrangements, compliance with education and training protocols, and responsibility for serving on the emergency call roster that the Hospital maintains for purposes of complying with the Emergency Medical Treatment and Active Labor Act (EMTALA) or any criteria specifically waived by the Chief Executive Officer (after receiving the recommendation of the President of the Medical Staff, balancing the impact of waiving any criteria against the importance of the patient care need justifying the grant of temporary Privileges);

(ii) the individual's documented experience and current competence; and

(iii) in the case of temporary Privileges for teaching purposes, the expertise, extent of clinical experience, and reputation of the individual, as well as the Hospital's need for Practitioners trained in the respective procedure/skill.

(c) Temporary Privileges for an important patient care need will be effective immediately upon Notice to the Practitioner and shall be granted for a period of time correlating to the important patient care need, not to exceed a term of 120 Days. When the important patient care need that serves as the basis for Temporary Privileges ceases to exist (e.g. the Practitioner for whom the individual is serving as a locum tenens returns to work), the temporary Privileges will likewise expire, upon Notice to the Practitioner.

4.B.3. Conditions Applicable to Temporary Privileges:

(1) Prior to any temporary Privileges being granted, the individual must agree in writing that he or she is subject to and will abide by the Bylaws, policies, and Rules and Regulations, procedures and protocols of the Medical Staff and the Hospital, as may be amended from time to time, and must sign any and all attestations and releases required by the Hospital and/or Medical Staff (e.g. CMS-required attestations).

(2) Temporary Privileges are granted as a temporary courtesy only and do not give rise to any expectation of continued Clinical Privileges at the Hospital. They may be withheld or withdrawn, at any time, in the discretion of the Chief Executive Officer, acting on behalf of the Board, after consulting with the President of the Medical Staff, the CMO, the chairperson of the Credentials Committee, or the department chairperson. If temporary Privileges are withdrawn, the department chairperson or the President of the Medical Staff will assign to another Practitioner with appropriate Clinical Privileges the 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 Practitioner.

(3) The first time any particular temporary Privileges are granted to a Practitioner, the Practitioner shall be subject to the focused professional practice evaluation process applicable to all initially granted Clinical Privileges, in accordance with the Medical Staff policy on Focused Professional Practice Evaluation.

4.C. EMERGENCY SITUATIONS

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

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

(3) When the emergency situation no longer exists, the patient will be assigned by the department chairperson or the President of the Medical Staff to a Member with appropriate Clinical Privileges, considering the wishes of the patient.

4.D. DISASTER PRIVILEGES

(1) When the Hospital Emergency Operations Plan has been implemented and the immediate needs of patients in the facility cannot be met, the Chief Executive Officer or his or her designee, Chief Medical Officer, or other individual who has been designated to oversee the Hospital Emergency Operations Plan may, after consulting with the President of the Medical Staff, grant disaster Privileges to

eligible volunteers who are licensed independent practitioners ("volunteers") using the modified credentialing process set forth below.

(2) Before disaster Privileges are granted, the Hospital will obtain:

(a) the volunteer's valid, government-issued photo identification (e.g., driver's license or passport); and

(b) one of the following:

(i) a current picture or 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 recognized state or federal response organization or group;

(v) identification indicating that the individual has been granted authority by a government entity to provide patient care, treatment, or services in disaster circumstances; or

(vi) confirmation by a Licensed Independent Practitioner currently privileged by the Hospital or by a staff member with personal knowledge of the volunteer practitioner's ability to act as a licensed independent practitioner during a disaster.

(3) Primary source verification of the following qualifications of the volunteer will begin as soon as the immediate situation is under control and must be completed within 72 hours from the time the volunteer begins to provide service at the Hospital:

(a) current, unrestricted license to practice that is recognized in Washington and is not subject to any restrictions, probationary terms, or conditions not generally applicable to all licensees;

(b) current, unrestricted DEA registration (linked to a license recognized in this state), as applicable to the disaster Privileges being sought by the Practitioner;

(c) current, valid professional liability insurance coverage in a form and in amounts as determined by the Hospital;

(d) evidence of relevant training, experience, and current competence;

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

(f) confirmation that the individual is not an Ineligible Person, by viewing the Office of Inspector General List of Excluded Individuals/Entities or the General Services Administration's Excluded Parties List System (EPLS) and System for Award Management, as well as the Washington State Health Care Authority list of excluded providers.

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

(5) Disaster Privileges are granted as a temporary courtesy and emergency management coping strategy only and primarily exist for the benefit of the Hospital and the community it serves, rather than for the benefit of the volunteer. A grant of disaster Privileges does not give rise to any expectation of continued Clinical Privileges at the Hospital. They may be withheld or withdrawn, at any time, in the discretion of the Board, Chief Executive Officer or his or her designee, Chief Medical Officer, or other individual who has been designated to oversee the Hospital Emergency Operations Plan. Disaster Privileges may continue as long as disaster-related patient care coverage needs still exist, up to 120 days. Disaster Privileges do not automatically terminate once the Hospital's emergency operations center discontinues its operations. Rather, disaster Privileges shall terminate automatically, upon Notice to the volunteer, when the disaster is resolved and the immediate needs of patients in the Hospital can be met by Medical Staff Members and other Practitioners, or if the Hospital finds it is unable to confirm the volunteer's qualifications through the primary source verification process. When disaster Privileges are withdrawn or subject to automatic termination, the department chairperson or the President of the Medical Staff will assign to another Practitioner with appropriate Clinical Privileges the responsibility for the care of patients until they are discharged.

(6) The following safeguards must be in place to verify that patient safety is assured while care is being provided by volunteers pursuant to disaster Privileges:

(a) Upon granting disaster Privileges to a Practitioner, the Hospital will issue the Practitioner an appropriate Hospital security ID and assign that Practitioner to a Medical Staff Member, if possible, with whom to collaborate in the care of disaster victims and other patients.

(b) The Medical Staff will oversee the care provided by volunteer Practitioners. After consultation with the President of the Medical Staff or other individual directing medical care at the Hospital during the disaster, the individual granting disaster Privileges will assign a Member of the Medical Staff to provide oversight to each Practitioner who has been granted disaster Privileges. This oversight will be conducted through direct observation, mentoring, clinical record review, or another appropriate mechanism developed by the Medical Staff and Hospital.

4.E. EXCLUSIVE ARRANGEMENTS

(1) From time to time, the Hospital may enter into exclusive contracts or arrangements ("exclusive arrangements") with Practitioners and/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 in accordance with the terms of this Policy.

(2) To the extent that the Board of Directors by resolution or other arrangement confers the exclusive right to perform specified services to one or more Practitioners or groups of Practitioners or otherwise closes a department or service, then no Practitioners except those authorized by or pursuant to the resolution or arrangement may exercise Clinical Privileges to perform the specified services. Only Practitioners so authorized are eligible to apply for the Clinical Privileges included in the resolution or arrangement.

(3) Prior to the Hospital entering into any exclusive arrangement in a clinical service that has not previously been subject to such arrangement, the Board of Directors will request the Medical Executive Committee (or a subcommittee of its members appointed by the Chairperson of the Medical Executive Committee) to review the proposal under consideration by the Board of Directors and comment on the quality of care and clinical service implications of the proposed arrangement. After providing the Medical Executive Committee the opportunity to comment, the Board of Directors will consider whether or not to proceed with the exclusive arrangement.

(4) If the Board of Directors makes a preliminary determination to proceed with an exclusive arrangement that would have the effect of preventing a Practitioner from

exercising or renewing Clinical Privileges that had previously been granted, the affected Practitioner is entitled to the following notice and review procedures:

(a) Notice of the proposed exclusive arrangement and the right to request to meet with the Board to discuss the matter prior to the proposed arrangement being executed or finalized.

(b) At the meeting, which shall be at a time and place specified by the Board, the affected Practitioner will be entitled to present information relevant to the decision to enter into the arrangement.

(c) If, following this meeting, the Board determines to enter into the exclusive arrangement, the affected Practitioner will be notified that he or she is ineligible to continue to exercise or to renew the Clinical Privileges covered by the exclusivity. The ineligibility begins on the date specified by the Board.

(d) The procedural rights outlined above will be the Practitioner's exclusive remedy. The provisions in Article 7 of this Policy are inapplicable to this administrative determination.

(e) The inability of a Practitioner to exercise Clinical Privileges because of an exclusive contract or arrangement is not a matter that requires a report to the state licensure board or to the National Practitioner Data Bank.

(5) After the procedures set forth in (3) and (4) of this Section, the Board will make a final determination regarding whether to proceed with the exclusive arrangement.

(6) In the event of any conflict between this Policy or the Medical Staff Bylaws and the terms of any contract or Board resolution, the terms of the contract or Board resolution will control.

