

**MEDICAL STAFF BYLAWS, POLICIES, AND
RULES AND REGULATIONS
OF
UPMC PINNACLE HOSPITALS
(Harrisburg, West Shore and
Community Osteopathic)**

**POLICY ON
ALLIED HEALTH PROFESSIONALS**

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ARTICLE 1

GENERAL

1.A. DEFINITIONS

The definitions that apply to terms used in all the Medical Staff documents are set forth in the Medical Staff Credentials Policy document.

1.B. TIME LIMITS

Time limits referred to in this Policy are advisory only and are not mandatory, unless it is expressly stated that a particular right is waived by failing to take action within a specified period.

1.C. DELEGATION OF FUNCTIONS

- (1) When a function is to be carried out by a member of Hospital management, by a Medical Staff member, or by a Medical Staff committee, the individual, or the committee through its chair, may delegate performance of the function to one or more designees.
- (2) When a Medical Staff member is unavailable or unable to perform an assigned function, one or more of the Medical Staff Leaders may perform the function personally or delegate it to another appropriate individual.

ARTICLE 2

SCOPE AND OVERVIEW OF POLICY

2.A. SCOPE OF POLICY

- (1) This Policy addresses those Allied Health Professionals who are permitted to provide patient care services in the Hospital and are listed in the Appendices to this Policy.
- (2) This Policy sets forth the credentialing process and the general practice parameters for these individuals, as well as guidelines for determining the need for additional Allied Health Professionals at the Hospital.

2.B. ALLIED HEALTH PROFESSIONALS

- (1) Only those Allied Health Professionals that have been approved by the Board shall be permitted to practice at the Hospital.

2.C. ADDITIONAL POLICIES

The Board shall adopt a separate credentialing protocol for each classification of Allied Health Professionals that it approves to practice in the Hospital. These separate protocols shall supplement this Policy and shall address the specific matters set forth in Section 3.B of this Policy.

ARTICLE 3

GUIDELINES FOR DETERMINING THE NEED FOR NEW

ALLIED HEALTH PROFESSIONALS

3.A. DETERMINATION OF NEED

- (1) Whenever an Allied Health Professional that has not been approved by the Board requests permission to practice at the Hospital, the Advanced Practice Provider Leadership Council will evaluate the need for that particular Allied Health Professional at the next regularly scheduled meeting and make a recommendation to the Credentials Committee for its review and recommendation at the next regularly scheduled meeting, which will then be reviewed and recommended at the next regularly scheduled Medical Executive Committee meeting, and forwarded to the Board or Expedited Board for final action.
- (2) As part of the process of determining need, the Allied Health Professional shall be invited to submit information about the nature of the proposed practice, why Hospital access is sought, and the potential benefits to the community by having such services available at the Hospital.
- (3) The Advanced Practice Provider Leadership Council may consider the following factors when making a recommendation to the Credentials Committee as to the need for the services of Allied Health Professionals:
 - (a) the nature of the services that would be offered;
 - (b) any state license or regulation which outlines the scope of practice that the Allied Health Professional is authorized by law to perform;
 - (c) any state “non-discrimination” or “any willing provider” laws that would apply to the Allied Health Professional;
 - (d) the business and patient care objectives of the Hospital, including patient convenience;
 - (e) the community’s needs and whether those needs are currently being met or could be better met if the services offered by the Allied Health Professional were provided at the Hospital;
 - (f) the type of training that is necessary to perform the services that would be offered and whether there are individuals with more training currently providing those services;

- (g) the availability of supplies, equipment, and other necessary Hospital resources;
- (h) the need for, and availability of, trained staff to support the services that would be offered; and
- (i) the ability to appropriately supervise performance and monitor quality of care.

3.B. DEVELOPMENT OF POLICY

- (1) If the Advanced Practice Provider Leadership Council determines that there is a need for the particular Allied Health Professional at the Hospital, the committee shall recommend to the Credentials Committee at the next regularly scheduled meeting. The Allied Health Professional will submit the following for review:
 - (a) any specific qualifications and/or training that they must possess beyond recommended
 - (b) a detailed description of their authorized scope of practice or clinical privileges;
 - (c) any specific conditions that apply to their functioning within the Hospital as recommended
 - (d) any supervision requirements, if applicable.
- (2) In developing such recommendations the Advanced Practice Provider Leadership Council shall consult the appropriate department chair(s) and consider relevant state law and may contact applicable professional societies or associations.

ARTICLE 4

QUALIFICATIONS, CONDITIONS, AND RESPONSIBILITIES

4.A. QUALIFICATIONS

4.A.1. Eligibility Criteria:

To be eligible to apply for initial and continued permission to practice at the Hospital, Allied Health Professionals must, where applicable:

- (a) have a current, unrestricted license, certification, or registration to practice in Pennsylvania and have never had a license, certification, or registration to practice revoked, suspended, or limited by Pennsylvania or any other state agency;
- (b) where applicable to their practice, have a current, unrestricted DEA registration, or DEA waiver while pending receipt of DEA;
- (c) be located (office and residence) close enough to fulfill their responsibilities as an Allied Health Professional and to provide timely and continuous care for their patients in the Hospital;
- (d) have current, valid professional liability insurance coverage in a form and in amounts satisfactory to the Hospital;
- (e) have never 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;
- (f) have never been, and are not currently, excluded, precluded, or debarred from participation in Medicare, Medicaid, or other federal or state governmental health care program;
- (g) have never had clinical privileges or scope of practice denied, revoked, or terminated by any health care facility or health plan for reasons related to clinical competence or professional conduct;
- (h) have never relinquished or resigned affiliation, clinical privileges, or a scope of practice during an investigation or in exchange for not conducting such an investigation;
- (i) have never been convicted of, or entered a plea of guilty or no contest, to any felony; or to any misdemeanor relating to controlled substances, illegal drugs, insurance or health care fraud or abuse, child abuse, elder abuse, or violence;

- (j) satisfy all additional eligibility qualifications relating to their specific area of practice that may be established by the Hospital;
- (k) document compliance with all applicable training and/or educational protocols that may be adopted by the Medical Executive Committee and/or required by the Hospital, including, but not limited to, those involving electronic medical records, patient safety, and infection; and
- (l) if seeking to practice as an Allied Health Professional as required by Pennsylvania law and/or Hospital policy, have a supervision agreement and/or collaborative agreement with a physician who is appointed to the Medical Staff (the “Supervising /Collaborating Physician”).

