UPMC
POLICY AND PROCEDURE MANUAL

POLICY: HS-MS0002*
INDEX TITLE: Medical Staff

SUBJECT: Credentials Policy
DATE: April 1, 2024

MEDICAL STAFF BYLAWS, POLICIES, AND RULES AND REGULATIONS OF UPMC

CREDENTIALS POLICY

This policy applies to the following United States based UPMC facilities, including any providers who practice therein:

☒ UPMC Children's Hospital of Pittsburgh	☒ UPMC Pinnacle Hospitals
☒ UPMC Magee-Womens Hospital	☒ Harrisburg Campus
☒ UPMC Altoona	☒ West Shore Campus
☒ UPMC Bedford	☒ Community Osteopathic Campus
☒ UPMC Chautauqua	☒ UPMC Carlisle
☒ UPMC East	☒ UPMC Memorial
☒ UPMC Hamot	☒ UPMC Lititz
☒ UPMC Horizon	☒ UPMC Hanover
☒ Shenango Campus	☒ UPMC Muncy
☒ Greenville Campus	☒ UPMC Wellsboro
☒ UPMC Jameson	☒ UPMC Williamsport
☒ UPMC Kane	☒ Williamsport Campus
☒ UPMC McKeesport	☒ Divine Providence Campus
☒ UPMC Mercy	☒ UPMC Cole
☒ UPMC Northwest	☒ UPMC Somerset
☒ UPMC Passavant	☒ UPMC Western Maryland
☒ Main Campus	
☒ Cranberry	
☒ UPMC Presbyterian Shadyside	
☒ Presbyterian Campus	
☒ Shadyside Campus	
☒ UPMC Western Psychiatric Hospital	
☒ UPMC St. Margaret	

Provider-based Ambulatory Surgery Centers

☒ UPMC Altoona Surgery Center
☒ UPMC Children's Hospital of Pittsburgh North
☒ UPMC St. Margaret Harmar Surgery Center
☒ UPMC South Surgery Center
☒ UPMC Center for Reproductive Endocrinology and Infertility
☒ UPMC Digestive Health and Endoscopy Center
☒ UPMC Surgery Center – Carlisle
☒ UPMC Surgery Center Lewisburg
☒ UPMC Pinnacle Procedure Center
☒ UPMC West Mifflin Ambulatory Surgery Center
☒ UPMC Community Surgery Center
☒ UPMC Leader Surgery Center

Free-Standing Ambulatory Surgery Facilities:

☐ UPMC Hamot Surgery Center **(JV)**
☐ Hanover SurgiCenter
☐ UPMC Specialty Care York Endoscopy
☐ Susquehanna Valley Surgery Center
☐ West Shore Surgery Center **(JV)**

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ARTICLE 1

GENERAL

1.A. DEFINITIONS

Unless otherwise indicated, the following definitions shall apply to terms used in this Policy, as well as the Medical Staff Bylaws documents and other policies of the Medical Staff:

(1) "ADMINISTRATIVE LEADERSHIP" means the Hospital President, Chief Operating Officer, VPMA, Chief Nursing Officer, or any Administrator on call at a Participating UPMC Hospital.

(2) "ADVANCED PRACTICE PROFESSIONAL" ("APP") means individuals other than Medical Staff members who provide a medical level of care or perform surgical tasks consistent with granted clinical privileges, but who may be required by law and/or the Participating UPMC Hospital to exercise some or all of those clinical privileges under the direction of, or in collaboration with, a Supervising/Collaborating Physician pursuant to a written Supervision/Collaborative agreement. Those individuals currently practicing as Advanced Practice Professionals at a Participating UPMC Hospital will be maintained in the local Medical Staff Office.

(3) "ALLIED HEALTH PROFESSIONAL" ("AHP") means an individual who is permitted by law or the Participating UPMC Hospital to function only under the direction of a Supervising/Collaborating Physician, pursuant to a written Supervision/Collaboration agreement and consistent with a defined scope of practice. At some Participating UPMC Hospitals, the clinical practice of Allied Health Professionals may be assessed and managed by Human Resources in accordance with Human Resources policies, in which case, the procedures and the provisions of the Medical Staff Bylaws and associated policies shall not apply. Those individuals currently practicing as Allied Health Professionals at a Participating UPMC Hospital will be maintained in the local Medical Staff Office.

(4) "AMBULATORY SURGICAL FACILITY" or "ASF" means an outpatient facility that provides specialty or multispecialty surgical treatment to patients that do not require hospitalization after surgery.

(5) "APPOINTMENT" means the granting of membership to the Medical Staff by the Board at a Participating UPMC Hospital to one of the defined categories outlined in Article 2 of the Medical Staff Bylaws or the granting of permission to practice to an Advanced Practice Professional or Licensed Independent Practitioner.

(6) "AUTOMATIC RELINQUISHMENT/AUTOMATIC RESIGNATION" of appointment and/or clinical privileges are administrative actions that occur by operation of this Policy or other applicable Medical Staff policy. They are not professional review actions that must be reported to the National Practitioner Data Bank or to any state licensing board or agency, nor do they entitle the Practitioner to a hearing or appeal.

(7) "BOARD" means the governing body (i.e., the Board of Directors or Trustees) of a Participating UPMC Hospital or its designated committee.

(8) "CLINICAL PRIVILEGES" or "PRIVILEGES" means the authorization granted by the Board to render specific clinical procedures and patient care services, for which the Medical Staff Leaders and Board have developed eligibility and other credentialing criteria and FPPE and OPPE standards. There are several types of clinical privileges, including, but not limited to, telemedicine privileges, temporary privileges, and disaster privileges.

(9) "COLLEGIAL COUNSELING" means a formal, planned, face-to-face discussion between the Practitioner and one or more Medical Staff Leaders. Collegial Counseling only occurs after a Practitioner has had an opportunity to provide input regarding a concern.

(10) "CONFIDENTIAL PEER REVIEW EVALUATIONS" mean the written evaluations of the quality and efficiency of services ordered or performed by Professional Health Care Providers prepared by, or on behalf of, other Professional Health Care Providers. These include, but are not limited to:

(a) confidential reference evaluations obtained when an individual applies for appointment, reappointment, and/or clinical privileges;

(b) affiliation verifications from other hospitals that contain an assessment of the quality and efficiency of services;

(c) Case Review Forms and similar assessments prepared by Peer Review Committees or Professional Health Care Providers on behalf of Peer Review Committees; and

(d) any reports, correspondence, minutes, or other documentation prepared by, or on behalf of, a Peer Review Committee that contain an evaluation of the quality and efficiency of services.

Confidential Peer Review Evaluations are a subset of Privileged Peer Review Information.

(11) "CORE PRIVILEGES" means a defined grouping of privileges for a specialty or subspecialty that includes the fundamental patient care services that are routinely

taught in residency and/or fellowship training for that specialty or subspecialty and which have been determined by the Medical Staff Leaders and Board to require closely related skills and experience.

(12) "CREDENTIALS COMMITTEE" means the Participating UPMC Hospital's Credentials Committee, or any system or regional Credentials Committee as designated by a Participating UPMC Hospital, which will be responsible for making recommendations pertaining to appointment, reappointment, and/or clinical privileges, as described in this Policy. The composition and duties of this Committee are described in the Medical Staff Organization Manuals of each Participating UPMC Hospital.

(13) "CREDENTIALS POLICY" means this Policy, which shall supersede all prior Credentials Policies, and which shall be amended in accordance with Article 11.

(14) "DAYS" means calendar days.

(15) "DENTIST" means a doctor of dental surgery ("D.D.S.") or Doctor of Dental Medicine ("D.M.D.").

(16) "DEPARTMENT CHAIR" means the applicable head of a Medical Staff department at a Participating UPMC Hospital (e.g., Chair of Medicine) or those with similar positions and titles.

(17) "DEPARTMENT COMMITTEE" means a committee comprised of Professional Health Care Providers who are responsible for, among other things, assessing the quality and efficiency of services ordered or performed by Practitioners within their respective department and performing the other functions described in Medical Staff policy.

(18) "EDUCATIONAL LETTER" is a letter that describes the opportunities for improvement that were identified in the care reviewed and offers specific recommendations for future practice.

(19) "FOCUSED PROFESSIONAL PRACTICE EVALUATION" or "FPPE" means a time-limited period during which a Practitioner's professional performance is evaluated. All initially-granted clinical privileges, whether at the time of initial appointment, reappointment, or during the term of appointment, shall be subject to FPPE.

(20) "HOSPITAL PRESIDENT" means the individual appointed by the Board to act on its behalf in the overall management of a Participating UPMC Hospital.

(21) "INFORMATION LETTER" is a letter that is intended to help Practitioners self-correct and improve their performance solely through providing timely feedback. The Professional Practice Evaluation Committee will prepare a list of

objective occurrences (i.e., not subject to interpretation) for which Information Letters are appropriate.

(22) "INITIAL MENTORING EFFORTS" means informal discussions, mentoring, counseling, sharing of comparative data, and similar efforts that do not meet the criteria for Collegial Counseling. The Medical Staff policies encourage the use of Initial Mentoring Efforts to assist Practitioners in continually improving their practices.

(23) "INVESTIGATION" means a non-routine, formal process to review questions or concerns pertaining to a Practitioner. Only the Medical Executive Committee at a Participating UPMC Hospital has the authority to initiate and conduct an Investigation. By contrast, the processes that address issues of clinical performance, professional conduct, and health involving Practitioners that utilize Initial Mentoring Efforts or Progressive Steps do not constitute Investigations.

(24) "LEADERSHIP COUNCIL" means the Participating UPMC Hospital's Leadership Council, which will be responsible for performing the functions described in this and other Medical Staff policies. The composition and duties of this Committee are described in the Medical Staff Organization Manual of each Participating UPMC Hospital. If a Participating UPMC Hospital does not have a recognized Leadership Council, the functions described in this Policy shall be performed by the Medical Staff President and VPMA of the Participating UPMC Hospital, on behalf of the Hospital's Medical Executive Committee.

(25) "LICENSED INDEPENDENT PRACTITIONER" ("LIP") means individuals other than Medical Staff members who are permitted by law and by the Participating UPMC Hospital to provide patient care services without direction or collaboration/supervision, within the scope of their license and consistent with the clinical privileges granted. Licensed Independent Practitioners also include those Physicians not appointed to the Medical Staff who seek to exercise certain limited clinical privileges at the Hospital under the conditions set forth in this Policy (i.e., moonlighting residents). Those individuals currently practicing as Licensed Independent Practitioners at a Participating UPMC Hospital will be maintained in the local Medical Staff Office.

(26) "MEDICAL EXECUTIVE COMMITTEE" ("MEC") means the Medical Staff Executive Committee at a Participating UPMC Hospital and may also refer to a local campus MEC, as appropriate. The composition and duties of each MEC are described in the Medical Staff Bylaws of each Participating UPMC Hospital.

(27) "MEDICAL STAFF" means all Physicians and other types of Practitioners who have been appointed to the Medical Staff by the relevant Participating UPMC Hospital's Board.

(28) "MEDICAL STAFF LEADER" means any Medical Staff Officer, Department Chair, Section Chief (as applicable), and committee chair at a Participating UPMC Hospital.

(29) "MEDICAL STAFF MEMBER" means any Physicians or other types of Practitioners who have been designated as members of the Medical Staff by the Board at a Participating UPMC Hospital.

(30) "MEDICAL STAFF SERVICES" means the Medical Staff Office at the relevant Participating UPMC Hospital or any delegated Credentials Verification Office ("CVO").

(31) "NON-PRIVILEGED INFORMATION" means information and documentation that is reviewed and is a component part of the credentialing process related to initial appointment, reappointment, and/or the granting of clinical privileges, but that is not confidential and privileged under the Pennsylvania Peer Review Protection Act or other relevant state law. Examples of this information include, but are not limited to:

(a) primary source verification documents (e.g., license, education, training, DEA, etc.);

(b) queries to the Office of Inspector General, List of Excluded Providers and Entities;

(c) results of criminal background checks, including any mandated child abuse checks;

(d) application forms;

(e) confirmation of adequate professional liability insurance coverage for the clinical privileges requested;

(f) professional liability actions;

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

(h) information regarding citizenship requirements, such as service on committees, participation in the emergency call roster, willingness to contribute to required Medical Staff functions, and similar duties and responsibilities; and

(i) complaints and/or positive feedback received from patients and/or families.

All Non-Privileged Information is maintained in an individual's Credentials File.

(32) "NOTICE" means written communication by regular U.S. mail, Hospital mail, hand delivery, e-mail, facsimile, website, or other electronic method.

(33) "ONGOING PROFESSIONAL PRACTICE EVALUATION" or "OPPE" means the ongoing review and analysis of data that helps to identify any issues or trends in Practitioners' performance that may impact quality of care and patient safety.

(34) "ORAL AND MAXILLOFACIAL SURGEON" means an individual with a D.D.S. or a D.M.D. degree, who has completed additional training in oral and maxillofacial surgery.

(35) "PARTICIPATING UPMC HOSPITAL" means a UPMC Hospital that has adopted this Policy through its Medical Executive Committee and Board. This term may also mean any free-standing ambulatory surgery facilities within UPMC that have adopted this Policy. A list of Participating UPMC Hospitals that are covered by this Policy is outlined in **Appendix B**. For purposes of this Policy, the specific Participating UPMC Hospital where the Policy is being applied (e.g., the hospital that is credentialing a Practitioner) will be referred to as "the Hospital."

(36) "PATIENT CONTACTS" means any admission, consultation, procedure, physical response to emergency call, evaluation, treatment, or service performed in any facility operated by the Participating UPMC Hospital or affiliate, including outpatient facilities. Patient contacts do not include referrals for diagnostic or laboratory tests or x-rays.

(37) "PEER REVIEW" means the evaluation of the quality and efficiency of services ordered or performed by Professional Health Care Providers. This evaluation is conducted by other Professional Health Care Providers who serve on, or have been authorized to act on behalf of, a Peer Review Committee. Peer Review is also known as Professional Practice Evaluation ("PPE").

Peer Review activities include, but are not limited to, the following:

(a) the assessment of a Professional Health Care Provider's clinical performance, professionalism, health, and utilization practices in accordance with the procedures in this Policy and related Medical Staff policies;

(b) use of the following tools and procedures to address any questions or concerns that may be identified with a Professional Health Care Provider: mentoring and counseling, other collegial efforts and progressive steps, Performance Improvement Plans, focused reviews, precautionary suspensions, investigations, and hearing and appeals; and

(c) the portions of the initial appointment and reappointment processes that involve the evaluation of the quality and efficiency of services ordered or performed by a Professional Health Care Provider.

(38) "PEER REVIEW COMMITTEE" means any committee that engages in Peer Review. Peer Review Committees include, but are not limited to, the following:

(a) Medical Executive Committee, Professional Practice Evaluation Committee, System PPEC, Credentials Committee, Leadership Council, Department Committee, or any other standing or ad hoc committee that performs Peer Review;

(b) a committee that engages in Peer Review that is formed by the Physician Services Division ("PSD"), University of Pittsburgh Physicians ("UPP"), UPMC Community Medicine, Inc. ("CMI"), or other UPMC affiliated physician groups, such as those at UPMC Altoona, Chautauqua, Hamot, Central Pennsylvania, and North Central Pennsylvania;

(c) clinical departments, sections, and service lines when engaging in Peer Review;

(d) Hearing Officers and hearing and appellate review panels;

(e) the Board of any UPMC Entity and its committees; and

(f) any individual who is authorized to perform functions on behalf of a Peer Review Committee, including Medical Staff Leaders, VPMA, Hospital personnel, and experts or consultants retained to assist in Peer Review activities.

All Peer Review Committees are also "professional review bodies" as that term is defined in the Health Care Quality Improvement Act of 1986, 42 U.S.C. §11101 *et seq*.

(39) "PERFORMANCE IMPROVEMENT PLAN" or "PIP" is a voluntary agreement between a Practitioner and a Medical Staff committee by which the Practitioner takes certain steps to improve their clinical practice or conduct.

(40) "PERMISSION TO PRACTICE" means the authorization granted to Advanced Practice Professionals and Licensed Independent Practitioners to exercise clinical privileges at the Participating UPMC Hospital.

(41) "PHYSICIAN" means both doctors of medicine ("M.D.s") and doctors of osteopathy ("D.O.s").

(42) "PODIATRIST" means a doctor of podiatric medicine ("D.P.M.").

(43) "PRACTITIONER" means any individual who has been granted clinical privileges and/or appointment by the Board at a Participating UPMC Hospital, including, but not limited to, Medical Staff Members, Advanced Practice Professionals, and Licensed Independent Practitioners. Some Participating UPMC Hospitals may also credential and manage Allied Health Professionals through their Medical Staff, in which case, "Practitioner" would also include Allied Health Professionals.

