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

CREDENTIALS POLICY

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ARTICLE 1

GENERAL

1.A. DEFINITIONS

Unless otherwise indicated, the definitions that apply to terms used in this Policy are set forth in the Medical Staff Glossary.

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 Pennsylvania that is not subject to any restrictions, conditions, or probationary terms;

(2) not currently be under investigation by any state licensing agency and have never had a license to practice denied, revoked, restricted, or suspended by 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 be 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 under any criminal investigation or indictment and have not been convicted of, or entered a plea of guilty or no contest to, any felony; or to any misdemeanor relating to (i) controlled substances, (ii) illegal drugs, (iii) driving under the influence ("DUI"), (iv) Medicare, Medicaid, or insurance or health care fraud or abuse, (v) child abuse, (vi) elder abuse, (vii) violence against another, or (viii) 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);
- Employed providers will have their clearances completed in conjunction with the Human Resources employment policy;
- Independent providers will complete the clearances individually. At initial appointment, independent providers will provide results performed within the last five (5) years to the medical staff office;
- All providers will renew their clearances every five (5) years and submit results to the medical staff office (independent) or human resources (employed);
- Failure to comply will result in automatic suspension until the clearances and results are submitted;

(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 two years;

(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 (i.e., 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 must document that he or she is willing and able to:

(i) respond within 30 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) the acute nature of the patient's condition or (b) as required for a particular specialty as recommended by the MEC and approved by the Board);

(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:

(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;

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

(iii) a podiatric surgical residency program accredited by the Council on Podiatric Medical Education of the American Podiatric Medical 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/American Board of Podiatric Medicine 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 May 22, 1995 and are not applicable to Medical Staff members who were appointed prior to that date. Those Medical Staff members shall be grandfathered and 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. 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 Allied Health Professionals:

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

(2) have completed his or her professional education and is either certified by the appropriate nationally recognized certification organization or, if he or she 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; and

(3) agree to the Standards of Practice outlined in Article 8 of this Policy, as applicable.

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 he or she 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. In reviewing the request for a waiver, the Credentials Committee may consider the specific qualifications of the applicant in question, including the application form and any additional information submitted, 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 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) The Board's determination regarding whether to grant a waiver is final. No applicant is entitled to a waiver or to a hearing if the Board determines not to grant a waiver. A determination 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 Pennsylvania licensure board or the National Practitioner Data Bank.

(e) 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.

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

(g) 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 he or she:

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

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

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

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

(e) has had in the past, or currently has, Medical Staff appointment, permission to practice as an Allied Health Professional, 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 national origin, culture, race, gender, sexual orientation, gender identity, age, ethnic/national identity, religion, disability 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 in force 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 his or her 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 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;

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

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

(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;

(w) if practicing as an Advanced Practice Professional, to strictly comply with the standards of practice applicable to the functioning of Advanced Practice Professionals in the hospital setting, as set forth in Section 8.B of this Policy; and

(x) 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 government-issued photo identification.

(c) The applicant shall sign the application and certify that he or she is able to perform the privileges requested and the responsibilities of appointment.

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

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) <u>Immunity</u>:

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 any of its affiliates or subsidiaries, or any of their Boards, Board members, Medical Staffs, Medical Staff members, Allied Health Professionals, representatives, or agents, or 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 Hospital, its Medical Staff, 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 appointment to the Medical Staff and/or clinical privileges, 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 Hospital, its Medical Staff, Medical Staff Leaders, and their 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, its Medical Staff, and their authorized representatives to release information to (i) other hospitals, health care facilities, managed care organizations, and their agents when information is requested in order to evaluate his or her professional qualifications for appointment, privileges, and/or participation at the requesting organization/facility, (ii) persons or entities external to the Hospital 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 Hospital or Medical Staff policies, 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"), UPMC Emergency Medicine, Inc. ("ERMI") or other UPMC affiliated physician groups, such as those at UPMC Altoona, Chautauqua, Hamot, Pinnacle, and Susquehanna;
- 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 this Policy are the sole and exclusive remedy with respect to any professional review action taken by the Hospital.

(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, he or she shall reimburse the Hospital, any of its affiliates or subsidiaries, and any of their Board members, Medical Staff members, Allied Health Professionals, authorized representatives, agents, and employees 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 Hospital's professional review activities;

(4) as applicable, to any third-party inquiries received after the individual leaves the Medical Staff or no longer practices as an Allied Health Professional about his or her 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 the Medical Staff Glossary. 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 forms approved by the MEC 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 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) The Department Committee Chair or representative 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 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 his or her 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) or Section 8.F.2 of this Policy, as pertinent, such conditions do not entitle an individual to request the procedural rights set forth in Article 7 or Article 8 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) or 8.F.2 of this Policy, as pertinent, 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.

(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) A newly appointed member's appointment and privileges will expire if he or she 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.

(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) Requests for clinical privileges will not be processed unless the individual has satisfied all threshold eligibility criteria (or has obtained a waiver in accordance with Section 4.A.2).

(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 the Medical Staff Glossary.

(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 his or her 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 Allied Health Professional, 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.

(1) 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 his or her 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.

(2) If the individual is requesting a waiver of the requirement that each individual apply for the full core of privileges in his or her specialty, the process set forth in this paragraph shall apply.

(i) Formal Request: The individual must forward a written or electronic request to Medical Staff Services, which must indicate the specific patient care services within the core that the Practitioner does not wish to provide, state a good cause basis for the request, and include evidence that the individual does not provide the patient care services at issue in any health care facility.

(ii) Review Process: A request for a waiver shall be submitted to the Credentials Committee for consideration. In reviewing the request for a waiver, the Credentials Committee shall specifically consider the factors outlined in Paragraph (f) below and may obtain input from the relevant Department Committee. The Credentials Committee's recommendation will be forwarded to the MEC, which shall 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.

(iii) On-Call Obligations: By applying for a waiver related to limiting the scope of core privileges, the Medical Staff member nevertheless agrees to participate in the general on-call schedule for the relevant specialty and to maintain sufficient competency to assist other members of the Medical Staff in assessing and stabilizing patients who require services within that specialty, if this call responsibility is required by the Medical Staff leadership after review of the specific circumstances involved. If, upon assessment, a patient needs a service that is no longer provided by the individual pursuant to the waiver, the individual shall work cooperatively with the other Medical Staff members in arranging for another individual with appropriate clinical privileges to care for the patient or, if such an individual is not available, in arranging for the patient's transfer.

(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.

If an individual fails to complete the tasks listed above prior to the effective date of the resignation, he or she will not be considered to have resigned "in good standing" for purposes of future reference responses.

(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 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 or Oral and Maxillofacial Surgeon 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 Physician who is a member of the Medical Staff before dental or oral 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 dental or 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 Surgeon 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 Podiatrists:

(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 Physician who is a member of the Medical Staff 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 a Training Program.

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 Fellows Seeking Clinical Privileges.

A physician in training at the fellowship level may request clinical privileges in an area for which he or she has already completed residency training if he or she 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 providing services from a distant-site location may be granted telemedicine privileges regardless of whether the individual is Appointed to the Medical Staff or granted permission to practice as an Allied Health Professional.