4.A.2. Waiver of Eligibility Criteria:

- (a) Any individual who does not satisfy one or more of the criteria outlined above may request a waiver. The individual requesting the waiver bears the burden of demonstrating **exceptional** circumstances, and that his or her qualifications are equivalent to, or exceed, the criterion in question.
- (b) A request for a waiver will be submitted to the Credentials Committee for consideration. In reviewing the request for a waiver, the Credentials Committee may consider the specific qualifications of the individual in question, input from the relevant department chair, and the best interests of the Hospital and the community it serves. Additionally, the Credentials Committee may, in its discretion, consider the application form and other information supplied by the applicant. The Credentials Committee’s recommendation will be forwarded to the Medical Executive Committee. Any recommendation to grant a waiver must include the specific basis for the recommendation.
- (c) The Medical Executive Committee will review the recommendation of the Credentials Committee and make a recommendation to the Board regarding whether to grant or deny the request for a waiver. Any recommendation to grant a waiver must include the specific basis for the recommendation.
- (d) No individual is entitled to a waiver or to a hearing if the Board determines not to grant a waiver. A determination that an individual is not entitled to a waiver is not a “denial” of permission to practice, clinical privileges, or scope of practice. Rather, the individual is ineligible to request permission to practice as an Allied Health Professional.
- (e) The granting of a waiver in a particular case is not intended to set a precedent for any other individual or group of individuals.

- (f) An application form that does not satisfy an eligibility criterion will not be processed until the Board has determined that a waiver should be granted.

4.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 applicable, as part of the initial request for permission to practice, as reflected in the following factors:

- (a) relevant training, experience, and demonstrated current competence, including medical/clinical knowledge, technical and clinical skills, clinical judgment, and an understanding of the contexts and systems within which care is provided;
- (b) adherence to the ethics of 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 or scope of practice requested;
- (e) ability to work harmoniously with others, including, but not limited to, interpersonal and communication skills sufficient to enable them to maintain professional relationships with patients, families, and other members of health care teams; and
- (f) recognition of the importance of, and willingness to support, 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.

4.A.4. No Entitlement to Medical Staff Appointment:

Allied Health Professionals shall not be appointed to the Medical Staff. Allied Health Professionals will be actively engaged in the medical staff and departmental meetings.

4.A.5. Non-Discrimination Policy:

No individual shall be denied permission to practice at the Hospital on the basis of age, sex, race, creed, or national origin.

4.B. GENERAL CONDITIONS OF PRACTICE

4.B.1. Assumption of Duties and Responsibilities:

As a condition of permission to practice at the Hospital, all Allied Health Professionals (and their Supervising/Collaborating Physicians, as applicable) shall specifically agree to the following:

- (a) to provide continuous and timely quality care to all patients in the Hospital for whom the individual has responsibility;
- (b) to abide by all Bylaws, policies, and Rules and Regulations of the Hospital and Medical Staff in force during the time the individual is appointed;
- (c) to accept committee assignments, participate in quality improvement and professional practice evaluation activities, and such other reasonable duties and responsibilities as may be assigned;
- (d) to comply with clinical practice or evidence-based protocols and pathways 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;
- (e) to comply with clinical practice or evidence-based protocols and pathways pertinent to his or her medical specialty, as may be adopted by the Medical Staff or the Medical Staff leadership, or to clearly document the clinical reasons for variance;
- (f) to notify the Vice President of Medical Affairs, Department Chair or the President of the Medical Staff, in writing, of any change in the practitioner's status or any change in the information provided on the Allied Health Professional's application form. This information shall be provided with or without request, at the time the change occurs, and will include, but not be limited to:
 - any and all complaints regarding, or changes in, licensure or certification status, or DEA controlled substance authorization;
 - loss of professional liability insurance coverage;
 - changes in the practitioner's status 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;
 - arrest, charge, indictment, conviction, or a plea of guilty or no contest in any criminal matter other than a misdemeanor traffic citation;

- exclusion or preclusion from participation in Medicare/Medicaid or any sanctions imposed;
 - any changes in the practitioner’s ability to safely and competently exercise clinical privileges, or scope of practice, or to perform the duties and responsibilities of permission to practice because of health status issues, including, but not limited to, impairment due to addiction, alcohol use, or other similar issue (all of which shall be referred for review under the practitioner health policy); and
 - any charge of, or arrest for, driving under the influence (“DUI”) (Any DUI incident will be reviewed by the President of the Medical Staff and the Vice President of Medical Affairs so that they may understand the circumstances surrounding it. If they have any concerns after doing so, they will forward the matter for further review under the practitioner health policy or this AHP Policy.)
- (g) to immediately submit to an appropriate evaluation, which may include diagnostic testing (such as 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 Leaders and one member of the Administrative team) are concerned with the individual’s ability to safely and competently care for patients. The health care professional(s) to perform the testing and/or evaluations shall be determined by the Medical Staff Leaders and the Medical Staff member must execute all appropriate releases to permit the sharing of information with the Medical Staff Leaders;
- (h) to appear for personal or phone interviews in regard to an application for permission to practice as may be requested;
- (i) to maintain a current e-mail address with Medical Staff Services, which will be the official mechanism used to communicate all information to the practitioner other than peer review information pertaining to the practitioner and/or protected health information of patients (this e-mail address will not be shared by the Hospital; also, this provision (i) shall not be interpreted to limit the ability of Medical Staff Leaders to utilize confidential e-mail to communicate about ongoing peer review matters among and between themselves);
- (j) to refrain from illegal fee splitting or other illegal inducements relating to patient referral;
- (k) to refrain from assuming responsibility for diagnosis or care of hospitalized patients for which he or she is not qualified or without adequate supervision;

- (l) to refrain from deceiving patients as to the individual's status as an Allied Health Professional and to always wear proper Hospital identification of their name and status;
- (m) to seek consultation when required or necessary;
- (n) to complete, in a timely and legible manner, the medical and other required records, containing all information required by the Hospital;
- (o) to cooperate with all utilization oversight activities;
- (p) to perform all services and conduct himself/herself at all times in a cooperative and professional manner;
- (q) to promptly pay any applicable application fees, assessments, dues, and/or fines;
- (s) to comply with all applicable training and/or educational protocols that may be adopted by the Medical Executive Committee and/or required by the Hospital, including, but not limited to, those involving electronic medical records, patient safety, and infection control;
- (t) to satisfy applicable continuing education requirements; and
- (u) that, if there is any misstatement in, or omission from, the application, the Hospital may stop processing the application (or, if permission to practice has been granted prior to the discovery of a misstatement or omission, the permission may be deemed to be automatically relinquished). In either situation, there shall be no entitlement to the procedural rights provided in this Policy. 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.

4.B.2. Burden of Providing Information:

- (a) Allied Health Professionals seeking permission to practice or renewal of permission to practice shall 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 permission to practice and current clinical competence for any requested clinical privileges or scope of practice, including, but not limited to, information from other hospitals, information from the individual's Supervising/Collaborating Physician's office, and/or receipt of confidential evaluation forms from other practitioners.

