WASHINGTON HEALTH

MEDICAL STAFF

CREDENTIALING POLICY

Approved by the Board on June 11, 2025
Approved by the Medical Executive Committee on May 19, 2025

CREDENTIALING POLICY

TABLE OF CONTENTS

ARTICLE 1

GENERAL

1.A.TIME LIMITS

Time limits referred to in this Policy and related policies and manuals are advisory only and are not mandatory, unless it is expressly stated.

1.B. DELEGATION OF FUNCTIONS

(1) When a function is to be carried out by the Chief Executive Officer, by a Medical Staff member, or by a Medical Staff committee, the individual (or the committee through its chair) may delegate performance of the function to one or more designees.

(2) When a Medical Staff member is unavailable or unable to perform a necessary function, one or more of the Medical Staff Leaders may perform the function personally or delegate it to another appropriate individual.

1.C. CONFIDENTIALITY AND PEER REVIEW PROTECTION

1.C.1.Confidentiality:

All professional review activity and recommendations will be strictly confidential. No disclosures of any such information (discussions or documentation) may be made outside of the meetings of the committees charged with such functions, except:

(a) to another authorized individual and for the purpose of conducting professional review activity;

(b) as authorized by a policy; or

(c) as authorized by the Chief Executive Officer, by the Chief of Staff, or by legal counsel to the Hospital.

Individuals who breach confidentiality are at risk of strict sanctions, including legal repercussions. Breaches of confidentiality shall not constitute a waiver of any privilege. Any member of the Medical Staff or Advanced Practice Professional who becomes aware of a breach of confidentiality should inform the Chief Executive Officer, the Chief of Medical Services, the Chief of Staff, or the Chief of Staff-Elect or any Medical Staff officer.

1.C.2.Peer Review Protection:

All professional review activity will be performed by the peer review committees. Peer review committees include (but are not limited to):

(a) all standing and *ad hoc* Medical Staff committees;

(b) all departments and sections;

(c) hearing and appellate review panels;

(d) the Board and its various committees; and

(e) any other individual or body acting on behalf of a peer review committee, including experts or consultants retained to assist in professional review activity.

All oral and written communications, reports, recommendations, actions, and minutes made or taken by peer review committees are confidential and covered by the provisions of all applicable laws, including Cal. Civ. Code § 43.7; in addition, these peer review committees are deemed to be "professional review bodies" as that term is defined in the Health Care Quality Improvement Act of 1986 ("HCQIA"), 42 U.S.C. § 11101 et seq.

1.D. INDEMNIFICATION

Indemnification shall occur as set forth in Article 7 of the Medical Staff Bylaws.

1.E.DEFINITIONS

The following definitions apply to terms used in this Policy:

(1) "805 REPORT" refers to the written report filed with state licensing agencies in accordance with § 805 of the California Business and Professions Code.

(2) "ADVANCED PRACTICE PROFESSIONALS" are members of the Advanced Practice Professionals who have been granted clinical privileges by the Board. Refer to Appendix A for a list of these professionals.

(3) "ADVERSELY AFFECTING" privileges has the meaning defined in the HCQIA, that is, reducing, restricting, suspending, revoking, denying, or failing to renew clinical privileges or appointment.

(4) "ALLIED HEALTH PROFESSIONALS" are individuals authorized by law and by the Hospital to care for patients, but who are not in a licensing category eligible for Medical Staff membership. Advanced Practice Professionals are sometimes referred to collectively as the Advanced Practice Professionals. Further details on

the composition of the Allied Health Staff are set forth at Section 2.G of the Medical Staff Bylaws and in Appendix A of this policy.

(5) "ALLIED HEALTH STAFF" is a collective term used to refer to the Hospital's Allied Health Professionals. The Allied Health Staff is not part of the Medical Staff. Further details are set forth in Section 2.G of the Medical Staff Bylaws.

(6) "APPLICANT" means any individual who has submitted an application for initial appointment or reappointment to the Medical Staff or Advanced Practice Professionals. The term also encompasses individuals who apply solely for clinical privileges.

(7) "ATTENDING PHYSICIAN" means the physician who has overall responsibility for the coordination of a patient's care.

(8) "BOARD" means the Board of Directors, the duly constituted governing body holding overall administrative and professional responsibility for the Hospital.

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

(10) "CHIEF OF MEDICAL SERVICES" means the individual employed by the Hospital to act as a liaison between the Medical Staff and administration, to assist with the oversight of the credentialing and privileging processes, and to promote meaningful, timely, and effective peer review functions. In addition, the Chief of Medical Services supervises and directs the activities of the Medical Staff Services, providing administrative, informational, and clinical support to the Medical Staff.

(11) "CHIEF OF STAFF" means the individual elected by the Medical Staff and appointed by the Board to act in coordination and cooperation with the Chief of Medical Services, the Chief Executive Officer, and the Board in matters of mutual concern involving the care of patients in Washington Hospital.

(12) "CLINICAL PRIVILEGES" or "PRIVILEGES" means the authorization granted by the Board to render specific clinical procedures and patient care services, subject to the provisions of this Policy.

(13) "DAYS" means calendar days.

(14) "DENTIST" means a doctor of dental surgery or doctor of dental medicine.

(15) "HOSPITAL" means Washington Hospital Healthcare System.

(16) "HOSPITAL ADMINISTRATION" means the Chief Executive Officer or his or her designee, including the administrator on call.

(17) "MEDICAL EXECUTIVE COMMITTEE" means the Medical Executive Committee of the Medical Staff as set forth in the Medical Staff Bylaws.

(18) "MEDICAL STAFF" refers to the organized Medical Staff of the Hospital as set forth in the Medical Staff Bylaws. It includes physicians, dentists, and podiatrists.

(19) "MEDICAL STAFF LEADER" means any Medical Staff officer, department chair, section chair, or committee chair.

(20) "MEMBER" is a generic term that can refer to either members of the Medical Staff or members of the Advanced Practice Professionals.

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

(22) "PATIENT CONTACTS" includes any admission, consultation, procedure, response to emergency call, evaluation, treatment, or service performed in any facility operated by the Hospital or affiliate, including outpatient facilities (e.g., WOSC).[1]

(23) "PEER REVIEW COMMITTEES" include professional review bodies as defined in the HCQIA, that is, a health care entity (and the governing body or any committee of a health care entity) which conducts professional review activity. Examples of Peer Review Committees are given at Section 1.C.2, above.

(24) "PERFORMANCE IMPROVEMENT" ("PI") activities are structured processes intended to educate members of the Medical Staff and Advanced Practice Professionals about their performance, and to empower them to evaluate and improve their own performance.

(25) "PHYSICIAN" refers to doctors of medicine and to doctors of osteopathy.

(26) "PODIATRIST" means a doctor of podiatric medicine.

(27) "PROFESSIONAL REVIEW ACTION" has the meaning defined in the HCQIA.

(28) "PROFESSIONAL REVIEW ACTIVITY" has the meaning defined in the HCQIA.

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

[1] During our last meeting, we decided to revisit the definition of patient contacts in the future (specifically with regard to qualifications for Active Staff).

(30) “SUPERVISING PHYSICIAN” means a Medical Staff member with appropriate clinical privileges (including those related to supervision, as applicable) who has agreed in writing to supervise, and to accept full responsibility for, an Advanced Practice Professional while he or she is practicing in the Hospital.

(31) “SUPERVISION” means the supervision of an Advanced Practice Professional by a Supervising Physician. Supervision may or may not require the actual presence of the Supervising Physician, but it does require, at a minimum, that the Supervising Physician be readily available for consultation. The requisite level of supervision (general, direct, or personal) will be determined at the time each Advanced Practice Professional is credentialed and will be consistent with any applicable standardized procedures, delegation of services agreement, or written supervision agreement. Supervision must also be consistent with all privileging requirements established by the Medical Staff.

(32) “TELEMEDICINE” is the provision of clinical services to patients by practitioners from a distance via electronic communications.

ARTICLE 2

QUALIFICATIONS, CONDITIONS, AND RESPONSIBILITIES

2.A.QUALIFICATIONS

2.A.1.Threshold Eligibility Criteria:

To be eligible to apply for initial appointment, reappointment, or clinical privileges, an individual must, as applicable:

(a) have a current, unrestricted license to practice in California, which is not subject to any restrictions, probationary terms, or conditions not generally applicable to all licensees;

(b) have never had a license to practice denied, revoked, restricted or suspended by any state licensing agency;

(c) have never had an application for Medical Staff membership or clinical privileges not processed, or had membership or privileges automatically relinquished, at the Hospital or any of its affiliated entities, due to an omission or misrepresentation;

(d) have a current, unrestricted DEA registration in compliance with Hospital requirements (i.e., have all required levels on the DEA registration); exceptions to this requirement are the Pathologist, Tele-Radiologist and Administrative staff members.