(44) "PRIVILEGED PEER REVIEW INFORMATION" means any information maintained at a Participating UPMC Hospital in any format (verbal, written, or electronic) that involves the evaluation of the quality and efficiency of services ordered or performed by Professional Health Care Providers. Privileged Peer Review Information includes analyses, evaluations, reports, correspondence, records, proceedings, recommendations, actions, and minutes made or taken by, or on behalf of, Peer Review Committees, or in response to a request for information by another Peer Review Committee. Examples of this information include, but are not limited to:

(a) documentation created by or on behalf of Department Committees and the Professional Practice Evaluation Committee pursuant to the Professional Practice Evaluation/Peer Review Policy;

(b) Confidential Peer Review Evaluations as defined earlier in these Definitions;

(c) documentation of OPPE and FPPE activities, including the reports prepared by the Department Committees and Credentials Committee;

(d) assessments regarding the appropriateness of utilization patterns;

(e) morbidity and mortality data related to the specific individual;

(f) assessments of the Practitioner's health status and ability to perform the privileges requested competently and safely created at the request of, or obtained and maintained by, a Peer Review Committee for purposes of Peer Review. This includes, but is not limited to, records related to the assessment and treatment for drug or alcohol use and mental health counseling records;

(g) any information concerning Peer Review/professional practice activities and/or the voluntary or involuntary termination, limitation, reduction, or loss of appointment or clinical privileges at another hospital; and

(h) responses to queries to the National Practitioner Data Bank.

All Privileged Peer Review Information is maintained in an individual's Confidential Quality/Peer Review File.

(45) "PROFESSIONAL HEALTH CARE PROVIDER" has the meaning set forth in Pa. Stat. Ann. 63 P.S. §425.2 (or the comparable provision of any subsequent statute) or the relevant state peer review statute in another state, if the Participating UPMC Hospital is located outside of Pennsylvania.

(46) "PROFESSIONAL PRACTICE EVALUATION" or "PPE" refers to the relevant Participating UPMC Hospital's routine Peer Review process. It is used to evaluate a Practitioner's professional performance when any questions or concerns arise and includes all activities and documentation related to reviewing issues of clinical competence, professional conduct, care management, and health status. The PPE processes outlined in the Medical Staff policies are applicable to all Practitioners and are not intended to be a precursor to any disciplinary action, but rather are designed to promote improved patient safety and quality through continuous improvement.

(47) "PROFESSIONAL PRACTICE EVALUATION COMMITTEE" or "PPEC" is a multi-specialty peer review committee under state law that oversees the professional practice evaluation process at a Participating UPMC Hospital, conducts case reviews, and works with Practitioners in a constructive and educational manner to help address any clinical performance issues. It may also refer to a committee with similar functions and titles (e.g., Peer Review Committee or Committee for Professional Enhancement).

(48) "PROGRESSIVE STEPS" means Information Letters, Educational Letters, Collegial Counseling, and Performance Improvement Plans.

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

(50) "REAPPOINTMENT" means the granting of continued appointment to the Medical Staff by the Board at a Participating UPMC Hospital or the granting of continued permission to practice to an Advanced Practice Professional or Licensed Independent Practitioner.

(51) "REGION" means a group of UPMC Hospitals, as defined by UPMC and displayed in the UPMC Onboarding Guidebook.

(52) "RESTRICTION" means a professional review action that:

(a) is recommended by the Medical Executive Committee as part of an Investigation or agreed to by the Practitioner while the Practitioner is under Investigation; and

(b) limits the individual's ability to independently exercise their own clinical judgment (i.e., a mandatory concurring consulting requirement in which the consultant must approve the course of treatment in advance or a proctoring requirement in which the proctor is mandated to be present for the case and has the authority to intervene in the case, if necessary).

Restrictions do not include the following, whether recommended by the Medical Executive Committee or by any other Medical Staff committee:

(a) general consultation requirements, in which the Practitioner agrees to seek input from a consultant prior to providing care;

(b) observational proctoring requirements, in which the Practitioner agrees to have a proctor present to observe the Practitioner's provision of care; and

(c) other collegial performance improvement efforts, including Information Letters, Educational Letters, or Performance Improvement Plans that are suggested by the Medical Staff leadership and voluntarily agreed to by the Practitioner as a part of the routine PPE process.

(53) "SCOPE OF PRACTICE" means the authorization granted to an Allied Health Professional by the Board to perform certain clinical activities and functions under the Supervision of, or in collaboration with, a Supervising/Collaborating Physician.

(54) "SECTION CHIEF" means the applicable head of a Medical Staff section at a Participating UPMC Hospital (e.g., Chief of Neurosurgery), or those with similar positions and titles (e.g., Division Director).

(55) "SPECIAL NOTICE" means hand delivery, certified mail (return receipt requested), or overnight delivery service providing receipt.

(56) "SPECIAL PRIVILEGES" means clinical privileges that fall outside of the core privileges for a given specialty, which require additional education, training, and/or experience beyond that required for core privileges in order to demonstrate competence.

(57) "SUPERVISING/COLLABORATING PHYSICIAN" means a Medical Staff Member with clinical privileges who has agreed in writing to Supervise/Collaborate with an Advanced Practice Professional or an Allied Health Professional and to accept full responsibility for the actions of the Advanced Practice Professional or Allied Health Professional while the Advanced Practice Professional or Allied Health Professional is practicing at a Participating UPMC Hospital.

(58) "SUPERVISION/COLLABORATION" means the supervision of, or collaboration with, an Advanced Practice Professional or an Allied Health Professional by a Supervising/Collaborating Physician, that may or may not require the actual

presence of the Supervising/Collaborating Physician, but that does require, at a minimum, that the Supervising/Collaborating Physician be readily available for consultation. The requisite level of supervision (general, direct, or personal) shall be consistent with any applicable written Supervision/Collaboration agreement that may exist.

(59) "TELEMEDICINE" means the exchange of medical information from one site to another via electronic communications for the purpose of providing patient care, treatment, and services.

(60) "VICE PRESIDENT OF MEDICAL AFFAIRS" ("VPMA") means the individual designated to assist the Medical Staff in the performance of its functions, work in cooperation with the Medical Staff President, and serve as a liaison to the Board at a Participating UPMC Hospital, or those with similar positions and titles (e.g., a Chief Medical Officer).

(61) "VOTING STAFF" or "VOTING MEMBER" means those Practitioners who have been given the right to vote in all general and special meetings of the Medical Staff at a Participating UPMC Hospital. Voting rights are defined in the prerogatives of each Medical Staff category in the Medical Staff Bylaws of each Participating UPMC Hospital.

1.B. DELEGATION OF FUNCTIONS

(1) When a function under this Policy is to be carried out by a member of Administrative Leadership, a Medical Staff member, or by a Medical Staff committee, including a Peer Review Committee, the individual, or the committee through its chair, may delegate performance of the function to a qualified designee who is a Practitioner or Hospital employee (or a committee of such individuals). Any such designee must treat and maintain Privileged Peer Review Information in a strictly confidential manner and is bound by all other terms, conditions, and requirements of the Medical Staff Bylaws and related policies. In addition, the delegating individual or committee is responsible for ensuring that the designee appropriately performs the function in question. Any documentation created by the designee are records of the committee that is ultimately responsible for the review in a particular matter.

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

1.C. SUBSTANTIAL COMPLIANCE

While every effort will be made to comply with all provisions of this Policy, substantial compliance is required. Technical or minor deviations from the procedures set forth within this Policy do not invalidate any review or action taken.

ARTICLE 2

QUALIFICATIONS, CONDITIONS, AND RESPONSIBILITIES

2.A. QUALIFICATIONS

2.A.1. Threshold Eligibility Criteria:

To be eligible to apply for initial appointment, reappointment, and/or clinical privileges and as a condition of maintaining ongoing appointment and/or clinical privileges, individuals must satisfy the applicable eligibility criteria:

(a) All Practitioners:

(1) have a current, unrestricted license to practice in the state in which the Hospital is located that is not subject to any restrictions, conditions or probationary terms;

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

(3) where applicable to their practice, have a current, unrestricted DEA registration and state-controlled substance license and have never had a DEA registration or state-controlled substance license denied, revoked, restricted or suspended;

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

(5) not currently under any criminal investigation or indictment and have not been convicted of, or entered a plea of guilty or no contest to, Medicare, Medicaid, or other federal or state governmental or private third-party payer fraud or program abuse, nor have been required to pay civil monetary penalties for the same;

(6) have not been, and are not currently, excluded, precluded, or debarred from participation in Medicare, Medicaid, or other federal or state governmental health care program;

(7) have not been terminated from a post-graduate training program for reasons related to clinical competence or professional conduct (residency or fellowship or a similarly equivalent program for other categories of

Practitioners), nor resigned from such a program during an investigation or in exchange for the program not conducting an investigation;

(8) have not had appointment, clinical privileges, or scope of practice denied, suspended, revoked, or terminated by any health care facility or health plan, including at this Hospital, for reasons related to clinical competence or professional conduct;

(9) have not resigned appointment or relinquished clinical privileges or a scope of practice during an Investigation or in exchange for not conducting such an Investigation, including at this Hospital;

(10) not currently facing pending criminal charges or indictment and have not been convicted of, or entered a plea of guilty or no contest to, any felony; or to any misdemeanor relating to (i) controlled substances, (ii) illegal drugs, (iii) insurance or health care fraud or abuse, (iv) child abuse, (v) elder abuse, (vi) violence, or (vii) the Practitioner-patient relationship;

(11) demonstrate compliance with Federal (FBI) Criminal Background Clearance, Pennsylvania State Police Clearance, and Child Abuse History Clearance requirements in accordance with the Pennsylvania Child Protective Services Law (CPSL), where relevant based on the location of the Hospital;

(12) have or agree to make appropriate coverage arrangements ("appropriate coverage" means coverage by another credentialed Practitioner with appropriate specialty-specific privileges as determined by the Credentials Committee) with other Practitioners for those times when the individual will be unavailable;

(13) demonstrate recent clinical activity in their primary area of practice during the last year;

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

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

(16) agree to comply with all policies, training and educational protocols, and orientation requirements adopted by the MEC, the Hospital, or UPMC, including, but not limited to, those involving electronic medical records, the privacy and security of protected health information, infection control, patient safety initiatives, clinical protocols, and Medical Staff functions;

(17) document compliance with any immunization, vaccination, and/or health screening requirements as may be adopted by the MEC, the Hospital, or

UPMC (e.g., TB testing, mandatory flu vaccines, and infectious agent exposures); and

(18) have not been separated from employment with UPMC, or any of its subsidiaries, for issues related to clinical performance or professionalism.

(b) Additional Criteria for Medical Staff Members:

(1) be available on a continuous basis, either personally or by arranging appropriate coverage, to (i) respond to the needs of any inpatients for whom they have responsibility and (ii) respond to Emergency Department patients during those times when they are on call in a prompt, efficient, and conscientious manner. Compliance with this eligibility requirement means that the Practitioner should be willing and able to:

(i) respond within 15 minutes, via phone, to an initial contact from the Hospital; and

(ii) appear in person (or via approved technology-enabled direct communication and evaluation, i.e., telemedicine) to attend to a patient within 60 minutes of being requested to do so* (or more quickly based upon (a) a specific Hospital Policy; (b) the acute nature of the patient's condition; or (c) as required in accordance with department policy or as required for a particular specialty;

* Note, when there is a difference in opinion between the requestor and requestee over whether an in-person appearance is needed, the matter should be referred to the VPMA. However, per EMTALA, deference should be given to the requestor if the request is being made by the ED physician.

(2) agree to personally fulfill all responsibilities regarding emergency service call coverage for their specialty or to obtain appropriate coverage (as determined by the Credentials Committee) by another Practitioner with appropriate clinical privileges;

(3) have successfully completed (as applicable):

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

(ii) a dental or oral and maxillofacial surgery training program accredited by the Commission on Dental Accreditation of the American Dental Association ("ADA");

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

(iv) a clinical psychology training program accredited by the American Psychological Association;

(4) be certified in their primary area of practice at the Hospital by the appropriate specialty/subspecialty board of the American Board of Medical Specialties ("ABMS"), the AOA, the American Board of Oral and Maxillofacial Surgery, the American Board of Foot and Ankle Surgery, the Bureau of Osteopathic Specialists, the American Board of Oral and Maxillofacial Surgery, the ADA, the American Board of Podiatric Surgery, or the American Board of Professional Psychology, as applicable. Those applicants who are not board certified at the time of application but who have completed their residency or fellowship training within the last five years shall be eligible for Medical Staff appointment. However, in order to remain eligible, those applicants must achieve board certification in their primary area of practice within five years from the date of completion of their residency or fellowship training; and*

(5) maintain board certification in their primary area of practice at the Hospital on a continuous basis, and satisfy all requirements of the relevant specialty/subspecialty board necessary to do so (board certification status will be assessed at reappointment).*

* The requirements pertaining to board certification and maintenance of certification are applicable to those individuals who apply for initial staff appointment after the effective date of this policy and are not applicable to Medical Staff members who were appointed prior to that date. Those Medical Staff members who were appointed prior to that date shall be governed by any board certification requirements that may have been in effect at the time of their initial appointments.

In addition, in exceptional circumstances, the five-year time frame for initial applicants and the time frame for maintenance/recertification by existing members may be extended for one additional period, not to exceed two years, in order to permit an individual an additional opportunity to obtain or maintain certification. All such requests will be reviewed on a case-by-case basis and in order to be eligible to request an extension in these situations, an individual must, at a minimum, satisfy the following criteria:

(i) the individual has been on the Hospital's Medical Staff for at least two full years;

(ii) there have been no significant documented peer review concerns related to the individual's competence or behavior at the Hospital during the individual's tenure;

(iii) the individual provides a letter from the appropriate certifying board confirming that the individual remains eligible to take the certification examination within the next two years; and

(iv) the appropriate Department Committee at the Hospital provides a favorable report concerning the individual's quality and efficiency of services.

(c) Additional Criteria for APPs and LIPs:

(1) in the case of an Advanced Practice Professional, have a written collaborative/supervision agreement, as applicable, with a Supervising/Collaborating Physician, that meets all applicable requirements of state law and Hospital policy; and

(2) have completed all appropriate professional education and is either certified by the appropriate nationally recognized certification organization or, if APP or LIP is not certified, must acquire the appropriate nationally recognized professional certification at the first-time certification is available. All certifications must be maintained in order to remain eligible for appointment and clinical privileges.

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

(a) Any applicant who does not satisfy one or more of the threshold eligibility criteria outlined above may request that it be waived. Waivers of threshold eligibility criteria will not be granted routinely. The applicant requesting the waiver bears the burden of demonstrating (i) that the applicant is otherwise qualified, and (ii) **exceptional** circumstances exist (e.g., when there is a demonstrated Hospital or Medical Staff need for the services in question). Exceptional circumstances generally do not include situations where a waiver is sought for the convenience of an applicant (e.g., applicants who wish to defer taking board examinations).

(b) A request for a waiver shall be submitted to the Credentials Committee for consideration, along with the application form and any additional information submitted by the applicant. In reviewing the request for a waiver, the Credentials Committee may consider the specific qualifications of the applicant in question, input from the relevant Department Chair, and the best interests of the Hospital and the communities it serves. The Credentials Committee will forward its recommendation to the MEC. Any recommendation to grant a waiver must include the specific basis for the recommendation.

(c) The MEC shall review the recommendation of the Credentials Committee and make a determination regarding whether to grant a waiver. Any such determination is final.

(d) A determination to grant a waiver does not mean that the appointment, clinical privileges, or scope of practice will be granted, only that processing of the application can begin. A determination by the MEC that an applicant is not entitled to a waiver is not a "denial" of appointment, clinical privileges, or scope of practice. Rather, that individual is ineligible to request appointment, clinical privileges, or scope of practice. A determination of ineligibility is not a matter that is reportable to either the state licensure board or the National Practitioner Data Bank, nor does it provide the right to a hearing under this Policy.

(e) The granting of a waiver in a particular case does not set a precedent for any other applicant or group of applicants.

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

2.A.3. Factors for Evaluation:

The six ACGME general competencies (patient care, medical knowledge, professionalism, system-based practice, practice-based learning, and interpersonal communications) will be evaluated as part of the assessment of the initial grant or renewal of clinical privileges at time of appointment and reappointment, as reflected in the following factors:

(a) relevant training, experience, and demonstrated current competence, including medical/clinical knowledge, technical and clinical skills, and clinical judgment, and an understanding of the contexts and systems within which care is provided;

(b) adherence to the ethics of their profession, continuous professional development, an understanding of and sensitivity to diversity, and responsible attitude toward patients and their profession;

(c) good reputation and character;

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

(e) ability to work professionally with others, including, but not limited to, interpersonal and communication skills sufficient to enable them to maintain professional relationships with patients, families, and other members of health care teams; and

(f) recognition of the importance of, and willingness to support, the Hospital's and Medical Staff's commitment to quality care and a recognition that interpersonal skills and collegiality are essential to the provision of quality patient care.

2.A.4. No Entitlement to Appointment or Permission to Practice:

No individual is entitled to receive an application or to be granted appointment, reappointment, or particular clinical privileges merely because the individual:

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

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

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

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

(e) has had in the past, or currently has, Medical Staff appointment, permission to practice as an Advanced Practice Professional or Licensed Independent Practitioner, or clinical privileges at any hospital or health care facility;

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

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

2.A.5. Nondiscrimination:

Neither the Hospital nor the Medical Staff will discriminate in granting appointment, reappointment, and/or clinical privileges on the basis of race, color, religion, ancestry, national origin, age, sex, genetics, sexual orientation, gender expression, gender identity, or marital, familial, or disability status or status as a protected veteran or any other legally protected group status unrelated to the provision of patient care to the extent the individual is otherwise qualified.