- (b) Allied Health Professionals seeking permission or renewal of permission to practice have the burden of providing evidence that all the statements made and information given on the application are accurate and complete.
- (c) An application shall be complete when all questions on the application form have been answered, all supporting documentation has been supplied, and all information has been verified from primary sources. An application shall become incomplete if the need arises for new, additional, or clarifying information at any time during the credentialing process. Any application that continues to be incomplete 120 days after the attestation date of the application shall be deemed to be withdrawn.
- (d) The individual seeking permission to practice or renewal of permission to practice is responsible for providing a complete application, including adequate responses from references. An incomplete application will not be processed.

4.C. APPLICATION

4.C.1. Information:

- (a) Application forms for both initial and renewed permission to practice as an Allied Health Professional shall require detailed information concerning the individual's professional qualifications. The Allied Health Professional application forms existing now and as may be revised are incorporated by reference and made a part of this Policy.
- (b) In addition to other information, the applications shall seek the following:
 - (1) information as to whether the applicant's clinical privileges, scope of practice, permission to practice, and/or affiliation has ever been voluntarily or involuntarily relinquished, withdrawn, denied, revoked, suspended, reduced, subjected to probationary or other conditions, limited, terminated, or not renewed at any hospital, health care facility, or other organization, or is currently being investigated or challenged;
 - (2) information as to whether the applicant's license, certification, or registration to practice any relevant profession in any state, DEA registration, or any state's controlled substance license (if applicable) 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 included in the information from the National Practitioner Data Bank as the Credentials Committee, the Medical Executive Committee, or the Board may request;

- (4) current information regarding the applicant's ability to safely and competently exercise the clinical privileges or scope of practice requested; and
 - (5) a copy of government-issued photo identification.
- (c) The applicant shall sign the application and certify that he or she is able to perform the clinical privileges or scope of practice requested and the responsibilities of Allied Health Professionals.

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

By requesting an application and/or applying for permission to practice, 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 or the Board, any member of the Medical Staff or the Board, their authorized representatives, and third parties who provide information for any matter relating to permission to practice, clinical privileges, scope of practice, or the individual's qualifications for the same. This immunity covers any actions, recommendations, reports, statements, communications, and/or disclosures involving the individual that are made, taken, or received by the Hospital, its authorized agents, or third parties in the course of credentialing and peer review activities.

(b) Authorization to Obtain Information from Third Parties:

The individual specifically authorizes the Hospital, Medical Staff Leaders, and their authorized representatives (1) to consult with any third party who may have information bearing on the individual's professional qualifications, credentials, clinical competence, character, ability to perform safely and competently, ethics, behavior, or any other matter reasonably having a bearing on his or her qualifications for initial and continued permission to practice at the Hospital, 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 third parties to release this information to the Hospital and its authorized 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 Hospital.

(c) Authorization to Release Information to Third Parties:

The individual also authorizes Hospital representatives to release information to other hospitals, health care facilities, managed care organizations, government regulatory and licensure boards or agencies, and their agents when information is requested in order to evaluate his or her professional qualifications for permission to practice, clinical privileges, scope of practice, and/or participation at the requesting organization/facility, and any licensure or regulatory matter.

(d) Authorization to Share Information within UPMC Pinnacle Hospitals:

The individual specifically authorizes all of the Hospitals within UPMC Pinnacle Hospitals or a successor Health System to share credentialing and peer review information pertaining to the individual's clinical competence and/or professional conduct. This information may be shared at initial and renewed permission to practice and/or any other time during the individual's affiliation with the Hospital.

(e) Procedural Rights:

The Allied Health Professional agrees that the procedural rights set forth in this Policy are the sole and exclusive remedy with respect to any professional review action taken by the Hospital.

(f) Scope of Section:

All of the provisions in this Section 4.C.2 are applicable in the following situations:

- (1) whether or not permission to practice, clinical privileges, or scope of practice is granted;
- (2) throughout the term of any affiliation with the Hospital and thereafter;
- (3) should permission to practice, clinical privileges, or scope of practice be revoked, reduced, restricted, suspended, and/or otherwise affected as part of the Hospital's professional review activities; and
- (4) as applicable, to any third-party inquiries received after the individual leaves the Hospital about his/her tenure as a member of the Allied Health Professional staff.

ARTICLE 5

CREDENTIALING PROCEDURE

5.A. PROCESSING OF INITIAL APPLICATION TO PRACTICE

5.A.1. Request for Application:

- (a) Applications for appointment shall be submitted on forms approved by the Board, upon recommendation by the Medical Executive Committee and Credentials Committee.
- (b) An Allied Health Professional who has not been approved by the Board to practice at the Hospital shall be ineligible to receive an application. A determination of ineligibility does not entitle an Allied Health Professional to the procedural rights outlined in this Policy.
- (c) Applications may be provided to Allied Health Professionals who are in the final six months of their training. Such applications may be processed, but final action shall not be taken until all applicable threshold eligibility criteria are satisfied.

5.A.2. Initial Review of Application:

- (a) A completed application, with copies of all required documents, must be submitted to Physician and Practitioner Services within 30 days after receipt. The application must be accompanied by the application processing fee.
- (b) As a preliminary step, the application will be reviewed by Physician and Practitioner Services 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 an Allied Health Professional to the procedural rights outlined in this Policy.
- (c) Physician and Practitioner Services shall oversee the process of gathering and verifying relevant information and confirming that all references and other information or materials deemed pertinent have been received.

5.A.3. Steps to Be Followed for All Initial 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 peer references (from the same discipline where

practicable) and from other available sources, including individuals from the applicant's training program or from other health care entities where he or she has practiced.

- (b) An interview(s) with the applicant may be conducted. The purpose of the interview is to discuss and review any aspect of the applicant's application, qualifications, and requested clinical privileges or scope of practice. This interview may be conducted by a combination of any of the following: the department chair, the Credentials Committee, a Credentials Committee representative, the Medical Executive Committee, the President of the Medical Staff, and/or the Chief Executive Officer.

5.A.4. Department Chair-Procedure:

- (a) Physician and Practitioner Services shall provide the complete application and all supporting materials to the chair of each department in which the applicant seeks clinical privileges or scope of practice. The department chair shall prepare a written report regarding whether the applicant has satisfied all of the qualifications for permission to practice and the clinical privileges or scope of practice requested on a form provided by Physician and Practitioner Services.
- (b) The department chair shall be available to the Credentials Committee, the Medical Executive Committee, and the Board to answer any questions that may be raised with respect to the report and findings of that individual.
- (c) The Allied Health Professional will practice in accordance with state and federal guidelines within their scope of practice and clinical privileges. In addition, the Allied Health Professional will practice within the scope of privileges of that of at least one of the listed collaborating/supervising physicians.