4.F. USE OF OUTPATIENT ANCILLARY SERVICES BY NON-PRIVILEGED PRACTITIONERS

Non-Privileged Practitioners may order outpatient diagnostic tests and other outpatient services at the Hospital only in accordance with Washington and federal law and any Hospital policy governing the use of outpatient ancillary services by Non-Privileged Healthcare Practitioners.

ARTICLE 5
PROCEDURE FOR RENEWAL OF MEMBERSHIP AND CLINICAL PRIVILEGES

5.A. TERMS, CONDITIONS, & REQUIREMENTS OF INITIAL MEMBERSHIP AND PRIVILEGES CONTINUE TO APPLY

All terms, conditions, requirements, and procedures relating to initial Membership and Clinical Privileges will also apply to renewal and continuation of Membership and Clinical Privileges.

5.B. ADDITIONAL RENEWAL CRITERIA

5.B.1. Eligibility for Renewal:

To be eligible for renewal of Membership and Clinical Privileges and have an Application regarding the same processed, an individual must have, during the previous term of Membership and Clinical Privileges:

(1) completed all medical records such that he or she:

(a) is not subject to automatic relinquishment of clinical privileges due to failure to complete medical records, as per the Medical Staff Rules and Regulations and Hospital policy, at the time he or she submits the Application for renewal of Membership or Clinical Privileges;

(b) was not subject to automatic relinquishment of clinical privileges due to failure to complete medical records, as per the Medical Staff Rules and Regulations and Hospital policy, more than two times during the prior term of Membership or Clinical Privileges;

(2) completed all continuing medical education requirements established by the Medical Staff Rules and Regulations, any applicable Clinical Privilege delineation, or other Hospital or Medical Staff policy;

(3) satisfied all responsibilities applicable to Medical Staff Members and other Practitioners, including payment of any dues, fines, and assessments;

(4) continued to meet all qualifications and criteria for Membership and the Clinical Privileges requested;

(5) paid any applicable Application processing fee; and

(6) had sufficient Patient Contacts to enable the assessment of current clinical judgment and competence for any Clinical Privileges requested. Any Practitioner seeking renewal of Membership or Clinical Privileges who has had insufficient Patient

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Contacts, as determined by Hospital or Medical Staff policy, or who has been requested to submit additional evidence of current clinical competence, must submit such information as has been requested. The Application will not be considered Complete and processed further until the evidence has been received, reviewed, and deemed satisfactory. Information which may be requested includes, but is not limited to, a copy of the individual's confidential quality profile from his or her primary hospital or other organization, clinical information from his or her private office practice or other organization, or a quality profile from a managed care organization or insurer.

5.B.2. Factors for Evaluation:

In considering an Application for renewal of Membership or Clinical Privileges, the factors listed in Article 2 of this Policy will be considered. Additionally, the following factors will be evaluated as part of the renewal process:

(1) compliance with the Medical Staff Bylaws, Rules and Regulations, and policies of the Medical Staff and the Hospital;

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

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

(4) any ongoing and focused professional practice evaluations, peer review activity, and other evaluations;

(5) feedback received from patients and their families, visitors, or staff; and

(6) other reasonable indicators of continuing qualifications.

5.C. RENEWAL PROCESS

5.C.1. Request for Renewal of Membership and/or Clinical Privileges:

(1) Membership terms and terms of Clinical Privileges will not extend beyond two years. As set forth in Article 3 of this Policy, Membership terms and terms of Clinical Privileges may be for a term that is shorter than two years and may be subject to other conditions.

(2) Practitioners will be provided notification of the need to apply for renewal of Membership and/or Clinical Privileges 180 days prior to the expiration of their current term of Membership and/or Clinical Privileges.

(3) Failure to submit an Application for renewal of Membership and/or Clinical Privileges to the Medical Staff Office at least 120 days prior to the expiration of their current term of Membership and/or Clinical Privileges, or failure to Complete the Application (or keep it Complete), may result in the automatic expiration of Membership and Clinical Privileges at the end of the then current term. Practitioners have no right to demand that the Medical Staff leaders or Board schedule special meetings to review or act on their Applications in order to prevent expiration and/or a lapse, particularly when such Applications have not been timely submitted or Completed.

(4) Applications for Renewal of Membership and/or Clinical Privileges shall be processed in the same manner as Applications for Initial Membership and Clinical Privileges, as outlined in this Policy.

5.C.2. Potential Adverse Recommendation:

(1) If the Credentials Committee or the Medical Executive Committee is considering making a recommendation to deny the renewal of Membership or Clinical Privileges or a recommendation for any other action that would entitle the Applicant for renewal to request a hearing pursuant to this Policy, the committee chairperson will notify the Practitioner within 10 days of reaching the preliminary determination of the possible recommendation and invite the Practitioner to meet within 30 days of receiving the Notice, prior to any final recommendation being made.

(2) Prior to the meeting, the Practitioner will be provided information concerning the general nature of the concern that forms the basis of the recommendation being contemplated.

(3) At the meeting, the Practitioner will be invited to discuss, explain, and/or refute the concern. A summary of the discussion will be made and included with the committee's recommendation.

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

ARTICLE 6
MANAGING CONCERNS ABOUT PRACTITIONERS

6.A. OVERVIEW AND GENERAL PRINCIPLES

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

(1) This Policy empowers Medical Staff Leaders, Hospital administration, and the Board to use various options to gather information and address and resolve concerns about Practitioners. The various options available to Medical Staff Leaders, Hospital administration, and the Board, and the mechanisms they may use when concerns pertaining to competence, health or behavior are raised are outlined below and detailed in this Policy and in other Hospital and Medical Staff policies, as well as the Medical Staff Bylaws. These options include, but are not limited to, the following:

(a) collegial intervention and progressive steps;

(b) mandatory meetings;

(c) informal fact finding;

(d) ongoing and focused professional practice evaluation;

(e) clinical competency evaluations;

(f) fitness for practice evaluations;

(g) automatic relinquishment of Membership and Clinical Privileges;

(h) leaves of absence;

(i) precautionary suspension; and

(j) formal Investigation.

(2) In addition to these options, Medical Staff Leaders, Hospital administration, and/or the Board, as applicable, also have the discretion to determine whether a matter should be handled in accordance with another policy (e.g., the Medical Staff's policies on professionalism, health, and professional practice evaluation) or should be referred to the Medical Executive Committee for further action.

6.A.2. Documentation:

(1) Except as otherwise expressly provided, Medical Staff Leaders, Hospital administration, or the Board, as applicable, will document any meeting with a Practitioner that may take place pursuant to the processes and procedures outlined in this Article.

(2) Medical Staff Leaders, Hospital administration, or the Board, as applicable, may prepare a summary of the meeting held with the Practitioner, in which case the summary will be shared with the Practitioner and he or she will be provided an opportunity to review the summary and respond to it. The summary may be in the form of a memo, a follow-up letter to the Practitioner, or any other form deemed appropriate by the individual composing it.

(3) Initial documentation of a concern, any summary, and any response to the summary provided by the Practitioner are all confidential and privileged, protected peer review/ quality improvement documents and, as such, will be maintained in the Practitioner's confidential file.

6.A.3. No Recordings of Meetings:

It is the policy of the Hospital to maintain the confidentiality of all Medical Staff meetings. The discussions that take place at such meetings are conducted with the expectation of privacy. Therefore, individuals Present at any Medical Staff meeting are prohibited from making audio or video recordings at such meetings unless authorized, in writing, by the individual chairing the meeting or by the Chief Executive Officer. If recording has been authorized, a copy of the written permission must be submitted by the individual making the recording to the Chief Executive Officer, President of the Medical Staff, and chairperson of the relevant body (e.g. department, committee) in advance of the meeting and a copy of the recording must be promptly (within 24 hours after the meeting) provided to the Chief Executive Officer. This rule regarding recording applies to:

(1) meetings of Board members, members of Hospital Administration, and/or Medical Staff Leaders, or any of their designees, where the meeting involves discussions relating to credentialing, quality assessment and improvement, performance improvement, peer review, and professional practice evaluation activities;

(2) meetings of the Board, a Board subcommittee, the Medical Staff, a Medical Staff department, a Medical Staff committee, or a meeting of one or more Medical Staff officers; and

(3) medical staff hearings and appeals, as set forth in this Policy (except that a transcription or recording of the proceeding shall be made by arrangement of the Hospital, as set forth in the hearing and appeal procedures set forth herein).

6.A.4. No Right to Counsel:

(1) The processes and procedures outlined in this Article are designed to be carried out in an informal manner. Therefore, lawyers and other "representatives" or "advocates" will not be present for any meeting that takes place pursuant to this Article. By agreement of the President of the Medical Staff and Chief Executive Officer, an exception may be made to this general rule, in which case all interested parties will be allowed to have lawyers present.