(b) Requests for initial or renewed telemedicine privileges by distant-site Practitioners will be processed through one of the following options, as determined by the Hospital President in consultation with the President of the Medical Staff and VPMA:

(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 distant-site Practitioner must satisfy all qualifications and

requirements set forth in this Policy, except those relating to response times, coverage arrangements, and emergency call responsibilities.

(2) If the distant-site Practitioner is practicing at a distant hospital that participates in Medicare or is accredited by The Joint Commission 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 distant-site Practitioner is licensed in Pennsylvania;

(ii) a current list of clinical privileges granted to the distant-site Practitioner;

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

(iv) confirmation that the distant-site Practitioner 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 confirmation, attestations, or information required by the agreement or requested by the Hospital.

This information shall be provided to the MEC for review and recommendation to the Board for final action. Notwithstanding the process set forth in this subsection, the Hospital may determine that a distant-site Practitioner is ineligible for appointment or clinical privileges if the individual fails to satisfy the threshold eligibility criteria set forth in this Policy.

(c) Telemedicine privileges, if granted, shall be for a period of not more than two years.

(d) Distant-site Practitioners who have been 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 distant-site

Practitioner by patients, other practitioners or staff, will be shared with the hospital or entity providing telemedicine services.

(e) Telemedicine privileges granted in conjunction with a contractual agreement shall be incident to and coterminous with the agreement.

4.B. TEMPORARY CLINICAL PRIVILEGES

4.B.1. Eligibility to Request Temporary Clinical Privileges:

(a) Applicants. Temporary privileges for an applicant for initial appointment may be granted by the Hospital President under the following conditions:

(1) the applicant has submitted a complete application, along with any application fee;

(2) the verification process is complete, including verification of current licensure, 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 Office of Inspector General ("OIG") queries;

(3) the applicant demonstrates that (i) there are no current or previously successful challenges to his or her licensure or registration, and (ii) he or she has not been subject to involuntary termination of appointment or involuntary limitation, reduction, denial, or loss of clinical privileges, at another health care facility;

(4) the application is pending review by the MEC and the Board, following a favorable recommendation by the President of the Medical Staff and the Credentials Committee or its Chair, and after considering the evaluation of the Department Committee; and

(5) temporary privileges for a new applicant will be granted for a maximum period of 120 consecutive days.

(b) Locum Tenens. The Hospital President may grant temporary privileges to an individual serving as a locum tenens either for a Practitioner who is on vacation, attending an educational seminar, ill, or otherwise needs coverage assistance for a period of time, or when the Hospital requires additional coverage in a service area, under the following conditions:

(1) the applicant has submitted an appropriate application, along with any application fee;

(2) the verification process is complete, including verification of current licensure, current competence (verification of good standing in hospitals where the individual practiced for at least the previous year), 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 applicant demonstrates that (i) there are no current or previously successful challenges to his or her licensure or registration, and (ii) he or she has not been subject to involuntary termination of appointment 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 President of the Medical Staff and/or Credentials Committee Chair, after considering the evaluation of the Department Committee;

(5) the applicant will be subject to any focused professional practice requirements established by the Hospital; and

(6) the individual may exercise locum tenens privileges for a maximum of 180 days, consecutive or not, anytime during the 24-month period following the date they are granted, subject to the following conditions:

(i) the individual must notify Medical Staff Services at least 10 days prior to each time that he or she will be exercising these privileges (exceptions for shorter notice periods may be considered in situations involving health issues); and

(ii) along with this notification, the individual must inform Medical Staff Services of any change that has occurred to any of the information provided on the initial application for locum tenens privileges.

(c) Visiting. The Hospital President, upon recommendation of the President of the Medical Staff and the applicable Department Committee, may also grant temporary privileges in other limited situations when there is an important patient care, treatment, or service need, under the following circumstances:

(1) the temporary privileges are needed (i) for the care of a specific patient; (ii) when a proctoring or consulting Practitioner is needed, but is otherwise unavailable; or (iii) when necessary to prevent a lack or lapse of services in a needed specialty area;

(2) the following factors are considered and/or verified prior to the granting of temporary privileges: current licensure, relevant training or experience, current competence (verification of good standing in the individual's most recent hospital affiliation), current professional liability coverage acceptable to the Hospital, and results of a query to the National Practitioner Data Bank, and from OIG queries; and

(3) the grant of clinical privileges in these situations will not exceed 60 days.

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 privileges shall be immediately authorized to exercise visiting 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. For all other individuals, the verifications for such grants of privileges shall generally be accomplished in advance; however, in an emergency situation, where life-threatening circumstances exist, the verifications listed above may be completed immediately after the grant of privileges.

(d) Automatic Expiration. All grants of temporary privileges shall automatically expire upon the date specified at the time of initial granting unless further affirmative action is taken to renew such temporary privileges by the relevant Department Committee, the Chair of the Credentials Committee, the President of the Medical Staff, and the Hospital President.

(e) Compliance with Bylaws and Policies. Prior to any temporary privileges being granted, the individual must agree in writing to be bound by the Bylaws, Rules and Regulations, policies, procedures, and protocols of the Medical Staff and the Hospital.

(f) FPPE. Individuals who are granted temporary privileges will be subject to the Hospital policy regarding focused professional practice evaluation.

4.B.2. Supervision Requirements:

Special requirements of supervision and reporting may be imposed on any individual granted temporary clinical privileges.

4.B.3. Withdrawal of Temporary 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 his or her 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

(1) When the disaster plan has been implemented and the immediate needs of patients in the facility cannot be met, the Hospital President, the VPMA, or the President of the Medical Staff may use a modified credentialing process to grant disaster privileges to eligible volunteer licensed independent Practitioners ("volunteers"). Safeguards must be in place to verify that volunteers are competent to provide safe and adequate care.

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

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

(b) A volunteer's license may be verified in any of the following ways: (i) current Hospital picture ID card that clearly identifies the individual's professional designation; (ii) current license to practice; (iii) primary source verification of the license; (iv) identification indicating that the individual has been granted authority to render patient care in disaster circumstances or is a member of a Disaster Medical Assistance Team, the Medical Reserve Corps, the Emergency System for Advance Registration of Volunteer Health Professionals, or other recognized state or federal organizations or

groups; or (v) identification by a current Hospital employee or Medical Staff member who possesses personal knowledge regarding the individual's ability to act as a volunteer during a disaster.

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

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

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

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 covered 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 his or her 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 he or she 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 he or she 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 he or she 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 his or her 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 his or her confidential quality profile from his or her 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 the Medical Staff Glossary will also be evaluated as part of the reappointment process.

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

(a) An application for reappointment shall be made available to Practitioners at least four months prior to the expiration of their current appointment term. A completed reappointment application must be submitted to Medical Staff Services within 30 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 individual's privileges lapse due to a processing delay, subsequent Board action may be to grant reappointment and renewal of clinical privileges using the filed application, in accordance with the expedited process set forth in Section 3.A.7(a).