5.A.5. Credentials Committee Procedure:

- (a) The Credentials Committee shall review the report from the relevant department chair and shall make a recommendation.
- (b) The Credentials Committee may use the expertise of any individual on the Medical Staff or in the Hospital, or an outside consultant, if additional information is required regarding the applicant's qualifications.
- (c) After determining that an applicant is otherwise qualified for permission to practice and the clinical privileges or scope of practice requested, the Credentials Committee shall review the applicant's Health Status Confirmation Form to determine if there is any question about the applicant's ability to perform the privileges or scope of practice requested and the responsibilities of permission to practice. If so, the Credentials Committee may require the applicant to undergo a physical, mental, and/or behavioral examination by a physician(s) satisfactory to the Credentials Committee. 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 an incomplete application and all processing of the application shall cease. The cost of the health assessment will be borne by the applicant.

- (d) Initial appointment for all Allied Health Professionals shall be for a period of up to 12 months. The Credentials Committee may recommend the imposition of specific conditions. 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 education requirements). The Credentials Committee may also recommend that permission to practice be granted for a period of less than 12 months, in order to permit closer monitoring of an individual's compliance with any conditions.

5.A.6. Medical Executive Committee Procedure:

- (a) At its next regular meeting after receipt of the written findings and recommendation of the Credentials Committee, the Medical Executive Committee shall:
 - (1) adopt the findings and recommendations of the Credentials Committee as its own; or
 - (2) refer the matter back to the Credentials Committee for further consideration and responses to specific questions raised by the Medical Executive Committee prior to its final recommendation; or
 - (3) state its reasons in its report and recommendation, along with supporting information, for its disagreement with the Credentials Committee's recommendation.
- (b) If the recommendation of the Medical Executive Committee is favorable, the recommendation shall be forwarded to the Board.
- (c) If the recommendation of the Medical Executive Committee is unfavorable and would entitle the applicant to the procedural rights set forth in this Policy, the Medical Executive Committee shall forward its recommendation to the Chief Executive Officer, who shall promptly send special notice to the applicant. The Chief Executive Officer shall then hold the application until after the applicant has completed or waived the procedural rights outlined in this Policy.

5.A.7. Board Action:

- (a) The Board may delegate to a committee, consisting of at least two Board members, action on applications if there has been a favorable recommendation from the Credentials Committee and the Medical Executive Committee and there is no evidence of any of the following:
 - (1) a current or previously successful challenge to any license, certification, or registration;
 - (2) an involuntary termination, limitation, reduction, denial, or loss of permission to practice, clinical privileges, or scope of practice 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 and grant the clinical privileges or scope of practice requested shall be effective immediately and shall be forwarded to the Board for ratification at its next meeting.

- (b) When there has been no delegation to the Board Committee, upon receipt of a recommendation that the applicant be granted permission to practice and clinical privileges or scope of practice requested, the Board may:
 - (1) grant the applicant permission to practice and clinical privileges or scope of practice as recommended; or
 - (2) refer the matter back to the Credentials Committee or Medical Executive Committee 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 President of the Medical Staff. If the Board's determination remains unfavorable to the applicant, the Chief Executive Officer shall promptly send special notice to the applicant that the applicant is entitled to request the procedural rights as outlined in this Policy.
- (d) Any final decision by the Board to grant, deny, revise, or revoke permission to practice and/or clinical privileges or scope of practice will be disseminated to appropriate individuals and, as required, reported to appropriate entities.

5.A.8. Time Periods for Processing:

Once an application is deemed complete, it is expected to be processed within 90 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. CLINICAL PRIVILEGES

5.B.1. General:

The clinical privileges recommended to the Board for Allied Health Professionals shall be based upon consideration of the following factors:

- (a) education, relevant training, experience, and demonstrated current competence, including medical/clinical knowledge, technical and clinical skills, clinical judgment, interpersonal and communication skills, and professionalism with patients, families and other members of the health care team and peer evaluations relating to these criteria;
- (b) appropriateness of utilization patterns;
- (c) ability to perform the privileges requested competently and safely;
- (d) information resulting from ongoing and focused professional practice evaluation and other performance improvement activities, as applicable;
- (e) adequate professional liability insurance coverage for the clinical privileges requested;
- (f) the Hospital's available resources and personnel;
- (g) any previously successful or currently pending challenges to any licensure, certification, or registration, or the voluntary or involuntary relinquishment of such licensure, certification, or registration;
- (h) any information concerning professional review actions or voluntary or involuntary termination, limitation, reduction, or loss of appointment or clinical privileges at another hospital;
- (i) practitioner-specific data as compared to aggregate data, when available;
- (j) morbidity and mortality data related to the specific individual, and when statistically and qualitatively significant and meaningful, when available; and
- (k) professional liability actions, especially any such actions that reflect an unusual pattern or excessive number of actions.

5.B.2. FPPE to Confirm Competence:

Initially-granted clinical privileges, whether at the time of initial appointment, reappointment, or during the term of appointment, may be subject to focused professional practice evaluation (“FPPE”) in order to confirm competence. The FPPE process for these situations is outlined in the professional practice evaluation policy.

5.C. TEMPORARY CLINICAL PRIVILEGES

5.C.1. Request for Temporary Clinical Privileges:

(a) Applicants:

Temporary privileges for an applicant requesting initial permission to practice may be granted by the Chief Executive Officer or his or her designee, upon recommendation of the President of the Medical Staff, under the following conditions:

- (1) the Allied Health Professional has submitted a complete application, along with the application fee;
- (2) the verification process is complete, including, where applicable, verification of current licensure, certification, or registration, relevant training or experience, current competence, ability to exercise the privileges requested, and current professional liability coverage; compliance with privileges criteria; and consideration of information from the National Practitioner Data Bank, from a criminal background check, and from OIG queries;
- (3) the individual demonstrates that (i) there are no current or previously successful challenges to his or her licensure, certification, or registration and (ii) he or she has not been subject to involuntary termination of membership, or involuntary limitation, reduction, denial, or loss of clinical privileges at another health care facility;
- (4) the application is pending review by the Medical Executive Committee and the Board, following a favorable recommendation by the Credentials Committee, after considering the evaluation of the department chair; and
- (5) temporary privileges will be granted for a maximum period of 120 consecutive days.

(b) Locum Tenens:

The Chief Executive Officer or his/her designee, upon recommendation of the President of the Medical Staff, may grant temporary privileges to an Allied Health Professional serving as a locum tenens for an individual who is on vacation, attending an educational seminar, or ill, and/or otherwise needs coverage assistance for a period of time, under the following conditions:

- (1) the Allied Health Professional has submitted an appropriate application, along with the application fee;
- (2) the verification process is complete, including, where applicable, verification of current licensure, certification, or registration, relevant training or experience, current competence, ability to exercise the privileges requested, and current professional liability coverage; compliance with privileges criteria; and consideration of information from the National Practitioner Data Bank, from a criminal background check, and from OIG queries;
- (3) the individual demonstrates that (i) there are no current or previously successful challenges to his or her licensure, certification, or registration and (ii) he or she has not been subject to involuntary termination of membership, or involuntary limitation, reduction, denial, or loss of clinical privileges at another health care facility;
- (4) the applicant has received a favorable recommendation from the Credentials Committee Chair, after considering the evaluation of the department chair;
- (5) the applicant will be subject to any focused professional practice requirements established by the Hospital; and
- (6) temporary privileges will be granted for a maximum period of 120 consecutive days.