(2) Unless an exception has been granted, if the Practitioner refuses to meet without his or her lawyer (or other individual) present, the meeting will be canceled and it will be reported to the Medical Executive Committee that the individual declined to attend the meeting. Pursuant to the terms of this Policy and the Professional Practice Evaluation Policy, that may result in the automatic relinquishment of Membership and Clinical Privileges, upon Notice to the Practitioner.

6.A.5. No Right to the Presence of Others:

All Medical Staff activities, including the activities set forth in this Article, are confidential and privileged to the fullest extent permitted by law. Accordingly, except as permitted in this Article, the Practitioner may not be accompanied by friends, relatives, colleagues, advocates, representatives, emotional support persons, etc. when attending (being Present at) a meeting that takes place pursuant to this Article.

6.A.6. Involvement of Supervising/Collaborating Practitioner in Matters Pertaining to Practitioners Under Their Supervision:

If any peer review/professional practice evaluation activity, including any activity pursuant to this Article, pertains to the clinical competence or professional conduct of a Practitioner with a Supervising/Collaborating Practitioner, that Supervising/ Collaborating Practitioner may be provided Notice and may be invited to participate.

6.B. COLLEGIAL INTERVENTION AND PROGRESSIVE STEPS

(1) The use of collegial intervention efforts and progressive steps by Medical Staff Leaders, Hospital administration, or the Board, as applicable, is encouraged. All such efforts are fundamental and integral components of the Hospital's professional practice evaluation activities and are confidential and protected in accordance with state law.

(2) The goal of those efforts is to arrive at voluntary, responsive actions by the Practitioner to resolve an issue that has been raised. Collegial efforts and progressive steps may be carried out, within the discretion of Medical Staff Leaders and Hospital administration, but are not mandatory.

(3) Collegial intervention efforts and progressive steps are part of the Hospital's ongoing and focused professional practice evaluation activities and may include, but are not limited to, the following:

(a) sharing and discussing applicable policies, such as policies regarding appropriate behavior, emergency call obligations, and the timely and adequate completion of medical records;

(b) counseling, mentoring, monitoring, proctoring, consultation, and education, including formal retraining programs;

(c) facilitating a formal collegial intervention meeting (i.e., a planned, face-to-face meeting between an individual and one or more Medical Staff Leaders, Hospital administrators, and/or Board members) in order to directly discuss a matter and the steps that need to be taken to resolve it;

(d) sharing comparative quality, utilization, and other relevant information, including any variations from clinical protocols or guidelines;

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

(f) informational letters of guidance, education, or counseling; and

(g) developing a performance improvement plan, which may include a variety of tools and techniques that can result in a constructive and successful resolution of the concern.

6.C. INFORMAL FACT FINDING

During the course of reviewing and evaluating Applications for Medical Staff Membership, renewal of Membership, and/or Clinical Privileges, and conducting Professional Practice Evaluation activities, members of Hospital administration, Medical Staff leaders, and credentialing and PPE support professionals, and/or any of their designees, may engage in fact-finding activities that include, but are not limited to: conducting and documenting interviews with the Practitioner and interviews with witnesses and other people who may have relevant information about the question or concern, medical record review, document requests, document review, requests for clinical competency or fitness for practice evaluations, and/or preparation of summaries or other documentation related to the matter.

The activities described in this Section constitute informal fact finding as part of the routine review process, which is generally conducted to verify facts and determine whether any room for improvement exists and, if so, to determine best methods for achieving that improvement. These activities are not precursors to Professional Review Actions and do

not constitute an Investigation (which commences only by specific action of the Medical Executive Committee, as set forth in this Policy, or by action of the Board).

6.D. MANDATORY MEETING

(1) Whenever there is a concern regarding a Practitioner's clinical practice or professional conduct, Medical Staff Leaders, Hospital administration, and/or the Board may require the Practitioner's Presence at a mandatory meeting.

(2) Special Notice will be given at least three Days prior to the meeting and will inform the Practitioner that his or her Presence at the meeting is mandatory.

(3) Failure or refusal of a Practitioner to attend (be Present at) a mandatory meeting will result in an automatic relinquishment of Membership and Clinical Privileges as set forth in this Policy.

(4) If the Practitioner provides advance Notice to the Medical Staff office (and supporting evidence, if requested) that he or she cannot attend the mandatory meeting as scheduled due to a previously-scheduled, important calendar conflict (e.g., the Practitioner will be out of the country, will be attending an immediate family member's wedding, is scheduled to undergo a medical procedure), the individual(s) or body requesting the mandatory meeting should reschedule the meeting in lieu of implementing automatic relinquishment as set forth in this Policy. The discretion to determine whether to reschedule or implement automatic relinquishment lies with the individual(s) or body that requested the mandatory meeting.

(5) If the Practitioner does not attend a mandatory meeting and does not provide advance Notice to the Medical Staff office that he or she will not attend, but later provides information (and supporting evidence, if requested) that he or she did not receive the Special Notice of the meeting due to exceptional circumstances (e.g. being out of the country and without access to mailings and email communications during the relevant period), the individual(s) or body requesting the mandatory meeting should reschedule the meeting in lieu of implementing automatic relinquishment as set forth in this Policy. The discretion to determine whether to reschedule or implement automatic relinquishment lies with the individual(s) or body that requested the mandatory meeting.

6.E. ONGOING AND FOCUSED PROFESSIONAL PRACTICE EVALUATION

(1) Practitioners who have been granted a particular Clinical Privilege for the first time, whether at the time of an initial Application, a renewal, or pursuant to an

Application for additional Privileges made during the course of a current term of Clinical Privileges, will be subject to focused professional practice evaluation to confirm their competence.

(2) All Practitioners who provide patient care services at the Hospital, pursuant to Clinical Privileges that have been granted, will have their care evaluated on an ongoing basis. This ongoing professional practice evaluation process may include an analysis of data to provide feedback, to validate clinical competence and to identify issues in an individual's professional performance, if any.

(3) Concerns raised about a Practitioner's practice through the ongoing professional practice evaluation process or through a specialty-specific performance measure, a reported concern, or other triggers (e.g., clinical trend or specific case that requires further review, patient feedback, or sentinel event) will be evaluated or otherwise addressed through the focused professional practice evaluation process, as applicable.

(4) Ongoing and focused professional practice evaluation may utilize resources available on the Hospital Medical Staff, other Hospital personnel, or other individuals or organizations outside the Hospital, including external clinical reviewers and other outside consultants. All external/outside individuals or organizations performing ongoing and focused professional practice evaluation activities are doing so on behalf of the Hospital and its leaders.

(5) Issues and concerns that cannot be appropriately and constructively resolved through collegial intervention or the relevant policy (e.g., professional practice evaluation/peer review; professionalism; health) shall be referred to the Medical Executive Committee for its review in accordance with Section 6.J ("Inquiries and Investigations") of this Policy. Such collegial interventions and other progressive steps, however, are not mandatory prerequisites to Medical Executive Committee review.

6.F. CLINICAL COMPETENCY EVALUATION

(1) A Practitioner may be requested to immediately submit to a partial or complete clinical competency evaluation to determine his or her ability to competently exercise Clinical Privileges.

(2) A request for an evaluation may be made as follows:

(a) of an Applicant, by the Credentials Committee, in accordance with Article 3 of this Policy;

(b) of any Practitioner who has been granted Clinical Privileges, by the Investigating Committee, during an Investigation;

(c) of any Practitioner who has been granted Clinical Privileges, by any one of the following groups, if the group is concerned with the individual's current clinical competence:

(i) the Leadership Council;

(ii) the Committee on Professional Enhancement;

(iii) the Credentials Committee;

(iv) the Medical Executive Committee; or

(v) the Board of Directors.

An individual who has been requested to obtain a clinical competency evaluation may request review by the Medical Executive Committee prior to the requirement for evaluation becoming effective (or, if the MEC made the initial request for the evaluation, the Practitioner may seek review by the Board). The request for review must be made by the individual, in writing, submitted to the Medical Staff Office within 5 days of the Practitioner's receipt of the request for evaluation. After reviewing the request for evaluation, the MEC (or Board, if applicable) may uphold, modify, or remove the requirement for evaluation, in its sole discretion. There is no right to request a Medical Staff hearing or appeal or other due process as a result of being required to submit to a clinical competency evaluation, nor as a result of being required to provide the results of any such evaluation to the Hospital.

All costs associated with a clinical competency evaluation shall be borne by the Practitioner.

(3) The Medical Staff Leaders or committee that requests the evaluation will: (i) identify the individual or program to conduct 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 the reasons for the evaluation with the individual/program performing the evaluation and to allow the individual/program to discuss and report the results of that evaluation to the Medical Staff Leaders or relevant committee.

(4) Failure to obtain the requested evaluation and to do so within the required time frame may result in an Application being withdrawn or an automatic relinquishment of Membership and Clinical Privileges as set forth below.

6.G. FITNESS FOR PRACTICE EVALUATION

(1) A Practitioner may be requested to immediately submit to a partial or complete fitness for practice evaluation to determine his or her ability to safely practice.