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

(d) The application shall 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 shall 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) or Section 8.F.2 of this Policy, such conditions do not entitle an individual to request the procedural rights set forth in Article 7 or Article 8 of this Policy, as applicable.

(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 or Article 8, as applicable.

(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 AND ALLIED HEALTH PROFESSIONALS

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, Leadership Council, and Committee for Physician Enhancement 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 his or her 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 Awareness 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 Voluntary Enhancement 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 Pennsylvania 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. REQUEST TO REFRAIN FROM PRACTICING/PRECAUTIONARY SUSPENSION OR RESTRICTION OF CLINICAL PRIVILEGES

6.C.1. Grounds for Requests to Voluntarily Refrain from Practicing/ Precautionary Suspension or Restriction:

(a) Whenever, in their sole discretion, failure to take 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 proceed as follows:

(1) request that the Practitioner agree to voluntarily refrain from exercising privileges pending further review of the circumstances by the Leadership Council in accordance with Section 6.C.2 of this Policy (agreements to voluntarily refrain may also be utilized in other professional practice evaluation contexts such as Voluntary Enhancement Plans, the details of which are addressed in the relevant professional practice evaluation policy); or

(2) if the Practitioner is unwilling to voluntarily refrain from practicing pending further review, to suspend or restrict all or any portion of the individual's clinical privileges as a precaution, which actions shall be reviewed by the MEC in accordance with Section 6.C.3 of this Policy.

(b) The above actions can be taken at any time, including, but not limited to, immediately after the occurrence of an event that causes concern, following a pattern of occurrences that raises concern, or following a recommendation of the MEC that would entitle the individual to request a hearing.

(c) Precautionary suspension or restriction, or an agreement to refrain, is an interim step in the professional review activity, but it is not a complete professional review action in and of itself. It shall not imply any final finding of responsibility for the situation that caused the suspension, restriction, or agreement.

(d) These actions shall become effective immediately, shall promptly be reported to the Hospital President, the VPMA, and the President of the Medical Staff, and shall remain in effect unless the action is modified by the Hospital President or MEC.

(e) The Practitioner shall be provided a letter via Special Notice that memorializes the individual's agreement to voluntarily refrain from practicing or the imposition of a precautionary suspension and terms related to the same. The correspondence shall also contain 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), and shall be provided to the Practitioner within three days of the action.

6.C.2. Leadership Council Review Process for an Agreement to Voluntarily Refrain from Practicing:

(a) The Leadership Council shall review the matter resulting in a Practitioner's agreement to voluntarily refrain from exercising clinical privileges within a reasonable time under the circumstances, not to exceed 14 days. As part of this review, the Practitioner shall be given an opportunity to meet with the Leadership Council. Neither the Leadership Council 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 shall be prepared.

(b) After considering the matter resulting in an individual's agreement to voluntarily refrain and the individual's response, if any, the Leadership Council shall determine the appropriate next steps, which may include, but not be limited to, commencing a focused review, referring the matter for review pursuant to another policy, referring the matter to the MEC with a recommendation to initiate a formal Investigation, or taking some other action that is deemed appropriate under the circumstances. The Leadership Council shall also determine whether the agreement to voluntarily refrain from practicing should be continued throughout any further review process.

(c) There is no right to a hearing based on an individual's agreement to voluntarily refrain from practicing in accordance with this Section.

6.C.3. MEC Review Process for Precautionary Suspensions or Restrictions:

(a) The MEC shall review any matter resulting in a precautionary suspension or restriction within a reasonable time under the circumstances, not to exceed 14 days. As part of this review, the Practitioner shall be given an opportunity to meet with the MEC. The individual may propose ways other than precautionary suspension or restriction to protect patients and/or employees, depending on the circumstances. 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 shall be prepared.

(b) After considering the matters resulting in the suspension or restriction and the individual's response, if any, the MEC shall determine the appropriate next steps, which may include, but not be limited to, commencing a focused review or a formal Investigation, referring the matter for review pursuant to another policy, or recommending some other action that is deemed appropriate under the circumstances. The MEC shall also determine whether the precautionary suspension or restriction should be continued, modified, or terminated throughout any further review process (and hearing and appeal, if applicable).

(c) There is no right to a hearing based on the imposition or continuation of a precautionary suspension or restriction.

6.C.4. Care of Patients:

(a) Immediately upon an individual's agreement to voluntarily refrain from practicing or the imposition of a precautionary suspension or restriction, the Department Chair or the President of the Medical Staff shall assign to another Practitioner with appropriate clinical privileges responsibility for care of the individual's hospitalized patients, or to otherwise 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.

(b) All Practitioners have a duty to cooperate with the President of the Medical Staff, the Department Chair, the MEC, the VPMA, and the Hospital President in enforcing precautionary suspensions or restrictions or agreements to voluntarily refrain from practicing.

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 policy (e.g., peer review/professional practice evaluation policy, professionalism policy, Practitioner health 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 9 and **Appendix A**. Any ad hoc committee may include individuals not on the Medical Staff or affiliated as Allied Health Professionals and is a Peer Review Committee as defined in the Medical Staff Glossary. 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 Allied Health Professional).

(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 his or her 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) <u>Meeting with the Investigating Committee</u>.

(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 his or her 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 he or she

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 or Section 8.F.2, as applicable, 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 Pennsylvania 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) a DUI (with a referral for assessment by the PHP), (iv) Medicare, Medicaid, or insurance or health care fraud or abuse, (v) child abuse, (vi) elder abuse, (vii) violence against another, or (viii) the practitioner-patient relationship. When an automatic relinquishment occurs under this paragraph (b), the Leadership Council should meet within 72 hours of the relinquishment taking effect to assess the situation and determine whether the individual is eligible to request reinstatement.

(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 he or she meets 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, 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 Medical Staff 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, the Leadership Council, the Committee for Physician Enhancement, 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 (e) 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 the Hospital's current policy on delinquent medical records.

(d) Requests for reinstatement following the relinquishment of clinical privileges due to failure to provide requested information and/or failure to attend a special meeting shall be reviewed by the President of the Medical Staff and VPMA. If these two physician leaders recommend favorably on reinstatement, the individual may immediately resume clinical practice. If, however, any questions or concerns are noted, the matter will be referred to the full Leadership Council in accordance with (e) below.

(e) All other requests for reinstatement following a relinquishment of clinical privileges shall be reviewed by the Leadership Council. If the Leadership Council makes a favorable recommendation on reinstatement, 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. Except for parental leaves, 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. The Practitioner will be sent Special Notice informing him or her that a leave of absence has been enacted.

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 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 (except for maternity leave), 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:

- ***delinquent medical records*** in accordance with UPMC Pinnacle Policy;
- failure to meet any ***threshold eligibility criteria*** set forth in the Medical Staff Bylaws or Credentials Policy;
- failure to ***provide a required notification*** to Medical Staff Services; or
- the individual is ***arrested, charged, or indicted*** for any felony; or for any misdemeanor involving (i) controlled substances, (ii) illegal drugs, (iii) DUI, (iv) Medicare, Medicaid, or insurance or health care fraud or abuse, (v) child abuse, (vi) elder abuse, (vii) violence against another, or (viii) 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;

(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 his or her 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 MEDICAL STAFF MEMBERS

The hearing and appeal procedures in this Article are only applicable to Medical Staff members and are **not** applicable to Allied Health Professionals. The due process rights for Allied Health Professionals are set forth in Article 8 of this Policy.