2.B. GENERAL CONDITIONS OF APPOINTMENT AND REAPPOINTMENT

2.B.1. Basic Responsibilities and Requirements:

As a condition of being granted appointment, reappointment, and/or clinical privileges, and as a condition of maintaining ongoing appointment and/or clinical privileges, every Practitioner specifically agrees to the following:

(a) to provide continuous and timely quality care to all patients for whom the individual has responsibility;

(b) to abide by all Bylaws, policies, and Rules and Regulations of the Hospital, Medical Staff, and UPMC during the time the individual is appointed;

(c) to participate in Medical Staff affairs through committee service, participation in quality improvement and professional practice evaluation activities, and by performing such other reasonable duties and responsibilities as may be assigned;

(d) within the scope of the individual's clinical privileges, to provide emergency service call coverage, consultations, and care for unassigned patients (a member must complete all scheduled emergency service call obligations or arrange appropriate coverage);

(e) to comply with clinical practice or evidence-based medicine protocols that are established by, and must be reported to, regulatory or accrediting agencies or patient safety organizations, including those related to national patient safety initiatives and core measures, or clearly document the clinical reasons for variance;

(f) to comply with clinical practice or evidence-based medicine protocols pertinent to the individual's medical specialty, as may be adopted by the Medical Staff or the Medical Staff Leadership, or to clearly document the clinical reasons for variance;

(g) to inform Medical Staff Services, in writing, as soon as possible, but in all cases within 10 days, of any change in the Practitioner's status or any change in the information provided on the individual's application form. This information shall be provided with or without request and shall include, but not be limited to:

(1) any and all complaints regarding, or changes in, licensure status or DEA or state-controlled substance authorization,

(2) adverse changes in professional liability insurance coverage,

(3) the filing of a professional liability lawsuit against the Practitioner, any settlements or payments involving the Practitioner, or any verdicts against the Practitioner,

(4) changes in the Practitioner's status (appointment, permission to practice, or clinical privileges) at any other hospital or health care entity as a result of peer review activities or in order to avoid initiation of peer review activities,

(5) changes in the Practitioner's employment status at any medical group or hospital as a result of issues related to clinical competence or professional conduct,

(6) knowledge of a criminal investigation involving the individual, arrest, charge, indictment, conviction, or a plea of guilty or no contest in any criminal matter other than a misdemeanor traffic citation,

(7) exclusion or preclusion from participation in Medicare/Medicaid or any sanctions imposed,

(8) any changes in the Practitioner's ability to safely and competently exercise clinical privileges or perform the duties and responsibilities of appointment because of health status issues, including, but not limited to, a physical, mental, or emotional condition that could adversely affect the Practitioner's ability to practice safely and competently, or impairment due to addiction, alcohol use, or other similar issue (all of which shall be referred for review under the practitioner health policy),

(9) any referral to a state board health-related program, and

(10) any charge of, or arrest for, driving under the influence ("DUI") (which shall be referred for review under the practitioner health policy);

(h) to immediately submit to an appropriate evaluation, which may include diagnostic testing (including, but not limited to, a blood and/or urine test) and/or a complete physical, mental, and/or behavioral evaluation, if at least two Medical Staff Leaders (or one Medical Staff Leader and one member of the Administrative Leadership) are concerned with the individual's ability to safely and competently care for patients. In emergent circumstances in which a Practitioner is displaying behavior that may pose an immediate safety threat to patients or others, one individual (a Medical Staff Leader or a member of the Administrative Leadership) may require that the individual submit to an evaluation as described above. The health care professional(s) to perform the testing and/or evaluations shall be determined by the Medical Staff Leader(s), and the Practitioner must execute all appropriate releases to permit the sharing of information with the Medical Staff Leaders;

(i) to meet with Medical Staff Leaders and/or members of the Administrative Leadership upon request, to provide information regarding professional qualifications upon written request, and to participate in collegial efforts with Medical Staff Leaders and/or Administrative Leadership as may be requested;

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

(k) to maintain and monitor a current UPMC or other approved e-mail address or other approved electronic communication channel (e.g., secure portal or text) with Medical Staff Services, which will be the primary mechanism used to communicate all Medical Staff information to the Practitioner;

(l) to provide a valid mobile phone number, with texting capability, in order to facilitate Practitioner-to-Practitioner communication;

(m) to not engage in illegal fee splitting or other illegal inducements relating to patient referral;

(n) to not delegate responsibility for hospitalized patients to any individual who is not qualified or adequately supervised;

(o) to not deceive patients as to the identity of any individual providing treatment or services and to always wear proper Hospital identification of their name and status;

(p) to seek consultation whenever required or necessary;

(q) to utilize the electronic medical record system for patients referred or admitted to the Hospital;

(r) to cooperate with all care management activities;

(s) to perform all services and conduct himself or herself at all times in a cooperative and professional manner;

(t) where applicable to the Participating Hospital, to at all times conduct themselves in compliance with the highest standards of business ethics and integrity, as reflected in the Hospital's Corporate Responsibility Program including, without limitation, the Hospital's Standards of Conduct and the Ethical and Religious Directives for Catholic Health Services (the "ERDs");

(u) to promptly pay any applicable dues, assessments, and/or fines;

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

(w) that, if there is any misstatement in, or omission from, the application, the Hospital may stop processing the application (or, if appointment has been granted prior to the discovery of a misstatement or omission, appointment and clinical privileges may be deemed to be automatically relinquished). In either situation, there shall be no entitlement to a hearing or appeal. The individual will be informed in writing of the nature of the misstatement or omission and permitted to provide a written response for the Credentials Committee's consideration. If the determination is made to not process an application or that appointment and privileges should be automatically relinquished pursuant to this provision, the individual may not reapply for a period of at least two years.

2.B.2. Burden of Providing Information:

(a) Individuals seeking appointment, reappointment, and/or clinical privileges 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 about an individual's qualifications. The information to be produced includes such quality data and other information as may be needed to assist in an appropriate assessment of overall qualifications for appointment, reappointment, and current clinical competence for any requested clinical privileges, including, but not limited to, information from other hospitals, information from the individual's office practice, information from insurers or managed care organizations in which the individual participates, and/or receipt of confidential evaluation forms completed by referring/referred to physicians.

(b) Individuals seeking appointment, reappointment, and/or clinical privileges have the burden of providing evidence that all the statements made and information given on the application are accurate and complete.

(c) Complete Application: An application shall be complete when all questions on the application form have been answered, all supporting documentation has been supplied, all information has been verified from primary sources, and any required application fees and applicable fines have been paid. An application shall become incomplete if the need arises for new, additional, or clarifying information at any time during the credentialing process. Whenever there is a need for new, additional, or clarifying information – outside of the normal, routine credentialing process – the application will not be processed until the information is provided. If the application continues to be incomplete 30 Days after the individual has been notified of the additional information required, the application will be deemed to be withdrawn and the individual may not submit another application for appointment or clinical privileges for a period of two years.

(d) The individual seeking appointment, reappointment and/or clinical privileges is responsible for providing a complete application, including adequate responses from references. An incomplete application shall not be processed.

2.C. APPLICATION

2.C.1. Information:

(a) Applications for appointment and reappointment shall contain a request for specific clinical privileges and shall require detailed information concerning the individual's professional qualifications.

(b) In addition to other information, the applications shall seek the following:

(1) information as to whether the applicant's appointment or clinical privileges have been voluntarily or involuntarily relinquished, withdrawn, denied, revoked, suspended, subjected to probationary or other conditions, reduced, limited, terminated, or not renewed at any other hospital, health care facility, or other organization, or are currently being investigated or challenged;

(2) information as to whether the applicant's license to practice any relevant profession in any state, DEA registration, or any state's controlled substance license has been voluntarily or involuntarily suspended, modified, terminated, restricted, or relinquished or is currently being investigated or challenged;

(3) information concerning the applicant's professional liability litigation experience, including past and pending claims, final judgments, or settlements; the substance of the allegations as well as the findings and the ultimate disposition; and any additional information concerning such proceedings or actions as the Credentials Committee, the MEC, or the Board may request;

(4) current information regarding the applicant's ability to safely and competently exercise the clinical privileges requested; and

(5) a copy of a U.S. government-issued photo identification.

(c) The applicant shall sign the application and certify that they are able to perform the privileges requested and the responsibilities of appointment.

2.C.2. Grant of Immunity and Authorization to Obtain/Release Information:

By requesting an application and/or applying for appointment, reappointment, or clinical privileges, the individual expressly accepts the conditions set forth in this Section:

(a) Immunity:

To the fullest extent permitted by law, the individual releases from any and all liability, extends immunity to, and agrees not to sue the Hospital and those UPMC Entities designated on their application form (the "UPMC Entities"), their Boards, any members of their Medical Staffs, their authorized representatives and agents, and any third parties who provide information for any matter relating to appointment, reappointment, clinical privileges, or the individual's qualifications for the same. This immunity covers any actions, recommendations, communications, and/or disclosures involving the individual that are made, taken, or received by any entities or individuals named above in the course of credentialing and peer review activities. This immunity also extends to any reports that may be made to government regulatory and licensure boards or agencies pursuant to federal or state law.

(b) Authorization to Obtain Information from Third Parties:

The individual specifically authorizes the UPMC CVO, the UPMC Entities, their Medical Staff Leaders, and their authorized agents and 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 the individual's qualifications for initial and continued appointment to the Medical Staff and/or clinical privileges, or to otherwise participate with UPMC Entities 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. The individual also specifically authorizes these third parties to release this information to the UPMC CVO, the UPMC Entities, their Medical Staffs, and their authorized agents and representatives upon request. Further, the individual agrees to sign necessary consent forms to permit a consumer reporting agency to conduct a criminal background check on the individual and report the results to the designated UPMC Entities.

(c) Authorization to Release Information to Third Parties:

The individual also authorizes the UPMC Entities, their Medical Staff Leaders, and their authorized representatives and agents to release information to (i) other hospitals, health care facilities, managed care organizations, and their agents when information is requested in order to evaluate the individual's professional qualifications for appointment, clinical privileges, and/or participation at the requesting organization/facility, (ii) persons or entities external to the UPMC Entities that are assessing the individual's professional qualifications, competence, or health pursuant to a review that the individual has been notified is occurring under applicable policy (hospital or Medical Staff) at a UPMC Entity, and (iii) any government regulatory and licensure boards or agencies pursuant to federal or state law. The disclosure of any Privileged Peer Review Information in response to such inquiries does not waive any associated privilege, and any and all disclosures shall be made with the understanding that the receiving entity will only use such Privileged Peer Review Information for Peer Review purposes.

(d) Authorization to Share Information among UPMC Entities:

The individual specifically authorizes UPMC Entities (as defined below) and their authorized agents to share with one another any Privileged Peer Review Information maintained in any format (verbal, written, or electronic) that involves (i) the evaluation of the quality and efficiency of services ordered or performed by the individual, or (ii) the individual's professional qualifications, competence, conduct, health, experience, or patient care practices. This Privileged Peer Review Information and documentation may be shared at any time, including, but not limited to, any initial evaluation of an individual's qualifications, any periodic reassessment of those qualifications, or when a question is raised about the individual. For purposes of this Section, a UPMC Entity means:

(1) any entity which:

(i) directly or indirectly, through one or more intermediaries, is controlled by or integrated with UPMC; and

(ii) has a formal peer review/professional practice evaluation process and an established Peer Review Committee, as evidenced by internal bylaws or policy.

Entities that are "controlled by or integrated with UPMC" for purposes of this definition include, but are not limited to, the following entities, as well as those individuals, committees, and boards who act on their behalf:

- UPMC Hospitals;
- UPMC Ambulatory Surgery Centers;
- the Physician Services Division ("PSD"), University of Pittsburgh Physicians ("UPP"), UPMC Community Medicine, Inc. ("CMI"), or other UPMC affiliated physician groups, such as those at UPMC Altoona, Chautauqua, Hamot, Central Pennsylvania, and North Central Pennsylvania;
- any joint ventures in which UPMC has an interest of 50 percent or more; and
- any entity that is managed, via a written management services agreement, by one of the entities described in this subsection (1); and

(2) any entity not included in subsection (1) that provides patient care services and that:

(i) has a formal peer review/professional practice evaluation process and an established Peer Review Committee, as evidenced by internal bylaws or policy; and

(ii) has appropriate provisions regarding the sharing of Privileged Peer Review Information consistent with the UPMC Information Sharing Policy in a professional services contract or separate agreement with UPMC or a UPMC Entity identified in subsection (1).

(e) Hearing and Appeal Procedures:

The individual agrees that the hearing and appeal procedures set forth in the UPMC Entities' bylaws or credentialing policy are the sole and exclusive remedy with respect to any professional review action taken at the UPMC Entities.

(f) Legal Actions:

If, despite this Section, an individual institutes legal action challenging any credentialing, privileging, peer review, or other action affecting appointment or clinical privileges, or any report that may be made to a regulatory board or agency, and does not prevail, the individual shall reimburse the UPMC Entities and any members of their Medical Staffs or Board, authorized representatives and agents, and any employees of the UPMC Entities who are involved in the action for all costs incurred in defending such legal action, including reasonable attorney's fees, expert witness fees, and lost revenues.

(g) Scope of Section:

All of the provisions in this Section 2.C.2 are applicable in the following situations:

(1) whether or not appointment or clinical privileges are granted;

(2) throughout the term of any appointment or reappointment period and thereafter;

(3) should appointment, reappointment, or clinical privileges be revoked, reduced, restricted, suspended, and/or otherwise affected as part of the UPMC Entities' professional review activities;

(4) as applicable, to any third-party inquiries received, or to the sharing of information among UPMC Entities that may occur, after the individual's appointment, clinical privileges, or other affiliation with the UPMC Entities ends regarding the individual's tenure at the Hospital; and

(5) as applicable, to any reports that may be made to government regulatory and licensing boards or agencies pursuant to federal or state law.

ARTICLE 3

PROCEDURE FOR INITIAL APPOINTMENT AND CLINICAL PRIVILEGES

3.A. PROCEDURE FOR INITIAL APPOINTMENT AND CLINICAL PRIVILEGES

3.A.1. General Principles:

(a) This Article describes each step in the review process regarding applications for initial appointment and clinical privileges.

(b) A determination to appoint an applicant to the Medical Staff is based upon an assessment of the applicant's qualifications for appointment. These factors are described in the definition of Non-Privileged Information in this Policy.

(c) A determination to appoint does not confer any clinical privileges or right to admit or treat patients at the Hospital. The granting of specific clinical privileges is a separate determination based upon a peer review assessment of the quality and efficiency of services ordered or performed by a Practitioner and other relevant factors. The factors that are assessed in granting clinical privileges are described in the definitions of Confidential Peer Review Evaluations, Privileged Peer Review Information, and Non-Privileged Information contained in this Policy. Additional provisions regarding the granting of clinical privileges are found in Article 4.

3.A.2. Request for Application:

(a) Applications for appointment and clinical privileges will be submitted on approved forms or submitted through an approved portal/website.

(b) An individual seeking initial appointment and privileges will be sent information that (i) outlines the threshold eligibility criteria for appointment outlined earlier in this Policy, (ii) outlines the applicable criteria for the clinical privileges being sought, and (iii) provides access to the application form.

(c) Residents or fellows who are in the final six months of their training may apply to the Medical Staff. Such applications may be processed, but final action on the applications shall not become effective until all applicable threshold eligibility criteria are satisfied.

3.A.3. Information to Be Gathered Regarding Applicants:

(a) Evidence of the applicant's character, professional competence, qualifications, behavior, and ethical standing shall be examined. This information may be contained in the application and obtained from Confidential Peer Review Evaluations (from the same discipline where practicable) and from other available

sources, including the applicant's past or current Department Chairs at other health care entities, residency/fellowship training director, and others who may have knowledge about the applicant's education, training, experience, and ability to work with others.

(b) An interview(s) with the applicant may be conducted as part of the review process. The purpose of the interview is to discuss and review any aspect of the applicant's application, experience, qualifications, and requested clinical privileges. This interview may be conducted by a combination of any of the following: the Department Committee, a Department Committee representative, the Credentials Committee, a Credentials Committee representative, the MEC, the President of the Medical Staff, the VPMA, and/or the Hospital President. Applicants do not have the right to be accompanied by counsel to interviews being requested by any of the individuals or committees referenced above.

3.A.4. Initial Review of Application:

(a) A completed application form with copies of all required documents must be returned to Medical Staff Services and/or the Credentials Verification Office ("CVO").

(b) As a preliminary step, the application shall be reviewed by Medical Staff Services and/or CVO to determine that all questions have been answered and that the individual satisfies all threshold eligibility criteria. Incomplete applications shall not be processed. Individuals who fail to return completed applications or fail to meet the threshold eligibility criteria shall be notified that their applications shall 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.

(c) Medical Staff Services and/or CVO shall conduct primary source verification of information relevant to the applicant's qualifications for appointment, as described in detail in the definition of Non-Privileged Information. Medical Staff Services and/or CVO shall then provide a report regarding Non-Privileged Information.

(d) Medical Staff Services and/or CVO shall also obtain (i) Confidential Peer Review Evaluations from Professional Health Care Providers (e.g., Hospital Affiliation Reports, Department Chair Evaluations, and Peer Reference Evaluations) regarding the quality and efficiency of services provided by the applicant, (ii) responses to National Practitioner Data Bank queries, and (iii) any other available Privileged Peer Review Information regarding the applicant.