5.C.2. Termination of Temporary Clinical Privileges:

- (a) The Chief Executive Officer may, at any time after consulting with the President of the Medical Staff, the Chair of the Credentials Committee, the department chair, or the Vice President of Medical Affairs, terminate temporary privileges.
- (b) The granting of temporary privileges is a courtesy. Neither the denial nor termination of temporary privileges will entitle the individual to the procedural rights set forth in Article 8.

5.D. PROCESSING APPLICATIONS FOR RENEWAL TO PRACTICE

5.D.1. Submission of Application:

- (a) The grant of permission to practice will be for a period not to exceed two years. A request to renew clinical privileges or scope of practice will be considered only upon submission of a completed renewal application.
- (b) at minimum no less than 60 days prior to the date of expiration of an Allied Health Professional's clinical privileges or scope of practice, Physician and Practitioner Services will notify the individual of the date of expiration and provide the individual with a renewal application.
- (c) Failure to submit a complete application at least 30 days prior to the expiration of the individual's current term will result in automatic expiration of clinical privileges or scope of practice at the end of the then current term, unless the application can still be processed in the normal course, without extraordinary effort on the part of Physician and Practitioner Services and the Medical Staff Leaders.
- (d) Once an application for renewal of clinical privileges or scope of practice has been completed and submitted, it will be evaluated following the same procedures outlined in this Policy regarding initial applications.

5.D.2. Renewal Process for Allied Health Professionals:

- (a) The procedures pertaining to an initial request for clinical privileges, including eligibility criteria and factors for evaluation, will be applicable in processing requests for renewal for these practitioners.
- (b) As part of the process for renewal of clinical privileges, the following factors will be considered:
 - (1) an assessment prepared by the applicable department chair;
 - (2) reappointment criteria for all requested clinical privileges, as stated on the appropriate privilege form, have been met;
 - (3) results of the Hospital's performance improvement and ongoing and focused professional practice evaluation activities, taking into consideration, when applicable, practitioner-specific information compared to aggregate information concerning other individuals in the same or similar specialty (provided that, other practitioners will not be identified);
 - (4) resolution of any verified complaints received from patients or staff; and

(5) any focused professional practice evaluations.

ARTICLE 6

CONDITIONS OF PRACTICE APPLICABLE TO

ALLIED HEALTH PROFESSIONALS

6.A. STANDARDS OF PRACTICE FOR THE UTILIZATION OF ALLIED HEALTH PROFESSIONALS IN THE INPATIENT HOSPITAL SETTING

- (1) Allied Health Professionals are permitted to function within their scope of practice in the inpatient Hospital setting. As a condition of being granted permission to practice at the Hospital, all Allied Health Professionals specifically agree to abide by the standards of practice set forth in this Section. In addition, as a condition of being permitted to utilize the services of Allied Health Professionals in the Hospital, all Medical Staff members who serve as Supervising/Collaborating Physicians to such individuals also specifically agree to abide by the standards set forth in this Section.
- (2) The following standards of practice apply to the functioning of Allied Health Professionals in the inpatient hospital setting:
 - (a) Admitting Privileges.

Allied Health Professionals are not granted inpatient admitting privileges within their scope of practice as per the Clinical Practice Rules and Regulations.
 - (b) Emergency On-Call Coverage.

Per their written agreement, Allied Health Professionals may participate with on call coverage schedules. The Supervising/Collaborating or substitute physicians may delegate on-call coverage within the scope of practice of the Allied Health Professional. The Supervising/Collaborating or substitute physician must personally see the patient when requested by the Emergency Department provider.
 - (c) Daily Inpatient Rounds. Allied Health Professionals may perform daily inpatient rounds within their scope of practice in accordance with state regulations.
 - (d) Physician Assistants will have counter signatures required as per the Medical Staff Bylaws in accordance with state regulations.

6.B QUESTIONS REGARDING THE AUTHORITY OF ALLIED HEALTH PROFESSIONALS

- (1) Should any Medical Staff member or Hospital employee who is licensed or certified by the state have any question regarding the clinical competence or authority of an Allied Health Professional, either to act or to issue instructions outside the physical presence of the Supervising/Collaborating Physician in a particular instance, the Medical Staff member or Hospital employee shall have the right to require that the Allied Health Professional's Supervising/Collaborating Physician validate, either at the time or later, the instructions of the Allied Health Professional. Any act or instruction of the Allied Health Professional shall be delayed until such time as the staff member or Hospital employee can be certain that the act is clearly within the scope of the Allied Health Professional's activities as permitted by the Board.
- (2) Any question regarding the clinical practice or professional conduct of a Allied Health Professionals will be immediately reported to the Supervising/Collaborating physician and department chair. If the professional conduct violation is egregious enough, the Vice President and department chair will consult the Medical Staff President.

ARTICLE 7

PROCEDURES FOR QUESTIONS INVOLVING

ALLIED HEALTH PROFESSIONALS

7.A. COLLEGIAL INTERVENTION

- (1) This Policy encourages the use of progressive steps by Medical Staff Leaders and Hospital management, beginning with collegial and educational efforts, to address questions relating to an individual's clinical practice and/or professional conduct. The goal of these efforts is to arrive at voluntary, responsive actions by the individual to resolve questions that have been raised.
- (2) Collegial intervention efforts are a part of the Hospital's ongoing and focused professional practice evaluation activities.
- (3) Collegial intervention efforts may include, but are not limited to, counseling, sharing of comparative data, monitoring, and additional training or education. All such efforts shall be documented in an individual's confidential file.
- (4) The relevant Medical Staff Leader(s), in conjunction with the Chief Executive Officer or Vice President of Medical Affairs, shall determine whether to direct that a matter be handled in accordance with another policy (e.g., code of conduct policy; practitioner health policy; professional practice evaluation policy) or to direct the matter to the Medical Executive Committee for further review.

7.B. INVESTIGATIONS

7.B.1. Initiation of Investigation:

Whenever a question involving clinical competence or professional conduct of an Allied Health Professional is referred to, or raised by, the Medical Executive Committee, the Medical Executive Committee shall review the matter and determine whether to conduct an investigation, to direct the matter to be handled pursuant to another policy (e.g., code of conduct policy; practitioner health policy; professional practice evaluation policy), or to proceed in another manner. The Medical Executive Committee may determine to refer matters involving disruptive behavior or sexual harassment to the Board for further action. Prior to making its determination, the Medical Executive Committee may discuss the matter with the individual (and his or her Supervising/Collaborating Physician, where applicable). An investigation shall begin only after a formal determination by the Medical Executive Committee to do so.