(e) be located close enough to fulfill Medical Staff responsibilities and to provide timely and continuous care for his or her patients in the Hospital in accordance with the Medical Staff Rules and Regulations;

(f) have current, valid professional liability insurance coverage in a form and in amounts satisfactory to the Board, Hospital, and Medical Executive Committee;

(g) have never been excluded or precluded from participation in Medicare, Medicaid, or any other federal or state governmental health care program;

(h) have never had Medical Staff or Advanced Practice Professionals appointment, clinical privileges, or status as a participating provider denied, revoked, or terminated by any health care facility or health plan, including this Hospital, for reasons related to clinical competence or professional conduct;

(i) have never resigned Medical Staff or Advanced Practice Professionals appointment, or relinquished privileges, during an investigation (or in exchange for not conducting such an investigation at any health care facility, including this Hospital);

(j) have never been terminated from a post-graduate training program (including a residency or fellowship for physicians or a similar program for other categories of practitioners) or resigned from such a program during an investigation or in exchange for the program not conducting an investigation;

(k) have never been required to pay a civil monetary penalty for governmental fraud or program abuse as described in 42 U.S. Code subchapters xviii-xix;

(l) have not, within the past seven years, been convicted of, or entered a plea of guilty or no contest to, any felony or misdemeanor related to: (i) controlled substances; (ii) illegal drugs; (iii) insurance or health care fraud (including Medicare, Medicaid or other federal or state governmental or private third-party payer fraud or program abuse); (iv) violent acts; (v) sexual misconduct; (vi) moral turpitude, or (vii) child or elder abuse;

(m) have an appropriate coverage arrangement, as determined by the Credentials Committee, with other members of the Medical Staff for those times when the individual will be unavailable;

(n) document compliance with all applicable training and educational protocols that may be adopted by the Medical Executive Committee and required by the Board, including (but not limited to) those involving electronic medical records, patient safety, and utilization review;

(o) furnish evidence of immunity to rubella and measles, as well as all other health screening and immunity requirements (as set forth by Hospital and/or Medical Staff policy);

(p) meet eligibility requirements that are applicable to clinical privileges being sought or granted;

(q) if applying for privileges in an area that is covered by an exclusive contract or arrangement, meet the specific requirements set forth in that contract (and, as applicable, be part of the group or entity that is a party to the contract);

(r) demonstrate recent clinical activity in his or her primary area of practice, in an acute care hospital, during the last two years;

(s) have successfully completed:

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

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

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

(iv) for membership on the Advanced Practice Professionals, have satisfied the applicable training requirements as established by the Hospital;

(t) be certified in their primary area of practice at the Hospital by the appropriate specialty/subspecialty board of the American Board of Medical Specialties, the American Osteopathic Association, the American Board of Oral and Maxillofacial Surgery, the American Dental Association, or the American Board of Foot and Ankle Surgery, as applicable.[2] Applicants who are not board certified at the time of application but who have completed their residency or fellowship training within the last seven years will 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 seven years from the date of completion of their residency or fellowship training;

(u) maintain board certification in their primary area of practice at the Hospital and, to the extent required by the applicable specialty/subspecialty board, satisfy recertification requirements. Recertification will be assessed at reappointment; and

(v) if seeking to practice as an Advanced Practice Professional, must have a written agreement with an appropriately-privileged Supervising Physician (with the agreement meeting all applicable requirements set by California law and Hospital policy).

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. 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).

~~2~~ Individuals who were members of the Medical Staff prior to June 1998 are exempt from this requirement (and from the maintenance of board certification requirement), but are encouraged to pursue board certification.

(b) A request for a waiver must 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, input from the relevant department chair, and the best interests of the Hospital and the communities it serves. Additionally, the Credentials Committee may, in its discretion, consider the application form and other information supplied by the applicant.

(c) The Credentials Committee will forward its recommendation, including the basis for such, to the Medical Executive Committee. Any recommendation to grant a waiver must include the specific basis for the recommendation.

(d) The Medical Executive Committee will review the recommendation of the Credentials Committee and make a recommendation to the Board regarding whether to grant or deny the request for a waiver. Any recommendation to grant a waiver must include the specific basis for the recommendation.

(e) The Board's determination regarding whether to grant a waiver is final. A determination not to grant a waiver is not a "denial" of appointment or clinical privileges and the individual who requested the waiver is not entitled to a hearing. A determination to grant a waiver in a particular case is not intended to set a precedent. A determination to grant a waiver does not mean that appointment will be granted, only that processing of the application can begin.

2.A.3.Factors for Evaluation:

The following factors will be evaluated as part of the appointment and reappointment processes:

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

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

(c) good reputation and character;

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

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

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

2.A.4.No Entitlement to Appointment:

No one is entitled to receive an application, be appointed, be reappointed or be granted or exercise particular clinical privileges merely because he or she:

(a) is employed by this Hospital or its subsidiaries or has a contract with this 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 or Allied health staff appointment or 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:

No one will be denied appointment or clinical privileges on the basis of ancestry, color, creed, disability/medical condition that is unrelated to the capacity to provide patient care, gender, marital status (or registered domestic partner status), national origin, race, religion, sex, or sexual orientation.

2.B.GENERAL CONDITIONS OF APPOINTMENT, REAPPOINTMENT, AND CLINICAL PRIVILEGES

2.B.1.Basic Responsibilities and Requirements:

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

(a) to provide continuous and timely care;

(b) to be subject to and abide by the Bylaws, Rules and Regulations, and other policies of the Hospital and Medical Staff (as well as any revisions or amendments thereto);

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

(d) be available on a continuous basis, either personally or by arranging appropriate coverage, to respond to the needs of their inpatients and Emergency Department patients in a prompt, efficient, and conscientious manner. ("Appropriate coverage" means coverage by another member of the Medical Staff with appropriate specialty-specific privileges as determined by the Credentials Committee.) Compliance with this eligibility requirement means that the practitioner must document that he or she is willing and able to:

(1) respond within 15 minutes, via phone, to an initial STAT page from the Hospital and respond within 30 minutes, via phone, to all other initial pages; and

(2) appear in person to attend to their patient within 30 minutes of being requested to do so (or more quickly based upon (i) the acute nature of the patient's condition or (ii) as required for a particular specialty as recommended by the Medical Executive Committee and approved by the Board);

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

(f) to obtain, when requested, an appropriate fitness for practice evaluation, which may include diagnostic testing (such as blood and/or urine test) or a complete physical, mental, and/or behavioral evaluation, as set forth later in this Policy;

(g) to participate in personal or phone interviews in regard to an application for initial appointment or reappointment (if requested);

(h) to use the Hospital and/or WOSC sufficiently to allow continuing assessment of current competence;

(i) to seek consultation whenever necessary;

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

(k) to act in a cooperative and professional manner;

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

(m) to utilize the Hospital's electronic medical record system;

(n) to satisfy continuing medical education requirements;

(o) to attend and participate in applicable orientation programs at the Hospital;

(p) to comply with all applicable training and educational protocols that may be adopted by the Medical Executive Committee, including (but not limited to) those involving electronic medical records, infection control, patient safety, and utilization review;

(q) to maintain a current e-mail address with the Medical Staff Office, which will be the primary mechanism used to communicate to all Medical Staff and Allied Health Staff;

(r) to disclose conflicts of interest regarding relationships with pharmaceutical companies, device manufacturers, other vendors or other persons or entities as may be required by Hospital or Medical Staff policies, including (but not limited to) disclosure of financial interests in any product or medical device not already in use at the Hospital that a Medical Staff member may request the Hospital to purchase;

(s) to refrain from illegal fee splitting or other illegal inducements relating to patient referral;

(t) that, if the individual is a member of the Medical Staff who serves or plans to serve as a Supervising Physician to an Advanced Practice Professional, that the member of the Medical Staff will abide by the supervision requirements and conditions of practice set forth in Article 8; and

(u) that, if the individual is an Advanced Practice Professional, he or she will abide by the conditions of practice set forth in Article 8.

2.B.2.Burden of Providing Information:

(a) All applicants and members have the burden of producing information deemed adequate by the Hospital and Medical Staff for a proper evaluation of current competence, character, ethics, and other qualifications and for resolving any doubts.

(b) All applicants and members have the burden of providing evidence that all the statements made and all information provided by the applicant in support of the application are accurate and complete.

(c) An application will be complete when all questions on the application form have been answered, all supporting documentation has been supplied, and all information has been verified from primary sources. An application will become incomplete if the need arises for new, additional, or clarifying information. Any application that continues to be incomplete 60 days after the applicant has been notified of the additional information required will be deemed to be withdrawn.

(d) Applicants are responsible for providing a complete application, including adequate responses from references and all information requested from third parties for a proper evaluation. An incomplete application will not be processed.

(e) Applicants and members are responsible for notifying the Chief of Staff (in writing) of any change in status or any change in the information provided on the application form. This information is required to be provided with or without request, at the time the change occurs, and includes, but is not limited to:

(1) any and all complaints pending, documents or other information known to the practitioner regarding, or changes in, licensure status or DEA controlled substance authorization;

(2) changes in professional liability insurance coverage;

(3) the filing of a professional liability lawsuit against the practitioner;

(4) arrest, charge, indictment, conviction, or a plea of guilty or no contest in any criminal matter;

(5) exclusion or preclusion from participation in Medicare, Medicaid or any other federal or state health care program or any sanctions imposed with respect to the same; and

(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, including, but not limited to, impairment due to addiction (all of which will be referred for review under the Practitioner Health Policy).

2.C.APPLICATION

2.C.1.Information:

(a) Application forms for appointment, reappointment, and clinical privileges will be approved by the Board, upon recommendation by the Credentials Committee and the Medical Executive Committee.

(b) The applications for initial appointment, reappointment, and clinical privileges existing now and as may be revised are incorporated by reference and made a part of this Policy.

(c) The application will contain a request for specific clinical privileges and will require detailed information concerning the applicant's professional qualifications. The applicant will sign the application and certify that he or she is able to perform the privileges requested and the responsibilities of appointment.

2.C.2.Misstatements and Omissions:

(a) Any misstatement in, or omission from, the application renders the application incomplete and provides grounds to stop processing the application. The applicant will be informed in writing of the nature of the misstatement or omission and permitted to provide a written response. The Chief of Staff will review the response and determine whether the application should be processed further.

(b) If appointment has been granted prior to the discovery of a misstatement or omission, appointment and privileges may be deemed to be automatically relinquished pursuant to this Policy.

(c) No action taken pursuant to this section will entitle the applicant or member to a hearing or appeal.

2.C.3.Grant of Immunity and Authorization to Obtain/Release Information:

(a) Conditions Prerequisite to Application and Consideration:

As a condition of having a request for application considered or applying for appointment, reappointment, or clinical privileges, every individual accepts the terms set forth in this Section.

(b) Scope of Conditions:

The terms set forth in this Section:

(1) commence with the individual's initial contact with the Hospital, whether an application is furnished or appointment, or clinical privileges are granted;

(2) apply throughout the credentialing process and the term of any appointment, reappointment, or clinical privileges; and

(3) survive for all time, even if appointment, reappointment, or clinical privileges are denied, revoked, reduced, restricted, suspended, or

otherwise affected as part of the Hospital's or Medical Staff's professional review activities (and even if the individual no longer maintains appointment or clinical privileges at the Hospital).