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 to the Medical Staff;

(2) denial of reappointment to the Medical Staff;

(3) revocation of appointment to the Medical Staff;

(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 his or her file:

(a) determination that an applicant for membership fails to meet the threshold eligibility qualifications or criteria for membership;

(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 Awareness 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 Voluntary Enhancement 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, provided the member has not actively participated in the matter at any previous level; and/or

(ii) physicians or laypersons not connected with the Hospital (i.e., 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 9 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 his or her 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 his or her counsel and any expert(s) have executed Business Associate agreements in connection with any patient Protected Health Information contained in any documents provided.

(b) Upon receipt of the above agreement and representation, the individual requesting the hearing 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 Pennsylvania 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 on the Medical Staff.

(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, he or she 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, he or she shall read the entire transcript of the portion of the hearing from which he or she 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 he or she satisfies, on a continuing basis, all criteria for initial appointment, reappointment and clinical privileges, 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

CONDITIONS OF PRACTICE AND DUE PROCESS RIGHTS FOR ALLIED HEALTH PROFESSIONALS

8.A. RIGHTS AND PREROGATIVES

The rights and responsibilities for Advanced Practice Professionals (**Appendix C**), Licensed Independent Practitioners (**Appendix B**), and Dependent Practitioners (**Appendix D**) are set forth in Article 2 of the Bylaws and this Article.

8.B. STANDARDS OF PRACTICE FOR THE UTILIZATION OF ADVANCED PRACTICE PROFESSIONALS IN THE HOSPITAL SETTING

(1) Advanced Practice Professionals are permitted to function in the Hospital setting in collaboration with and under the supervision and oversight of the Supervising/Collaborating Physician (or substitute physician). As a condition of being granted appointment, all Advanced Practice 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 Advanced Practice Professionals in the Hospital, all Medical Staff members who serve as Supervising/Collaborating Physicians (or substitute 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 Advanced Practice Professionals ("APPs") in the Hospital setting:

(a) Exercise of Clinical Privileges.

(i) APPs: APPs may exercise those clinical privileges that have been granted to them pursuant to their approved delineation of clinical privileges. The delineation of privileges will specify the requisite levels of supervision that apply to an APP's privileges (general, direct, or personal).

(ii) Supervising/Collaborating Physicians: Supervising/Collaborating Physicians (or substitute physicians) must be available by phone, email, or other modality to respond in a timely manner to the APP or to others caring for the patient. The Supervising/Collaborating Physicians (or substitute physicians) are only required to be physically present with an APP when the APP's privileges require "personal" supervision.

(b) Admitting Privileges.

(i) APPs: With the exception of Certified Nurse Midwives ("CNM"), APPs are not granted admitting privileges and may not admit patients independently. However, APPs may examine the patient, gather data, order tests, and generate other documentation to help facilitate a patient's admission. They may also write admission orders on behalf of their Supervising/Collaborating Physicians.

(ii) Supervising/Collaborating Physicians: Supervising/Collaborating Physicians (or substitute physicians) must review and co-sign all admission orders made by an APP on their behalf.

(c) Consultations.

(i) APPs: APPs may respond to consultation requests directed to their Supervising/Collaborating Physicians by examining the patients, gathering data, ordering tests, and generating documentation. They must then discuss the patients with their Supervising/Collaborating Physicians.

(ii) Supervising/Collaborating Physicians: Supervising/Collaborating Physicians (or substitute physicians) must in all cases review the APPs' documentation and discuss the patients with the APP. If requested, they must also be available to consult with the APP. (***Note***: Additional guidance regarding the process for requesting consultations, when there must be personal contact with the consulting physician, and the time frames for the various types of consult requests (i.e., stat or routine) are set forth in the Medical Staff Rules and Regulations.)

(d) Emergency On-Call Coverage.

(i) APPs: APPs may not be listed on the emergency on-call roster. However, APPs may examine the patient, gather data, order tests, and generate other documentation regarding the patient as follows:

- When contacted directly by Emergency Department personnel and requested to do so; or
- When requested by their Supervising/Collaborating Physician after the Supervising/Collaborating Physician has discussed the patient with Emergency Department personnel.

(ii) Emergency Department Personnel: It shall be within the sole discretion of the Emergency Department personnel caring for the patient whether it is appropriate to contact an APP prior to contacting the Supervising/Collaborating Physician. If it is not deemed appropriate, the Emergency Department personnel will directly discuss the patient with the Supervising/Collaborating Physician and reach agreement regarding the patient's care, including the role of the APP in that care.

(iii) Supervising/Collaborating Physicians: Supervising/Collaborating physicians (or substitute physicians) must respond to all calls specifically directed to them in a timely manner, in accordance with the requirements set forth in this Policy. They must also assess (either in person or via telemedicine) any patient when requested to do so by an Emergency Department physician.

(e) Calls Regarding Supervising/Collaborating Physician's Hospitalized Inpatients.

(i) APPs: APPs may generally respond to calls from Hospital personnel seeking assistance from Supervising/Collaborating Physicians regarding their hospitalized inpatients.

(ii) Supervising/Collaborating Physicians: Supervising/Collaborating Physicians (or substitute physicians) may be asked to personally respond to a call from the floor or special care units if the Hospital personnel seeking assistance has discussed the patient with the Supervising/Collaborating Physician (or substitute physician) and reached an agreement regarding the patient's care.

(f) Daily Inpatient Rounds for Attending Physicians.

(i) Advanced Practice Professionals: Advanced Practice Professionals are permitted to perform daily inpatient rounds and discuss patients with the patients' Attending Physician (i.e., their Supervising/Collaborating Physician).

(ii) Supervising/Collaborating Physicians: Supervising/Collaborating Physicians (or substitute physicians) who are designated as an Attending Physician may also be asked to visit the patient in accordance with the guidelines outlined in the Medical Staff Rules and Regulations.

Additional exemptions or exceptions to these Standards may be granted by the MEC for specific clinical situations and services, upon demonstration of good cause shown.

8.C. OVERSIGHT BY SUPERVISING/COLLABORATING PHYSICIAN

(1) Any activities permitted to be performed at the Hospital by an Advanced Practice Professional or Dependent Practitioner shall be performed only in collaboration with or under the supervision or direction of a Supervising/Collaborating Physician.

(2) Advanced Practice Professionals and Dependent Practitioners may function in the Hospital only so long as (i) they are supervised by a Supervising/Collaborating Physician who is currently appointed to the Medical Staff, and (ii) they have a current, written supervision or collaboration agreement with the Supervising/ Collaborating Physician. In addition, should the Medical Staff appointment or clinical privileges of the Supervising/Collaborating Physician be revoked or terminated, the clinical privileges of the Advanced Practice Professional or the scope of practice of the Dependent Practitioner shall be automatically relinquished (unless the individual will be supervised by another Supervising/Collaborating Physician appointed to the Medical Staff).