3.A.5. Department Committee and Chief Nursing Officer Procedure:

(a) Medical Staff Services shall transmit the complete application and all supporting materials to the relevant Department Committee in which the applicant seeks

clinical privileges. The Department Committee shall prepare a written report regarding whether the applicant has satisfied all of the qualifications for appointment and the clinical privileges requested on a form provided by Medical Staff Services.

(b) In addition to review by the Department Committee, all Practitioners who are seeking clinical privileges to practice as advanced practice nurses at a Magnet Hospital shall also be evaluated by the Chief Nursing Officer (or designee).

(c) The Department Committee Chair or representative (and the Chief Nursing Officer, when relevant) shall be available to the Credentials Committee, the MEC, and the Board to answer any questions that may be raised with respect to the report and findings of the Department Committee.

3.A.6. Credentials Committee Procedure:

(a) The Credentials Committee shall review and consider the report prepared by the relevant Department Committee representative (and the Chief Nursing Officer, when relevant) and shall make a recommendation.

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

(c) After determining that an applicant is otherwise qualified for appointment and privileges, the Credentials Committee may require the applicant to provide information regarding the applicant's health status and/or to undergo a physical, mental, and/or behavioral examination by a physician(s) satisfactory to the Credentials Committee if there is any question about the applicant's ability to perform the clinical privileges requested and the responsibilities of appointment. The results of this examination shall be made available to the committee for its consideration. Failure of an applicant to undergo an examination within a reasonable time after being requested to do so in writing by the Credentials Committee shall be considered a voluntary withdrawal of the application and all processing of the application shall cease. The cost of the health assessment will be borne by the applicant.

(d) The Credentials Committee may recommend specific conditions on appointment and/or clinical privileges. These conditions may relate to behavior (e.g., personal code of conduct) or to clinical issues (e.g., general consultation requirements, appropriate documentation requirements, proctoring, completion of CME requirements). The Credentials Committee may also recommend that appointment be granted for a period of less than two years in order to permit closer monitoring of an individual's compliance with any conditions. Unless these matters involve the specific recommendations set forth in Section 7.A.1(a) of this Policy, such

conditions do not entitle an individual to request the procedural rights set forth in Article 7 of this Policy.

3.A.7. MEC Recommendation:

(a) At its next regular meeting after receipt of the reports from the Credentials Committee and the Department Committee, the MEC shall:

(1) adopt the findings and recommendation presented to it; or

(2) refer the matter back to the Department Committee or the Credentials Committee for further consideration and responses to specific questions raised by the MEC prior to its final recommendation; or

(3) disagree with the findings and recommendations presented to it and make its independent recommendation regarding the applicant.

(b) If the recommendation of the MEC is to appoint and grant clinical privileges, the recommendation shall be forwarded to the Board.

(c) If the recommendation of the MEC is unfavorable and would entitle the applicant to request a hearing in accordance with Section 7.A.1(a) of this Policy, the MEC shall forward its recommendation to the Hospital President, who shall promptly send Special Notice to the applicant. The Hospital President shall then hold the application until after the applicant has completed or waived a hearing and appeal.

3.A.8. Board Action:

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

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

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

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

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

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

(1) appoint the applicant and grant clinical privileges as recommended; or

(2) refer the matter back to the Department Committee or MEC or to another source inside or outside the Hospital for additional research or information; or

(3) reject or modify the recommendation.

(c) If the Board determines to reject a favorable recommendation, it should first discuss the matter with the Chair of the Credentials Committee and the Chair of the MEC. If the Board's determination remains unfavorable to the applicant, the Hospital President shall promptly send Special Notice to the applicant that the applicant is entitled to request a hearing.

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

3.A.9. Time Periods for Processing:

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

3.A.10. Duration of Appointment:

All initial appointments and any other initial grants of clinical privileges pursuant to this Policy shall be for a duration of not more than two years.

3.B. FPPE TO CONFIRM COMPETENCE AND PROFESSIONALISM

(1) All initially-granted clinical privileges, whether at the time of initial appointment, reappointment, or during the term of appointment, will be subject to focused professional practice evaluation ("FPPE") in order to confirm competence, which may be more fully described in Hospital policy.

(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 Department Committee.

(3) Unless a waiver or exception is granted, a newly appointed member's appointment and privileges will expire if the member fails to fulfill the clinical activity requirements within the time frame recommended by the Department Committee and approved by the Credentials Committee. In such case, the individual may not reapply for initial appointment or privileges for two years.

(4) If a member who has been granted additional clinical privileges fails to fulfill the clinical activity requirements within the time frame approved by the Credentials Committee, the additional clinical privileges will expire and the member may not reapply for the privileges in question for two years, unless a waiver or exception is granted.

(5) 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 member will be entitled to a hearing and appeal.

ARTICLE 4

CLINICAL PRIVILEGES

4.A. CLINICAL PRIVILEGES

4.A.1. General:

(a) Appointment or reappointment shall not confer any clinical privileges or right to admit or treat patients at the Hospital. Each Practitioner who has been granted appointment is entitled to exercise only those clinical privileges specifically granted by the Board. Clinical privileges, once granted, may be exercised in person or via technology-enabled direct communication and evaluation (i.e., telemedicine) when that modality of treatment is available and has not been otherwise limited on the relevant delineation of privileges.

(b) The grant of clinical privileges includes responsibility for emergency service call established to fulfill the Hospital's responsibilities under the Emergency Medical Treatment and Active Labor Act and/or other applicable requirements or standards.

(c) For requests for clinical privileges to be processed, all threshold criteria applicable to the clinical privileges being requested must be satisfied.

(d) Requests for clinical privileges that are subject to an exclusive contract will not be processed except as consistent with the contract.

(e) An applicant may request to opt out of the full core when requesting Core Privileges by providing a statement supporting the request.

(f) The clinical privileges recommended to the Board shall be based upon a peer review assessment of the quality and efficiency of services ordered or performed by a Practitioner and other relevant factors. The factors that are assessed in granting clinical privileges are described in detail in the definitions of Confidential Peer Review Evaluations, Privileged Peer Review Information, and Non-Privileged Information contained in Article 1 of this Policy.

(g) Core privileges, special privileges, clinical privilege delineations, and/or the criteria for the same shall be developed or endorsed by the relevant Department Chair and shall be forwarded to the Credentials Committee for review and recommendation. The Credentials Committee will forward its recommendations to the MEC, which will review the matter and forward its recommendations to the Board for final action.

(h) The applicant has the burden of establishing the applicant's qualifications and current competence for all clinical privileges requested.

(i) The report of the Department Committee in the department in which clinical privileges are sought shall be forwarded to the Chair of the Credentials Committee and processed as a part of the initial application for staff appointment.

4.A.2. Privilege Modifications and Waivers:

(a) Scope. This Section applies to all requests for modification of clinical privileges during the term of appointment (increases and relinquishments), resignation from the Medical Staff or as an Advanced Practice Professional or Licensed Independent Practitioner, and waivers related to eligibility criteria for clinical privileges or the scope of those privileges.

(b) Submitting a Request. Requests for privilege modifications, waivers, and resignations must be submitted in writing or electronically to Medical Staff Services.

(c) Increased Privileges.

(1) Requests for increased privileges must state the specific additional clinical privileges requested and provide information sufficient to establish eligibility, as specified in applicable criteria, and current clinical competence.

(2) If the individual is eligible and the application is complete, it will be processed in the same manner as an application for initial clinical privileges unless the applicable Department Chair, in consultation with the Credentials Committee, determines that the privileges being requested are for a "new procedure" as defined in Section 4.A.3. In such cases, the matter will be referred for review in accordance with that section.

(d) Waivers.

Any individual who does not satisfy one or more eligibility criteria for clinical privileges may request that it be waived. The individual requesting the waiver bears the burden of demonstrating **exceptional** circumstances and that the individual's qualifications are equivalent to, or exceed, the criterion in question. All such requests shall be processed in accordance with Section 2.A.2 of this Policy. In addition to the factors defined in Section 2.A.2, the Medical Staff leadership may also consider the additional factors set forth in Section 4.A.2(f) in considering all such requests.

(e) Relinquishment and Resignation of Privileges.

(1) Relinquishment of Individual Privileges. 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 privileges. All such requests will be processed in the same manner as a request for waiver, as described above.

(2) Resignation of Appointment and Privileges. A request to resign appointment and relinquish all clinical privileges must specify the desired date of resignation, which must be at least 30 days from the date of the request, and be accompanied by evidence that the individual will be able to accomplish the following by the specified end date:

(i) completion of all medical records;

(ii) as applicable, the appropriate discharge or transfer of responsibility for the care of any hospitalized patient who is under the individual's care at the time of resignation; and

(iii) as applicable, the completion of scheduled emergency service call or formal arrangement for appropriate coverage to satisfy this responsibility.

After consulting with the President of the Medical Staff, the Hospital President will act on the resignation request with a report on the matter forwarded to the MEC. If an individual fails to complete the tasks listed above prior to the effective date of the resignation, the individual will not be considered to have resigned "in good standing" for purposes of future reference responses.

An individual who has resigned voluntarily from the Medical Staff may be reinstated if the request is made within 90 days; however, the individual must first provide updated information verifying that the information submitted on the individual's most recent application form has not changed.

(f) Factors for Consideration. The Medical Staff Leaders and Board may consider the following factors, among others, when deciding whether to recommend or grant a modification (increases and/or relinquishments) or waiver related to core privileges:

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

(2) whether sufficient notice has been given to provide a smooth transition of patient care services;

(3) fairness to the individual requesting the modification or waiver, including past service and the other demands placed on the individual;

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

(5) the expectations of other members of the Medical Staff who are in different specialties but who rely on the specialty in question in the care of patients who present to the Hospital;

(6) any perceived inequities in modifications or waivers being provided to some, but not others;

(7) any gaps in call coverage that might/would result from an individual's removal from the call roster for the relevant privilege and the feasibility and safety of transferring patients to other facilities in that situation; and

(8) how the request may affect the Hospital's ability to comply with applicable regulatory requirements, including the Emergency Medical Treatment and Active Labor Act.

(g) Effective Date. If the Board grants a modification or waiver related to privileges, it shall specify the date that the modification or waiver will be effective. Failure of a Practitioner to request privilege modifications or waivers in accordance with this Section shall, as applicable, result in the Practitioner retaining appointment and clinical privileges and all associated responsibilities.

(h) Procedural Rights. No individual is entitled to a modification or waiver related to privileges. Individuals are also not entitled to a hearing or appeal or other process if a waiver or a modification related to a relinquishment of privileges is not granted.

4.A.3. Clinical Privileges for New Procedures:

(a) Requests for clinical privileges to perform either a procedure not currently being performed at the Hospital or a new technique to perform an existing procedure (hereafter, "new procedure") shall not be processed until (1) a determination has been made by Hospital administration that the procedure shall be offered by the Hospital, and (2) criteria to be eligible to request those clinical privileges have been established as set forth in this Section.

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

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

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

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

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

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

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

Hospital administration shall review this report and consult with the President of the Medical Staff, the Department Chair, and the Credentials Committee (any of which may conduct additional research as may be necessary) and shall make a preliminary determination as to whether the new procedure should be offered to the community.

(c) If the preliminary determination of the Hospital is favorable, the Credentials Committee will determine whether the request constitutes a "new procedure" as defined by this Section or if it is an extension of an existing privilege. If it is determined that it does constitute a "new procedure," the Credentials Committee will then develop threshold credentialing criteria to determine those individuals who are eligible to request the clinical privileges at the Hospital. In developing the criteria, the Credentials Committee may conduct additional research and consult with experts, as necessary, and develop recommendations regarding:

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

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

(3) the manner of addressing the most common complications that may arise in the performance of the new procedure;

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

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

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

(e) The Board will make a reasonable effort to render the final decision within 60 days of receipt of the MEC's recommendation. If the Board determines to offer the procedure or service, it will then establish the minimum threshold qualifications that an individual must demonstrate in order to be eligible to request the clinical privileges in question.

(f) Once the foregoing steps are completed, specific requests from eligible Practitioners who wish to perform the procedure or service may be processed.

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

(a) Requests for clinical privileges that previously at the Hospital have been exercised only by individuals from another specialty shall 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 privileges in question.

(b) As an initial step in the process, the Practitioner seeking the privilege will prepare and submit a report to the Credentials Committee that specifies the minimum qualifications needed to perform the procedure safely and competently, whether the individual's specialty is performing the privilege at other similar hospitals, and the experiences of those other hospitals in terms of patient care outcomes and quality of care. The Administrative Leadership will confirm the request is permissible under any existing exclusive contracts or Board directives regarding a closed service that are in place at the Hospital before the request is forwarded to the Credentials Committee.

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

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

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

(2) 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;

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

(4) the manner in which the privileges 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

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

(e) The Credentials Committee shall forward its recommendations to the MEC, which shall review the matter and forward its recommendations to the Board for final action. The Board shall make a reasonable effort to render the final decision within 60 days of receipt of the MEC's recommendation.

(f) Once the foregoing steps are completed, specific requests from eligible Practitioners who wish to exercise the privileges in question may be processed.

4.A.5. Clinical Privileges for Hospitals That Privilege Dentists and Oral and Maxillofacial Surgeons:

(a) For any patient who meets the classification of ASA 1 (normal, healthy patients) or ASA 2 (patients with mild systemic disease with no functional limitations), Dentists and Oral and Maxillofacial Surgeons may admit such patients, perform a complete admission history and physical examination, and assess the medical risks of any surgical procedure to be performed or the medical management of the patient's condition, if they are deemed qualified to do so by the Credentials Committee and MEC. They must, nevertheless, have a relationship with a Physician on the Medical Staff (established and declared in advance) who is available to respond and become involved with that individual's care should any medical issue arise with the patient that is outside of their scope of practice.

(b) For any patient who meets ASA 3 or 4 classifications, a medical history and physical examination of the patient shall be made and recorded by a qualified Practitioner who has been granted clinical privileges to complete medical histories and physical examinations before dental surgery may be performed. In addition, a designated Physician shall be responsible for the medical care of the patient throughout the period of hospitalization.

(c) The Dentist or Oral and Maxillofacial Surgeon shall be responsible for the oral surgery care of the patient, including the appropriate history and physical examination, as well as all other appropriate elements of the patient's record. Dentists and Oral and Maxillofacial Surgeons may write orders within the scope of their licenses and consistent with relevant Hospital policies and Rules and Regulations.

4.A.6. Clinical Privileges for Hospitals That Privilege Podiatrists: [1]

(a) For any patient who meets the classification of ASA 1 (normal, healthy patients) or ASA 2 (patients with mild systemic disease with no functional limitations), Podiatrists may admit such patients, perform a complete admission history and physical examination, and assess the medical risks of any surgical procedure to be performed or the medical management of the patient's condition, if they are deemed qualified to do so by the Credentials Committee and MEC. They must, nevertheless, have a relationship with a Physician on the Medical Staff (established and declared in advance) who is available to respond and become involved with that individual's care should any medical issue arise with the patient that is outside of their scope of practice.

(b) For any patient who meets ASA 3 or 4 classifications, a medical history and physical examination of the patient shall be made and recorded by a qualified Practitioner who has been granted clinical privileges to complete medical histories and physical examinations before podiatric surgery may be performed. In addition, a designated Physician member of the Medical Staff shall be responsible for the medical care of the patient throughout the period of hospitalization.

(c) The Podiatrist shall be responsible for the podiatric surgery care of the patient, including the appropriate history and physical examination, as well as all other appropriate elements of the patient's record. Podiatrists may write orders within the scope of their licenses and consistent with relevant Hospital policies and Rules and Regulations.

4.A.7. Physicians in Training:

(a) Residents in Training:

Physicians in residency training shall not hold appointments to the Medical Staff and shall not be granted clinical privileges. The program director, clinical faculty, and/or attending staff member shall be responsible for the direction and supervision of the on-site and/or day-to-day patient care activities of each trainee, who shall be permitted to perform only those clinical functions set out in curriculum requirements, affiliation agreements, and/or training protocols approved by the Hospital. The applicable program director shall be responsible for verifying and evaluating the qualifications of each physician in training.

(b) Moonlighting Residents:

(1) Physicians who are in a residency training program and who wish to moonlight as a part of a training shift may be granted specific privileges in accordance with the review process described in this Policy. In order to be eligible for moonlighting privileges, an individual must meet all relevant

[1] Those podiatrists practicing in an ASF may perform histories and physicals without limitation.

(2) eligibility criteria for the clinical privileges requested (or be granted a waiver) and must:

(i) have a license to practice in the state where services are being provided (interim or without restriction); and

(ii) where applicable to their practice, have a current, unrestricted DEA registration.

(2) A resident who is moonlighting must comply with the institutional and program training requirements. Failure to comply with these requirements or termination from the residency program will result in the automatic relinquishment of clinical privileges, without a right to the hearing and appeal procedures.

(c) Moonlighting Fellows:

A physician in training at the fellowship level may request clinical privileges in an area for which the individual has already completed residency training if the individual can demonstrate that all necessary eligibility criteria as set forth in this Policy have been met or is granted a waiver. Requests for such clinical privileges shall be reviewed in accordance with the initial credentialing process outlined in this Policy and, if granted, shall be subject to all relevant oversight provisions, including ongoing and focused professional practice evaluation. Physicians in training at the fellowship level may only be granted clinical privileges in those areas for which they can demonstrate current clinical competence.