(c) Use and Disclosure of Information about Individuals:

(1) Information Defined:

For purposes of this Section, "information" means information about the individual, regardless of the form (which will include verbal, electronic, and paper), which pertains to the individual's appointment, reappointment, or clinical privileges, or the individual's qualifications for the same, including, but not limited to:

(a) information pertaining to the individual's clinical competence, professional conduct, reputation, ethics, and ability to practice safely with or without accommodation;

(b) any matter addressed on the application form or in the Medical Staff Bylaws, Credentialing Policy, and other Hospital or Medical Staff policies and Rules and Regulations;

(c) any reports about the individual which are made by the Hospital, its Medical Staff Leaders, or their representatives to the National Practitioner Data Bank or relevant state licensing boards/agencies; and

(d) any references received or given about the individual.

(2) Authorization for Criminal Background Check:

The individual agrees to sign consent forms to permit a consumer reporting agency to conduct a criminal background check and report the results to the Hospital and Medical Staff.

(3) Authorization to Obtain Information from Third Parties:

The individual authorizes the Hospital, Medical Staff Leaders, and their representatives to request or obtain information from third parties and specifically authorizes third parties to release information to the Hospital and Medical Staff.

(4) Authorization to Disclose Information to Third Parties:

The individual authorizes the Hospital, Medical Staff Leaders, and their representatives to disclose information to other hospitals, health care

facilities, managed care organizations, government regulatory and licensure boards or agencies, and their representatives to assist them in evaluating the individual's qualifications.

(d) Hearing and Appeal Procedures:

The individual agrees that the hearing and appeal procedures set forth in this Policy will be the sole and exclusive remedy with respect to any professional review action taken by the Hospital or Medical Staff.

(e) Immunity:

To the fullest extent permitted by law, the individual releases from any and all liability, extends immunity to, and agrees not to sue the Hospital, the Board, and the Medical Staff, their authorized representatives, any members of the Medical Staff, Advanced Practice Professional, or Board, and any third party who provides information.

This immunity covers any actions, recommendations, reports, statements, communications, or disclosures that are made, taken, or received by the Medical Staff, the Hospital, their representatives, or third parties in the course of credentialing and peer review activities or when using or disclosing information as described in this Section. Nothing herein will be deemed to waive any other immunity or privilege provided by federal or California law.

(f) Legal Actions:

If, despite this Section, an individual institutes legal action challenging any credentialing, privileging, peer review, or other professional review action or activity and does not prevail, he or she will reimburse the Hospital, the Board, the Medical Staff, their authorized representatives, any members of the Medical Staff or Advanced Practice Professionals or Board, and any third party who provides information involved in the action for all costs incurred in defending such legal action, including costs and attorneys' fees, and expert witness fees.

ARTICLE 3

PROCEDURE FOR INITIAL APPOINTMENT AND PRIVILEGES

3.A.PROCEDURE FOR INITIAL APPOINTMENT AND PRIVILEGES

3.A.1.Application:

(a) Prospective applicants will be sent the application form and a letter that outlines the threshold eligibility criteria for appointment and the applicable criteria for clinical privileges.

(b) A completed application form with copies of all required documents must be returned to the Medical Staff Office within 60 days after receipt by the applicant. The application must be accompanied by the application fee.

(c) A single extension of 30 days may be granted by the Credentials Committee.

(d) Applications may be provided to residents who are in the final six months of their training. Final action will not be taken until all applicable threshold eligibility criteria are satisfied.

3.A.2.Initial Review of Application:

(a) As a preliminary step, the application will be reviewed by the Medical Staff Office to determine that all questions have been answered and that the applicant satisfies all threshold eligibility criteria. Applicants who fail to return completed applications or fail to meet the threshold eligibility criteria will be notified that their applications will not be processed. A determination of ineligibility does not entitle the individual to a hearing and appeal.

(b) The Medical Staff Office will oversee the process of gathering and verifying relevant information, and confirming that all references and other information deemed pertinent have been received.

(c) Evidence of the applicant's character, professional competence, qualifications, behavior, and ethical standing will be examined. This information may be contained in the application, and obtained from references and other available sources, including the applicant's past or current department chair at other health care entities, residency training director, and others who may have knowledge about the applicant's education, training, experience, and ability to work with others. The National Practitioner Data Bank and the Office of Inspector General, Medicare/Medicaid Exclusions will be queried, as required, and a criminal background check will be obtained. Past and current 805 reports will be

reviewed, as will any pending actions by the Medical Board of California (or other applicable licensing agencies).

(d) An interview(s) with the applicant will be conducted. The purpose of the interview is to discuss and review any aspect of the applicant's application, qualifications, and requested clinical privileges. This interview will be conducted by one or any combination of any of the following (as determined by the chair of the Credentials Committee): the department chair, the Credentials Committee, a Credentials Committee representative, the Medical Executive Committee, the Chief of Staff, Chief of Medical Services, or the Chief Executive Officer.

(e) The Medical Staff Office will transmit the complete application and all supporting materials to the chair of each department in which the applicant seeks clinical privileges. The department chair will complete a written form regarding whether the applicant has satisfied all of the qualifications for appointment and the clinical privileges requested.

(f) Once the application is ready for consideration by the Credentials Committee, the Medical Staff Office will post the name of the applicant in the Medical Staff lounge. Members of the Medical Staff are invited to submit, in writing and with full details, information relevant to the applicant's qualifications. Members who submit such information should understand and be willing to discuss these comments with the Credentials Committee (if requested).

3.A.3.Credentials Committee Procedure:

(a) The Credentials Committee will consider the report prepared by the department chair(s) and will make a recommendation.

(b) The Credentials Committee may use the expertise of the department chair(s), 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, if there is any question about the applicant's ability to perform the privileges requested and the responsibilities of appointment, the Credentials Committee may require a fitness for practice evaluation by a physician(s) satisfactory to the Credentials Committee. The results of this evaluation will be made available to the Committee.

(d) The Credentials Committee may recommend the imposition of specific conditions related to behavior, health, or clinical issues. 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 the applicant's compliance with any conditions.

(e) If the recommendation of the Credentials Committee is delayed longer than 60 days, the chair of the Credentials Committee will send a letter to the applicant, with a copy to the Chief Executive Officer, explaining the reasons for the delay.

3.A.4. Medical Executive Committee Recommendation:

(a) At its next regular meeting after receipt of the written report and recommendation of the Credentials Committee, the Medical Executive Committee will:

(1) adopt the report and recommendation of the Credentials Committee as its own; or

(2) refer the matter back to the Credentials Committee for further consideration of specific questions; or

(3) state its reasons for disagreement with the report and recommendation of the Credentials Committee.

(b) If the recommendation of the Medical Executive Committee is to appoint, the recommendation will be forwarded to the Board of Directors through the Joint Conference Committee.

(c) If the recommendation of the Medical Executive Committee would entitle the applicant to request a hearing, the Medical Executive Committee will forward its recommendation to the Chief of Staff, who will promptly send special notice to the applicant. The Chief of Staff will then hold the application until after the applicant has completed or waived a hearing and appeal.

3.A.5. Board Action:

(a) Upon receipt of a recommendation that the applicant be granted appointment and clinical privileges, the Board may:

(1) grant appointment and clinical privileges as recommended; or

(2) refer the matter back to the Credentials Committee, the Medical Executive Committee, or another source for additional research or information; or

(3) modify the recommendation.

(b) If the Board disagrees with a favorable recommendation, it should first discuss the matter with the chair of the Credentials Committee and the chair of the Medical Executive Committee. If the Board's determination remains unfavorable, the Chief of Staff will promptly send special notice that the applicant is entitled to request a hearing.

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

3.A.6. Time Periods for Processing:

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

ARTICLE 4

CLINICAL PRIVILEGES

4.A.CLINICAL PRIVILEGES

4.A.1.General:

(a) Appointment or reappointment will not confer any clinical privileges or right to practice at the Hospital. Only those clinical privileges granted by the Board may be exercised. All clinical privileges must be exercised in compliance with this policy.

(b) A request for privileges will be processed only when an applicant satisfies threshold eligibility criteria for the delineated privileges. An individual who does not satisfy the eligibility criteria for clinical privileges may request a waiver.

(c) Requests for clinical privileges that are subject to an exclusive contract or arrangement will only be processed in accordance with the applicable contract.

(d) Recommendations for clinical privileges will be based on consideration of the following:

(1) education, relevant training, experience, and demonstrated current competence, including medical/clinical knowledge, technical and clinical skills, judgment, interpersonal and communication skills, compliance with policies relating to conduct, and professionalism with patients, families, and other members of the health care team and peer evaluations relating to these criteria;

(2) appropriateness of utilization patterns;

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

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

(5) availability of coverage in case of the applicant's illness or unavailability;

(6) adequate professional liability insurance coverage for the clinical privileges requested;

(7) the Hospital's available resources and personnel;

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

(9) any information concerning professional review actions or voluntary or involuntary termination, limitation, reduction, or loss of appointment or clinical privileges at another hospital;

(10) practitioner-specific data as compared to aggregate data, when available;

(11) morbidity and mortality data, when available; and

(12) professional liability actions, especially any such actions that reflect an unusual pattern or number of actions.

(e) Requests for additional clinical privileges must state the additional clinical privileges requested and provide information sufficient to establish eligibility. If the member is eligible and the request is complete, it will be processed in the same manner as an application for initial clinical privileges.

4.A.2.Resignation of Appointment and Clinical Privileges:

A request to resign all clinical privileges must (a) specify the desired date of resignation, at least 30 days from the date of the request; and (b) provide evidence that the individual has completed all medical records and will be able to appropriately discharge or transfer responsibility for the care of any hospitalized patient. After consulting with the Chief of Staff, the Chief Executive Officer will act on the request.

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 ("new procedure") will not be processed until a determination has been made that the procedure will be offered by the Hospital and criteria for the clinical privilege(s) have been adopted.

(b) As an initial step in the process, the individual seeking to perform the new procedure will prepare and submit a report to the department chair and the Credentials Committee addressing the following:

(1) minimum 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) information on expected complication rates;

(6) whether this is an experimental procedure or service and, if so, the degree to which that raises additional concerns;

(7) whether the new procedure is being performed at other similar hospitals and the experiences of those institutions (including the extent to which third parties recognize and pay for the procedure); and

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

The department chair and the Credentials Committee will review this report, conduct additional research as necessary, and make a preliminary recommendation as to whether the new procedure should be offered at the Hospital.