7.B.2. Investigative Procedure:

- (a) Once a determination has been made to begin an investigation, the Medical Executive Committee will either investigate the matter itself, request that the Credentials Committee conduct the investigation, or appoint an ad hoc committee to conduct the investigation (“investigating committee”). The investigating committee will not include relatives or financial partners of the Allied Health Professional or, where applicable, the Allied Health Professional’s Supervising/Collaborating Physician.
- (b) The investigating committee shall have the authority to review relevant documents and interview individuals. It shall also have available to it the full resources of the Medical Staff and the Hospital, and the authority to use outside consultants, if needed.
- (c) 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.
- (d) The individual shall have an opportunity to meet with the investigating committee before it makes its report. Prior to this meeting, the individual will be informed of the general questions being investigated. At the meeting, the individual will be invited to discuss, explain, or refute the questions that gave rise to the investigation. No recording (audio or video) or transcript of the meeting shall be permitted or made. A summary of the interview will be prepared by the investigating committee and included with its report. This meeting is not a hearing, and none of the procedural rules for hearings will apply. The individual being investigated will not have the right to be represented by legal counsel at this meeting.
- (e) The investigating committee will make a reasonable effort to complete the investigation and issue its report within 30 days of the commencement of the investigation, provided that an outside review is not necessary. When an outside review is necessary, the investigating committee will make a reasonable effort to complete the investigation and issue its report within 30 days of receiving the results of the outside 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.
- (f) At the conclusion of the investigation, the investigating committee will prepare a report with its findings, conclusions, and recommendations.

7.B.3. Recommendation:

- (a) The Medical Executive Committee may accept, modify, or reject any recommendation it receives from an investigating committee. Specifically, the Medical Executive Committee may:
 - (1) determine that no action is justified;
 - (2) issue a letter of guidance, counsel, warning, or reprimand;
 - (3) impose conditions for continued permission to practice;
 - (4) impose a requirement for monitoring, proctoring, or consultation;
 - (5) impose a requirement for additional training or education;
 - (6) recommend reduction of clinical privileges or scope of practice;
 - (7) recommend suspension of clinical privileges or scope of practice for a term;
 - (8) recommend revocation of clinical privileges or scope of practice; or
 - (9) make any other recommendation that it deems necessary or appropriate.
- (b) A recommendation by the Medical Executive Committee that would entitle the individual to request a hearing will be forwarded to the Chief Executive Officer, who shall promptly inform the individual by special notice. The Chief Executive Officer shall hold the recommendation until after the individual has completed or waived his or her procedural rights.
- (c) If the Medical Executive Committee makes a recommendation that does not entitle the individual to request a hearing, it will take effect immediately and will remain in effect unless modified by the Board.

7.C. ADMINISTRATIVE SUSPENSION

- (1) The Medical Executive Committee, the President of the Medical Staff, the President-Elect, the department chair, or the Chief Executive Officer will each have the authority to impose an administrative suspension of all or any portion of the clinical privileges of any Allied Health Professional whenever a question has been raised about such individual's clinical care or professional conduct.
- (2) An administrative suspension will become effective immediately upon imposition, will immediately be reported to the Chief Executive Officer and the President of the Medical Staff, and will remain in effect unless or until modified by the Chief Executive Officer or

the Medical Executive Committee. The imposition of an administrative suspension does not entitle an Allied Health Professional to the procedural rights set forth in Article 8 of this Policy.

- (3) Upon receipt of notice of the imposition of an administrative suspension, the Chief Executive Officer and President of the Medical Staff will forward the matter to the Medical Executive Committee, which will review and consider the question(s) raised and thereafter make a recommendation to the Board.

7.D. AUTOMATIC RELINQUISHMENT OF CLINICAL PRIVILEGES OR SCOPE OF PRACTICE

- (1) An Allied Health Professional's clinical privileges or scope of practice shall be automatically relinquished, without entitlement to the procedural rights outlined in this Policy, in the following circumstances:
 - (a) the Allied Health Professional no longer satisfies any of the threshold eligibility criteria set forth in Section 4.A.1 or any additional threshold credentialing qualifications set forth in the specific Hospital policy relating to his or her discipline;
 - (b) the Allied Health Professional is arrested, charged, indicted, convicted, or enters a plea of guilty or no contest to any felony; or to 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; or (vi) violence against another (DUIs will be addressed in the manner outlined in Section 4.B.1(f) of this Policy);
 - (c) the Allied Health Professional fails to provide information pertaining to his or her qualifications for clinical privileges or scope of practice in response to a written request from the Credentials Committee, the Medical Executive Committee, the Chief Executive Officer, or any other committee authorized to request such information;
 - (d) the Allied Health Professional fails to attend a special meeting at the request of a Medical Staff Leader to discuss a concern with clinical practice or professional conduct;
 - (e) the Allied Health Professional fails to complete and/or comply with training and educational requirements that are adopted by the Medical Executive Committee and/or the Hospital;

- (f) a determination is made that there is no longer a need for the services of a particular discipline or category of Allied Health Professional;
 - (g) the Allied Health Professionals fails, for any reason, to maintain an appropriate relationship with a Supervising/Collaborating Physician as defined in this Policy;
or
 - (h) the Allied Health Professional employed by the Hospital has his or her employment terminated.
- (2) Requests for reinstatement:
- (a) Requests for reinstatement following the expiration of a license/certification/registration, controlled substance authorization, and/or insurance coverage will be processed by Physician and Practitioner Services. If any questions or concerns are noted, Physician and Practitioner Services will refer the matter for further review in accordance with (b) below.
 - (b) All other requests for reinstatement will be reviewed by the relevant department chair, the Chair of the Credentials Committee, the President of the Medical Staff, the Vice President of Medical Affairs, and the Chief Executive Officer. If both of these individuals make a favorable recommendation on reinstatement, the Allied Health Professional may immediately resume clinical practice at the Hospital. This determination will then be forwarded to the Credentials Committee, the Medical Executive Committee, and the Board for ratification. If, however, either of these individuals reviewing the request has any questions or concerns, those questions will be noted and the reinstatement request will be forwarded to the full Credentials Committee, Medical Executive Committee, and Board for review and recommendation.

7.E. LEAVE OF ABSENCE

- (1) An Allied Health Professional may request a leave of absence by submitting a written request to Physician and Practitioner Services. Except in extraordinary circumstances, this request will be submitted at least 30 days prior to the anticipated start of the leave in order to permit adjustment of the call roster and assure adequate coverage of clinical and/or administrative activities. The request must state the beginning and ending dates of the leave, which shall not exceed one year, and the reasons for the leave.