4.A.8. Telemedicine Privileges for Distant-Site Practitioners:

(a) A qualified individual may be granted telemedicine privileges. (This provision shall specifically not apply to those individuals who will be providing telemedicine services in addition to exercising other clinical privileges at a UPMC Hospital.)

(b) Requests for initial or renewed telemedicine privileges shall be processed through one of the following options, as determined by the Hospital President or designee in consultation with the President of the Medical Staff:

(1) A request for telemedicine privileges may be processed through the same process for Medical Staff applications, as set forth in this Policy. In such case, the individual must satisfy all qualifications and requirements set forth in the Medical Staff Bylaws and associated documents.

(2) If the individual requesting telemedicine privileges is practicing at a distant hospital that participates in Medicare or a telemedicine entity (as that term is defined by Medicare), a request for telemedicine privileges may be processed using an abbreviated process that relies on the credentialing and

privileging decisions made by the distant hospital or telemedicine entity. In such cases, the Hospital must ensure, through a written agreement that the distant hospital or telemedicine entity will comply with all applicable Medicare regulations and accreditation standards. The distant hospital or telemedicine entity must provide:

(i) confirmation that the Practitioner is licensed to practice in the state where services are being provided;

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

(iii) information indicating that the applicant has actively exercised the relevant privileges during the previous 12 months and has done so in a competent manner;

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

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

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

This information shall be provided to the Credentials Committee for review, which shall make a recommendation to the MEC regarding the grant of telemedicine privileges, which shall be forwarded to the Board for final action. Notwithstanding the process set forth in this subsection, the Hospital may determine that an applicant for telemedicine privileges is ineligible for appointment or clinical privileges if the applicant fails to satisfy the threshold eligibility criteria set forth in this Policy.

(c) Individuals granted telemedicine privileges shall be subject to the Hospital's peer review activities. The results of the peer review activities, including any adverse events and complaints filed about the Practitioner providing telemedicine services from patients, other Practitioners or staff, will be shared with the distant hospital or telemedicine entity, in accordance with the UPMC Policy on Sharing Peer Review Information Among UPMC Entities (HS-LE0019).

(d) Telemedicine privileges granted in conjunction with a service agreement shall be incident to and coterminous with that service agreement.

4.A.9. Clinical Privileges after Age 70:

Any Practitioner who is 70 years of age or older and who applies for appointment to the Medical Staff or any member of the Medical Staff who is 70 years of age or older shall be

required to undergo the evaluation process as set forth in the Late Career Practitioner Policy (HS-PS0511).

4.B. TEMPORARY CLINICAL PRIVILEGES

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

(a) Temporary privileges to an applicant for initial appointment may be granted by the Hospital President when the following conditions are met:

(1) the application is complete;

(2) information required of the initial applicant has been received and verified including the following: (i) current licensure; (ii) relevant training and experience; (iii) current competence; (iv) current professional liability coverage acceptable to the Hospital; (v) an ability to perform the clinical privileges requested; (vi) the result from a query to the National Practitioner Data Bank; and (vii) the result from a query to the Office of Inspector General's List of Excluded Individuals/Entities;

(3) the applicant demonstrates there have been: (i) no current or previously successful challenges to licensure or registration; and (ii) no involuntary limitation, restriction, reduction, denial, loss or termination of appointment or clinical privileges at another health care facility; and

(4) there has been a favorable review by the Department Committee and a favorable recommendation by the Credentials Committee, or its chair, and review by the MEC and Board is pending.

(b) The grant of temporary clinical privileges to an initial applicant will not exceed 120 days.

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

(a) When there is an important patient care, treatment, or service need, visiting temporary privileges may be granted by the Hospital President, when the following conditions are met:

(1) the important need is: (i) for the care of a specific patient; (ii) for proctoring or consultations; or (iii) when necessary to provide needed coverage in a specialty or service (e.g., locum tenens);

(2) the following information has been received and verified: (i) current licensure; (ii) relevant training and experience; (iii) current competence; (iv) current professional liability coverage acceptable to the Hospital; (v) the result from a query to the National Practitioner Data Bank; and

(vi) the result from a query to the Office of Inspector General's List of Excluded Individuals/Entities;* and

(3) there has been a favorable recommendation by the Department Committee and President of the Medical Staff.

* Any individual seeking visiting temporary privileges who is currently appointed in good standing to another UPMC Hospital with a grant of clinical privileges relevant to the request for visiting temporary privileges shall be immediately authorized to exercise visiting temporary privileges upon verification of good standing by Medical Staff Services and the completion of a query to the National Practitioner Data Bank; verification of the additional factors referenced above is not required.

(b) For Practitioners who are granted visiting temporary privileges as a locum tenens, the individual may exercise the temporary privileges for a maximum of 120 days. Any clinical privileges that are granted in conjunction with a contractual agreement will expire when the agreement is terminated, not renewed, or expires.

4.B.3. Withdrawal of Temporary Clinical Privileges:

(a) The Hospital President may withdraw temporary privileges at any time, after consulting with the President of the Medical Staff, the Chair of the Credentials Committee, the Department Chair, or the VPMA. Clinical privileges shall then expire as soon as patients have been discharged or alternate care has been arranged.

(b) If the care or safety of patients might be endangered by continued treatment by the individual granted temporary privileges, the Hospital President, the Department Chair, the President of the Medical Staff, or the VPMA may immediately withdraw all temporary privileges. The Department Chair or the President of the Medical Staff shall assign to another Practitioner responsibility for the care of such individual's patients until they are discharged or an appropriate transfer arranged. Whenever possible, consideration shall be given to the wishes of the patient in the selection of a substitute physician.

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 a 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 the Practitioner's license, regardless of department status or specific grant of clinical privileges.

(3) When the emergency situation no longer exists, the patient shall be assigned by the Department Chair or the President of the Medical Staff to a member with appropriate clinical privileges, considering the wishes of the patient.

4.D. DISASTER PRIVILEGES

Requests for disaster privileges shall be processed in accordance with the UPMC policy number HS-PS0501 (Disaster/Emergency Privileges Policy).

4.E. EXCLUSIVE ARRANGEMENTS

4.E.1. General Principles Applicable to All Exclusive Arrangements:

(a) Types of Exclusive Arrangements. The Hospital may enter into arrangements with Practitioners and/or groups of Practitioners for the exclusive performance of clinical and administrative services at the Hospital. The Hospital may accomplish this by:

(1) entering into a contract that confers the exclusive right to perform specified services to one or more Practitioners or groups of Practitioners; or

(2) passing a Board resolution that limits those who may exercise clinical privileges in a clinical specialty to employees of the Hospital or its affiliates.

(b) Credentialing Requirements. All such Practitioners must obtain and maintain clinical privileges at the Hospital in accordance with the terms and processes outlined in this Policy.

(c) Effect on Applicants for Clinical Privileges. Only Practitioners who are authorized by an exclusive arrangement are eligible to apply for the clinical privileges that are covered by the exclusive arrangement at the time of initial appointment or reappointment.

(d) Effect on Existing Clinical Privileges and Medical Staff Appointment.

(1) Subject to the review process in Section 4.E.2, Practitioners who were granted clinical privileges prior to an exclusive arrangement being established are no longer eligible to exercise the clinical privileges covered by the exclusive arrangement, unless they are parties to it or an exception has been granted to them;

(2) A Practitioner who leaves a group that maintains an exclusive arrangement with the Hospital is no longer eligible to exercise the clinical privileges covered by the arrangement upon the effective date of the Practitioner's departure from the group;

(3) If the Hospital establishes a new exclusive arrangement that replaces an existing exclusive arrangement, the Practitioners who were part of the former exclusive arrangement are no longer eligible to exercise the applicable clinical privileges, unless they join the new exclusive provider or an exception has been granted to them; and

(4) If ***all*** of an individual's clinical privileges are covered by an exclusive arrangement to which the individual is not a party, the individual will be deemed to have voluntarily resigned from the Medical Staff.

(e) No Hearing and No Reporting Obligations. The inability of a Practitioner to exercise clinical privileges because of an exclusive arrangement is not a matter that entitles the Practitioner to request a hearing as outlined in Article 7 or requires a report to the state licensure board or to the National Practitioner Data Bank.

(f) Contract Provisions Control. Except as provided in (b) above (i.e., requirement that all Practitioners be fully credentialed), in the event of any conflict between this Policy or the Medical Staff Bylaws and the terms of any exclusive contract, the terms of the contract shall control.

4.E.2. Process for Exclusive Arrangements in ***New*** Specialty Areas:

(a) MEC Review. Prior to the Hospital establishing an exclusive arrangement in a ***new*** specialty area (i.e., no prior exclusive arrangement), the Board will request the MEC's review of the matter. The MEC (or a subcommittee of its members appointed by the President of the Medical Staff) will review the quality of care and service implications of the proposed exclusive arrangement and provide a report of its findings and recommendations to the Board within 30 days of the Board's request.

As part of its review, the MEC (or subcommittee) may obtain relevant information concerning quality of care and service matters from (i) members of the applicable specialty involved, (ii) members of other specialties who directly utilize or rely on the specialty in question, and (iii) Hospital administration. However, the actual terms of any such exclusive arrangement, and any financial information related to it, including but not limited to the remuneration to be paid to the Practitioners who may be a party to the arrangement, are not relevant and shall neither be disclosed to the MEC nor discussed as part of the MEC's review.

(b) Meeting with Board or Board Committee. After receiving the MEC's report, the Board shall determine whether or not to proceed with an exclusive arrangement in the new specialty area. If the Board determines to do so, and if that determination would have the effect of preventing an existing Practitioner from exercising clinical privileges that had previously been granted, the affected Practitioner is entitled to the following notice and review procedures (*Note*: If more than one Practitioner in a relevant specialty area will be affected by the determination of the Board, the

following procedures will be coordinated to address all requested meetings in a combined and consolidated manner):

(1) The affected Practitioner shall be given at least 30 days' advance notice of the anticipated effective date of the exclusive arrangement and shall have the right to meet with the Board or a committee designated by the Board to discuss the matter prior to the exclusive contract being signed by the Hospital or the Board resolution becoming effective. Any such meeting must be requested by the affected Practitioner and held within 30 days of the notice, unless this time frame is extended by mutual agreement.

(2) At the meeting, the affected Practitioner shall be entitled to present any information that the Practitioner believes is relevant to the Board's determination to enter into the exclusive arrangement.

(3) If, following this meeting, the Board confirms its initial determination to enter into the exclusive arrangement, the affected Practitioner shall then be notified that the Practitioner is ineligible to continue to exercise the clinical privileges covered by the exclusive arrangement, as described in Section 4.E.1(d) above.

(4) The affected Practitioner shall not be entitled to any procedural rights beyond those outlined in this Section with respect to the Board's decision or the effect of the decision on the Practitioner's clinical privileges, notwithstanding the provisions in Article 7 of this Policy.

ARTICLE 5

PROCEDURE FOR REAPPOINTMENT

5.A. PROCEDURE FOR REAPPOINTMENT

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

5.A.1. Eligibility for Reappointment:

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

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

(b) satisfied all Medical Staff responsibilities, including payment of dues, fines, and assessments;

(c) continued to meet all qualifications and criteria for appointment and the clinical privileges requested, including those set forth in Section 2.A.1 of this Policy;

(d) paid the reappointment processing fee, if any; and

(e) if applying for renewal of clinical privileges, had sufficient patient contacts to enable the assessment of current clinical judgment and competence for the privileges requested. Any individual seeking reappointment who has minimal activity at the Hospital must submit such information as may be requested (such as a copy of the individual's confidential quality profile from the individual's primary hospital, clinical information from the individual's office practice, and/or a quality profile from a managed care organization or insurer) before the application shall be considered complete and processed further. To the extent that information provided or portions thereof may include or be based upon Privileged Peer Review Information, it will be maintained in a manner consistent with its privileged status.

5.A.2. Factors for Evaluation:

In considering an individual's application for reappointment, the factors listed in Section 2.A.3 of this Policy will be considered. In addition, the information defined as Privileged Peer Review Information and Non-Privileged Information in Article 1 of this Policy will also be evaluated as part of the reappointment process.

5.A.3. Reappointment Application and Processing of Application:

(a) An application for reappointment should be made available to Practitioners at least six months prior to the expiration of their current appointment term. A completed reappointment application should be submitted to Medical Staff Services within 90 days.

(b) Failure to submit a complete application at least three months prior to the expiration of the Practitioner's current term may result in the automatic expiration of appointment and clinical privileges at the end of the then current term of appointment unless the application can still be processed in the normal course, without extraordinary effort on the part of Medical Staff Services and the Medical Staff Leaders. If an application for reappointment is submitted timely, but the Medical Staff and/or Board has not acted on it prior to the end of the current term, the individual may be granted a limited reappointment not to exceed 120 days.

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

(d) The application should be reviewed by Medical Staff Services to determine that all relevant information has been received and verified and that the individual satisfies all threshold eligibility criteria for reappointment and for the clinical privileges requested.

(e) The steps outlined in Article 3 for the initial appointment process should then be followed for the reappointment process.

5.A.4. Conditional Reappointments:

(a) Recommendations for reappointment and renewed privileges may be contingent on a Practitioner's compliance with certain specific conditions that have been recommended. These conditions may relate to behavior (e.g., personal code of conduct) or to clinical issues (e.g., general consultation requirements, appropriate documentation requirements, including timely completion of medical records, proctoring, completion of CME requirements). Unless the conditions involve the matters set forth in Section 7.A.1(a) of this Policy, such conditions do not entitle an individual to request the procedural rights set forth in Article 7 of this Policy.

(b) Reappointments may be recommended for periods of less than two years in order to permit closer monitoring of an individual's compliance with any conditions that have been recommended. A recommendation for reappointment for a period of less than two years does not, in and of itself, entitle an individual to the procedural rights set forth in Article 7.

(c) In addition, in the event the applicant for reappointment is the subject of an unresolved professional practice evaluation concern, a formal Investigation, or a hearing at the time reappointment is being considered, a conditional reappointment

for a period of less than two years may be granted pending the completion of that process.

5.A.5. Potential Adverse Recommendation:

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

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

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

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

(e) If the Board determines to reject a favorable recommendation from the MEC, it should first discuss the matter with the Chair of the Credentials Committee and the Chair of the MEC. If the Board's determination remains unfavorable to the applicant, the Hospital President shall promptly send a Special Notice to the applicant that the applicant is entitled to request a hearing under this Policy.

5.A.6. Time Periods for Processing:

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

5.B. FPPE TO CONFIRM COMPETENCE AND PROFESSIONALISM

All initially-granted clinical privileges, whether at the time of initial appointment, reappointment, or during the term of appointment, will be subject to focused professional practice evaluation ("FPPE") in order to confirm competence. The FPPE process for these situations is outlined in Section 3.B of this Policy.

ARTICLE 6

QUESTIONS INVOLVING MEDICAL STAFF MEMBERS, ADVANCED PRACTICE PROFESSIONALS, AND LICENSED INDEPENDENT PRACTITIONERS

6.A. INITIAL MENTORING EFFORTS AND PROGRESSIVE STEPS

(1) This Policy encourages the use of Initial Mentoring Efforts and Progressive Steps by Medical Staff Leaders and Administrative Leadership to address questions relating to a Practitioner's clinical practice, professional conduct, and/or health. The goal of these efforts is to arrive at voluntary, responsive actions by the Practitioner to resolve questions that have been raised. Medical Staff Leaders and members of the Administrative Leadership have been authorized by the MEC to engage in Initial Mentoring Efforts and Progressive Steps and all of these activities are undertaken on behalf of these committees as part of their Peer Review functions.

(2) Initial Mentoring Efforts include activities such as:

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

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

There is no requirement that these efforts be documented, though brief documentation is encouraged to help determine if a pattern may be developing that would recommend a more formal response. When such documentation is created, it constitutes Privileged Peer Review Information and shall be maintained in the individual's Confidential Quality/Peer Review File, consistent with its privileged status.

(3) Progressive Steps are defined as follows:

(a) addressing minor performance issues through Information Letters;

(b) sending an Educational Letter that describes opportunities for improvement and provides specific guidance and suggestions;

(c) facilitating formal Collegial Counseling (i.e., a planned, face-to-face meeting between an individual and one or more Medical Staff Leaders) in

order to directly discuss a matter and the steps needed to be taken to resolve it; and

(d) developing a Performance Improvement Plan, which may include a wide variety of tools and techniques that can result in a constructive and successful resolution of the concern.

All progressive steps shall be documented in a constructive manner and included in an individual's confidential file. All such documentation constitutes Privileged Peer Review Information and shall be maintained in a confidential manner consistent with its privileged status. Any written responses to any of these Progressive Steps by the individual shall also be included in the individual's Confidential Quality/Peer Review File.

(4) All of these efforts are fundamental and integral components of the Hospital's Peer Review/professional practice evaluation activities and are confidential and privileged in accordance with state law.

(5) Initial Mentoring Efforts and Progressive Steps are encouraged, but are not mandatory, and shall be within the discretion of the appropriate Medical Staff Leaders and Administrative Leadership, acting on behalf of Peer Review Committees. When a question arises, the Medical Staff Leaders and/or Administrative Leadership may:

(a) address it pursuant to the Initial Mentoring Efforts and Progressive Steps provisions of this Section;

(b) refer the matter for review in accordance with the Medical Staff's policies pertaining to peer review/professional practice evaluation, professionalism, Practitioner health, and/or other relevant policy; or

(c) refer it to the MEC for its review and consideration in accordance with Section 6.D of this Article.