(c) If the preliminary recommendation is favorable, the Credentials Committee will then develop threshold credentialing criteria to determine those individuals who are eligible to request the clinical privileges. In developing the criteria, the Credentials Committee may conduct additional research and consult with experts, as necessary, and develop recommendations regarding:

(1) the minimum 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 quality of relevant training programs;

(4) the extent (time frame and mechanism) of focused monitoring and supervision that should occur if the privileges are granted; 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 Medical Executive Committee, which will review the matter and forward its recommendations to the Board for final action.

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

(a) Requests for clinical privileges that previously have been exercised only by members in another specialty will not be processed until the steps outlined in this section have been completed and a determination has been made regarding the member's eligibility to request the clinical privilege(s) in question.

(b) As an initial step in the process, the individual seeking the privilege will 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 clinical privilege at other similar hospitals, and the experiences of those other hospitals.

(c) The Credentials Committee will 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 clinical privileges at issue. If it does, the Committee may develop recommendations regarding:

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

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

(3) 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;

(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;

(5) the manner in which the procedure would be reviewed as part of the Hospital's ongoing and focused professional practice evaluation activities (which may include assessment of both long-term and short-term outcomes for all relevant specialties); and

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

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

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

(a) For any patient who meets the classifications of ASA 1 (normal, healthy patients) or ASA 2 (patients with mild systemic disease with no functional limitations), dentists and oral and maxillofacial surgeons may admit the patient and perform a complete admission history and physical examination, and assess the medical risks of the procedure on the patient, if they are deemed qualified to do so by the Credentials Committee and Medical Executive Committee. They must, nevertheless, have an agreement with a physician on the Medical Staff (established and declared in advance) who is available to respond should any medical issue arise with the patient.

(b) For any patient who meets ASA 3 or higher classifications, a medical history and physical examination of the patient will 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 will be responsible for the medical care of the patient throughout the period of hospitalization.

(c) The dentist or oral and maxillofacial surgeon will be responsible for the oral surgery care of the patient, including the appropriate history and physical examination, as well as all other appropriate elements of the patient's record. Dentists and oral and maxillofacial surgeons may write orders within the scope of their licenses and consistent with relevant Hospital policies and rules and regulations.

4.A.6.Clinical Privileges for Podiatrists:

(a) For any patient who meets the classifications of ASA 1 (normal, healthy patients) or ASA 2 (patients with mild systemic disease with no functional limitations), podiatrists may admit the patient and perform a complete admission history and physical examination, and assess the medical risks of the procedure on the patient, if they are deemed qualified to do so by the Credentials Committee and Medical Executive Committee. They must, nevertheless, have an agreement with a physician on the Medical Staff (established and declared in advance) who is available to respond should any medical issue arise with the patient.

(b) For any patient who meets ASA 3 or higher classifications, a medical history and physical examination of the patient will be made and recorded by a physician who is a member of the Medical Staff before podiatric surgery will be performed. In addition, a designated physician will be responsible for the medical care of the patient throughout the period of hospitalization.

(c) The podiatrist will be responsible for the podiatric care of the patient, including the podiatric history and the podiatric physical examination, as well as all appropriate elements of the patient's record. Podiatrists may write orders which are within the scope of their license and consistent with relevant Hospital policies and rules and regulations.

4.A.7.Physicians in Training:

(a) Physicians in training will not be granted appointment to the Medical Staff or clinical privileges. The program director, clinical faculty, or attending staff member will be responsible for the direction and supervision of the on-site or day-to-day patient care activities of each trainee, who will be permitted to perform only those clinical functions set out in curriculum requirements, affiliation agreements, or training protocols approved by the Medical Executive Committee or its designee, and the Graduate Medical Education Committee of the Hospital. The applicable program director will be responsible for verifying and evaluating the qualifications of each physician in training.

(b) Individuals who are in training who wish to moonlight (outside of the training program) may be granted specific privileges as set forth in this Policy. A resident who is moonlighting must comply with the institutional and program training requirements. Loss of employment in the training program will result in the automatic relinquishment of clinical privileges, without a right to the hearing and appeal procedures.

4.A.8.Telemedicine Privileges:

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

(b) A qualified individual may be granted telemedicine privileges, but need not be appointed to the Medical Staff.

(c) Requests for initial or renewed telemedicine privileges will be processed through the same process as Medical Staff and Allied Health Staff applications, as set forth in this Policy. In such case, the individual must satisfy all qualifications and requirements set forth in this Policy, except those relating to geographic location and coverage arrangements.

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

(e) Individuals granted telemedicine privileges will be subject to the Medical Staff's peer review activities. The results of the peer review activities, including any adverse events and complaints filed about the practitioner providing telemedicine

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

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

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

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 the Policy Regarding FPPE to Confirm Practitioner Competence and Professionalism.

4.B. PROCTORING

4.B.1 GENERAL PROVISIONS

Except as otherwise determined by the MEC or the department, all initial appointees to the Medical Staff and all members granted new clinical privileges shall be subject to a period of proctoring. Each appointee or recipient of new clinical privileges shall be assigned to a department where performance on an appropriate number of cases shall be observed by the chairperson of the department, or the chairperson's designee, to determine suitability to continue to exercise the clinical privileges granted in that department. The exercise of clinical privileges in any other department shall also be subject to direct observation by that department's chairperson or their designee. The member shall remain subject to such proctoring until the MEC has been furnished with:

A. a report signed by the chairperson of the department to which the member is assigned describing the types and numbers of cases observed and the evaluation of the applicant's performance, a statement that the applicant appears to meet all of the qualifications for unsupervised practice in that department, has discharged all of the responsibilities of staff membership, and has not exceeded or abused the prerogatives of the category to which the appointment was made; and

B. a report signed by the chairpersons of the other departments in which the appointee may exercise clinical privileges, describing the types and number of cases observed and the evaluation of the applicant's performance and a statement that the member has satisfactorily demonstrated the ability to exercise the clinical privileges initially granted in those departments.

4.B.2 PROCTORSHIP

A. Privileges are granted conditionally until proctorship has been

successfully completed.

B. All departments shall proctor a minimum of 6 cases.

C. If possible, departments will assign 2 or more proctors.

D. The proctors will be designated by the chairperson from the department to which the proctoree has been assigned. The proctors shall be members of the Washington Hospital Medical Staff in good standing and with unrestricted privileges.

E. The proctors shall perform direct observation and review of the related medical records for a minimum of 6 cases, covering a broad range of the major privileges requested by the applicant.

F. The proctor(s) may elect to observe more than the prescribed number of cases.

G. Proctorship shall be completed as soon as possible within the first 12 months of granting conditional privileges unless the member's performance is questionable and additional review is needed. Exceptions may also be made on a case by case review by the MEC for Consultants, Dermatologists, Allergists (adult & pediatric) and clinical immunologists. Proctorship may be terminated when the prescribed number of cases have been completed successfully.

H. If proctorship is instituted for members requesting additional privileges, the number of proctors and the length of the proctorship period and/or the number of cases to be proctored, is at the discretion of the department committee. Direct observation and chart review shall be performed.

I. When any problem relating to the professional performance of the proctoree is detected, the physician being proctored and the department chair should be notified immediately and steps should be taken to rectify the problem.

J. When the proctoree is planning to perform a procedure or admit a patient, he/she should notify the proctor directly at the earliest opportunity. The proctor should make every effort to accommodate the proctoree.

K. Proctoring must be carried out in an unbiased, confidential and objective manner.

L. At the end of the proctorship period, one of several actions should be taken, the practitioner should be notified and the information should be placed in the credentials file. The recommendation would be:

1. discontinue proctorship;

2. extend proctorship (up to a maximum of 12 months) due to questionable performance; or

3. terminate privileges and/or membership.

M. Upon request, the practitioner is entitled to any procedural rights granted in the Bylaws.

N. If proctorship was for a new privilege the recommendation would be:

1. discontinue proctorship;

2. extend proctorship (up to a maximum of 12 months) due to questionable performance; or

3. terminate privilege.

O. Within the proctorship period, the practitioner should also be monitored for compliance with other staff and hospital requirements (e.g. ability to work cooperatively with members of the Medical Staff and Hospital staff, timely completion of medical records, adequacy of medical records, meeting attendance, etc.)

P. Proctorship may be reinstituted at any time, at the discretion of the MEC, should serious questions arise regarding a Medical Staff member's clinical competence. Upon request, the practitioner may be entitled to any procedural rights granted in the Medical Staff Bylaws.

4.B.3 FAILURE TO SUCCESSFULLY COMPLETE PROCTORSHIP

If an initial appointee or member granted new clinical privileges fails to successfully complete proctorship within the time allowed, those specific clinical privileges shall automatically terminate and the member shall be entitled to a hearing upon request, pursuant to the Medical Staff Bylaws.

4.C.TEMPORARY CLINICAL PRIVILEGES

4.C.1 Temporary Clinical Privileges:

(a) Temporary privileges may be granted by the Chief Executive Officer, upon recommendation of the Chief of Staff, to:

(1) applicants for initial appointment whose complete application is pending review by the Board, following a favorable recommendation of the Medical Executive Committee. In order to be eligible for temporary clinical privileges, an applicant must have demonstrated ability to perform the clinical privileges requested and have had no (i)

current or previously successful challenges to licensure or registration or (ii) involuntary restriction, reduction, denial or termination of membership or clinical privileges at another health care facility.

(2) non-applicants, when there is an important patient care, treatment, or service need, including the following:

(i) the care of a specific patient;

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

(iii) proctoring; or

(iv) when serving as a locum tenens for a member of the Medical Staff or Advanced Practice Professionals.

(b) The following verified information will be considered prior to the granting of any temporary clinical privileges: current licensure, relevant training, experience,

current competence, current professional liability coverage acceptable to the Hospital, and results of a query to the National Practitioner Data Bank.

(c) The grant of temporary clinical privileges will not exceed 90 days.