(3) Except as set forth below, the Supervising/Collaborating Physician shall be notified of a concern related to clinical competence, performance, and/or professional conduct that involves any Advanced Practice Professional or Dependent Practitioner with whom the physician has a supervisory or collaborative relationship. Notification to the Supervising/Collaborating Physician as described in this Section is not required, or may be delayed, if the Medical Staff Leaders conducting the review determine that notification would be inconsistent with a fair and effective review. Without limiting the foregoing, the Supervising/ Collaborating Physician will be copied on all correspondence that an Advanced Practice Professional or Dependent Practitioner receives from the Medical Staff Leaders and/or may be invited to participate in any meetings or interventions. The Supervising/Collaborating Physician shall maintain all such information in a confidential manner.

8.D. QUESTIONS REGARDING AUTHORITY OF AN ADVANCED PRACTICE PROFESSIONAL OR DEPENDENT PRACTITIONER

(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 Advanced Practice Professional or Dependent Practitioner, 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 Advanced Practice Professional's or Dependent Practitioner's Supervising/Collaborating Physician validate, either at the time or later, the instructions of the Advanced Practice Professional or Dependent Practitioner. Any act or instruction of the Advanced Practice Professional or Dependent Practitioner 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 Advanced Practice Professional's or Dependent Practitioner's activities as permitted by the Board.

(2) Any question regarding the clinical practice or professional conduct of an Advanced Practice Professional or Dependent Practitioner shall be immediately reported to the President of the Medical Staff, the relevant Department Chair, or the VPMA who shall address the matter in accordance with the relevant Medical Staff policy. The individual to whom the concern has been reported may also discuss the matter with the Supervising/Collaborating Physician.

8.E. RESPONSIBILITIES OF SUPERVISING/COLLABORATING PHYSICIAN

(1) Physicians who wish to utilize the services of an Advanced Practice Professional or Dependent Practitioner who is not an employee of the Hospital specifically agree to the following:

(a) notify Medical Staff Services of this fact in advance and must ensure that the individual has been appropriately credentialed in accordance with this Policy or with applicable Human Resources policies and procedures before the Advanced Practice Professional or Dependent Practitioner participates in any clinical or direct patient care of any kind in the Hospital;

(b) provide, or to arrange for, professional liability insurance coverage for the Advanced Practice Professional or Dependent Practitioner in amounts required by the Board. The insurance must cover any and all activities of the Advanced Practice Professional or Dependent Practitioner in the Hospital. Evidence of such coverage will be provided as a part of the Advanced Practice Professional or Dependent Practitioner credentialing; and

(c) provide the Hospital with notice of any revisions or modifications that are made to any supervision or collaboration agreement that may be required by the state. This notice must be provided to Medical Staff Services within three days of any such change.

(2) All Physicians who utilize the services of an Advanced Practice Professional or Dependent Practitioner in the Hospital must abide by the standards of practice in Section 8.B above.

(3) The number of Advanced Practice Professionals or Dependent Practitioners acting under the supervision of one Supervising/Collaborating Physician, as well as the care they may provide, will be consistent with any applicable state statutes and regulations and any other policies adopted by the Hospital. The Supervising/Collaborating Physician will make all appropriate filings with the relevant state board regarding the supervision and responsibilities of the Advanced

Practice Professional or Dependent Practitioner, to the extent that such filings are required, and shall provide a copy of the same to Medical Staff Services.

8.F. PROCEDURAL RIGHTS FOR ADVANCED PRACTICE PROFESSIONALS AND LICENSED INDEPENDENT PRACTITIONERS

8.F.1. General:

Advanced Practice Professionals and Licensed Independent Practitioners shall not be entitled to the hearing and appeals procedures set forth in Article 7 of this Policy. Rather, any and all procedural rights to which these Practitioners are entitled are set forth in this Article.

8.F.2. Grounds for Hearing and Notice of Rights:

(a) Advanced Practice Professionals and Licensed Independent Practitioners are entitled to request a hearing whenever the MEC makes one of the following recommendations:

(1) denial of requested clinical privileges;

(2) revocation of clinical privileges;

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

(4) a Restriction of clinical privileges for more than 30 days.

(b) If the Board makes any of the above determinations without an adverse recommendation by the MEC, an Advanced Practice Professional or Licensed Independent Practitioner would also be entitled to request a hearing. In this instance, all references in this Article to the MEC will be interpreted as a reference to the Board.

(c) 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.

(d) If the Advanced Practice Professional or Licensed Independent Practitioners wants to request a hearing, the request must be in writing, directed to the Hospital President, within 30 days after receipt of written notice of the adverse recommendation.

(e) 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.

(f) The individual shall have the right to receive copies of the documentation relied upon by the MEC; however, prior to receiving any confidential documents, the individual requesting the hearing must sign a confidentiality agreement under which the individual agrees that all documents and information shall be maintained as confidential and within the protected peer review process and shall not be disclosed or used for any purpose outside of the hearing. The individual must also provide a written representation that his or her counsel has executed Business Associate agreements in connection with any patient information contained in any documents provided.

8.F.3. Hearing Committee:

(a) If a request for a hearing is made in a timely manner, the Hospital President, in conjunction with the President of the Medical Staff, shall appoint a Hearing Committee composed of up to three individuals (including, but not limited to, individuals appointed to the Medical Staff, Advanced Practice Professionals, Licensed Independent Practitioners, individuals not connected to the Hospital, or any combination of these individuals) and a Presiding Officer, who may be legal counsel to the Hospital. The Hearing Committee shall not include anyone who previously participated in the recommendation, any relatives or practice partners of the Practitioner requesting the hearing, or any competitors of the affected individual.

(b) The Hospital President, in consultation with the President of the Medical Staff, will appoint a Presiding Officer ("Presiding Officer"), who will be an attorney and may be legal counsel to the Hospital. The role of the Presiding Officer will be to 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. The Presiding Officer will maintain decorum throughout the hearing.

(c) As an alternative to the Hearing Committee described in paragraph (a) of this Section, the Hospital President, in conjunction 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 shall preferably be an attorney at law. The Hearing Officer may not be in direct economic competition with the individual requesting the hearing and shall 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 shall be deemed to refer instead to the Hearing Officer, unless the context would clearly otherwise require.

(d) 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.F.4. 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 MEC will first present the reasons for the recommendation. The Practitioner requesting the hearing 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 Practitioner requesting the hearing and the MEC may be accompanied 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 Practitioner requesting the hearing will have the burden of demonstrating, by clear and convincing evidence, that the recommendation of the MEC 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 Practitioner requesting the hearing and the MEC 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.F.5. 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 Hospital President. The Hospital President will send a copy of the written report

and recommendation by Special Notice to the Practitioner who requested the hearing and to the MEC.