(2) A request for an evaluation may be made as follows:

  (a) of an Applicant, by the Credentials Committee, in accordance with Section 3.A.3 of this Policy;

  (b) of any Medical Staff Member or Practitioner who has been granted Clinical Privileges, by the Investigating Committee, during an Investigation;

  (c) of any Practitioner who is requesting reinstatement from a leave of absence that was taken for health reasons;

  (d) of any Medical Staff Member or Practitioner who has been granted Clinical Privileges, by any one of the following groups, if the group is concerned with the Practitioner's ability to safely and competently care for patients:

    (i) the Leadership Council;

    (ii) the Committee on Professional Enhancement;

    (iii) the Credentials Committee;

    (iv) the Medical Executive Committee; or

    (v) the Board of Directors.

A Practitioner who is suspected of being under the influence of illegal drugs or of alcohol, or who is suspected of using prescription drugs or other lawful substances in an unlawful manner or in a manner that violates Hospital or Medical Staff policy or the terms of any conditions on the Practitioner's Membership or Privileges (including the terms of a Performance Improvement Plan) may be required to immediately (or within the timeframe determined by the requestor) submit to a fitness for practice evaluation for the purposes of determining the extent of any substance use/abuse.

In all other cases, a Practitioner who has been requested to obtain a fitness for practice evaluation may request review by the Medical Executive Committee prior to the requirement for evaluation becoming effective (or, if the MEC made the initial request for the evaluation, the Practitioner may seek review by the Board). The request for review must be made by the individual, in writing, submitted to the Medical Staff Office within 5 days of the Practitioner's receipt of the request for evaluation. After reviewing the request for evaluation, the MEC (or Board, if applicable) may uphold, modify, or remove the requirement for evaluation, in its

sole discretion. There is no right to request a Medical Staff hearing or appeal or other due process as a result of being required to submit to a fitness for practice evaluation, nor as a result of being required to provide the results of any such evaluation to the Hospital.

All costs associated with a fitness for practice evaluation shall be borne by the Practitioner.

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

(4) Failure to obtain the requested evaluation and to do so within the required time frame may result in an Application being withdrawn or an automatic relinquishment of Membership and Clinical Privileges as set forth below.

6.H. AUTOMATIC RELINQUISHMENT

Any of the occurrences described in this Section will constitute grounds for the automatic relinquishment of a Practitioner's Membership and Clinical Privileges. An automatic relinquishment is considered an administrative action and, as such, it does not trigger an obligation on the part of the Hospital to file a report with the National Practitioner Data Bank.

Except as otherwise provided below, an automatic relinquishment of Membership and Clinical Privileges will be effective immediately upon actual notice or Special Notice to the Member.

6.H.1. Failure to Pay Dues:

Failure of a Practitioner to timely pay dues after receiving Notice of the amount due and the timeline for payment will result in automatic relinquishment of Membership and Privileges until such time as all outstanding amounts have been paid in full by the Practitioner and he or she has been notified of reinstatement by the Medical Staff Office.

6.H.2. Failure to Complete Medical Records:

Failure of a Practitioner to complete medical records in accordance with applicable policies and Rules And Regulations, after notification by the medical records department of

delinquency and the passing of any grace period, may result in automatic relinquishment of all Clinical Privileges.

6.H.3. Failure to Satisfy Threshold Eligibility Criteria:

Failure of a Practitioner to continuously evidence satisfaction of any of the threshold eligibility criteria set forth in Section 2.A.1 of this Policy will result in automatic relinquishment of Membership and Clinical Privileges.

6.H.4. Failure to Provide Information:

(1) Failure of a Practitioner to notify, immediately (and in no event later than one business day after being provided notice of the change), the President of the Medical Staff or Chief Executive Officer of any change in any information provided on or in conjunction with an Application for initial or renewed Membership or Clinical Privileges or of their failure to satisfy any of the threshold eligibility criteria set forth in Article 2 of this Policy or failure to provide the additional information required by Section 2.A.3.(3) of this Policy will result in the automatic relinquishment of Membership and Clinical Privileges.

(2) Failure of a Practitioner to provide information pertaining to that Practitioner's qualifications for Membership or Clinical Privileges in response to a written request from the Leadership Council, Credentials Committee, Committee on Professional Enhancement, Medical Executive Committee, Board, Chief Executive Officer, or Chief Medical Officer, or from any other individual or committee authorized to request the information, will result in the automatic relinquishment of Membership and Clinical Privileges. The information must be provided within the time frame established by the requesting party. Any relinquishment will continue in effect until the information has been provided to the satisfaction of the requesting party and reinstatement is granted as set forth below.

6.H.5. Criminal Activity:

The occurrence of specific criminal actions will result in the automatic relinquishment of Membership and Clinical Privileges. Specifically, with respect to any felony or misdemeanor pertaining to the following items: (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) domestic, child, or elder abuse:

(1) a conviction, plea of guilty, or plea of no contest will result in an automatic relinquishment of Membership and all Clinical Privileges; and

(2) an arrest, charge, or indictment will result in automatic relinquishment of Membership and all Clinical Privileges until such time as the appropriate individual or body (MEC, Board, CEO, or CMO) can review the matter to determine whether the circumstances surrounding the arrest, charge, or indictment are such that reinstatement pending resolution of the matter can be granted without affecting patient safety, quality of care, and hospital operations. The burden is on the Practitioner to provide evidence showing that reinstatement is appropriate despite the unresolved concerns raised by the arrest, charge, or indictment. Reinstatement will be within the discretion of the appropriate individual or body (MEC, Board, CEO, or CMO), the decision of which shall be final without recourse to the hearing and appeal processes or any other procedures.

6.H.6. Failure to Attend a Mandatory Meeting:

Failure to attend (be Present at) a mandatory meeting requested by the Medical Staff Leaders or Hospital administration, after Special Notice has been given, will result in the automatic relinquishment of Membership and Clinical Privileges. The relinquishment will remain in effect until the Practitioner attends the mandatory meeting and reinstatement is granted as set forth below.

6.H.7. Failure to Complete or Comply with Training or Educational Requirements:

Failure of a Practitioner to comply with or complete within required time limits 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 or EMTALA requirements, will result in the automatic relinquishment of Clinical Privileges.

To assist Practitioners in avoiding automatic relinquishment in accordance with this section, the Medical Staff Office will provide a Practitioner with Special Notice of his pending or current non-compliance with training and/or education requirements. This Special Notice may be delivered to the Practitioner beginning 3 days prior to the deadline for completion of training/education, or at any time thereafter. The Practitioner will have three days following receipt of Special Notice to avoid automatic relinquishment by completing the education/training.

Once automatic relinquishment has occurred, it will remain in effect until the Practitioner completes the required training/education and has been reinstated in accordance with this Policy.

6.H.8. Failure to Comply with Request for Fitness for Practice Evaluation or a Clinical Competency Evaluation:

Failure of an Applicant or Practitioner to submit a Fitness for Practice Form or undergo a requested fitness for practice evaluation or clinical competency evaluation and to do so

within the requested time frame, to submit to diagnostic testing (such as blood, urine, or hair testing) immediately upon request, 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, for Applicants, be considered a voluntary withdrawal of the Application or, for Practitioners, will result in the automatic relinquishment of Membership and Clinical Privileges.

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

(1) A request for reinstatement from automatic relinquishment upon completion of all delinquent medical 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 and resignation of all Clinical Privileges.

(2) Requests for reinstatement from an automatic relinquishment following non-payment of dues, failure to complete required education or training, the expiration or lapse of a license, controlled substance authorization, insurance coverage, or any other failure to satisfy any of the threshold eligibility criteria by virtue of the natural expiration of the Practitioner's qualification, 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 subsection (4) of this Section, below.

(3) Requests for reinstatement from an automatic relinquishment related to a criminal arrest, charge, or indictment will be as set forth in 6.H.5(2), above.

(4) All other requests for reinstatement from an automatic relinquishment will be reviewed by the relevant department chairperson, the chairperson of the Credentials Committee, the President of the Medical Staff, the Chief Medical Officer, and the Chief Executive Officer. If all these individuals make a favorable recommendation on reinstatement, the Practitioner may immediately resume clinical practice at the Hospital. 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.

(5) The Practitioner requesting reinstatement bears the burden of demonstrating that the matter leading to automatic relinquishment has been resolved.

(6) Failure, within 60 Days of a relinquishment, to resolve the matter leading to the automatic relinquishment, provide notice to the Medical Staff Office of the resolution, provide any additional requested information, and be reinstated as set

forth above, will result in an automatic resignation from the Medical Staff and resignation of all Clinical Privileges.

6.I. LEAVES OF ABSENCE

6.I.1. Initiation:

Leaves of absence are necessary or desirable for many reasons. However, because leaves of absence can cause disruption to the normal operations of the Hospital and/or Medical Staff (including administration of the ED schedule) and sometimes raise patient safety concerns (such as when the leave is related to a health issue or is extended), it is important that certain procedures be followed when Practitioners take leave.