(d) For non-applicants, who are granted temporary locum tenens privileges, the individual may exercise locum tenens privileges for a maximum of 120 days, consecutive or not, anytime during the 24-month period following the grant of privileges, subject to the following conditions:

(1) the individual must notify the Medical Staff Office at least 15 days prior to exercising these privileges (exceptions for shorter notice periods may be considered in situations involving health issues); and

(2) the individual must inform the Medical Staff Office of any change that has occurred to the information provided on the application form for locum tenens privileges.

(e) Prior to any temporary clinical privileges being granted, the individual must agree in writing that he or she is subject to and shall abide by the Bylaws, policies, and Rules and Regulations of the Medical Staff and the Hospital and any revisions or amendments thereto.

(f) The granting of temporary clinical privileges is a courtesy that may be withdrawn by the Chief Executive Officer at any time, after consulting with the Chief of Staff, the chair of the Credentials Committee or the department chair. (In some cases, withdrawal of temporary privileges may trigger an 805 report. Concerns should be addressed on a case-by-case basis with legal

counsel, as these issues are often fact-sensitive.)

(g) The department chair or the Chief of Staff will assign to another member of the Medical Staff responsibility for the care of patients until they are discharged. Whenever possible, consideration will be given to the wishes of the patient in the selection of a substitute physician.

4.C.E 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 member 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 will be assigned by the department chair or the Chief of Staff to a member with appropriate clinical privileges, considering the wishes of the patient.

4.D.DISASTER PRIVILEGES

(1) When the Emergency Operations Plan has been implemented and the immediate needs of patients in the facility cannot be met, the Chief Executive Officer or the Chief of 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: (1) current Hospital picture ID card that clearly identifies the individual's professional designation; (2) current license to practice; (3) primary source verification of the license; (4) 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 Resource Corps, the Emergency System for Advance Registration of Volunteer Health Professionals, or other recognized state or federal organizations or groups; or (5) identification by a current Hospital employee or Medical Staff or Allied Health Staff member who possesses personal knowledge regarding the individual's ability to act as a volunteer during a disaster.

(c) The Medical Staff Office will maintain records of the above for the respective volunteers. If possible, the medical license and government-issued photo identification will be copied. If this is not possible, the license and identification must be examined and logged on the Physicians' Credentialing Log.

(3) Each volunteer will be given a badge and assigned by the Medical Staff Office to work with a Medical Staff physician (in a "buddy system").

(4) 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.

(5) 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.

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

ARTICLE 5

PROCEDURE FOR REAPPOINTMENT

5.A.PROCEDURE FOR REAPPOINTMENT

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

5.B.REAPPOINTMENT CRITERIA

5.B.1.Eligibility for Reappointment:

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

(a) completed all medical records such that he or she is not delinquent (as per the Medical Staff Rules and Regulations and Hospital policy) at the time he or she submits the application for reappointment or renewal of clinical privileges;

(b) completed all continuing medical education requirements;

(c) satisfied all Medical Staff and Advanced Practice Professionals responsibilities, including payment of any dues, fines, and assessments;

(d) continued to meet all qualifications and criteria for appointment and the clinical privileges requested;

(e) paid any applicable reappointment processing fee; and

(f) had sufficient patient contacts to enable the assessment of current clinical judgment and competence for the privileges requested. Any member 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 his or her private office practice, or a quality profile from a managed care organization or insurer) before the application will be considered complete and processed further.

5.B.2.Factors for Evaluation:

In considering an application for reappointment, the factors listed in Section 2.A.4 of this Policy will be considered. Additionally, the following factors will be evaluated as part of the reappointment process:

(a) compliance with the bylaws, rules and regulations, and policies of the Medical Staff, as well as Hospital policies that have been reviewed and approved by the MEC. That approval shall not be unreasonably withheld;

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

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

(d) any focused professional practice evaluations;

(e) verified complaints received from patients or staff; and

(f) other reasonable indicators of continuing qualifications.

5.C. REAPPOINTMENT PROCESS

5.C.1.Reappointment Application Form:

(a) Appointment terms will not extend beyond two years.

(b) An application for reappointment will be furnished to eligible members at least six months prior to the expiration of their current appointment term.

(c) The Medical Staff Office may assess a reappointment processing fee.

(d) Failure to return a complete application within 60 days of receipt may result in the automatic expiration of appointment and clinical privileges at the end of the then current term of appointment.

(e) The application will be reviewed by the Medical Staff Office to determine that all questions have been answered and that the member satisfies all threshold eligibility criteria for reappointment and for the clinical privileges requested.

(f) The Medical Staff Office will oversee the process of gathering and verifying relevant information. The Medical Staff Office will also be responsible for confirming that all relevant information has been received.

5.C.2.Conditional Reappointments:

(a) Recommendations for reappointment may be subject to an applicant's compliance with specific conditions. These conditions may relate to behavior (e.g., professional code of conduct) or to clinical issues (e.g., general consultation

requirements, proctoring, completion of CME requirements). Reappointments may be recommended for periods of less than two years in order to permit closer monitoring of a member's clinical performance, professional conduct, and ongoing qualifications for appointment and privileges.

(b) A recommendation of a conditional reappointment or for reappointment for a period of less than two years does not, in and of itself, entitle a member to request a hearing or appeal.

(c) In the event the applicant for reappointment is the subject of an 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.C.3.Potential Adverse Recommendation:

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

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

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

(d) This meeting is not a hearing, and none of the procedural rules for hearings will apply. The member may consult with legal counsel, but legal counsel may not be present at the meeting itself.

ARTICLE 6

QUESTIONS INVOLVING MEDICAL STAFF
OR ADVANCED PRACTICE
PROFESSIONALS MEMBERS

6.A.OVERVIEW AND GENERAL PRINCIPLES

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

(a) This Policy empowers Medical Staff Leaders and Hospital Administration to use various options to address and resolve questions raised about members of the Medical Staff and Advanced Practice Professionals. The various options available to Medical Staff Leaders and Hospital Administration and the mechanisms they may use when questions pertaining to competence, health or behavior are raised are outlined below and include, but are not limited to, the following:

(1) collegial intervention and progressive steps;

(2) ongoing and focused professional practice evaluations;

(3) mandatory meeting;

(4) fitness for practice evaluation (including blood and/or urine test);

(5) competency evaluation;

(6) automatic relinquishment of appointment and clinical privileges;

(7) leaves of absence;

(8) precautionary suspension; and

(9) formal investigation.

(b) In addition to these options, Medical Staff Leaders and Hospital Administration also have the discretion to determine whether a matter should be handled in accordance with another policy (e.g., professionalism policy, practitioner health policy, professional practice evaluation policy) or should be referred to the Medical Executive Committee for further action.

6.A.2.Documentation:

(a) Except as otherwise expressly provided, Medical Staff Leaders and Hospital Administration may use their discretion to decide whether to document any

meeting with an individual that may take place pursuant to the processes and procedures outlined in this Article.

(b) Any documentation that is prepared will be shared with the individual. The individual will have an opportunity to review the documentation and respond to it. The initial documentation, along with any response, will be maintained in the individual's confidential file.

6.A.3. No Recordings of Meetings:

It is the policy of the Hospital to maintain the confidentiality of all Medical Staff meetings, including, but not limited to, discussions relating to credentialing, quality assessment, performance improvement, and peer review activities. The discussions that take place at such meetings are private conversations that occur in a private place. In addition to existing bylaws and policies governing confidentiality, individuals in attendance at such meetings are prohibited from making audio or video recordings at such meetings unless authorized to do so in writing by the individual chairing the meeting and by the Chief Executive Officer.

6.A.4. No Right to Counsel:

(a) The processes and procedures outlined in this Article are designed to be carried out in an informal manner. Therefore, lawyers will not be present for any meeting that takes place pursuant to this Article. By agreement of the Chief of Staff and Chief Executive Officer, an exception may be made to this general rule.

(b) If the individual refuses to meet without his or her lawyer present, the meeting will be canceled and it will be reported to the Medical Executive Committee that the individual failed to attend the meeting.

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

Peer review activities are confidential and privileged to the fullest extent permitted by law. Accordingly, the individual may not be accompanied by friends, relatives or colleagues when attending a meeting that takes place pursuant to this Article.

6.A.6. Involvement of Supervising Physician in Matters Pertaining to Advanced Practice Professionals Members:

If any peer review activity pertains to the clinical competence or professional conduct of an Advanced Practice Professionals member, the Supervising Physician (if any) will be notified and may be invited to participate.

6.B.C COLLEGIAL INTERVENTION AND PROGRESSIVE STEPS

(1) The use of collegial intervention efforts and progressive steps by Medical Staff Leaders and Hospital Administration is encouraged.

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

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

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

(b) counseling, mentoring, monitoring, proctoring, consultation, and education;

(c) sharing comparative quality, utilization, and other relevant information, including any variations from clinical protocols or guidelines, in order to assist an individual to conform his or her practice to appropriate norms;

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

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

(f) Performance Improvement Plans.

6.C.ONGOING AND FOCUSED PROFESSIONAL PRACTICE EVALUATION

(1) Individuals who are 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 to confirm their competence.

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

(3) When concerns are raised about an individual's practice through the ongoing practice evaluation process or through a specialty-specific trigger, a reported concern, or other triggers (i.e., clinical trend or specific case that requires further

review, patient complaint, corporate compliance issue, or sentinel event), a focused professional practice evaluation will be undertaken to evaluate the concern.

6.D.MANDATORY MEETING

(1) Whenever there is a concern regarding an individual's clinical practice or professional conduct, Medical Staff Leaders may require the individual to attend a mandatory meeting.

(2) Special notice will be given at least three days prior to the meeting and will inform the individual that attendance at the meeting is mandatory.

(3) Failure of an individual to attend a mandatory meeting may result in an automatic relinquishment of appointment and privileges as set forth below.

6.E.F FITNESS FOR PRACTICE EVALUATION

(1) An individual may be requested to submit to an appropriate evaluation (such as blood and/or urine test) or a complete fitness for practice evaluation to determine his or her ability to safely and competently practice.