(b) Within ten days after notice of such recommendation, the Practitioner who requested the hearing and/or the MEC 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 Hospital President 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 Hospital President 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.F.6. 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. The Board may serve as the Appellate Review Committee or the Chair of the Board may appoint an Appellate Review Committee composed of not less than three persons, either members of the Board or others, including but not limited to reputable persons outside the Hospital.

(b) 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.

(c) The Practitioner and the MEC will each have the right to present a written statement on appeal.

(d) At the sole discretion of the Appellate Review Committee, the Practitioner and a representative of the MEC may also appear personally to discuss their position.

(e) 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.

(f) The Practitioner will receive Special Notice of the Board's action. A copy of the Board's final action will also be sent to the MEC for information.

8.G. PROCEDURAL RIGHTS FOR DEPENDENT PRACTITIONERS

(1) In the event that a recommendation is made by the MEC that a Dependent Practitioner not be granted the scope of practice requested or that a scope of practice previously granted be restricted or terminated, the individual shall be notified of the recommendation. The notice shall include a specific statement of the reasons for the recommendation and shall advise the individual that he or she may request a meeting with the MEC before its recommendation is forwarded to the Board for final action.

(2) If the Dependent Practitioner desires to request a meeting, he or she must make such request in writing and direct it to the Hospital President within 30 days after receipt of the written notice of the adverse recommendation.

(3) If a meeting is requested in a timely manner, it shall be scheduled to take place within a reasonable time frame. The meeting shall be informal and shall not be considered a hearing. The Dependent Practitioner and his or her Supervising/Collaborating Physician shall both be permitted to attend and participate in the meeting. However, no counsel for either the Dependent Practitioner or the MEC shall be present.

(4) Following this meeting, the MEC shall make its final recommendation to the Board.

8.H. DETERMINATION OF NEED

(1) Whenever a Licensed Independent Practitioner, Advanced Practice Professional, or Dependent Practitioner in a category that has not been approved by the Board requests permission to practice at the Hospital, the Board shall refer the matter to the Credentials Committee or appoint an ad hoc committee to evaluate the need for that particular category of practitioner and to make a recommendation to the MEC for its review and recommendation and then to the Board for final action.

(2) As part of the process of determining need, the individual 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 Credentials Committee or ad hoc committee may consider the following factors when making a recommendation to the MEC and the Board as to the need for the

services of this category of Licensed Independent Practitioners, Advanced Practice Professionals, or Dependent Practitioners:

(a) the nature of the services that would be offered;

(b) any state license or regulation which outlines the scope of practice that the type of practitioner is authorized by law to perform;

(c) any state "non-discrimination" or "any willing provider" laws that would apply to the type of practitioner;

(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 relevant type of practitioner 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.

8.I. DEVELOPMENT OF POLICY

(1) If the Credentials Committee or ad hoc committee determines that there is a need for the relevant category of practitioner at the Hospital, the committee shall recommend to the MEC and the Board a separate policy for the pertinent type of practitioner that addresses:

(a) any specific qualifications and/or training that they must possess beyond those set forth in this Policy;

(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 beyond those set forth in this Policy; and

(d) any supervision requirements, if applicable.

(2) In developing such policies, the Credentials Committee or ad hoc committee shall consult the appropriate department chair(s) and consider relevant state law and may contact applicable professional societies or associations. The committee may also recommend to the Board the number of Licensed Independent Practitioners, Advanced Practice Professionals, or Dependent Practitioners that are needed in a particular category.

ARTICLE 9

CONFLICT OF INTEREST GUIDELINES FOR PEER REVIEW ACTIVITIES

9.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.

9.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.

9.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, Committee for Physician Enhancement 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 his or her own application or the professional practice evaluation of the care he or she 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 Voluntary Enhancement 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, Committee for Physician Enhancement, Investigating Committee, and/or MEC).

(2) Credentials Committee, Leadership Council, and Committee for Physician Enhancement Members

As a general rule, an Interested Member may fully participate as a member of the Credentials Committee, Leadership Council, and Committee for Physician Enhancement 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 10

CONFIDENTIALITY AND PEER REVIEW PROTECTIONS

10.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).

10.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.* and the Hospital's peer review policies and procedures. Peer review committees are defined in the Medical Staff Glossary. 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 Pennsylvania Peer Review Protection Act, 63 P.S. §425.1 *et seq*.

(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 11

HOSPITAL EMPLOYEES

(a) Except as provided below, the employment of an individual by the Hospital 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, Hospital-employed members are bound by all of the same conditions and requirements in this Policy that apply to non-Hospital employed members.

(c) A request for appointment, reappointment, clinical privileges, or scope of practice, submitted by an applicant or member who is employed by the Hospital 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 Hospital Administrative personnel, as appropriate under applicable Medical Staff and Hospital 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 will be provided to appropriate Hospital administrative personnel (as appropriate). However, nothing herein will require the individual's employer to follow this Policy.

ARTICLE 12

AMENDMENTS

This Policy may be amended by the process outlined in Article 9 of the Medical Staff Bylaws.

ARTICLE 13

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.

Medical Staff/MEC: __May 20, 2022_____________

Board of Directors: __May 27, 2022_____________

APPENDIX A

CONFLICT OF INTEREST GUIDELINES

Potential Conflicts	Levels of Participation								
	Provide Information	Department Committee	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 VEP 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 Committee for Physician Enhancement have no disciplinary authority.

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

N – ("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 9.A.3 of this Credentials Policy.

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

Those individuals currently practicing as Licensed Independent Practitioners at the Hospital are as follows:

Moonlighting Resident or Fellow

Neurophysiologist

Psychologist

APPENDIX C

Those individuals currently practicing as Advanced Practice Professionals at the Hospital are as follows:

Certified Nurse Midwife ("CNM")

Certified Physician Assistant ("PA-C")

Certified Registered Nurse Anesthetist ("CRNA")

Certified Registered Nurse Practitioner ("CRNP")

Certified Surgical Tech First Assist

Radiology Practitioner Assistant ("RPA")

RN First Assistants ("RNFA")

APPENDIX D

Those individuals currently practicing as Dependent Practitioners at the Hospital are as follows:

Licensed Professional Counselor

Private Surgical Scrub Technicians

APPENDIX E

MEDICAL STAFF POLICY REGARDING PEER REVIEW, ONGOING PROFESSIONAL PRACTICE EVALUATION (OPPE) & FOCUSED PROFESSIONAL PRACTICE EVALUATION (FPPE)

SCOPE

Applies to all credentialed members of the Medical Staff and Allied Health Practitioners.

EXCEPTION:
No volume providers with medical staff membership only and without clinical privileges per Joint Commission clarification are exempt from the Ongoing Professional Performance Evaluation and Focused Professional Practice Evaluation requirements contained within this document.

I. PURPOSE:

To assure that the hospital, through the activities of its medical staff, assesses the ongoing professional practice and competence of its medical staff, conducts professional practice evaluations, and uses the results of such assessments and evaluations to improve professional competence, practice, and the quality of patient care;

To define those circumstances in which an external review or focused review may be necessary

To address identified issues in an effective and consistent manner.