- (2) Except for maternity leaves, Allied Health Professionals must report to Physician and Practitioner Services anytime they are away from 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. Under such circumstances, the Vice President Medical Affairs, in consultation with the President of the Medical Staff, may trigger an automatic medical leave of absence.
- (3) Individuals requesting reinstatement will submit a written summary of their professional activities during the leave, and any other information that may be requested by the Hospital. Requests for reinstatement will then be reviewed by the relevant department chair, the Chair of the Credentials Committee, the President of the Medical Staff, the Vice President of Medical Affairs, and the Chief Executive Officer. If all these individuals make a favorable recommendation on reinstatement, the Allied Health Professional may immediately resume practice at the Hospital. This determination will then be forwarded to the Credentials Committee, the Medical Executive Committee, and the Board for ratification. If, however, any of these individuals reviewing the request has any questions or concerns, those questions will be noted and the reinstatement request will be forwarded to the full Credentials Committee, Medical Executive Committee, and Board for review and recommendation. In the event the Medical Executive Committee determines to take action that would entitle the individual to the procedural rights set forth in Article 8, the individual will be given special notice.
- (4) If the leave of absence was for health reasons (except for maternity leaves), 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.
- (5) Absence for longer than one year shall result in automatic relinquishment of Medical Staff appointment and clinical privileges unless an extension is granted by the Chief Executive Officer and Vice President of Medical Affairs. Extensions shall be considered only in extraordinary cases where the extension of a leave is in the best interest of the Hospital. 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.
 - (1) Failure to request reinstatement from a leave of absence in a timely manner shall be deemed a voluntary resignation of Medical Staff appointment and clinical privileges.
 - (2) 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.

ARTICLE 8

PROCEDURAL RIGHTS FOR ALLIED HEALTH PROFESSIONALS

Allied Health Professionals shall not be entitled to the hearing and appeals procedures set forth in the Medical Staff Credentials Policy. Any and all procedural rights to which these individuals are entitled are set forth in this Article.

8.A. PROCEDURAL RIGHTS FOR ALLIED HEALTH PROFESSIONALS

8.A.1. Notice of Recommendation and Hearing Rights:

- (a) In the event a recommendation is made by the Medical Executive Committee that an Allied Health Professional not be granted clinical privileges or that the privileges previously granted be restricted for a period of more than 30 days, terminated, or not renewed, the individual will receive special notice of the recommendation. The special notice will include a general statement of the reasons for the recommendation and will advise the individual that he or she may request a hearing.
- (b) The rights and procedures in this Section will also apply if the Board, without a prior adverse recommendation from the Medical Executive Committee, makes a recommendation not to grant clinical privileges or that the privileges previously granted be restricted, terminated, or not renewed. In this instance, all references in this Article to the Medical Executive Committee will be interpreted as a reference to the Board.
- (c) If the Allied Health Professional wants to request a hearing, the request must be in writing, directed to the Chief Executive Officer, within 30 days after receipt of written notice of the adverse recommendation.
- (d) The hearing will be convened as soon as is practical, but no sooner than 30 days after the notice of the hearing, unless an earlier hearing date has been specifically agreed to by the parties.

8.A.2. Hearing Committee:

- (a) If a request for a hearing is made timely, the Chief Executive Officer, or his or her designee, in consultation with the President of the Medical Staff, will appoint a Hearing Committee composed of up to three individuals (including, but not limited to, members of the Medical Staff, Allied Health Professionals, Hospital administration, individuals not connected with the Hospital, or any combination of these individuals) and a Presiding Officer, who may be legal counsel to the Hospital. The Hearing Committee will not include anyone who previously participated in the recommendation, any relatives or

practice partners of the Allied Health Professional, or any competitors of the affected individual.

- (b) As an alternative to the Hearing Committee described in paragraph (a) of this Section, the Chief Executive Officer, in consultation with the President of the Medical Staff, may instead appoint a Hearing Officer to perform the functions that would otherwise be carried out by the Hearing Committee. The Hearing Officer will preferably be an attorney at law. The Hearing Officer may not be in direct economic competition with the individual requesting the hearing and will not act as a prosecuting officer or as an advocate to either side at the hearing. If the Hearing Officer is an attorney, he or she shall not represent clients who are in direct economic competition with the affected individual. In the event a Hearing Officer is appointed instead of a Hearing Committee, all references in this Article to the Hearing Committee or Presiding Officer will be deemed to refer instead to the Hearing Officer, unless the context would clearly otherwise require.
- (c) The hearing shall be convened as soon as is practical, but no sooner than 30 days after the notice of the hearing, unless an earlier hearing date has been specifically agreed to by the parties.

8.A.3. Hearing Process:

- (a) A record of the hearing will be maintained by a stenographic reporter or by a recording of the proceedings. Copies of the transcript will be available at the individual's expense.
- (b) The hearing will last no more than six hours, with each side being afforded approximately three hours to present its case, in terms of both direct and cross-examination of witnesses.
- (c) At the hearing, a representative of the Medical Executive Committee will first present the reasons for the recommendation. The Allied Health Professional will be invited to present information to refute the reasons for the recommendation.
- (d) Both parties will have the right to present witnesses. The Presiding Officer will permit reasonable questioning of such witnesses.
- (e) The Allied Health Professional and the Medical Executive Committee may be represented at the hearing by legal counsel. However, while counsel may be present at the hearing, counsel will not call, examine, or cross-examine witnesses or present the case.
- (f) The Allied Health Professional will have the burden of demonstrating, by clear and convincing evidence, that the recommendation of the Medical Executive Committee was arbitrary, capricious, or not supported by substantial evidence. The quality of care

provided to patients and the smooth operation of the Hospital will be the paramount considerations.

- (g) The Allied Health Professional and the Medical Executive Committee will have the right to prepare a post-hearing memorandum for consideration by the Hearing Committee. The Presiding Officer will establish a reasonable schedule for the submission of such memoranda.

8.A.4. Hearing Committee Report:

- (a) Within 20 days after the conclusion of the proceeding or submission of the post-hearing memoranda, whichever date is later, the Hearing Committee will prepare a written report and recommendation. The Hearing Committee will forward the report and recommendation, along with all supporting information, to the Chief Executive Officer. The Chief Executive Officer will send a copy of the written report and recommendation by special notice to the Allied Health Professional and to the Medical Executive Committee.
- (b) Within ten days after notice of such recommendation, the Allied Health Professional and/or the Medical Executive Committee may make a written request for an appeal. The request must include a statement of the reasons, including specific facts, which justify an appeal.
- (c) The grounds for appeal will be limited to an assertion that there was substantial failure to comply with this Policy during the hearing, so as to deny a fair hearing, and/or that the recommendation of the Hearing Committee was arbitrary, capricious, or not supported by substantial evidence.
- (d) The request for an appeal will be delivered to the Chief Executive Officer by special notice.
- (e) If a written request for appeal is not submitted timely, the appeal is deemed to be waived and the recommendation and supporting information will be forwarded to the Board for final action. If a timely request for appeal is submitted, the Chief Executive Officer will forward the report and recommendation, the supporting information and the request for appeal to the Board. The Chair of the Board will arrange for an appeal.