(2) A request for an evaluation may be made of an applicant during the initial appointment or reappointment processes or of a member during an investigation. A request for an evaluation may also be made when at least two Medical Staff Leaders (or one Medical Staff Leader and one member of the Hospital Administration) are concerned with the individual's ability to safely and competently care for patients.

(3) The Medical Staff Leaders or committee that requests the evaluation will:

(a) identify the health care professional(s) to perform the evaluation;

(b) inform the individual of the time period within which the evaluation must occur; and

(c) provide the individual with all appropriate releases and/or authorizations to allow the Medical Staff Leaders, or relevant committee, to discuss with the health care professional(s) the reasons for the evaluation and to allow the health care professional to discuss and report the results to the Medical Staff Leaders or relevant committee.

(4) Failure to obtain the requested evaluation may result in an application being withdrawn or an automatic relinquishment of appointment and privileges as set forth below.

6.F.C COMPETENCY ASSESSMENT

(1) An individual may be requested to participate in a competency assessment to determine his or her ability to safely and competently practice.

(2) A request for a competency assessment may be made of a member during the reappointment process, as part of the collegial intervention process, or during an investigation. The request may be made by Medical Staff Leaders, the Credentials Committee, the Medical Executive Committee, an Investigating Committee or the Professional Practice Evaluation Committee.

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

(4) Failure to obtain the requested assessment may result in an automatic relinquishment of appointment and privileges as set forth below.

6.G.AUTOMATIC RELINQUISHMENT

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

Except as otherwise provided below, an automatic relinquishment of appointment and privileges will be effective immediately upon actual or special notice to the individual.

6.G.1.Failure to Complete Medical Records:

Failure of an individual to complete medical records, after notification by the medical records department of delinquency in accordance with applicable policies and rules and regulations, may result in automatic relinquishment of all clinical privileges.

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

Failure of an individual to continuously evidence satisfaction of any of the threshold eligibility criteria set forth in this Policy will result in automatic relinquishment of appointment and clinical privileges.

6.G.3.Failure to Provide Information:

(a) Failure of an individual to notify the Chief of Staff or Chief Executive Officer of any change in any information provided on an application for initial appointment or reappointment may, as determined by the Medical Executive Committee, result in the automatic relinquishment of appointment and clinical privileges.

(b) Failure of an individual to provide information pertaining to an individual's qualifications for appointment or clinical privileges in response to a written request from the Credentials Committee, the Medical Executive Committee, or any other authorized committee may, as determined by the Medical Executive Committee, result in the automatic relinquishment of appointment and clinical privileges until the information is provided to the satisfaction of the requesting party.

6.G.4.Failure to Attend a Mandatory Meeting:

Failure to attend a mandatory meeting requested by the Medical Staff Leaders or Hospital Administration, after appropriate notice has been given, may, as determined by the Medical Executive Committee, result in the automatic relinquishment of appointment and clinical privileges. The relinquishment will remain in effect until the individual attends the mandatory meeting and reinstatement is granted as set forth below.

6.G.5.Failure to Complete or Comply with Training or Educational Requirements:

Failure of an individual to complete or comply with training and educational requirements that are adopted by the Medical Executive Committee and/or required by the Board, including, but not limited to, those pertinent to electronic medical records or patient safety, will result in the automatic relinquishment of clinical privileges.

6.G.6.Failure to Comply with Request for Fitness for Practice Evaluation:

(a) Failure of an applicant to undergo a requested fitness for practice evaluation or to execute any of the required releases (i.e., to allow the Medical Staff Leaders, or the relevant committee, to discuss with the health care professional(s) the reasons for the evaluation and to allow the health care professional to report the results to the Medical Staff Leaders or relevant committee) will be considered a voluntary withdrawal of the application.

(b) Failure of a member to undergo a requested fitness for practice evaluation or to execute any of the required releases (i.e., to allow the Medical Staff Leaders, or the relevant committee, to discuss with the health care professional(s) the reasons for the evaluation and to allow the health care professional to report the results to the Medical Staff Leaders or relevant committee) will result in the automatic relinquishment of appointment and privileges.

6.G.7.Failure to Comply with Request for Competency Assessment:

Failure of a member to undergo a requested competency assessment or to execute any of the required releases (i.e., to allow the Medical Staff Leaders, or the relevant committee, to discuss with the health care professional(s) the reasons for the assessment and to allow the health care professional to report the results of the assessment to the Medical Staff Leaders or relevant committee) will result in the automatic relinquishment of appointment and privileges.

6.G.8.Reinstatement from Automatic Relinquishment and Automatic Resignation:

(a) If an individual believes that the matter leading to the automatic relinquishment of appointment and privileges has been resolved within 60 days of the relinquishment, the individual may request to be reinstated.

(b) A request for reinstatement from an automatic relinquishment following completion of all delinquent records will be processed in accordance with applicable policies and rules and regulations. Failure to complete the medical records that caused relinquishment within the time required will result in automatic resignation from the Medical Staff or Allied Health Staff.

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

(d) All other requests for reinstatement from an automatic relinquishment will be reviewed by the relevant department chair, the chair of the Credentials Committee, the Chief of Staff, the Chief of Medical Services, and the Chief Executive Officer. If all these individuals make a favorable recommendation on reinstatement, the individual may immediately resume clinical practice at the Hospital. This determination will then be forwarded to the Credentials Committee, the Medical Executive Committee, and the Board for ratification. If, however, any of the individuals reviewing the request have any questions or concerns, those questions will be noted and the reinstatement request will be forwarded to the full Credentials Committee, Medical Executive Committee and Board for review and recommendation.

(e) Failure to resolve a matter leading to an automatic relinquishment within 60 days of the relinquishment, and to be reinstated as set forth above, will result in an automatic resignation from the Medical Staff or Allied Health Staff.

6.H.LEAVES OF ABSENCE

6.H.1.Initiation:

(a) A leave of absence of up to one year must be requested in writing and submitted to the Chief of Staff. The request should, when possible, state the beginning and ending dates and the reasons for the leave. Except in extraordinary circumstances, the request will be submitted at least 30 days prior to the anticipated start of the leave.

(b) The Chief of Staff will determine whether a request for a leave of absence will be granted. The granting of a leave of absence or reinstatement may be conditioned upon the individual's completion of all medical records.

(c) Members of the Medical Staff or Allied Health Staff must report to the Chief of Staff any time they are away from Medical Staff, Allied Health Staff, 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, the Chief Executive Officer, in consultation with the Chief of Staff, may trigger an automatic medical leave of absence at any point after becoming aware of the Medical Staff member's absence from patient care.

(d) 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 will be final, with no recourse to a hearing and appeal.

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

During a leave of absence, the individual will not exercise any clinical privileges and will be excused from Medical Staff and Allied Health Staff responsibilities (e.g., meeting attendance, committee service, emergency service call obligations). The obligation to pay dues will continue during a leave of absence except that a member granted a leave of absence for U.S. military service will be exempt from this obligation.

6.H.3.Reinstatement:

(a) Individuals requesting reinstatement will submit a written summary of their professional activities during the leave and any other information that may be requested by the Hospital and/or Medical Staff. Requests for reinstatement will then be reviewed by the relevant department chair, the chair of the Credentials Committee, the Chief of Staff, the Chief of Medical Services, and the Chief Executive Officer.

(b) If a favorable recommendation on reinstatement is made, the individual may immediately resume clinical practice. However, if any of the individuals reviewing the request have any questions, those questions will be noted and the reinstatement request will be forwarded to the full Credentials Committee, Medical Executive Committee, and Board.

(c) 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 capable of resuming a hospital practice and safely exercising the clinical privileges requested.

(d) Absence for longer than one year will constitute the resignation of Medical Staff or Allied Health Staff appointment and clinical privileges unless an extension is granted by the Chief of Staff and/or Medical Executive Committee. Extensions will be considered only in extraordinary cases where the extension of a leave is in the best interests of the Hospital and Medical Staff.

(e) If an individual's current appointment is due to expire during the leave, the individual's appointment and clinical privileges will expire at the end of the appointment period, and the individual will be required to apply for reappointment.

6.I. PRECAUTIONARY SUSPENSION OR RESTRICTION OF CLINICAL PRIVILEGES

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

(a) Whenever failure to take action may result in imminent danger to the health and/or safety of any individual, the Chief Executive Officer, the Chief of Staff, the Medical Executive Committee, or a Medical Staff Officer is authorized to (1) afford the individual an opportunity to voluntarily refrain from exercising clinical privileges while the matter is being reviewed; or (2) suspend or restrict all or any portion of an individual's clinical privileges.

(b) A precautionary suspension can be imposed at any time, including after a specific event, a pattern of events, or a recommendation by the Medical Executive Committee that would entitle the individual to request a hearing. When possible, prior to the imposition of a precautionary suspension, the person(s) considering the suspension will meet with the individual and review the concerns that support the suspension and afford the individual an opportunity to respond.

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

(d) A precautionary suspension is effective immediately and will be promptly reported to the Chief Executive Officer and the Chief of Staff. A precautionary

suspension will remain in effect unless it is modified by the Medical Executive Committee.

(e) Within three days of the imposition of a suspension, the individual will be provided with a brief written description of the reason(s) for the action, including the names and medical record numbers of the patient(s) involved (if any).

(f) The relevant Supervising Physician will be notified when the affected individual is an Allied Health Professional Staff member.

6.I.2.Medical Executive Committee Procedure:

(a) Within a reasonable time, not to exceed 14 days of the imposition of the suspension, the Medical Executive Committee will review the reasons for the suspension.

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

(c) At the meeting, the individual may provide information to the Medical Executive Committee and should respond to questions that may be raised by committee members. The individual may also propose ways, other than precautionary suspension, to protect patients, employees or others while the matter is being reviewed.

(d) After considering the reasons for the suspension and the individual's response, if any, the Medical Executive Committee will determine whether the precautionary suspension should be continued, modified, or lifted. The Medical Executive Committee may also determine whether to begin an investigation.

(e) If the Medical Executive Committee decides to continue the suspension, it will send the individual written notice of its decision, including the basis for it.