"Professional Practice Evaluation" is considered an element of the peer review process and the records and proceedings relating to this policy are confidential and privileged to the fullest extent permitted by applicable law.

The personal presence of an assigned practitioner who does not have a treatment relationship with the patient, who is designated to provide clinical teaching or to monitor the clinical performance of another practitioner to facilitate quality of care to patients, as required for purposes of credentialing, reappointment, quality improvement, FPPE, or corrective action.

FOCUSED PROFESSIONAL PRACTICE EVALUATION (FPPE)

A. Initiation of FPPE

FPPE will be initiated in the following instances:

- Upon initial appointment;
- When a new privilege is requested by an existing practitioner;
- When a question arises through the OPPE process, individual case review, or other peer review process regarding a currently privileged practitioner's

ability to provide safe, high-quality patient care. For example, when a trigger is exceeded and preliminary review indicates a need for further evaluation.

A recommendation of FPPE may be made by:

- The Credentials Committee;
- A Department of the Medical Staff;
- The Chief of the Department;
- A special committee of the medical staff;
- The MEC
- Vice President of Medical Affairs

The FPPE monitoring plan for a new practitioner, or newly requested privilege(s) will be specific to the requested privileges or group of privileges.

FPPE is not considered an investigation as defined in the Medical Staff Bylaws and is not subject to the bylaws provisions related to investigations. If FPPE results in an action plan to perform an investigation, the process identified in the Medical Staff Bylaws would be followed.

B. Timeframe for Collection and Reporting

The period of FPPE must be time-limited. Time-limited may be defined by:

- A specific period of time; or
- A specific volume (number of procedures/admissions/encounters)

FPPE shall begin with the applicant's first admission(s), encounter(s), or performance of the newly requested privilege. FPPE should optimally be completed within three months, or a suitable period based upon volume. The period of FPPE may be extended as necessary at the discretion of the medical staff but may not extend beyond the first biennial reappointment.

C. Methods for Conducting FPPE/Communication to the Practitioner

FPPE may be accomplished by:

1. Chart reviews, both concurrent and/or retrospective
2. Simulation
3. Discussion with the involved practitioner and/or other individuals involved in the care of the practitioner's patients
4. Direct observation/proctoring
5. For dependent AHPs, FPPE methods may include review or proctoring by the sponsoring physician
6. Internal or external peer review

The terms of all FPPE shall be communicated in writing to the affected practitioner or AHP, including the following:

- The cause for the focused monitoring
- The anticipated duration
- The specific mechanism by which monitoring will occur (i.e., chart reviews, proctoring, peer observation, etc.)

D. Performance Monitoring Criteria and Triggers

Monitoring criteria, including specific performance elements to be monitored, as well as thresholds or triggers, are developed and approved by the medical staff or medical staff departments/committees. The triggers are defined as potentially unacceptable levels of performance. Triggers to consider include, but are not limited to:

- A single egregious case or evidence of a practice trend
- Exceeding the predetermined thresholds established for OPPE
- Patient/staff complaints
- Non-compliance with Medical Staff Bylaws, Rules and Regulations
- Elevated infection, mortality and/or complication rates
- Failure to follow approved clinical practice guidelines
- Behavior that undermines a culture of safety

If the results for a practitioner or AHP exceed thresholds established by the Medical Staff, outliers may be forwarded for peer review after initial screening by the Quality Management Department.

E. Conclusion of FPPE

At the conclusion of the initial FPPE, findings will be reviewed by the Medical Executive Committee or responsible Department, for decision and recommendation. Decisions may include moving forward with OPPE, extending the period of FPPE, development of a performance improvement plan, or recommending to limit or suspend the privilege. Such recommendations are reported to and approved by the Medical Executive Committee and Board of Directors. For recommendations resulting in restriction, suspension, revocation of specific privileges or other limitation on privileges, the processes pursuant to the Medical Staff Hearing Plan and Appeals procedure will apply.

Each practitioner or AHP will be notified of their performance and outcome(s) following FPPE. A letter is forwarded to the Medical Staff member or AHP including, but not limited to, the following:

- An overall summary of the findings and outcome of FPPE

- Specific actions, if any, that need to be taken by the practitioner or AHP to address any quality concerns and the method for follow-up to ensure that the concerns have been addressed
- If the focused review is complete or will continue (duration will be specific if the focused review will continue)
- The period of initial FPPE is completed and the practitioner or AHP will move into OPPE
- The period of FPPE for a specific privilege is completed and the practitioner or AHP will continue with OPPE

At the end of the period of focused evaluation, in the event that the practitioner or AHP's activity/volume has not been sufficient to meet the requirements of FPPE:

- The practitioner or AHP may voluntarily resign the relevant privilege(s), or
- The practitioner or AHP may submit a written request for an extension of the period of focused evaluation, or
- If the practitioner or AHP has sufficient volume of the privileges in question at another local facility, external peer references specific to the privilege/procedure may be obtained.
- FPPE may be extended at the discretion of the responsible medical staff department or committee.

The practitioner or AHP is not entitled to a hearing or other procedural rights for any privilege that is voluntarily relinquished.

Results of FPPE are maintained in the Practitioner or AHP's confidential medical staff quality file.

F. Performance Improvement Plan

If FPPE outcomes identify the need for an improvement plan, the plan will be drafted by the responsible medical staff department, committee or chair. The written improvement plan and supporting FPPE outcomes should be presented to the Medical Executive Committee for approval. The involved Practitioner or AHP should also be offered the opportunity to address the MEC and respond to the findings before the improvement plan is finalized and implemented.

Methods identified to resolve performance issues shall be clearly defined. Examples of improvement methods may include:

- Necessary education
- Proctoring and/or mentoring
- Counseling
- Practitioner Assistance Program
- Suspension or revocation of privilege, subject to the provisions of the Bylaws.

Following approval by the Medical Executive Committee (MEC), the Department or Committee Chair, or VPMA will meet with the Practitioner or AHP to communicate the improvement plan. If the Practitioner or AHP does not agree with the plan and/or refuses to implement the improvement plan, the outcome will be reported to the responsible department chief and/or Medical Executive Committee for resolution.

ONGOING PROFESSIONAL PRACTICE EVALUATION (OPPE)

A. Timeframe for Collection and Reporting

OPPE will be initiated and reported on all providers with clinical privileges. Results of OPPE will be reported for review and/or action every three to six months if possible, and in no event less frequently than every nine months.