Accordingly, leaves of absence are expected to be initiated/obtained through the methods described in this Section. Except in extraordinary circumstances, a request for leave must be submitted in writing, to the Leadership Council, at least 30 Days prior to the anticipated start of the leave. The request must state the reasons for the leave, and should, when possible, state the anticipated beginning and ending dates.

Leave of absence may be requested as follows:

(1) General Leave

Whenever a Practitioner intends to be away from Medical Staff or patient care responsibilities for more than 60 days, it is required that the Practitioner request a leave of absence. Leaves may be requested for good cause (such as education, training, care of a disabled or sick relative, care of a new child, travel, volunteer service) and are available for time periods lasting up to two years.

Except in cases of military leave, maternity or paternity leave, and medical leave, leaves of absence are matters of courtesy, not of right. The Leadership Council will determine whether a request for a leave of absence will be granted, after consulting with the department chairperson and any other individual(s) or committee(s) deemed necessary or desirable. The granting of a leave of absence or reinstatement may be conditioned upon the individual's completion of all medical records prior to the commencement of the leave or by a particular deadline.

In the event that it is determined that an individual has not demonstrated good cause for a leave, or where a request for extension of an existing leave is not granted, the determination will be final, with no recourse to a hearing and appeal.

(2) Medical Leave by Request

A Practitioner must report to the Leadership Council any time he or she expects to be or has been away from Medical Staff or patient care responsibilities for longer

than 30 Days, where the reason for the absence is related to the Practitioner's health. Leaves of absence related to the Practitioner's health (e.g., for diagnosis, treatment, recovery, or ongoing monitoring) will be granted routinely upon receipt of evidence (as requested) showing the Practitioner intends to use the leave for a personal health-related reason.

(3) Medical Leave, Triggered by Absence

Upon becoming aware that a Practitioner has been away from Medical Staff or patient care responsibilities for longer than 30 Days for a reason related to the Practitioner's health, the Leadership Council may trigger an automatic medical leave of absence for the Practitioner even when no request has been received. The Practitioner will be sent Special Notice informing him or her that a leave of absence has been triggered.

(4) Maternity and Paternity Leave

Leaves of absence to adopt, foster, deliver, and/or care for a new baby or child will be granted routinely upon receipt of evidence (as requested) showing the Practitioner is expecting to add (or has added) a new child to his/her immediate family.

(5) Military Service Leave

Leaves of absence to fulfill military service obligations shall be granted routinely upon receipt of evidence showing deployment orders.

6.I.2. Duties of Practitioners on Leave:

During a leave of absence, the individual will not exercise any Clinical Privileges at the Hospital and will be excused from Medical Staff prerogatives and responsibilities (e.g., meeting attendance/Presence, 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.

6.I.3. Reinstatement:

(1) All Practitioners who have been on a leave of absence must be processed for reinstatement prior to resuming practice at the Hospital.

(2) Practitioners requesting reinstatement will submit a written summary of their activities during the leave, an attestation that no changes have occurred in any information the Practitioner provided on his or her last Application or, if changes

have occurred, a detailed description of such changes, and any other information that may be requested by the Hospital.

(3) In addition, if the leave of absence was for health reasons (including a maternity leave during which the Practitioner gave birth to a child), the request for reinstatement must be accompanied by a report from the Physician or other treating health care professional treating the Practitioner, indicating that the Practitioner is capable of resuming a hospital practice and safely exercising the Clinical Privileges requested.

(4) Requests for reinstatement will be reviewed by the relevant department chairperson, the chairperson of the Credentials Committee, the President of the Medical Staff, the Chief Medical Officer and the Chief Executive Officer. Any of them may request additional information, including a fitness for practice evaluation, a clinical competency evaluation, or information concerning the Practitioner's current clinical competence.

(5) If a favorable recommendation on reinstatement is made, the Chief Executive Officer may grant reinstatement on behalf of the Board and the Practitioner 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.

(6) If a Practitioner's current Membership and/or Clinical Privileges are due to expire during the leave, they will expire at the end of their natural term. At the conclusion of the leave of absence, the Practitioner will be required to submit an Application for renewal of Membership and Clinical Privileges as part of the reinstatement process.

6.J. PRECAUTIONARY SUSPENSION OR RESTRICTION OF CLINICAL PRIVILEGES

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

(1) Whenever failure to take action may result in imminent danger to the health and/or safety of any individual, the Leadership Council, Medical Executive Committee, Board, or any two of the following individuals, acting together as a professional committee, may immediately suspend or restrict all or any portion of a Practitioner's Clinical Privileges: (a) the Chief Executive Officer, (b) the President of the Medical Staff, (c) the Vice-President of the Medical Staff, (d) the Chair of the Committee on Professional Enhancement, (e) the chairperson of the relevant clinical department, and/or (f) the Chief Medical Officer.

(2) A precautionary suspension or Restriction can be imposed at any time, including as a result of a specific concern, the occurrence of a specific event, a pattern of events, or a recommendation by the Medical Executive Committee that would entitle the Practitioner to request a hearing. When possible, prior to the imposition of a precautionary suspension, the person(s) considering the suspension or Restriction will meet with the Practitioner and review the concerns that support the suspension or Restriction and afford the Practitioner an opportunity to respond. If the Practitioner voluntarily refrains from exercising Clinical Privileges for longer than 30 days while the matter is being reviewed, it must be reported to the National Practitioner Data Bank.

(3) Precautionary suspension or Restriction is an interim step in the Professional Review Activity and does not imply any final finding regarding the concerns supporting the suspension or Restriction.

(4) A precautionary suspension or Restriction is effective immediately and will be promptly reported to the Chief Executive Officer and the President of the Medical Staff. A precautionary suspension or Restriction will remain in effect unless it is modified by the Leadership Council, Medical Executive Committee, or Board.

(5) Within three Days of the imposition of a suspension or Restriction, the Practitioner 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 Notice will advise the Practitioner that suspensions or Restrictions lasting longer than 30 Days must be reported to the National Practitioner Data Bank. If the circumstances giving rise to the precautionary suspension or Restriction include a determination or finding that the individual engaged in unprofessional conduct as defined by Washington law, the Notice shall also inform the Practitioner of any report that must be filed with the appropriate Washington state agency.

(6) If the Practitioner has a Supervising/Collaborating Practitioner, that Supervising/ Collaborating Practitioner will be notified.

<u>6.J.2. Medical Executive Committee Procedure:</u>

(1) Within a reasonable time, not to exceed 10 Days after the imposition of the suspension or Restriction, the Medical Executive Committee will review the reasons for the suspension or Restriction.

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

(3) At the meeting, the Practitioner may provide information to the Medical Executive Committee and should respond to any questions that may be raised by committee

Members. The Practitioner may provide information to the Medical Executive Committee, including alternatives to the precautionary suspension or Restriction which will protect patients, employees or others while the matter is being reviewed.

(4) After considering the reasons for the suspension or Restriction and the Practitioner's response, if any, the Medical Executive Committee will determine whether the precautionary suspension should be continued, modified, or lifted. The Medical Executive Committee may also determine whether to refer the matter for further inquiry or investigation in accordance with this Policy.

(5) If the Medical Executive Committee decides to continue the suspension or Restriction, it will send the Practitioner written Notice of its decision, including the basis for it.

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

(7) Upon the imposition of a precautionary suspension or Restriction, the President of the Medical Staff will assign responsibility for the care of any hospitalized patients to another Practitioner with appropriate Clinical Privileges and the Practitioner will be removed from the call schedule. Whenever possible, consideration will be given to the wishes of the patient in the selection of a covering Practitioner with appropriate Clinical Privileges.

6.K. INQUIRIES AND INVESTIGATIONS

6.K.1. Initial Inquiry:

(1) Whenever a serious question has been raised, where collegial efforts have not resolved an issue, or a precautionary suspension or Restriction has been continued regarding any of the following, the matter may be referred to the President of the Medical Staff, the department chairperson, the chairperson of a standing committee, the Chief Medical Officer, the Chief Executive Officer, or the chairperson of the Board:

(a) clinical competence or clinical practice, including patient care, treatment or management and failure to follow adopted protocols and guidelines;

(b) the known or suspected violation of applicable internal and external ethical standards, or the bylaws, policies, rules and regulations, and other adopted standards of the Hospital or the Medical Staff, or applicable laws and regulations;

(c) conduct that is considered lower than the standards of the Hospital or disruptive to the orderly operation of the Hospital or its Medical Staff, including the inability of the Practitioner to work harmoniously with others;

(d) ability to perform, with or without reasonable accommodation, the essential functions of Medical Staff Membership and/or Clinical Privileges; or

(e) the qualifications of the individual for Medical Staff Membership or Clinical Privileges.