(6) Should any recommendation be made or an action taken that entitles an individual to a hearing in accordance with this Policy, the individual is entitled to be accompanied by legal counsel at that hearing. However, Practitioners do not have the right to be accompanied by counsel when the Medical Staff Leaders and members of the Administrative Leadership are engaged in Initial Mentoring Efforts or other Progressive Steps. These efforts are intended to resolve issues in a constructive manner and do not involve the formal hearing process. In addition, there shall be no recording (audio or video) or transcript made of any meetings that involve Initial Mentoring Efforts or Progressive Steps activities.

6.B. PROFESSIONAL PRACTICE EVALUATION ACTIVITIES

Professional practice evaluation activities shall be conducted in accordance with the Medical Staff's policies pertaining to peer review/professional practice evaluation, professionalism, Practitioner health, and/or other relevant policy. Matters that are not satisfactorily resolved through Initial Mentoring Efforts and Progressive Steps or through one of these policies shall be referred to the MEC for its review in accordance with Section 6.D below. Such interventions and evaluations, however, are not mandatory prerequisites to MEC review.

6.C. PRECAUTIONARY SUSPENSION OR RESTRICTION OF CLINICAL PRIVILEGES

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

(a) Whenever, in their sole discretion, failure to take such action may result in imminent danger to the health and/or safety of any individual, the MEC OR any Medical Staff Officer or relevant Department Chair, acting in conjunction with the Hospital President or the VPMA, shall have the authority to (1) suspend or restrict all or any portion of an individual's clinical privileges or (2) afford the individual an opportunity to voluntarily refrain from exercising clinical privileges while the matter is being reviewed. The process defined below will apply regardless of the option used in this paragraph.

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

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

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

(e) Within three days of the imposition of a suspension, the individual will be provided with a brief written description of the reason(s) for the action, including the names and medical record numbers of the patient(s) involved (if any). The relevant Supervising/Collaborating Physician will be notified when the affected individual is an Advanced Practice Professional.

(f) Upon the imposition of a precautionary suspension, the President of the Medical Staff will assign responsibility for the care of any hospitalized patients to another

individual with appropriate clinical privileges. Whenever possible, consideration will be given to the wishes of the patient in the selection of a covering physician.

6.C.2. MEC Procedure:

(a) Within a reasonable time, not to exceed 14 days of the imposition of the suspension or restriction, the MEC will review the reasons for the action.

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

(c) At the meeting, the individual may provide information to the MEC and must respond to questions raised by committee members. The individual may also propose ways, other than precautionary suspension or restriction, to protect patients, employees or others while the matter is being reviewed. Neither the MEC nor the individual shall be accompanied by legal counsel at this meeting, and no recording (audio or video) or transcript of the meeting shall be permitted or made; however, minutes of the meeting will be prepared.

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

(e) If the MEC recommends that the suspension be continued, it will send the individual written notice of its recommendation, including the basis for it. If the MEC recommends that the suspension be modified, or lifted, this recommendation will be forwarded to the Hospital President for final action.

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

6.C.3. Care of Patients:

Immediately upon an individual's agreement to voluntarily refrain from practicing or the imposition of a precautionary suspension or restriction, the President of the Medical Staff shall assign to another individual with appropriate clinical privileges responsibility for care of the individual's hospitalized patients, or to aid in implementing the precautionary suspension, restriction, or agreement to refrain from practicing, as appropriate. The assignment shall be effective until the patients are discharged. The wishes of the patient shall be considered in the selection of a covering physician but may not always be accommodated.

6.D. INVESTIGATIONS

6.D.1. Initial Review:

(a) Where Initial Mentoring Efforts or other Progressive Steps under one or more of the policies referenced in this Article have not resolved an issue and/or when there is a single instance of such severity that in the discretion of Medical Staff Leaders it requires further review, regarding:

(1) the clinical competence or clinical practice of any Practitioner, including the care, treatment or management of a patient or patients;

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

(3) the known or suspected violation by any Practitioner of applicable ethical standards or the Bylaws, Rules and Regulations, and policies of the Hospital or the Medical Staff; and/or

(4) conduct by any Practitioner 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,

the matter may be referred to the President of the Medical Staff, the relevant Department Chair, the chair of a standing committee, the VPMA, or the Hospital President.

(b) In addition, if the Board becomes aware of information that raises concerns about any Practitioner, the matter shall be referred to the President of the Medical Staff, the relevant Department Chair, the chair of a standing committee, the VPMA, or the Hospital President for review and appropriate action in accordance with this Policy.

(c) The person to whom the matter is referred shall conduct or arrange for an inquiry to determine whether the question raised has sufficient credibility to warrant further review and, if so, shall forward it in writing to the MEC.

(d) No action taken pursuant to this Section shall constitute an Investigation.

6.D.2. Initiation of Investigation:

(a) When a question involving a Practitioner's clinical competence or professional conduct is referred to, or raised by, the MEC, the MEC shall review the matter and determine whether to conduct an Investigation, to direct the matter to be handled pursuant to another Medical Staff policy, or to proceed in another manner. Prior to making its determination, the MEC may discuss the matter with the individual. An

Investigation shall begin only after a formal determination by the MEC to do so. The MEC's determination shall be recorded in the minutes of the meeting where the determination is made.

(b) The MEC shall inform the individual that an Investigation has begun. The notification shall include:

(1) the date on which the Investigation was commenced;

(2) the committee that will be conducting the Investigation, if already identified;

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

(4) a copy of Section 6.D.3 of this Policy, which outlines the process for Investigations.

This notification may be delayed if, in the MEC's judgment, informing the individual immediately would compromise the Investigation or disrupt the operation of the Hospital or Medical Staff.

6.D.3. Investigative Procedure:

(a) Selection of Investigating Committee.

Once a determination has been made to begin an Investigation, the MEC shall either investigate the matter itself or appoint an ad hoc committee to conduct the Investigation, keeping in mind the conflict of interest guidelines outlined in Article 8 and **Appendix A**. Any ad hoc committee may include individuals not on the Medical Staff or affiliated as Advanced Practice Professionals or Licensed Independent Practitioners, and is a Peer Review Committee as defined in Article 1 of this Policy. Whenever the questions raised concern the clinical competence of the individual under review, the ad hoc committee shall include a peer of the individual (e.g., physician, dentist, podiatrist, oral surgeon, or relevant discipline of Advanced Practice Professional or Licensed Independent Practitioner).

(b) Investigating Committee's Review Process.

(1) The committee conducting the Investigation ("investigating committee") shall have the authority to review relevant documents and interview individuals. A summary of each interview will be prepared and the interviewee will be asked to review, revise, and sign the summary, which will then be included as an attachment to the investigating committee's report.

(2) The investigating committee shall also have available to it the full resources of the Medical Staff and the Hospital, including the authority to arrange for an external review, if needed. An external review may be used whenever the Hospital and investigating committee determine that:

(i) there are ambiguous or conflicting findings by internal reviewers;

(ii) the clinical expertise needed to conduct the review is not available on the Medical Staff;

(iii) an external review is advisable to prevent allegations of bias, even if unfounded; or

(iv) the thoroughness and objectivity of the Investigation would be aided by such an external review.

If a decision is made to obtain an external review, the individual under Investigation shall be notified of that decision and the nature of the external review. However, the individual under Investigation may not demand an external review or dictate who performs the external review. Upon completion of the external review, the individual shall be provided a copy of the reviewer's report and provided an opportunity to respond to it in writing.

(3) The investigating committee may require a physical, mental, and/or behavioral examination of the individual by a health care professional(s) acceptable to it. The individual being investigated shall execute a release (in a form approved or provided by the investigating committee) allowing (i) the investigating committee (or its representative) to discuss with the health care professional(s) conducting the examination the reasons for the examination; and (ii) the health care professional(s) conducting the examination to discuss and provide documentation of the results of such examination directly to the investigating committee. The cost of such health examination shall be borne by the individual.

(c) Meeting with the Investigating Committee.

(1) The individual under Investigation shall have an opportunity to meet with the investigating committee before it makes its report. Prior to this meeting, the individual shall be informed of the general questions being investigated. The investigating committee may also ask the individual to provide written responses to specific questions related to the Investigation and/or a written explanation of the individual's perspective on the events that led to the Investigation for review by the investigating committee prior to the meeting.

(2) This meeting is not a hearing, and none of the procedural rules for hearings shall apply. No recording (audio or video) or transcript of the meeting shall be permitted or made. Neither the individual being investigated nor the investigating committee will be accompanied by legal counsel at this meeting.

(3) At the meeting, the individual shall be invited to discuss, explain, or refute the questions that gave rise to the Investigation or that have been identified by the investigating committee during its review. A summary of the interview shall be prepared by the investigating committee and included with its report. The interview summary will be shared with the individual prior to the investigating committee finalizing its report, so that the individual may review it and recommend suggested changes. A suggested change should only be accepted if the investigating committee believes it more accurately reflects what occurred at the meeting.

(d) Time Frames for Investigation.

The investigating committee shall make a reasonable effort to complete the Investigation and issue its report within 30 days of the commencement of the Investigation, provided that an external review is not necessary. When an external review is necessary, the investigating committee shall make a reasonable effort to complete the Investigation and issue its report within 30 days of receiving the results of the external review. These time frames are intended to serve as guidelines and, as such, shall not be deemed to create any right for an individual to have an Investigation completed within such time periods.

(e) Investigating Committee's Report.

(1) At the conclusion of the Investigation, the investigating committee shall prepare a report of the Investigation. The report should include a summary of the review process (e.g., a list of documents that were reviewed, any individuals who were interviewed, etc.), specific findings and conclusions regarding each concern that was under review, and the investigating committee's recommendations.

(2) In making its recommendations, the investigating committee shall strive to achieve a consensus as to what is in the best interests of patient care and the smooth operation of the Hospital, while balancing fairness to the individual, recognizing that fairness does not require that the individual agree with the recommendation. Specifically, the committee may consider:

(i) relevant literature and clinical practice guidelines, as appropriate;

(ii) all of the opinions and views that were expressed throughout the review, including report(s) from any external review(s);

(iii) any information or explanations provided by the individual under review; and

(iv) other information as deemed relevant, reasonable, and necessary by the investigating committee.

6.D.4. Recommendation:

(a) The MEC may accept, modify, or reject any recommendation it receives from an ad hoc investigating committee if one was appointed by the MEC. In either case, at the conclusion of the Investigation, the MEC may:

(1) determine that no action is justified;

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

(3) impose conditions for continued appointment;

(4) impose a requirement for monitoring, proctoring, or consultation;

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

(6) recommend reduction of clinical privileges;

(7) recommend suspension or Restriction of clinical privileges for a term;

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

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

(b) If a recommendation by the MEC would entitle the individual to request a hearing in accordance with Section 7.A.1, the recommendation will be forwarded to the Hospital President, who shall promptly inform the individual by Special Notice. The Hospital President shall hold the recommendation until after the individual has completed or waived a hearing and appeal.

(c) A determination by the MEC that does not entitle the individual to request a hearing will take effect immediately. All such determinations shall be reported to the Board and will remain in effect unless modified by the Board. In the event the Board considers a modification that would entitle the individual to request a hearing, the Hospital President shall inform the individual by Special Notice. No final action shall occur until the individual has completed or waived a hearing and appeal.

(d) When applicable, any recommendations or actions that are the result of an Investigation or hearing and appeal shall be monitored by Medical Staff Leaders on an ongoing basis through the Hospital's performance improvement activities or pursuant to the applicable policies regarding conduct, as appropriate.

6.E. AUTOMATIC RELINQUISHMENT/ACTIONS

6.E.1. General:

An automatic relinquishment is considered an administrative action that occurs by operation of this Policy. As such, it does not trigger an obligation on the part of the Hospital to file a report with the National Practitioner Data Bank or the state licensure board and shall take effect without hearing or appeal. It takes effect without the right to the procedural rights outlined in this Policy (i.e., hearing and appeal). Any request for reinstatement of appointment and clinical privileges will be reviewed in accordance with the procedures outlined in this Section 6.E.

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

(a) An individual's appointment and clinical privileges shall be automatically relinquished if the individual fails to continuously satisfy any of the threshold eligibility criteria set forth in this Policy (except for board certification requirements, which shall be assessed at time of reappointment). These eligibility criteria are set forth in Sections 2.A.1 and 5.A.1 of this Policy and include, but are not limited to, the maintenance of an unrestricted license, compliance with any health screening requirements, fulfillment of all emergency service call obligations, no disciplinary actions taken by another hospital, and any criteria specific to an Advanced Practice Professional.

(b) In addition to the above, an individual's appointment and clinical privileges shall be automatically relinquished if the individual is arrested, charged, or indicted for any felony; or for any misdemeanor involving (i) controlled substances, (ii) illegal drugs, (iii) Medicare, Medicaid, or insurance or health care fraud or abuse, (iv) child abuse, (v) elder abuse, (vi) violence against another, or (vii) the Practitioner-patient relationship.

(c) Automatic relinquishment shall take effect immediately upon actual or Special Notice to the individual and continue, unless a waiver of the threshold eligibility criteria is granted pursuant to Section 2.A.2, or until the matter is resolved and the individual is granted reinstatement, as may be applicable.

(d) If the underlying matter leading to automatic relinquishment under this Section 6.E.2 is resolved within 60 days (i.e., the individual either demonstrates that they meet all applicable eligibility criteria or is granted a waiver regarding the eligibility criteria in question in accordance with Section 2.A.2), the individual may request reinstatement in accordance with Section 6.E.7. In addition, if an arrest,

charge or indictment as defined above has not been fully resolved within the 60-day time period, an individual may request reinstatement but bears the burden of demonstrating, in the full discretion of the Leadership Council, that the underlying matter does not raise concerns about the individual's professional qualifications and/or ability to completely and safely exercise clinical privileges.

(e) Failure to resolve any matter that results in an automatic relinquishment within 60 days of the date of relinquishment shall result in an automatic resignation of appointment and clinical privileges.

6.E.3. Failure to Provide Required Notification to Medical Staff Services:

(a) Practitioners must notify Medical Staff Services, in writing, within 10 days of the occurrence of any of the following events:

(1) changes in the Practitioner's licensure status or DEA or state-controlled substance authorization;

(2) changes in the Practitioner's appointment or clinical privileges at another hospital or health care facility because of issues related to clinical competence or professional conduct, including the Practitioner's resignation while under investigation;

(3) changes in the Practitioner's employment status at any medical group or hospital because of issues related to clinical competence or professional conduct;

(4) the Practitioner's arrest, charge, indictment, conviction, or a plea of guilty or no contest in any criminal matter (other than a misdemeanor traffic citation);

(5) the Practitioner's exclusion or preclusion from participation in Medicare/Medicaid or any sanctions imposed;

(6) any changes in the Practitioner's ability to safely and competently exercise clinical privileges or perform the duties and responsibilities of appointment because of health status issues;

(7) the Practitioner's participation in a state Practitioner health program; and

(8) any charge of, or arrest for, driving under the influence ("DUI").

Failure of a Practitioner to provide this notification shall result in the automatic relinquishment of appointment and clinical privileges.

(b) When an automatic relinquishment occurs under this Section 6.E.3, the Practitioner will be given the opportunity to submit a written response for the Leadership Council's consideration. The relinquishment shall remain in effect unless the Leadership Council determines, in its sole discretion, that the Practitioner has provided a satisfactory explanation and has eliminated any concern regarding the failure to provide the required notification. If the Leadership Council makes this determination, the Practitioner's appointment and clinical privileges will be reinstated upon the Leadership Council's receipt of any additional information or documentation regarding the issue that may be requested by the Leadership Council.

(c) If the Leadership Council determines that the Practitioner has failed to provide a satisfactory explanation and eliminate the concerns, the Practitioner's appointment and clinical privileges shall be automatically resigned.

6.E.4. Failure to Complete Medical Records:

In accordance with the Hospital's current policy on delinquent medical records, failure to complete medical records in a timely manner may result in automatic relinquishment of clinical privileges.

6.E.5. Failure to Provide Requested Information:

Failure to provide information pertaining to an individual's professional qualifications, clinical care, or professionalism, in response to a written request from the Credentials Committee, the MEC, Leadership Council, the Professional Practice Evaluation Committee, the VPMA, the Hospital President, or any other committee authorized to request such information, shall result in the automatic relinquishment of all 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 is provided to the satisfaction of the requesting party. If the requested information is not provided within 30 days of the date of relinquishment, it shall result in automatic resignation of appointment and clinical privileges.

6.E.6. Failure to Attend Special Meeting:

(a) Whenever there is a concern regarding the clinical practice or professional conduct involving any Practitioner, a Medical Staff Leader may require the individual to attend a special meeting with one or more of the Medical Staff Leaders, one or more members of the Administrative Leadership, and/or with a standing or ad hoc committee of the Medical Staff.

(b) No legal counsel shall be present at this meeting, and no recording (audio or video) or transcript shall be permitted or made.

(c) The notice to the individual regarding this meeting shall be given in writing at least three days prior to the meeting and shall inform the individual that attendance at the meeting is mandatory.

(d) Failure of the individual to attend the meeting shall result in the automatic relinquishment of all clinical privileges until such time as the individual does attend the special meeting. If the individual does not attend the special meeting within 30 days of the date of relinquishment, it shall result in automatic resignation of appointment and clinical privileges.