8.A.5. Appellate Review:

- (a) An Appellate Review Committee appointed by the Chair of the Board will consider the record upon which the adverse recommendation was made. New or additional written information that is relevant and could not have been made available to the Hearing Committee may be considered at the discretion of the Appellate Review Committee. This review will be conducted within 30 days after receiving the request for appeal.

- (b) The Allied Health Professional and the Medical Executive Committee will each have the right to present a written statement on appeal.
- (c) At the sole discretion of the Appellate Review Committee, the Allied Health Professional and a representative of the Medical Executive Committee may also appear personally to discuss their position.
- (d) Upon completion of the review, the Appellate Review Committee will provide a report and recommendation to the full Board for action. The Board will then make its final decision based upon the Board's ultimate legal responsibility to grant privileges and to authorize the performance of clinical activities at the Hospital.
- (e) The Allied Health Professional will receive special notice of the Board's action. A copy of the Board's final action will also be sent to the Medical Executive Committee for information.

ARTICLE 9

HOSPITAL EMPLOYEES

- A. Except as provided below, the employment of an Allied Health Professional by the Hospital shall be governed by the Hospital's employment policies and manuals and the terms of the individual's employment relationship and/or written contract. To the extent that the Hospital's employment policies or manuals, or the terms of any applicable employment contract, conflict with this Policy, the employment policies, manuals and descriptions and terms of the individual's employment relationship and/or written contract shall apply.
- B. Except as noted in A, Hospital-employed Allied Health Professionals are bound by all of the same conditions and requirements in this Policy that apply to non-Hospital employed Allied Health Professionals.
- C. A request for clinical privileges, on an initial basis or for renewal, submitted by an Allied Health Professional who is seeking employment or who is employed by the Hospital shall be processed in accordance with the terms of this Policy. A report regarding each practitioner's qualifications shall then be made to Hospital management or Human Resources (as appropriate) to assist the Hospital in making employment decisions.
- D. A request for a scope of practice on an initial basis or for renewal from an Allied Health Professional who is seeking employment or is employed by the Hospital shall be evaluated by the Hospital through the Human Resources policies and procedures, using the same qualifications set forth in Section 4.A.1 of this Policy.
- E. If a concern about an employed Allied Health Professional's clinical competence or professional conduct originates with the Medical Staff, the concern will be reviewed and addressed in accordance with Articles 7 and 8 of this Policy, after which a report will be provided to Hospital management or Human Resources (as appropriate).

ARTICLE 10

AMENDMENTS

This Policy may be amended in accordance with Article 9 of the Medical Staff Bylaws.

ARTICLE 11

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.

Approved by the Medical Executive Committee April 26, 2016

Approved by the Board May 16, 2016

APPENDIX A

CERTIFIED REGISTERED NURSE PRACTITIONERS

The CRNP has completed a CRNP program which is approved by the Pennsylvania State Boards of Medicine and Nursing (Boards) or, if completed in another state, is equivalent to programs approved by the Boards.

APPENDIX B

PHYSICIAN ASSISTANTS - CERTIFIED

The applicant must have a Master's or baccalaureate degree. The applicant must have successfully completed a Physician Assistant - Certified program accredited by the ARC-PA or its predecessors and the national certifying examination given by the National Commission on Certification of Physician Assistants.

APPENDIX C

CERTIFIED NURSE MIDWIVES

Midwifery practice is the independent management of women's health care, focusing on pregnancy, childbirth, the postpartum period, care of the newborn and the family planning and gynecological needs of women. The certified nurse-midwife practices within a health care system that provides for consultation, collaborative management or referral as indicated by the health status of the client. Certified nurse-midwives practice in accord with the current Standards of Practice for Nurse-Midwifery, as defined by the American College of Nurse-Midwives.

Nurse-midwifery care is primarily intended for healthy women. However, when women experience medical, gynecological and/or obstetrical complications, the certified nurse-midwife can continue to be instrumental in their care.

The Board will grant a nurse-midwife license to an applicant who meets the following requirements. The applicant shall:

- (1) Be licensed as a registered nurse in this Commonwealth.
- (2) Satisfy the licensure requirements in § 16.12 (relating to general qualifications for licenses and certificates).
- (3) Have successfully completed a midwife program.
- (4) Have obtained one of the following:
 - (i) A passing grade on a midwife examination. The Board accepts the passing grade on the certifying examination of the ACNM or AMCB as determined by the ACNM or AMCB or successor organization as recognized by the Board.
 - (ii) Certification as a midwife by the American College of Nurse-Midwives (ACNM) before the ACNM certification examination was first administered in 1971. To be eligible for renewal of a nurse-midwife license, the nurse-midwife shall maintain National certification available to the profession and recognized by the Board.

APPENDIX D

CERTIFIED REGISTERED NURSE ANESTHETISTS

Graduation from an approved program of anesthesia accredited by the Council on Accreditation of Nurse Anesthesia Educational programs or a predecessor or successor agency; and Current certification or active participation in the examination process leading to certification by the Council on Certification of Nurse Anesthetists or recertification by the Council on Recertification of Nurse Anesthetists; and Current state licensure as a registered professional nurse in the Commonwealth of Pennsylvania, and in compliance with any applicable state statutory or regulatory requirements concerning certified registered nurse anesthetists. The certified nurse anesthetist is authorized to administer anesthesia in cooperation with a surgeon or dentist. The nurse anesthetist's performance shall be under the overall direction/supervision of a physician, dentist or podiatrist.

APPENDIX E

ADDITIONAL PRACTITIONERS

Additional Practitioners including but not limited to Genetic Counselors, Licensed Clinical Social Worker, Psychologist, Professional Counselor, Radiologist Extenders (Radiology-Technologist (RT), Radiology Practitioner Assistants (RPA), Registered Radiologist Assistants (RRA), Master's Degree Social worker and Registered Dietician– working within the state regulated scope of practice.

RPAs and RRAs will act only under the supervision of radiologists on the Medical Staff, who delegate specific duties to the RPAs or RRAs. Under no circumstances will RPAs or RRAs be permitted to act as independent practitioners. When an RPA or RRA is performing a delegated medical service, the radiologist who delegated the service shall be present in the facility. Additionally, each radiologist who intends to delegate the performance of medical services to an RPA or RRA shall submit a letter stating that the radiologist will delegate these services in compliance with the requirements of the delegation of duties regulation promulgated by the State Board of Medicine at 49 Pa. Code § 18.402.

APPENDIX F

CHAIR ROLE

The chair of the Advanced Practice Provider Leadership Council must be an Allied Health Professional; affiliated with UPMC Pinnacle Hospitals. Duties of the chair included meeting attendance, agenda preparation and all other duties as assigned by the committee.

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