(2) The person or committee to whom the concern is referred may conduct informal fact finding and will make a sufficient inquiry to determine whether the concern is credible and, if so, may forward it to the Medical Executive Committee. If the Practitioner has a Supervising/ Collaborating Practitioner, that Supervising/Collaborating Practitioner may also be notified.

(3) To preserve impartiality, the person to whom the matter is directed shall not be a member of the same practice as, or a relative of, the person that is being reviewed, unless such Restriction is deemed not practicable, appropriate, or relevant by the President of the Medical Staff.

(4) No inquiry or other action taken pursuant to this Section will constitute an Investigation.

6.K.2. Initiation of Investigation:

(1) The Medical Executive Committee will review the matter in question, may discuss the matter with the Practitioner, 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 or the Board.

(2) The Medical Executive Committee will inform the Practitioner that an Investigation has begun. In rare instances, notification may be delayed if, in the judgment of the Medical Executive Committee, informing the Practitioner immediately might compromise the integrity of the Investigation or disrupt the operation of the Hospital or Medical Staff.

(3) 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.K.3. Investigative Procedure:

(1) Once a determination has been made to begin an Investigation, the Medical Executive Committee will investigate the matter itself or appoint a committee to do so. The committee conducting the Investigation, including the Medical Executive Committee, will be referred to as the "Investigating Committee" throughout this Article. The Investigating Committee may include individuals who are not Members of the Medical Staff and have not been granted Clinical Privileges at the Hospital. The Investigating Committee will consist of at least two members (but preferably an odd number of members, to avoid tied votes when voting becomes necessary to reach an outcome) and will not include any individual who:

(a) is in direct economic competition with the Practitioner being investigated;

(b) is professionally associated with, a relative of, or involved in a referral relationship with, the Practitioner being investigated;

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

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

(2) Whenever the questions raised concern the clinical competence of the Practitioner under review, the Investigating Committee will include a Peer of the Practitioner.

(3) The Investigating Committee may:

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

(b) conduct interviews;

(c) use outside consultants, as needed; or

(d) 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.

(4) As part of the Investigation, the Practitioner will have an opportunity to meet with the Investigating Committee. Prior to this meeting, the Practitioner will be informed of the concerns being investigated and will be invited to discuss, explain, or refute the questions or to submit a written statement prior to the meeting. A

summary of the interview will be made and included with the Investigating Committee's report. This meeting is not a hearing, and none of the procedural rules for hearings will apply. Lawyers will not be present at this meeting.

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

(6) At the conclusion of the Investigating Committee's portion of the Investigation, it will prepare a report to the Medical Executive Committee with its findings, conclusions, and recommendations.

6.K.4. MEC Recommendation:

(1) The Medical Executive Committee may accept, modify, or reject any recommendation it receives from an Investigating Committee and shall make a recommendation to the Board in accordance with (2) and (3) of this Section, as set forth below. Specifically, the Medical Executive Committee may:

(a) determine that additional information, inquiry, or Investigation is required and refer the matter to the appropriate individual or body;

(b) determine that no action is justified;

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

(d) impose conditions for continued Membership and Clinical Privileges;

(e) require monitoring, proctoring or consultation;

(f) require additional training or education;

(g) recommend reduction or Restriction of Clinical Privileges;

(h) recommend suspension of Clinical Privileges for a specified period of time;

(i) recommend revocation of Membership or Clinical Privileges; or

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

(2) Unless the recommendation by the Medical Executive Committee entitles the Practitioner to request a hearing in accordance with Article 7, the recommendation will be considered a final action, which will take effect immediately and will remain in effect, unless modified by the Board. The Practitioner shall bear the costs associated with the implementation of any final action (e.g. the costs of proctoring, additional training, education).

(3) A recommendation by the Medical Executive Committee that would entitle the Practitioner to request a hearing will be forwarded to the Chief Executive Officer, who will promptly inform the individual by Special Notice. The recommendation will not be forwarded to the Board for final action until after the Practitioner has completed or waived a hearing and appeal.

(4) If the Board makes a modification to the recommendation of the Medical Executive Committee that would entitle the Practitioner to request a hearing, the Chief Executive Officer will inform the Practitioner by Special Notice. In that case, no final action will occur until the Practitioner has completed or waived a hearing and appeal.

(5) If final action has been taken on any matter that was subject to an Investigation or if the Board formally resolves to close an Investigation, the Investigation will be considered concluded.

6.L. ACTIONS OCCURRING AT OTHER AFFILIATED ENTITIES

In accordance with Section 2.C.3(3) of this Policy and any other policy governing the sharing of credentialing and peer review information among Affiliated Entities, all Affiliated Entities may share with each other information regarding peer review/ professional practice evaluation activities, including but not limited to any activity set forth in this Article 6.

ARTICLE 7
HEARING AND APPEAL PROCEDURES

The procedures set forth in this Article apply to Members of the Medical Staff and Practitioners who have been granted Clinical Privileges.

7.A. INITIATION OF HEARING

7.A.1. Grounds for Hearing:

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

(a) denial of initial Medical Staff Membership, renewed Medical Staff Membership, or requested Clinical Privileges;

(b) revocation of Membership or Clinical Privileges;

(c) suspension of Clinical Privileges for more than 30 Days (other than precautionary suspension)

(d) restriction of clinical privileges for more than 30 days that is the result of a professional review action based on clinical competence or professional conduct that leads to the inability of a practitioner to exercise his or her own independent judgment in a professional setting (e.g., a mandatory concurring consultation requirement); or

(e) denial of reinstatement from a leave of absence as set forth in Section 6.H.(3), if the reasons relate to professional competence or conduct.

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

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

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

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

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

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

(3) a lapse, withdrawal of, or decision not to grant temporary Privileges;

(4) automatic relinquishment of Membership or Clinical Privileges;

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

(6) precautionary suspension;

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

(8) activation of a leave of absence on behalf of a practitioner, by the Chief Executive Officer and/or CMO, in accordance with this Policy;

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

(10) the voluntary acceptance of a performance improvement plan;

(11) determination that an Application is not Complete;

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

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

(14) changes to Medical Staff Membership prerogatives (e.g., voting rights, eligibility for committee membership); or

(15) any other collegial intervention as defined in Section 6.E.

7.A.3. Notice of Recommendation:

The Chief Executive Officer will promptly give Special Notice of a recommendation which entitles an individual to request a hearing. This Special Notice will contain:

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

(2) a statement that the individual has the right to request a hearing on the recommendation within 30 Days of receipt of this Special Notice; and

(3) a copy of this Article.

7.A.4. Request for Hearing:

An individual has 30 Days following receipt of the Special Notice to request a hearing, in writing, to the Chief Executive Officer, including the name, address, and telephone number of the individual's counsel, if any. Failure to request a hearing within the required time frame will constitute waiver of the right to a hearing, and the recommendation will be transmitted to the Board for final action.

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

(1) The Chief Executive Officer will schedule the hearing and provide to the individual requesting the hearing, by Special Notice, the following:

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

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

(c) the names of the Hearing Panel Members and Presiding Officer (or Hearing Officer) if known; and

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

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

7.A.6. Hearing Panel, Presiding Officer, and Hearing Officer:

(1) Hearing Panel:

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

(a) The Hearing Panel will consist of at least three members, one of whom will be designated as chairperson. The chairperson will serve as the Presiding Officer when one has not been appointed.

(b) The Hearing Panel must include at least one individual who is all of the following:

  (i) a Peer of the individual requesting the hearing, and
  (ii) a Member of the same Medical Staff category, if the individual requesting the hearing is a Medical Staff Member, and
  (iii) a Practitioner with current Clinical Privileges, who is in Good Standing.

(c) In the case of a hearing that is provided pursuant to a delegated credentialing arrangement with a health plan or other third party payor, the majority of the hearing panel will be comprised of Peers of the individual who requested the hearing.

(d) The remaining members of a Hearing Panel may be any combination of Practitioners and/or other Physicians, health care professionals, or laypersons who are not connected with the Hospital.

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

(f) Employment by, or other contractual arrangement with, the Hospital or an Affiliated Entity will not preclude an individual from serving on the Panel.

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

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

  (ii) is professionally associated with, a relative of, or involved in a referral relationship with, 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.

(2) Presiding Officer:

(a) The Chief Executive Officer, after consultation with the President of the Medical Staff, may appoint an attorney to serve as Presiding Officer. The Presiding Officer will not act as an advocate for either side at the hearing.

(b) 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.

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

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

(3) Hearing Officer:

(a) 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 and not issues of clinical competence, knowledge, or technical skill, the Chief Executive Officer, after consulting with and obtaining the agreement of the President of the Medical Staff, may appoint a Hearing Officer. The Hearing Officer, who should preferably 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.