6.E.7. Request for Reinstatement:

(a) Requests for reinstatement following the expiration or lapse of a license, controlled substance authorization, and/or insurance coverage will be processed by Medical Staff Services. If any questions or concerns are noted, Medical Staff Services will refer the matter for further review in accordance with (d) below.

(b) Requests for reinstatement for failure to notify Medical Staff Services of the events specified in Section 6.E.3 of this Policy will be managed in accordance with that Section.

(c) Requests for reinstatement following the relinquishment of clinical privileges due to medical record delinquencies will be accomplished in accordance with applicable Hospital policy.

(d) All other requests for reinstatement following a relinquishment of clinical privileges shall be reviewed by the Leadership Council. If a favorable recommendation on reinstatement is made, the individual may immediately resume clinical practice at the Hospital. If, however, the Leadership Council has any questions or concerns, those questions shall be noted, and the reinstatement request shall be forwarded to the Credentials Committee, MEC, and Board for review and recommendation.

6.F. LEAVES OF ABSENCE

6.F.1. Initiation:

(a) A Practitioner may request a leave of absence by submitting a written request to Medical Staff Services. The request must state the beginning and ending dates of the leave, which shall not exceed one year, and the reasons for the leave.

(b) The VPMA shall determine whether a request for a leave of absence shall be granted. In determining whether to grant a request, the VPMA shall consult with the President of the Medical Staff and the relevant Department Chair. The granting of a leave of absence, or reinstatement, as appropriate, may be conditioned upon the individual's completion of all medical records.

(c) Leaves for Health Issues. Practitioners must report to the VPMA any time they are away from Medical Staff and/or patient care responsibilities for longer than 30 Days and the reason for such absence is related to their physical or mental health or otherwise to their ability to care for patients safely and competently. Upon becoming aware of such circumstances (whether by report of the Practitioner or otherwise), the Hospital President and/or VPMA, in consultation with the President of the Medical Staff, may trigger an automatic medical leave of absence at any point after becoming aware of the Practitioner's absence from patient care. A Special Notice informing the Practitioner that a leave of absence has been enacted will then be sent.

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

During the leave of absence, the individual shall not exercise any clinical privileges. In addition, the individual shall be excused from all Medical Staff and clinical responsibilities (e.g., meeting attendance, committee service, emergency service call obligations) during this period.

6.F.3. Reinstatement:

(a) Individuals requesting reinstatement shall submit a written summary of their professional activities, if any, during the leave, and any other information that may be requested by the Hospital. Requests for reinstatement shall then be reviewed by the Leadership Council. If the Leadership Council makes a favorable recommendation on reinstatement, the Medical Staff member may immediately resume clinical practice at the Hospital. If, however, the Leadership Council has any questions or concerns, those questions shall be noted and the reinstatement request shall be forwarded to the full Credentials Committee, MEC, and Board for review and recommendation. If a request for reinstatement is not granted for reasons related to clinical competence or professional conduct, the individual shall be entitled to request a hearing and appeal.

(b) If the leave of absence was for health reasons the request for reinstatement must be accompanied by a report from the individual's physician indicating that the individual is physically and/or mentally capable of resuming a hospital practice and safely exercising the clinical privileges requested.

(c) Absence for longer than one year shall result in automatic relinquishment of appointment and clinical privileges unless an extension is granted by the VPMA. Extensions shall be considered only in extraordinary cases where the extension of a leave is in the best interest of the Hospital.

(d) If an individual's current appointment is due to expire during the leave, the individual must apply for reappointment, or appointment and clinical privileges shall lapse at the end of the appointment period.

(e) Failure to request reinstatement from a leave of absence in a timely manner shall be deemed a voluntary resignation of appointment and clinical privileges.

(f) Leaves of absence are matters of courtesy, not of right. In the event that it is determined that an individual has not demonstrated good cause for a leave, or where a request for extension is not granted, the determination shall be final, with no recourse to a hearing and appeal.

6.G. ACTION AT ANOTHER UPMC HOSPITAL

(1) In accordance with the UPMC Information Sharing Policy, each UPMC Hospital will share information regarding the implementation or occurrence of any of the following actions with all other UPMC Hospitals at which an individual maintains appointment, clinical privileges, or any other permission to care for patients:

(a) ***automatic relinquishment or resignation*** of appointment or clinical privileges for:

- failure to meet any ***threshold eligibility criteria*** set forth in the Medical Staff Bylaws or Credentials Policy, or

- the individual is ***arrested, charged, or indicted*** for any felony; or for any misdemeanor involving (i) controlled substances, (ii) illegal drugs, (iii) Medicare, Medicaid, or insurance or health care fraud or abuse, (iv) child abuse, (v) elder abuse, (vi) violence against another, or (vii) the Practitioner-patient relationship;

(b) ***voluntary agreement to modify clinical privileges*** or ***to refrain from exercising*** some or all clinical privileges for a period of time for reasons related to the individual's clinical competence, conduct, or health;

(c) any ***denial, suspension, revocation, or termination*** of appointment and/or clinical privileges related to clinical competence, conduct, or health;

(d) participation in a ***Voluntary Enhancement Plan or Performance Improvement Plan*** under the relevant professional practice evaluation policy or professionalism policy;

(e) a grant of ***conditional appointment or clinical privileges*** (either at initial appointment or reappointment), or conditional continued appointment or clinical privileges; and/or

(f) any other event which, in the sole discretion of the UPMC Hospital making the notification, raises a ***significant concern about the Practitioner's clinical competence, professional conduct, health/ability to safely***

practice, or utilization practices in accordance with the Information Sharing Policy.

(2) Upon receipt of notice that any of the actions set forth in Paragraph (1) have occurred at any UPMC Hospital, that action will either:

(a) automatically and immediately take effect at the UPMC Hospital receiving the notice; or

(b) be cause for the UPMC Hospital receiving the notice to determine that the individual no longer satisfies the eligibility criteria set forth in this Policy and has therefore automatically relinquished the individual's appointment and privileges.

The automatic effectiveness of any such action, or an automatic relinquishment based on such action, will not entitle the individual to any additional procedural rights (including advance notice, additional peer review, formal Investigation, hearing, or appeal) beyond what occurred at the UPMC Hospital taking the original action. All information that is shared pursuant to Paragraph (1) above will be reviewed by Medical Staff Leaders at the receiving UPMC Hospital to determine whether additional steps may be necessary.

(3) The Board may waive the automatic effectiveness of an action or an automatic relinquishment at the receiving UPMC Hospital, following its review of the MEC's recommendation. However, the automatic effectiveness or relinquishment will continue until such time as a waiver has been granted and the Practitioner has been notified in writing of such. Waivers are within the discretion of the Board and are final. They will be granted only as follows:

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

(b) after a full review of the specific circumstances and any relevant documents (including peer review documents) from the UPMC Hospital where the action first occurred. The burden is on the affected Practitioner to provide evidence showing that a waiver is appropriate.

The denial of a waiver pursuant to this Section will not entitle the individual to any procedural rights, including advance notice, additional peer review, formal Investigation, hearing, or appeal.

ARTICLE 7

HEARING AND APPEAL PROCEDURES FOR PRACTITIONERS

7.A. INITIATION OF HEARING

7.A.1. Grounds for Hearing:

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

(1) denial of initial appointment;

(2) denial of reappointment;

(3) revocation of appointment;

(4) denial of requested clinical privileges, whether at the time of initial appointment, reappointment, or during the course of appointment;

(5) revocation of clinical privileges;

(6) suspension of clinical privileges for more than 30 days (other than precautionary suspension which entitles an individual to the procedures outlined in Section 6.C.3 of this Policy and which are deemed fair under the circumstances);

(7) a Restriction of clinical privileges for more than 30 days; or

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

(b) No other recommendations shall entitle the individual to a hearing.

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

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

None of the following actions shall constitute grounds for a hearing, and they shall take effect without hearing or appeal, provided that the individual shall be entitled to submit a written explanation to be placed into the individual's file:

(a) determination that an applicant for membership fails to meet the threshold eligibility qualifications or criteria for membership, including those who are excluded from submitting an application for a defined period of time under the Hospital's Medical Staff Bylaws documents;

(b) ineligibility to request membership or privileges, or to continue privileges, because a relevant specialty is closed under a Medical Staff development plan or is covered under an exclusive provider agreement;

(c) determination that an applicant for clinical privileges fails to meet the eligibility criteria to hold the privilege;

(d) determination that an application is incomplete or untimely;

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

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

(g) expiration of membership and privileges as a result of failure to submit an application for reappointment within the allowable time period;

(h) issuance of an Information Letter, Educational Letter, or any other letter of guidance, counsel, warning, or reprimand;

(i) determination that conditions, monitoring, supervision, proctoring, or a general consultation requirement (i.e., the individual must obtain a consult but need not get prior approval for the treatment) is appropriate for an individual;

(j) determination that a requirement for additional training or continuing education is appropriate for an individual;

(k) the voluntary acceptance of a Performance Improvement Plan;

(l) any requirement to complete a health assessment, diagnostic testing, a complete physical, mental or behavioral evaluation, or a clinical competency evaluation pursuant to any Bylaws-related document;

(m) conducting an Investigation into any matter or the appointment of an ad hoc investigating committee;

(n) grant of conditional appointment or reappointment or of an appointment or reappointment period that is less than two years;

(o) Restriction or suspension of clinical privileges for less than 30 days;

(p) precautionary suspension;

(q) automatic relinquishment of appointment or privileges or automatic resignation;

(r) denial of a request for a leave of absence, for an extension of a leave or for reinstatement from a leave if the reasons do not relate to clinical competence or professional conduct;

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

(t) withdrawal of temporary privileges;

(u) requirement to appear for a special meeting;

(v) termination of any contract with or employment by the Hospital; and

(w) any other action that is not specifically listed in Section 7.A.1(a).

7.B. THE HEARING

7.B.1. Notice of Recommendation:

The Hospital President shall promptly give Special Notice of a recommendation which entitles an individual to request a hearing. This notice shall contain:

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

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

(c) a copy of this Article.

7.B.2. Request for Hearing:

An individual has 30 days following receipt of the notice to request a hearing. The request shall be in writing to the Hospital President and shall include the name, address, and telephone number of the individual's counsel, if any. Failure to request a hearing shall

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

7.B.3. Notice of Hearing and Statement of Reasons:

(a) The Hospital President shall schedule the hearing and provide, by Special Notice to the individual requesting the hearing, the following:

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

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

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

(4) a statement of the specific reasons for the recommendation, including a list of patient records (if applicable), and a general description of the information supporting the recommendation. This statement does not bar presentation of additional evidence or information at the hearing, so long as the additional material is relevant to the recommendation or the individual's qualifications and the individual has a sufficient opportunity to review and rebut the additional information.

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

7.B.4. Hearing Panel, Presiding Officer, and Hearing Officer:

(a) Hearing Panel:

The Hospital President, after consulting with the President of the Medical Staff, shall appoint a Hearing Panel in accordance with the following guidelines:

(1) The Hearing Panel shall consist of at least three members and may include any combination of:

(i) any member of the Medical Staff or other Practitioner, provided the individual has not actively participated in the matter at any previous level; and/or

(ii) physicians, other Practitioners, or laypersons not connected with the Hospital (e.g., physicians not on the Medical Staff or laypersons not affiliated with the Hospital).

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

(3) Employment by, or other contractual arrangement with, the Hospital or an affiliate shall not preclude an individual from serving on the Panel.

(4) The Panel shall not include any individual who is in direct economic competition with the individual requesting the hearing.

(5) The Panel will not include any individual who is professionally associated with, related to, or involved in a significant referral relationship with, the individual requesting the hearing.

(6) The Panel shall not include any individual who is demonstrated to have an actual bias, prejudice, or conflict of interest that would prevent the individual from fairly and impartially considering the matter.

(7) In addition, the appointment of the Hearing Panel shall comply with the guidelines set forth in the conflict of interest provisions found in Article 8 of this Policy and in **Appendix A**.

(b) Presiding Officer:

(1) The Hospital President, after consulting with the President of the Medical Staff, shall appoint a Presiding Officer who shall be an attorney. The Presiding Officer may not be, or represent clients who are, in direct competition with the individual who requested the hearing and may not currently represent the Hospital in any legal matters. The Presiding Officer shall not act as an advocate for either side at the hearing.

(2) The Presiding Officer shall:

(i) 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;

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

(iii) maintain decorum throughout the hearing;

(iv) determine the order of procedure;

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

(vi) conduct argument by counsel on procedural points within or outside the presence of the Hearing Panel at the Presiding Officer's discretion.

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

(4) The Presiding Officer may participate in the private deliberations of the Hearing Panel and be a legal advisor to it but shall not be entitled to vote on its recommendations.

(c) Hearing Officer:

(1) As an alternative to a Hearing Panel, for matters limited to issues involving professional conduct, the Hospital President, after consulting with the President of the Medical Staff, may appoint a Hearing Officer, preferably an attorney, to perform the functions of a Hearing Panel. The Hearing Officer may not be, or represent clients who are, in direct economic competition with the individual requesting the hearing.

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

(d) Objections:

Any objection to any member of the Hearing Panel, to the Presiding Officer, or to the Hearing Officer, shall be made in writing, within 10 days of receipt of notice, to the Hospital President. A copy of such written objection must be provided to the President of the Medical Staff and must include the basis for the objection. The President of the Medical Staff shall be given a reasonable opportunity to comment. The Hospital President shall rule on the objection and give notice to the parties. The Hospital President may request that the Presiding Officer make a recommendation as to the validity of the objection.

(e) Compensation:

The Hearing Panel, Presiding Officer, and/or Hearing Officer may be compensated by the Hospital, but the individual requesting the hearing may participate in any such compensation should the individual wish to do so.

7.B.5. Counsel:

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

7.C. PRE-HEARING PROCEDURES

7.C.1. General Procedures:

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

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

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

(d) The hearing shall last no more than 15 hours, with each side being afforded approximately seven and one-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 shall be concluded after a maximum of 15 hours. The Presiding Officer may, after considering any objections, grant limited extensions upon a demonstration of good cause and to the extent compelled by fundamental fairness.

7.C.2. Time Frames:

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

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

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

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

7.C.3. Witness List:

(a) At least 10 days before the pre-hearing conference, the individual requesting the hearing shall provide a written list of the names of witnesses expected to offer testimony on the individual's behalf.

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

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

7.C.4. Provision of Relevant Information:

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

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

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

(2) reports of experts relied upon by the MEC;

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

(4) copies of any other documents relied upon by the MEC.

The provision of this information shall not waive any privilege under the state peer review protection statutes.

(c) The individual shall have no right to discovery beyond the above information. No information shall be provided regarding other Practitioners at the Hospital.

(d) At least 10 days prior to the pre-hearing conference (or as otherwise agreed upon by both sides), each party shall provide the other party with its proposed exhibits. All objections to documents or witnesses shall be submitted in writing at least five days in advance of the pre-hearing conference. The Presiding Officer shall not entertain subsequent objections unless the party offering the objection demonstrates good cause.

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

7.C.5. Pre-Hearing Conference:

The Presiding Officer shall require the individual and the MEC or their representatives (who may be counsel) to participate in a pre-hearing conference, which shall be held no later than 14 days prior to the hearing. At the pre-hearing conference, the Presiding Officer shall establish the time to be allotted to each witness's testimony and cross-examination and shall resolve all procedural questions, including any objections to exhibits, witnesses, or the time limitation for the hearing.

7.C.6. Stipulations:

The parties and their counsel, if applicable, shall use their best efforts to develop and agree upon stipulations, so as to provide for a more orderly and efficient hearing by narrowing the issues on which live testimony is reasonably required.

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

The following documents shall be provided to the Hearing Panel in advance of the hearing: (a) a pre-hearing statement that either party may choose to submit; (b) exhibits offered by the parties following the pre-hearing conference (without the need for authentication); and (c) any stipulations agreed to by the parties.

7.D. HEARING PROCEDURES

7.D.1. Rights of Both Sides and the Hearing Panel at the Hearing:

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

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

(2) to introduce exhibits;

(3) to cross-examine any witness on any matter relevant to the issues;

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

(5) to submit proposed findings, conclusions and recommendations to the Hearing Panel as part of the Post-Hearing statement referenced in this Article, following the close of the hearing session(s).

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

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

7.D.2. Record of Hearing:

A stenographic reporter shall be present to make a record of the hearing. The cost of the reporter shall be borne by the Hospital. Copies of the transcript shall be available at the individual's expense. Oral evidence shall be taken only on oath or affirmation administered by any person entitled to notarize documents in this state.

7.D.3. Failure to Appear:

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

7.D.4. Presence of Hearing Panel Members:

A majority of the Hearing Panel shall be present throughout the hearing. In unusual circumstances when a Hearing Panel member must be absent from any part of the hearing, the member shall read the entire transcript of the portion of the hearing from which the member was absent.

7.D.5. Persons to Be Present:

The hearing shall be restricted to those individuals involved in the proceeding, the President of the Medical Staff, and the Hospital President. In addition, administrative personnel may be present as requested by the Hospital President or the President of the Medical Staff.

7.D.6. Order of Presentation:

The MEC shall first present evidence in support of its recommendation. Thereafter, the burden shall shift to the individual who requested the hearing to present evidence.