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

(g) Upon the imposition of a precautionary suspension, the Chief of Staff will assign responsibility for the care of any hospitalized patients to another individual with appropriate clinical privileges. Whenever possible, consideration will be given to the wishes of the patient in the selection of a covering physician.

6.J.INVESTIGATIONS

6.J.1.Initial Review:

(a) Whenever a serious question has been raised, or where collegial efforts have not resolved an issue regarding the following, the matter may be referred to the Chief of Staff, the department chair, the chair of a standing committee, the Chief of Medical Services, the Chief Executive Officer, or the Chair of the Board:

(1) clinical competence or clinical practice, including patient care, treatment or management;

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

(3) the known or suspected violation of applicable ethical standards or the bylaws, policies, rules and regulations of the Hospital or the Medical Staff; or

(4) conduct that is considered lower than the standards of the Hospital or disruptive to the orderly operation of the Hospital, its Medical Staff or its Allied Health Staff, including the inability of the member to work harmoniously with others.

(b) In addition, if the Board becomes aware of information that raises concerns about the qualifications of any Medical Staff or Allied Health Staff member, the matter will be referred to the Chief of Staff, the Chief of Medical Services, or the Chief Executive Officer.

(c) The person to whom the question is referred will make a sufficient inquiry to determine whether the question is credible and, if so, may forward it to the Medical Executive Committee. If the question pertains to an Allied Health Staff member, the Supervising Physician may also be notified.

(d) To preserve impartiality, the person to whom the matter is directed will not be a member of the same practice as, or a relative of, the person who is being reviewed, unless such restriction is deemed not practicable, appropriate, or relevant by the Chief of Staff.

(e) No action taken pursuant to this section will constitute an investigation.

6.J.2. Initiation of Investigation:

(a) The Medical Executive Committee will review the matter in question, may discuss the matter with the individual, and will determine whether to conduct an investigation or direct that the matter be handled pursuant to another policy. An

investigation will commence only after a determination by the Medical Executive Committee.

(b) The Medical Executive Committee will inform the individual that an investigation has begun. Notification may be delayed if, in the judgment of the Medical Executive Committee, informing the individual immediately might compromise the investigation or disrupt the operation of the Hospital, Medical Staff, or Allied Health Staff.

6.J.3. Investigative Procedure:

(a) Once a determination has been made to begin an investigation, the Medical Executive Committee will investigate the matter itself or appoint an individual or committee ("Investigating Committee") to do so. The Investigating Committee may include individuals not on the Medical Staff or Allied Health Staff. The Investigating Committee will not include any individual who:

(1) is in direct economic competition with the individual being investigated;

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

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

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

(b) Whenever the questions raised concern the clinical competence of the individual under review, the Investigating Committee will include a peer of the individual.

(c) The individual will be notified of the composition of the Investigating Committee. Within five days of receipt of this notice, the individual must submit any reasonable objections to the service of any Investigating Committee member to the Chief of Staff. The objections must be in writing. The Chief of Staff will review the objection and determine whether another member should be selected to serve on the Investigating Committee.

(d) The Investigating Committee may:

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

(2) conduct interviews;

(3) use outside consultants, as needed, for timeliness, expertise, thoroughness and objectivity; or

(4) require an examination or assessment by a health care professional(s) acceptable to it. The individual being investigated will execute a release allowing the Investigating Committee to discuss with the health care professional(s) the reasons for the examination or assessment and allowing the health care professional to discuss and report the results to the Investigating Committee.

(e) As part of the investigation, the individual will have an opportunity to meet with the Investigating Committee. Prior to this meeting, the individual will be informed of the questions being investigated and will be invited to discuss, explain, or refute the questions. A summary of the interview will be made and included with the Investigating Committee's report. This meeting is not a hearing, and none of the procedural rules for hearings will apply. Lawyers will not be present at this meeting.

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

(g) At the conclusion of the investigation, the Investigating Committee will prepare a report to the Medical Executive Committee with its findings, conclusions, and recommendations.

6.J.4.Recommendation:

(a) The Medical Executive Committee may accept, modify, or reject any recommendation it receives from an Investigating Committee. Specifically, the Medical Executive Committee may:

(1) determine that no action is justified;

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

(3) impose conditions for continued appointment;

(4) require monitoring, proctoring or consultation;

(5) require additional training or education;

(6) recommend reduction or restriction of clinical privileges;

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

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

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

(b) A recommendation by the Medical Executive Committee that does not entitle the individual to request a hearing will take effect immediately and will remain in effect unless modified by the Board.

(c) A recommendation by the Medical Executive Committee that would entitle the individual to request a hearing will be forwarded to the Chief Executive Officer, who will promptly inform the individual by special notice. The recommendation will not be forwarded to the Board until after the individual has completed or waived a hearing and appeal.

(d) If the Board makes a modification to the recommendation of the Medical Executive Committee that would entitle the individual to request a hearing, the Chief Executive Officer will inform the individual by special notice. No final action will occur until the individual has completed or waived a hearing and appeal.

ARTICLE 7

HEARING AND APPEAL PROCEDURES

7.A. INITIATION OF HEARING

7.A.1. Grounds for Hearing:

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

(1) denial of initial appointment, reappointment or requested clinical privileges;

(2) revocation of appointment or clinical privileges;

(3) any suspension of clinical privileges that lasts for more than 14 consecutive days;

(4) any restriction of clinical privileges;

(5) denial of reinstatement from a leave of absence if the reasons relate to professional competence or conduct; or

(6) any recommendation that results in an 805 report.

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

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

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

None of the following actions constitute grounds for a hearing, unless they result in an 805 report. These actions take effect without hearing or appeal. The individual is entitled to submit a written statement regarding these actions for inclusion in his or her file:

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

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

(c) a lapse, withdrawal of or decision not to grant or not to renew temporary privileges;

(d) automatic relinquishment of appointment or privileges;

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

(f) precautionary suspension;

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

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

(i) the voluntary acceptance of a performance improvement plan option;

(j) determination that an application is incomplete;

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

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

7.A.3. Notice of Recommendation:

The Chief of Staff will promptly give special notice of a recommendation which entitles an individual to request a hearing. This notice will 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.A.4. Request for Hearing:

An individual has 30 days following receipt of the notice to request a hearing, in writing, to the Chief of Staff, including the name, address, and telephone number of the individual's counsel, if any. Failure to request a hearing timely will constitute waiver of the right to a hearing, and the recommendation will be transmitted to the Board for final action.

7.A.4. Notice of Hearing and Statement of Reasons:

(a) The Chief of Staff will schedule the hearing and provide to the individual requesting the hearing, by special notice, the following:

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

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

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

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

(b) The hearing will begin as soon as practicable, but 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.[3]

7.A.6..Witness List:

(a) At least 15 days before the pre-hearing conference, the individual requesting the hearing will provide a written list of the names of witnesses expected to offer testimony on his or her behalf.

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

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

[3] Be aware that under most circumstances, CAL. BUS. & PROF. CODE § 809.2 sets a 60-day window for commencing a hearing (calculated after receipt of the request for hearing). However, there are certain exceptions that apply which may allow you to take more time (i.e., if the individual under review fails to provide certain kinds of information in a timely fashion).

7.A.7. Voir Dire:

The individual requesting the hearing will have the right to a reasonable opportunity to *voir dire* the panel members and the Hearing Officer.

7.A.8. Hearing Panel and Hearing Officer:

(a) Hearing Panel:

The Chief of Staff will appoint a Hearing Panel in accordance with the following guidelines:

(1) The Hearing Panel will consist of at least three members, one of whom will be designated as chair. In addition, there will be at least two alternates.

(2) The Hearing Panel may include any combination of:

(i) any member of the Medical Staff, or

(ii) physicians, other health professionals or laypersons not connected with the Hospital (i.e., physicians not on the Medical Staff or laypersons not affiliated with the Hospital).

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

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

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

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

(ii) is professionally associated with, a relative of, or involved in a referral relationship with, the individual requesting the hearing;

(iii) has an actual bias, prejudice, or conflict of interest that would prevent the individual from fairly and impartially considering the matter (as determined by the Hospital and/or Medical Staff's conflict of interest policy); or

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

(b) Hearing Officer:

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

(2) The Hearing Officer will:

(i) schedule and conduct a pre-hearing conference;

(ii) allow the participants in the hearing to have a reasonable opportunity to be heard and to present evidence, subject to reasonable limits on the number of witnesses and duration of direct and cross-examination;

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

(iv) maintain decorum throughout the hearing;

(v) determine the order of procedure;

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

(vii) conduct argument by counsel on procedural points outside the presence of the Hearing Panel unless the Panel wishes to be present.

(3) The Hearing Officer may be advised by legal counsel to the Hospital with regard to the hearing procedure. This advice will be shared with counsel for both parties, who will have an opportunity to offer their input.

(4) There will be no ex parte communications between the Hearing Officer and legal counsel regarding the hearing.

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

(c) Compensation:

Members of the Hearing Panel, or the Hearing Officer, may be compensated for their service by the Hospital. The individual requesting the

hearing is allowed to contribute to that compensation. Compensation will not constitute grounds for challenging the impartiality of the Hearing Panel members.

(d) Objections:

Any objection to any member of the Hearing Panel will be made in writing, within ten days of receipt of notice, to the Hearing Officer. (If the individual requesting the hearing has an objection to the Hearing Officer, he or she may instead make that to the Chief of Staff.) The objection must include reasons to support it. The Chief of Staff will rule on the objection and give notice to the parties. The Chief of Staff may request that the Hearing Officer make a recommendation as to the validity of the objection.

7.A.9.Counsel:

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

7.B.PRE-HEARING PROCEDURES

7.B.1.General Procedures:

The pre-hearing and hearing processes will be conducted in an informal manner, but consistent with California law. Formal rules of evidence or procedure shall not apply.

7.B.2.Time Frames:

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

(a) the pre-hearing conference will be scheduled at least 21 days prior to the hearing;

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

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

7.B.3.Provision of Relevant Information:

(a) Prior to receiving any confidential documents, the individual requesting the hearing must agree that all documents and information will be maintained as confidential and will not be disclosed or used for any purpose outside of the hearing. The individual must also provide a written representation that his or her counsel and any expert(s) have executed Business Associate Agreements in

connection with any patient Protected Health Information contained in any documents provided.