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

(4) Objections:

Any objection to any Member of the Hearing Panel, to the Hearing Officer, or to the Presiding Officer, will be made in writing, within ten Days of receipt of Notice, to the Chief Executive Officer. The objection must include reasons to support it. A copy of the objection will be provided to the President of the Medical Staff. The President of the Medical Staff will be given a reasonable opportunity to comment. The Chief Executive Officer will rule on the objection and give Notice to the parties. The Chief Executive Officer may request that the Presiding Officer make a recommendation as to the validity of the objection.

7.A.7. Counsel:

The Presiding Officer, Hearing Officer, and counsel for either party may be attorneys who are licensed to practice, in good standing, in any state.

7.B. PRE-HEARING PROCEDURES

7.B.1. General Procedures:

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

7.B.2. Witness List:

(1) At least 15 Days before the pre-hearing conference, the parties will exchange a written list of the names of witnesses expected to offer testimony on their behalf.

(2) The witness lists will include a brief summary of the anticipated testimony.

(3) The witness list of either party may, in the discretion of the Presiding Officer, be amended at any time during the course of the hearing, provided that Notice of the change is given to the other party.

7.B.3. Time Frames:

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

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

(2) the parties will exchange proposed exhibits at least 10 Days prior to the pre-hearing conference; and

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

7.B.4. Provision of Relevant Information:

(1) 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.

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

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

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

(c) copies of relevant minutes (with portions regarding other Practitioners and unrelated matters deleted); and

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

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

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

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

(5) Neither the individual, nor any other person acting on behalf of the individual, may contact Hospital employees or Practitioners whose names appear on the Medical Executive Committee's witness list or in documents provided pursuant to this Section concerning the subject matter of the hearing, until the 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 such employees or Practitioners, and confirmed their willingness to meet.

Any employee or Practitioner may agree or decline to be interviewed by or on behalf of the individual who requested a hearing.

7.B.5. Pre-Hearing Conference:

(1) 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.

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

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

(4) Evidence unrelated to the reasons for the recommendation or to the individual's qualifications for Membership or the relevant Clinical Privileges will be excluded.

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

7.B.6. Stipulations:

The parties 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:

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

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

(3) 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

15 hours, with each side being afforded approximately seven and a half hours to present its case, in terms of both direct and cross-examination of witnesses. Both parties are required to prepare their case so that a hearing will be concluded after a maximum of 15 hours. Considering the complexity of the case and fundamental fairness, the Presiding Officer may, after considering any objections, modify the time frame for the hearing.

7.C.2. Record of Hearing:

A stenographic reporter will be present to make a record of the hearing. The cost of the reporter will be borne by the 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.3. Rights of Both Sides and the Hearing Panel at the Hearing:

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

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

(b) to introduce exhibits;

(c) to cross-examine any witness;

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

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

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

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

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

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 evidence that is relevant to the individual's qualifications for Membership and Clinical Privileges will be admitted if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs.

7.C.6. Persons to Be Present:

The hearing will be restricted to those individuals involved in the proceeding. The presence of the individual who requested the hearing is mandatory. Administrative personnel may be present as requested by the Chief Executive Officer or the President of the Medical 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 certify that he or she read the entire transcript of 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 Chief Executive Officer for a reasonable period of time and 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 set forth in Section 7.C.4, as well as the burden on the individual to demonstrate that he or she satisfies, on a continuing basis, all criteria for initial Membership, renewed Membership, and Clinical Privileges, the Hearing Panel will recommend in favor of the Medical Executive Committee unless it finds that the individual who requested the hearing has proved, by clear and convincing evidence, that the

recommendation that prompted the hearing was arbitrary, capricious, or not supported by credible evidence.

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

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

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

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

7.E. APPEAL PROCEDURE

7.E.1. Time for Appeal:

(1) Within 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 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.

(2) If an appeal is not requested within 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:

(1) there was substantial failure by the Hearing Panel or the Presiding Officer to comply with this Article, so as to deny a fair hearing; or

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

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

Whenever an appeal is requested, the chairperson of the Board will schedule and arrange for the appellate review. 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:

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

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

(3) 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 10 Days to respond. In its sole discretion, the Review Panel may allow each party or its representative to appear personally and make oral argument not to exceed 30 minutes.

(4) 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, relevant evidence or that any opportunity to admit it at the hearing was improperly denied.

7.F. BOARD ACTION

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

(1) The Board will take final action within 30 Days after it (i) considers the appeal as a Review Panel, (ii) receives a recommendation from a separate Review Panel, or (iii) receives the Hearing Panel's report when no appeal has been requested.

(2) 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).

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

(4) The Board will render its final decision in writing, including the basis for its decision, and will send Special Notice to the individual. A copy will also be provided to the President of the Medical Staff.

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

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

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

ARTICLE 8
CONDITIONS OF PRACTICE APPLICABLE TO ADVANCED PRACTICE PROFESSIONALS

8.A. CONDITIONS OF PRACTICE APPLICABLE TO ADVANCED PRACTICE PROFESSIONALS

8.A.1. General:

As a condition of being granted permission to practice at the Hospital, all Advanced Practice Professionals specifically agree to abide by the standards of practice set forth in the Privilege delineation that they have been granted by the Board and the terms of the agreement with their Supervising/Collaborating Practitioner. In addition, as a condition of being permitted to utilize the services of Advanced Practice Professionals in the Hospital, all Practitioners who serve as Supervising/Collaborating Practitioners to such individuals also specifically agree to abide by the applicable standards set forth in this Article and the terms of their agreements.

8.A.2. Oversight by Supervising/Collaborating Practitioner:

(1) If the Medical Staff Membership or Clinical Privileges of a Supervising/Collaborating Practitioner are resigned, revoked or terminated, or the Advanced Practice Professional fails, for any reason, to maintain an appropriate Supervision relationship with a Supervising/Collaborating Practitioner as defined in this Policy, the Advanced Practice Professional's Clinical Privileges will be automatically relinquished, unless he or she has another Supervising/ Collaborating Practitioner who has been approved as part of the credentialing process.

(2) As a condition of Clinical Privileges, an Advanced Practice Professional and the Supervising/Collaborating Practitioner must provide the Hospital with Notice of any revisions or modifications that are made to the agreement between them, as well as any changes in the Supervising/Collaborating Practitioner. This Notice must be provided to the Medical Staff Office within three Days of any such change.

8.A.3. Questions Regarding the Authority of an Advanced Practice Professional:

(1) Should any Member of the Medical Staff, or any employee of the Hospital who is licensed or certified by the state, have a reasonable question regarding the clinical competence or authority of an Advanced Practice Professional to act or issue instructions outside the presence of the Supervising/Collaborating Practitioner, such individual will have the right to request that the Supervising/Collaborating Practitioner validate, either at the time or later, the instructions of the Advanced Practice Professional. Any act or instruction of the Advanced Practice Professional will be delayed until such time as the individual with the question has ascertained

that the act is clearly within the Clinical Privileges granted to the individual and the agreement with the Supervising/Collaborating Practitioner.

(2) Any question regarding the conduct of an Advanced Practice Professional will be reported to the President of the Medical Staff, the Chairperson of the Credentials Committee, the relevant department chair, the Chief Medical Officer, or the Chief Executive Officer for appropriate action. The individual to whom the concern has been reported will also discuss the matter with the Supervising/Collaborating Practitioner.

8.A.4. Responsibilities of Supervising/Collaborating Practitioners:

(1) Practitioners who wish to utilize the services of an Advanced Practice Professional in their clinical practice at the Hospital must notify the Medical Staff Office of this fact in advance and must ensure that the individual has been appropriately credentialed in accordance with this Policy before the Advanced Practice Professional performs services or engages in any kind of activity in the Hospital.

(2) The number of Advanced Practice Professionals acting under the Supervision of one Practitioner, as well as the care they may provide, will be consistent with applicable state statutes and regulations and any other policies adopted by the Hospital. The Supervising/Collaborating Practitioner will make any required filings with the appropriate Washington state agencies regarding the Supervision and responsibilities of the Advanced Practice Professional.

ARTICLE 9
CONFLICTS OF INTEREST

* Appendix B includes a chart that provides guidance for implementing these conflict of interest rules.

(1) General Principles:

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

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

(2) Practitioner and Immediate Family Members:

No Practitioner may participate in the review of his or her own Application or the professional practice evaluation of care he or she provided, except to provide information. No immediate family member (spouse or domestic partner, parent, child, sibling, or in-law) of a Practitioner whose Application or provision of care is being reviewed will participate in any aspect of the review process, except to provide information.

(3) Relevant Treatment Relationship:

An individual who has provided professional health services to a Practitioner whose Application or provision of care is under review shall not participate in the review process regarding the Practitioner except as follows:

(a) if the patient-physician relationship has terminated and the review process does not involve the health condition for which the Practitioner sought professional health services;

(b) to provide information that was not obtained through the treatment relationship; or

(c) to provide information that was obtained through the treatment relationship, as authorized by the Practitioner.