7.D.7. Admissibility of Evidence:

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

7.D.8. Post-Hearing Statement:

Each party shall have the right to submit a written statement, and the Hearing Panel may request that statements be filed, following the close of the hearing.

7.D.9. Postponements and Extensions:

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

7.E. HEARING CONCLUSION, DELIBERATIONS, AND RECOMMENDATIONS

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

Consistent with the burden on the individual to demonstrate that all criteria for initial appointment, reappointment and clinical privileges are satisfied on a continuing basis, the Hearing Panel shall recommend in favor of the MEC 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.E.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 shall conduct its deliberations outside the presence of any other person except the Presiding Officer. Thereafter, the Hearing Panel shall render a recommendation, accompanied by a report, which shall contain a concise statement of the basis for its recommendation.

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

The Hearing Panel shall deliver its report to the Hospital President. The Hospital President shall send by Special Notice a copy of the report to the individual who requested the hearing. The Hospital President shall also provide a copy of the report to the MEC.

7.F. APPEAL PROCEDURE

7.F.1. Time for Appeal:

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

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

7.F.2. Grounds for Appeal:

The grounds for appeal shall be limited to the following:

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

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

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

Whenever an appeal is requested as set forth in the preceding Sections, the Chair of the Board (or the Hospital President on behalf of the Chair) shall schedule and arrange for an appeal. The individual shall be given Special Notice of the time, place, and date of the appeal. The appeal shall be held as soon as arrangements can reasonably be made, taking into account the schedules of all the individuals involved.

7.F.4. Nature of Appellate Review:

(a) The Board may serve as the Review Panel or the Chair of the Board may appoint a Review Panel composed of not less than three persons, either members of the Board or others, including but not limited to reputable persons outside the Hospital, to consider the record upon which the recommendation before it was made and recommend final action to the Board.

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

(c) 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. Such additional evidence shall be accepted only if the Review Panel determines that the party seeking to admit it has demonstrated that it is relevant, new evidence that could not have been presented at the hearing, or that any opportunity to admit it at the hearing was improperly denied.

7.G. BOARD ACTION

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

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

(b) The Board may review any information that it deems relevant, including, but not limited to, the findings and recommendations of the MEC, Hearing Panel, and Review Panel (if applicable). The Board may adopt, modify, or reverse any recommendation that it receives or, in its discretion, refer the matter to any individual or committee for further review and recommendation, or make its own decision based upon the Board's ultimate legal authority for the operation of the Hospital and the quality of care provided.

(c) The Board shall render its final decision in writing, including specific reasons, and shall send Special Notice to the individual. A copy shall also be provided to the MEC for its information.

7.G.2. Further Review:

Except where the matter is referred by the Board for further action and recommendation by any individual or committee, the final decision of the Board shall be effective immediately and shall not be subject to further review. If the matter is referred for further action and recommendation, such recommendation shall be promptly made to the Board in accordance with the instructions given by the Board.

7.G.3. Right to One Hearing and One Appeal Only:

No member of the Medical Staff shall be entitled to more than one hearing and one appellate review on any matter.

ARTICLE 8

CONFLICT OF INTEREST GUIDELINES FOR PEER REVIEW ACTIVITIES

8.A.1. General Principles:

(a) All those involved in Peer Review activities (referred to collectively as "Medical Staff Functions" in this Article) must be sensitive to potential conflicts of interest ("COI") in order to be fair to the individual whose qualifications are under review, to protect the individual with the potential conflict, and to protect the integrity of the review processes.

(b) It is also essential that peers participate in Medical Staff Functions 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.

(c) A potential conflict of interest depends on the situation and not on the character of the individual. To promote this understanding, any individual with a potential conflict of interest shall be referred to as an "Interested Member."

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

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

(f) **Appendix A** to this Policy is a chart that outlines the conflict of interest guidelines that are applicable to Medical Staff Functions at the Hospital. The remainder of this Article is intended to supplement **Appendix A** and expand upon the guidelines that are summarized in the chart.

8.A.2. Process for Identifying Conflicts of Interest:

(a) Self-Disclosure. Any individual involved in Medical Staff Functions must disclose all personal conflicts of interest relevant to those activities to the committee chair or VPMA.

(b) Identification by Others. Any individual who is concerned about a potential conflict of interest on the part of any other individual who is involved in Medical Staff Functions should inform the committee chair or VPMA.

(c) Identification by Individual under Review. An individual who is the subject of review during any Medical Staff Functions is obligated to notify the committee chair or VPMA of any known or suspected conflicts of interest by others who are involved in such activities. Any potential conflict of interest that is not raised timely by the individual under review shall be deemed waived.

8.A.3. Implementation of Conflict of Interest Guidelines in **Appendix A**:

This section describes how to implement the Conflict of Interest Guidelines found in **Appendix A** of this Policy:

- Paragraph (a) identifies the three COI situations that require special treatment and rules during the performance of Medical Staff Functions, irrespective of the Interested Member's level of participation in the process (e.g., individual reviewer, Professional Practice Evaluation Committee member, MEC member);

- Paragraph (b) describes the other common situations that raise COI issues during the performance of Medical Staff Functions; and

- Paragraph (c) describes how to apply the guidelines in **Appendix A** to the common COI situations outlined in (b) at each level of the review processes.

(a) Three COI Situations that Require Special Treatment and Rules, Irrespective of an Interested Member's Level of Participation:

(1) Employment or Contractual Arrangement with the Hospital. Because Medical Staff Functions are performed on behalf of the Hospital, the interests of those who are employed by, or under contract with, the Hospital are aligned with the Hospital's interest in seeing that those activities are performed effectively, efficiently, and lawfully. As such, employment by, or other contractual arrangement with, the Hospital or any of its affiliated entities does not, in and of itself, preclude an Interested Member from participating in Medical Staff Functions.

(2) Self or Family Member. While Interested Members may provide information to other individuals involved in the review process, an Interested Member should not otherwise participate in the review of their own application or the professional practice evaluation of the care the Interested Member provided or in any such activities involving an immediate family member (spouse or domestic partner, parent, child, sibling, or in-law).

(3) Relevant Treatment Relationship. As a general rule, an Interested Member who has provided professional health services to a Practitioner whose application or provision of care is under review should not participate in the

review process regarding the Practitioner. However, 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, the Interested Member may participate fully in all Medical Staff Functions.

Furthermore, even if a current patient-physician relationship exists, the Interested Member may provide information to others involved in the review process if:

(i) the information was not obtained through the treatment relationship, or

(ii) the information was obtained through the treatment relationship, but the disclosure was authorized by the Practitioner under review through the execution of a HIPAA-compliant authorization form.

(b) Other Common Situations That Raise COI Issues During the Performance of Medical Staff Functions:

Participation by any Interested Member who is in one of the following situations – as it relates to the Practitioner under review – will be evaluated under the guidelines outlined in Paragraph (c) and **Appendix A**:

(1) Significant Financial Relationship (e.g., when the Interested Member and other Practitioners: are members of a small, single specialty group; maintain a significant referral relationship; are partners in a business venture; or are individuals practicing in a specialty for which a policy matter – such as clinical privileging criteria – is being considered);

(2) Direct Competitor (e.g., Practitioners in the same specialty, but in different groups);

(3) Close Friendships;

(4) History of Personal Conflict (e.g., former partner, ex-spouse, or where there has been demonstrated animosity);

(5) Personal Involvement in the Care That Is Subject to Review (e.g., where the Interested Member provided care in the case under review, but is not the subject of the review);

(6) Active Involvement in Certain Prior Interventions with the Individual under Review (e.g., where the Interested Member was involved in the development of a prior Performance Improvement Plan or in a disciplinary action involving the individual under review. This situation does not

include participation in initial education or collegial counseling efforts (e.g., sending an Educational Letter; meeting collegially with a colleague and sending a follow-up letter)); and/or

(7) Formally Raised the Concern about Another Individual (e.g., where the Interested Member's concern triggered the review of another Practitioner, as evidenced by the Interested Member's written report regarding the concern (i.e., sent a written concern to a Medical Staff Officer or VPMA, or filed a report through the Hospital's electronic reporting system)).

(c) Application of the Guidelines in **Appendix A** to the Performance of Medical Staff Functions:

(1) Individual Reviewers in Credentialing and Professional Practice Evaluation Activities

An Interested Member may participate as a Department Committee member because a check and balance is provided by a subsequent review by another Medical Staff committee. This includes, but is not limited to, the following:

(i) participation in the review of applications for initial and renewed appointment and clinical privileges (which is subsequently reviewed by the Credentials Committee and/or MEC); and

(ii) participation as a case reviewer in professional practice evaluation activities (which is subsequently reviewed by the Leadership Council, Professional Practice Evaluation Committee, Investigating Committee, and/or MEC).

(2) Credentials Committee, Leadership Council, and Professional Practice Evaluation Committee Members

As a general rule, an Interested Member may fully participate as a member of the Credentials Committee, Leadership Council, and Professional Practice Evaluation Committee because these committees do not possess any disciplinary authority and do not make any final recommendation that could adversely affect the appointment or clinical privileges of a Practitioner, which is only within the authority of the MEC and Board.

However, the chairs of these committees always have the discretion to recuse an Interested Member if they determine that the Interested Member's presence or participation would inhibit full and fair discussion of the issue, would skew the recommendation or determination of the committee, or would otherwise be unfair to the Practitioner under review.

(3) Medical Executive Committee

As a general rule, an Interested Member may fully participate as a member of the MEC when it is approving routine and favorable recommendations regarding the granting of initial appointment, reappointments, and clinical privileges.

However, an Interested Member should be recused from the MEC when that committee is considering a matter that could result in an adverse professional review action affecting the appointment or clinical privileges of a Practitioner. The Interested Member's participation in MEC meetings will be governed by the guidelines regarding recusal that are set forth in **Appendix A**.

(4) Investigating Committees

Once a formal Investigation has been initiated by the MEC, additional steps to manage conflicts of interest should be taken as a precaution. Therefore, an Interested Member should not be appointed as a member of an investigating committee and should not participate in the committee's deliberations or decision-making but may be interviewed and provide information if necessary for the committee to conduct a full and thorough Investigation.

(5) Hearing Panel

An Interested Member should not be appointed as a member of a Hearing Panel and should not participate in the Panel's deliberations or decision-making.

(6) Board

As a general rule, an Interested Member may fully participate as a member of the Board when it is approving routine and favorable recommendations regarding the granting of initial appointment, reappointments, and clinical privileges.

However, an Interested Member should be recused from the Board when the Board is considering action that will adversely affect appointment or clinical privileges of a Practitioner. The Interested Member's participation in Board meetings will be governed by the guidelines regarding recusal that are set forth in **Appendix A**.

ARTICLE 9

CONFIDENTIALITY AND PEER REVIEW PROTECTIONS

9.A. CONFIDENTIALITY

All Peer Review activity defined in this Policy and recommendations made shall be strictly confidential. Individuals participating in, or subject to, Peer Review activities shall make no disclosures of any such information (discussions or documentation) outside of committee meetings, except:

(1) when the disclosures are to another authorized Practitioner or authorized Hospital employee and are for the purpose of researching, investigating, or otherwise conducting legitimate Peer Review/professional practice evaluation activities;

(2) when the disclosures are authorized by a Medical Staff or Hospital policy; or

(3) when the disclosures are authorized, in writing, by the VPMA, Hospital President, or legal counsel to the Hospital.

Any breach of confidentiality may result in a professional review action and/or appropriate legal action. Such breaches are unauthorized and do not waive the peer review privilege. Any Practitioner who becomes aware of a breach of confidentiality must immediately inform the Hospital President or the President of the Medical Staff (or the VPMA if the President of the Medical Staff is the person committing the claimed breach).

9.B. PEER REVIEW PROTECTION

(1) All Peer Review activity pursuant to this Policy and related Medical Staff documents shall be performed by "review organizations" or "peer review committees" in accordance with the Pennsylvania Peer Review Protection Act, 63 P.S. §425.1 et seq. or other relevant state law, based on the location of the Hospital, and the Hospital's peer review policies and procedures. Peer review committees are defined in Article 1 of this Policy. All oral or written communications, reports, recommendations, actions, and minutes made or taken by such committees are confidential and covered by the provisions of the Hospital's state peer review statute.

(2) All Peer Review Committees shall also be deemed to be "professional review bodies" as that term is defined in the Health Care Quality Improvement Act of 1986, 42 U.S.C. §1101 et seq.

ARTICLE 10

UPMC EMPLOYEES

(a) Except as provided below, the employment of an individual by UPMC or one of its affiliates will be governed by applicable employment policies and manuals and the terms of the individual's employment relationship or written contract. To the extent that applicable employment policies or manuals, or the terms of any employment contract, conflict with this Policy, the employment policies, manuals and descriptions and terms of the individual's employment relationship or written contract will apply.

(b) Except as noted in (a) above, UPMC-employed members are bound by all of the same conditions and requirements in this Policy that apply to non-UPMC employed members.

(c) A request for appointment, reappointment, clinical privileges, or scope of practice, submitted by an applicant or member who is employed by UPMC or one of its affiliates, will be processed in accordance with the terms of this Policy. A report regarding each Practitioner's qualifications will be made to appropriate UPMC administrative personnel, as appropriate under applicable Medical Staff and UPMC policies, to assist with employment decisions.

(d) If a concern about an employed member's clinical competence, conduct or behavior arises, then the concern may be reviewed and addressed in accordance with this Policy, in which event a report may be provided to appropriate UPMC administrative personnel (as appropriate). However, nothing herein will require the individual's employer to follow this Policy.

ARTICLE 11

AMENDMENTS

(a) The Medical Review Council has been delegated the authority to develop and provisionally adopt amendments to this Policy by the Medical Executive Committees at the participating UPMC Hospitals. Any Medical Staff member at a participating UPMC Hospital may submit a request for a proposed amendment to this Policy to the Medical Review Council for its consideration.

(b) Notice of any provisionally adopted amendments will be provided to the Medical Executive Committees at each participating UPMC Hospital for review and adoption. Any provisional amendments to this Policy will take effect immediately upon receiving notice of the amendments from the Medical Review Council, subject to the procedures outlined in paragraphs (c) and (d) below.

(c) Upon receiving notice, each Medical Executive Committee at a participating UPMC Hospital will have 60 days to review and adopt the provisional amendments. During this time the Medical Executive Committee should share the amendments with the members of its Bylaws Committee and Medical Staff for input and feedback. Once adopted, the provisional amendments will be sent to the Board of the participating UPMC Hospital for approval.

(d) If any Medical Executive Committee fails to approve a provisional amendment within that time frame, a joint meeting of representatives from the Medical Review Council and the non-approving Medical Executive Committees at the participating UPMC Hospitals will be scheduled to discuss and resolve the disagreement. In the unlikely event that an agreement cannot be reached at that meeting, the provisional amendment will stand (at the discretion of the Medical Review Council), and the objecting Medical Executive Committee(s) may recommend to its Board that the Hospital opt out of this Policy and reestablish its own.

ARTICLE 12

ADOPTION

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

APPENDIX A

CONFLICT OF INTEREST GUIDELINES

Potential Conflicts	Levels of Participation								
	Provide Information	Department Committee[1]	Committee Member					Hearing Panel	Board
			Credentials	Leadership Council	PPEC	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	Y	Y	Y	Y	R	N	N	R
Direct competitor	Y	Y	Y	Y	Y	R	N	N	R
Close friends	Y	Y	Y	Y	Y	R	N	N	R
History of conflict	Y	Y	Y	Y	Y	R	N	N	R
Provided care in case under review (but not subject of review)	Y	Y	Y	Y	Y	R	N	N	R
Involvement in prior PIP or disciplinary action	Y	Y	Y	Y	Y	R	N	N	R
Formally raised the concern	Y	Y	Y	Y	Y	R	N	N	R

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

Y – ("Yes, with infrequent but occasional limitations") means the Interested Member may generally 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 Professional Practice Evaluation Committee have no disciplinary authority.

In addition, the Chair of the Credentials Committee, Leadership Council, or Professional Practice Evaluation Committee 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 – ("No") means the Interested Member should not serve in the indicated role.

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

***** Special rules apply both to the provision of information and participation in the review process in this situation. See Section 8.A.3 of this Policy.

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[1] Remove this column if the Medical Staff is non-departmentalized.

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. As set forth in the Medical Staff Bylaws, once a quorum has been established, the business of the meeting may continue and actions taken will be binding regardless of whether any subsequent recusal of members causes the number of individuals present at the meeting to fall below the number required for a quorum.

APPENDIX B

LIST OF PARTICIPATING UPMC HOSPITALS

The following UPMC Hospitals are covered by this Policy:

[INSERT GRID SHOWING ADOPTION DATES OF THE BOARDS AND MECS OF EACH PARTICIPATING UPMC HOSPITAL]

SIGNED: Donald M. Yealy, MD
Senior Vice President, UPMC and Chief Medical Officer, UPMC Health Services
ORIGINAL: April 1, 2024
APPROVALS:
Policy Review Subcommittee: March 13, 2024
Executive Staff: March 29, 2024 (effective April 1, 2024)
PRECEDE:
SPONSOR: UPMC Medical Staff Services

*** With respect to UPMC business units described in the Scope section, this policy is intended to replace individual business unit policies covering the same subject matter. In-Scope business unit policies covering the same subject matter should be pulled from all manuals.**