B. Indicators for Review

1. The type of data to be collected and related thresholds or triggers is determined by individual medical staff committees/departments and approved by the Medical Staff. Indicators may change as deemed appropriate by the department and/or medical staff and should be reviewed and approved on an annual basis. Data collected should not be limited to negative/outlier trending data. Good performance data should also be considered.

   a. Each Medical Staff department will select three to five *specialty-specific* indicators based upon their clinical service. These indicators may be evidence-based, such as post-op infection rate, etc.
   b. The Medical Staff will select *general* indicators that apply to all credentialed practitioners and AHPs.
   c. The Medical Staff may consider the six areas of "General Competencies" developed by the Accreditation Council for Graduate Medical Education (ACGME). These include:

      i. Patient care
      ii. Medical/clinical knowledge
      iii. Practice-based learning and improvement
      iv. Interpersonal and communication skills
      v. Professionalism
      vi. Systems-based practice

2. Thresholds/triggers for performance must be defined for the selected indicators. Triggers are defined as unacceptable levels of performance within the established defined criteria and are used to identify those performance outcomes that could trigger FPPE. Triggers to consider include, but are not limited to:

   Defined number of events occurring
   Defined number of individual peer reviews with adverse determinations

- Elevated infection, mortality, and/or complication rates
- Sentinel events
- Small number of admissions/procedures over an extended period of time
- Increasing lengths of stay in comparison to peers
- Increasing number of returns to surgery
- Frequent unanticipated readmission for the same issue
- Patterns of unnecessary diagnostic testing/treatments
- Failure to follow approved clinical practice guidelines

C. Oversight and Reporting

The organized Medical Staff delegates the collection of the selected performance indicators to the appropriate hospital department. The overall process, data compilation and reporting is coordinated by the Quality Department.

The review of performance data and any recommendation(s) for action, if necessary, may be the responsibility of one of the following:

- The Medical Executive Committee;
- The specific Medical Staff Department;
- The Chief of the Department;
- A standing or special committee of the medical staff.

D. Results and Reporting of Data Analysis

Data are analyzed and reported to determine whether to continue, limit, or revoke any existing privilege(s). The results of the individualized practitioner or AHP report are referenced in the MEC meeting minutes, maintained in the medical staff quality file and incorporated into the two-year reappointment process.

The outcome of the evaluation must be documented and maintained in the practitioner or AHP quality file.

During the course of OPPE, FPPE may be triggered by the following special circumstances:

- A single egregious case or evidence of a practice trend
- Exceeding the predetermined thresholds established for OPPE
- Patient/staff complaints
- Non-compliance with Medical Staff Bylaws, Rules and Regulations
- Elevated infection, mortality and/or complication rates
- Failure to follow approved clinical practice guidelines
- Behavior that undermines a culture of safety

At the completion of the review period, an overall summary of the results of OPPE will be communicated to the individual practitioner or AHP. The original report will be maintained in the practitioner or AHP medical staff quality file.

RESPONSIBILITIES OF THE QUALITY DEPARTMENT:

1. The Quality Department will be responsible for compiling and reporting results of FPPE and OPPE to the Medical Executive Committee.

2. In order to facilitate FPPE for Allied Health Professionals, and/or those practitioners requesting a new privilege, the practitioner or AHP must notify the Quality Department of the first scheduled procedure or encounter. The practitioner or AHP must also provide the Quality Department with a patient listing or log until the specified patient volume or FPPE requirement is met.

3. The OPPE practitioner or AHP-specific profile that illustrates performance over the two-year reappointment cycle will be utilized at the time of reappointment.

4 The Quality Department will be responsible for working with each Medical Staff Committee on an annual basis to review the continued relevance of the selected indicators and triggers.

INDIVIDUAL CASE REVIEW PROCESS

Cases identified with potential quality of care issues are referred to the appropriate Medical Staff Department or Committee for review. The Quality Department is responsible for coordinating the Peer Review Process.

Cases may be identified through OPPE, FPPE, case management, risk management, audits, sentinel events/serious safety events, clinician referrals, allegations of suspected substance abuse or disruptive behavior and other sources. All cases should be initially screened by the Quality Management department utilizing medical staff approved screening criteria, prior to forwarding for physician review. If there are no potential quality of care issues identified following the quality management screening, the case is closed, the findings are documented and trending is performed in the Quality Department.

If potential quality of care issues are identified through Quality Management screening, the following process for peer review shall be implemented:

A. Reviewer Selection & Duties

Reviews are completed by the designated Medical Staff Practitioner, Department or Committee (based upon the particular medical staff structure).

The designated reviewer may not review a case where he/she participated in the care.

B. Reviewer Disqualification & Replacement

If a reviewer does not feel he/she can adequately review a medical record due to a conflict of interest or believes he/she is not qualified to address a certain issue, the reviewer may discuss the issue with the Chairperson of the Committee, Department Chief or VPMA. If the Chair concurs, the Chair shall reassign the record(s) to another reviewer. If a member has reviewed a record that needs to be presented but is unable to attend the meeting, the member shall report to the Chair so that the presentation may be reassigned to another Committee member or presented by the Chairperson. If the chairperson is the practitioner subject to review, the record review will be assigned to another Active Staff member by the VPMA or to an external reviewer if circumstances are as described in Section D, below.

C. Communication to Involved Practitioner

Any Practitioner or AHP who is the subject of a review receiving an assigned peer review score of 3 or greater, shall be notified in writing at least two weeks prior to the medical staff meeting where the outcome of review is reported. Communication shall include the case medical record number, admission/discharge date, reason and outcome of the review. Comments and/or opinions made by the reviewer may be included, however, the identity of the reviewer should be redacted.

The involved Practitioner or AHP is provided the opportunity to respond to the results of the review in writing in advance of the meeting where the outcome is reported. At the request of the Department Chief or VPMA, the Practitioner or AHP may be invited to attend the meeting and discuss the case.

D. Circumstances Requiring External Peer Review

The MEC, VPMA, Department Chair or the Board of Directors may request external peer review by a practitioner who is Board certified within the same specialty in circumstances, including, but not limited to, the following:

- The pool of eligible reviewers is unable to serve
- There is no qualified practitioner on staff to conduct the review
- Litigation risk
- The facility has only a single practitioner in a particular specialty and no other practitioner has similar background, training or experience
- Other reasons as deemed by the MEC and Board.

No practitioner or AHP may require the Hospital to obtain external peer review if it is not deemed necessary by the VPMA, MEC, Department Chair or the Board of Directors.

E. Review Form Summary

Reviewing practitioners must complete the Peer Review Form, Attachment One, clearly and concisely. The reviewing practitioner must sign his/her name on the review form which shall grade the care and outcome based on the following schedule:

1 = Treatment appropriate, outcome good, and any patient impact was minimal
2 = Treatment appropriate but patient sustained significant adverse outcome
3= Treatment inappropriate but adverse impact on patient was minor or minimal, temporary or permanent harm
4 = Treatment inappropriate and patient sustained moderate to severe, temporary or permanent harm.

DOCUMENTATION OF PEER REVIEW ACTIVITIES:

Reports of OPPE and FPPE and individual case review findings and recommendations shall be presented to the MEC. The MEC may adopt the recommendations of the Medical Staff Department/Committee and/or make further recommendations, including recommendation for further investigation and/or Corrective Action in accord with the Medical Staff Bylaws.

All recommendations of the MEC other than for further investigation or Corrective Action shall be delivered to the Board. The Board shall make a final determination concerning any actions warranted based on the findings and recommendations of the MEC.

Results of OPPE, FPPE and Peer Review outcomes shall be documented and maintained in the practitioner's quality file and referenced at reappointment.