(4) Employment by or Contractual Relationship with the Hospital:

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

(5) <u>Actual or Potential Conflict Situations</u>:

With respect to a Practitioner whose Application or provision of care is under review, actual or potential conflict situations involving other Practitioners include, but are not limited to, the following. Any individual who has an actual or potential conflict listed below shall be referred to as an "Interested Person" in the remainder of this Article, for ease of reference:

(a) significant financial relationship (e.g., members of small, single specialty group; significant referral relationships; partners in business venture);

(b) direct competition;

(c) close friendship;

(d) a history of personal conflict;

(e) personal involvement in the care that is subject to review;

(f) raising the concern that triggered the review; and

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

(6) <u>Guidelines for Participation in Credentialing and Professional Practice Evaluation Activities</u>:

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

(a) <u>Initial Reviewers</u>. An Interested Person may participate as an initial reviewer in situations where a check and balance is provided by subsequent review by a Medical Staff committee. For example, this applies, but is not limited to, the following situations:

(i) participation in the review of Applications for initial and renewed Membership and Clinical Privileges (which are subsequently reviewed by the Credentials Committee and/or Medical Executive Committee); and

(ii) participation as a case reviewer in professional practice evaluation activities (which are subsequently reviewed by the Committee on Professional Enhancement, Investigating Committee, and/or Medical Executive Committee).

(b) Credentials Committee, Committee on Professional Enhancement, or Leadership Council Member. An Interested Person may fully participate as a member of these committees because these committees do not make any final recommendation that could adversely affect the Clinical Privileges of a Practitioner, which is only within the authority of the Medical Executive Committee. However, the chairs of these committees always have the discretion to recuse an Interested Person if they determine that the Interested Person's presence would inhibit full and fair discussion of the issue, would skew the recommendation or determination of the committee, or otherwise be unfair to the Practitioner under review.

(c) Investigating Committee. Once a formal Investigation has been initiated, additional precautions are required. Therefore, an Interested Person may not be appointed as a member of an investigating committee, but may be interviewed and provide information to the investigating committee if necessary for the committee to conduct a full and thorough Investigation.

(d) Medical Executive Committee. An Interested Person will be recused and may not participate as a member of the Medical Executive Committee when the Medical Executive Committee is considering a recommendation that could adversely affect the Clinical Privileges of a Practitioner, subject to the rules for recusal outlined below.

(e) Board. An Interested Person will be recused and may not participate as a member of the Board when the Board is considering a recommendation that could adversely affect the Clinical Privileges of a Practitioner, subject to the rules for recusal outlined below.

(7) Guidelines for Participation in Development of Privileging Criteria:

Recognizing that the development of privileging criteria can have a direct or indirect financial impact on particular Practitioners, the following guidelines apply. Any individual who has a personal interest in privileging criteria, including criteria for Clinical Privileges that cross specialty lines or Practitioner categories or criteria for New Procedures, as defined in Article 4, Part A of this Policy, may:

(a) provide information and input to the Advanced Practice Professional Review Committee, Credentials Committee, or an ad hoc committee charged with development of such criteria;

(b) participate in the discussions or actions of the Advanced Practice Professional Review Committee, Credentials Committee, or an ad hoc committee charged with development of such criteria because these committees do not make the final recommendation regarding the criteria (however, the chairperson of the Advanced Practice Professional Review Committee, Credentials Committee, or ad hoc committee always has the discretion to recuse an Interested Person in a particular situation); but

(c) not participate in the discussions or action of the Medical Executive Committee when it is considering its final recommendation to the Board regarding the criteria or participate in the final discussions or action of the Board related to the criteria.

(8) Rules for Recusal:

(a) When determining whether recusal in a particular situation is required, the President of the Medical Staff or Board or committee chair will consider whether the Interested Person's presence would inhibit full and fair discussion of the issue, would skew the recommendation or determination of the committee, or otherwise be unfair to the Practitioner under review.

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

(c) Any recusal will be documented in the committee's or Board's minutes.

(d) Whenever possible, an actual or potential conflict should be brought to the attention of the President of the Medical Staff or committee/Board chair, a recusal determination made, and the Interested Person informed of the recusal determination prior to the meeting.

(9) Other Considerations:

(a) Any Practitioner who is concerned about a potential conflict of interest on the part of any other Practitioner, including but not limited to the situations noted in the paragraphs above, must call the conflict of interest to the attention of the President of the Medical Staff or the applicable committee/Board chair. The Member's failure to notify will constitute a waiver of the claimed conflict. The President of the Medical Staff or the applicable committee/Board chair has the authority to make a final determination as to how best to manage the situation, guided by this Article, including recusal of the Interested Person, if necessary. If the President of the Medical Staff or the applicable committee/Board is the individual reported to have a conflict of interest, the President-Elect, vice chairperson of the committee, or another officer of the Board (as determined by the corporate bylaws), as applicable,

shall be authorized to make final determinations regarding management of the conflict.

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

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

ARTICLE 10
ADOPTION AND AMENDMENTS

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

(2) The amendment process for this Policy is set forth in the Bylaws.

(3) The Appendices to this Policy are attached for guidance and reference only. They are not governing. As such, the Appendices may be adopted and amended by the Medical Executive Committee, subject to approval of the Chief Executive Officer or designee, without the necessity of following any of the Notice or amendment procedures that apply to the Policy.

Adopted by the Medical Staff: ______________________________
11/21/2023

Approved by the Board: ______________________________
11/28/2023

Board Approval:
11/28/2023 - Removed the term "License Independent Practitioner"
12/21/2020- "Quorum" definitions revised to include voting outside of a meeting (mail, facsimile, e-mail, hand delivery, website posting, or telephone)
6/22/2020

APPENDIX A
ADVANCED PRACTICE PROFESSIONALS

The categories of Advanced Practice Professionals that have been approved by the Hospital, pursuant to this Policy, to practice at the Hospital are as follows:

APPs: *Physician Assistants (PAs)*
Advanced Practice Registered Nurses (APRNs)
Certified Nurse Midwives (CNMs)
Certified Registered Nurse Anesthetists (CRNAs)
Registered Nurse First Assistants (RNFAs)
Clinical Pharmacists

APPENDIX B

CONFLICT OF INTEREST GUIDELINES

Potential Conflicts	Levels of Participation								
	Provide Information	Individual Reviewer Application/ Case	Committee Member					Hearing Panel	Board
			Credentials Committee	Leadership Council	CPE	MEC	Investigating Committee		
Employment/contract relationship with hospital	Y	Y	Y	Y	Y	Y	Y	Y	Y
Self or family member	Y	N	R	R	R	R	N	N	R
Relevant treatment relationship*	Y	N	R	R	R	R	N	N	R
Significant financial relationship	Y	M	M	M	M	R	N	N	R
Direct competitor	Y	M	M	M	M	R	N	N	R
Close friends	Y	M	M	M	M	R	N	N	R
History of conflict	Y	M	M	M	M	R	N	N	R
Provided care in case under review (but not subject of review)	Y	M	M	M	M	R	N	N	R
Involvement in prior PIP or disciplinary action	Y	M	M	M	M	R	N	N	R
Formally raised the concern	Y	M	M	M	M	R	N	N	R

Y – (Green "Y") means the Interested Member may serve in the indicated role; no extra precautions are necessary.

M – (Yellow "M") means "maybe" the Interested Member may serve in the indicated role. It is legally permissible for Interested Members to serve in these roles because of the check and balance provided by the multiple levels of review and the fact that the Credentials

Committee, Leadership Council, and Committee On Professional Enhancement have no disciplinary authority. However, Hospital and Medical Staff leaders are encouraged to use diligence and common sense to make decisions on a case-by-case basis when the circumstances bring to light an allegation or concern of conflict.

In addition, the Chair of the Credentials Committee, Leadership Council, or Committee on Professional Enhancement always has the authority and discretion to recuse a member in a particular situation if the Chair determines that the Interested Member's presence would (i) inhibit the full and fair discussion of the issue before the committee, (ii) skew the recommendation or determination of the committee, or (iii) otherwise be unfair to the Practitioner under review.

N – (Red "N") means the Interested Member should not serve in the indicated role.

R – (Red "R") means the Interested Member should be recused, in accordance with the guidelines on the next page.

RULES FOR RECUSAL	
STEP 1 Confirm the conflict of interest	The Committee Chair or Board Chair should confirm the existence of a conflict of interest relevant to the matter under consideration.
STEP 2 Participation by the Interested Member 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 Chair or Board Chair 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 Board 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 MEC prior to being excused from the meeting); and (v) how the committee or Board 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 or Board's deliberation and decision-making.
STEP 4 Record the recusal in the minutes	The recusal should be documented in the minutes of the committee or Board. The minutes should reflect the fact that the Interested Member was excused from the meeting prior to deliberation and decision-making.