(b) Upon receipt of the above agreement and representation, the individual requesting the hearing will be provided with:

(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 Medical Executive Committee;

(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 Medical Executive Committee.

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

(c) The individual will have no right to discovery beyond the above information. No information will be provided regarding other practitioners on the Medical Staff or Allied Health Staff. In addition, there is no right to depose, interrogate, or interview witnesses or other individuals prior to the hearing.

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

(e) Neither the individual, nor any other person acting on behalf of the individual, may contact Hospital employees, Medical Staff members or Allied Health Staff members whose names appear on the Medical Executive Committee's witness list or in documents provided pursuant to this section concerning the subject matter of the hearing, until Hospital counsel has been notified and has contacted the individuals. The Hospital will advise the individual who requested the hearing once it has contacted such employees, Medical Staff members or Allied Health Staff members, and confirmed their willingness to meet. Any employee, Medical Staff member or Allied Health Staff member may agree or decline to be interviewed by or on behalf of the individual who requested a hearing.

7.B.4. Pre-Hearing Conference:

(a) The Hearing Officer will require the individual and the Medical Executive Committee (or a representative of each, who may be counsel) to participate in a pre-hearing conference, which will be held no later than 21 days prior to the hearing.

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

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

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

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

7.B.5.Stipulations:

The parties will use their best efforts to develop and agree upon stipulations to provide for a more efficient hearing.

7.B.6.Provision of Information to the Hearing Panel:

The following documents will 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) stipulations agreed to by the parties.

7.C. THE HEARING

7.C.1.Time Allotted for Hearing:

It is expected that the hearing will last no more than 15 hours, with each side being afforded approximately seven and a half hours to present its case, in terms of both direct and cross-examination of witnesses. Both parties are required to prepare their case so that a hearing will be concluded after a maximum of 15 hours, unless the Hearing Officer determines that more time is needed due to the complexity of the case.

The Hearing 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.Record of Hearing:

A stenographic reporter will be present to make a record of the hearing. The cost of the

reporter will be borne by the Hospital. Copies of the transcript will be available at the individual's expense. Oral testimony will be taken on oath or affirmation administered by any authorized person.

7.C.3. Rights of Both Sides and the Hearing Panel at the Hearing:

(a) At a hearing, both sides will have the following rights, subject to reasonable limits determined by the Hearing 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;

(4) to have representation by counsel (who may be present but not call, examine, or cross-examine witnesses, or present the case);

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

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

(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, or request documentary evidence.

7.C.4. Order of Presentation:

The Medical Executive Committee will first present evidence in support of its recommendation. Thereafter, the burden will shift to the individual who requested the hearing to present evidence.

7.C.5. Admissibility of Evidence:

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

7.C.6. Persons to Be Present:

The hearing will be restricted to those individuals involved in the proceeding. The Chief Executive Officer, Chief of Medical Services, and Chief of Staff are permitted to attend. In addition, the Chief Executive Officer and/or Chief of Staff may invite other administrative personnel who may be able to facilitate the hearing, subject to the approval of the Hearing Officer.

7.C.7. Presence of Hearing Panel Members:

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

7.C.8. Failure to Appear:

Failure, without good cause, to appear and proceed at the hearing will constitute a waiver of the right to a hearing and the matter will be forwarded to the Board for final action. The Hearing Panel will determine whether there has been a failure to appear and proceed with the hearing and, if so, whether the failure was without good cause.

7.C.9. Postponements and Extensions:

Postponements and extensions of time may be requested by anyone, but will be permitted only by the Hearing Officer or the Chief of Staff on a showing of good cause.

7.D. HEARING CONCLUSION, DELIBERATIONS, AND RECOMMENDATIONS

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

If the hearing involves the denial of an application for initial appointment, the applicant bears the burden of showing, by a preponderance of the evidence, that the individual satisfies all criteria and qualifications for initial appointment and clinical privileges. For all other hearings, the Medical Executive Committee bears the burden of showing, by a preponderance of the evidence, that the recommendation was reasonable and warranted.

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

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

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

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

7.E. APPEAL PROCEDURE

7.E.1. Time for Appeal:

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

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

7.E.2. Grounds for Appeal:

The grounds for appeal will be limited to the following:

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

(b) the recommendations of the Hearing Panel were made arbitrarily or capriciously or were not supported by substantial evidence; or

(c) the decision was not supported by the findings.

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

(a) Whenever an appeal is requested, the Chief Executive Officer will schedule and arrange for an appeal. The individual will be given special notice of the time, place, and date of the appeal. The appeal will be held as soon as arrangements can reasonably be made, taking into account the schedules of all the individuals involved.

(b) If the individual requesting the appeal fails to appear at the scheduled time of the appeal, he or she waives his or her right to an appeal.

7.E.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 members of the Board or others, including but not limited to reputable persons outside the Hospital.

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

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

(d) When requested by either party, the Review Panel may, in its discretion, accept additional oral or written evidence subject to the same rights of cross-examination provided at the Hearing Panel proceedings. Additional evidence will be accepted only if the Review Panel determines that the party seeking to admit it can demonstrate that it is new, relevant evidence or that any opportunity to admit it at the hearing was improperly denied.

(e) Each party may be represented by counsel in accordance with California law.

7.F. BOARD ACTION

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

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

(b) The Board may review any information that it deems relevant, including, but not limited to, the findings and recommendations of the Medical Executive Committee, Hearing Panel, and Review Panel (if applicable).

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

(d) The Board will render its final decision in writing, including the basis for its decision, and will send special notice to the individual. A copy will also be provided to the Chief of Staff.

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

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

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

ARTICLE 8

CONDITIONS OF PRACTICE APPLICABLE TO
ADVANCED PRACTICE PROFESSIONALS MEMBERS

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

8.A.1. Utilization of Advanced Practice Professionals in the Hospital Setting:

(a) Advanced Practice Professionals are not permitted to function independently in the inpatient or outpatient Hospital setting. As a condition of being granted permission to practice at the Hospital, all Advanced Practice Professionals specifically agree to abide by the standards of practice set forth in 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 Physicians to such individuals also specifically agree to abide by the standards set forth in this Section.

(b) The following standards of practice apply to the functioning of Advanced Practice Professionals in the Hospital setting (including applicable outpatient settings):

(1) Admitting Privileges. Advanced Practice Professionals are not granted inpatient admitting privileges and therefore may not admit patients independent of the Supervising Physician.

(2) Consultations. Advanced Practice Professionals may not independently provide patient consultations in lieu of the practitioners' Supervising Physicians. An Advanced Practice Professional may gather data and order tests; however, the Supervising Physician must personally perform the requested consultation within 24 hours (or more timely in the case of any emergency consultation request).

(3) Emergency On-Call Coverage. It will be within the discretion of the Emergency Department physician requesting assistance whether it is appropriate to contact an Advanced Practice Professional prior to the Supervising Physician. Advanced Practice Professionals may not independently participate in the emergency on-call roster (formally, or informally by agreement with their Supervising Physicians) in lieu of the Supervising Physician. The Supervising Physician (or his or her covering physician) must personally respond to all calls directed to him or her in a timely manner, in accordance with requirements set forth in this Policy. Following discussion with the Emergency Department, the Supervising Physician may direct an Advanced Practice Professional to see the patient,

gather data, and order tests for further review by the Supervising Physician. However, the Supervising Physician must still personally see the patient when requested by the Emergency Department physician.

(4) Calls Regarding Supervising Physician's Hospitalized Inpatients. It will be within the discretion of the Hospital personnel requesting assistance to determine whether it is appropriate to contact an Advanced Practice Professional prior to the Supervising Physician. However, the Supervising Physician must personally respond to all calls directed to him or her in a timely manner.

(5) Daily Inpatient Rounds. An Advanced Practice Professional may assist his or her Supervising Physician in fulfilling his or her responsibility to round daily on all inpatients for whom the Supervising Physician is the designated attending physician, as appropriate.

8.A.2.Oversight by Supervising Physician:

(a) Advanced Practice Professionals may function in the Hospital (including applicable outpatient settings) only so long as they have a Supervising Physician. Any activities permitted to be performed at the Hospital by an Advanced Practice Professional will be performed only under the oversight of the Supervising Physician.

(b) If the Medical Staff appointment or clinical privileges of a Supervising Physician are resigned, revoked or terminated, or the Advanced Practice Professional fails, for any reason, to maintain an appropriate supervision relationship with a Supervising Physician as defined in this Policy, the Advanced Practice Professional's clinical privileges will be automatically relinquished, unless he or she has another Supervising Physician who has been approved as part of the credentialing process.

(c) As a condition of clinical privileges, an Advanced Practice Professional and the Supervising Physician must provide the Medical Staff with notice of any revisions or modifications that are made to the agreement between them. This notice must be provided to the Chief of Staff within three days of any such change.

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

(a) Should any member of the Medical Staff, or any employee of the Hospital who is licensed or certified by the state, have a reasonable question regarding the clinical competence or authority of an Advanced Practice Professional to act or issue instructions outside the presence of the Supervising Physician, such individual will have the right to request that the Supervising Physician validate, either at the time or later, the instructions of the Advanced Practice Professional. Any act or

instruction of the Advanced Practice Professional will be delayed until such time as the individual with the question has ascertained that the act is clearly within the clinical privileges granted to the individual.

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

8.A.4.Responsibilities of Supervising Physicians:

(a) Physicians who wish to utilize the services of an Advanced Practice Professional in their clinical practice at the Hospital must notify the Medical Staff Office of this fact in advance and must ensure that the individual has been appropriately credentialed in accordance with this Policy before the Advanced Practice Professional performs services or engages in any kind of activity in the Hospital. Supervising Physicians will also be required to hold a specific privilege for supervision.

(b) Supervising Physicians who wish to utilize the services of Advanced Practice Professionals in the inpatient setting specifically agree to abide by the standards of practice set forth in Section 8.A.1 above, as well as all applicable privileging criteria.

(c) The number of Advanced Practice Professionals acting under the supervision of one Medical Staff member, as well as the care they may provide, will be consistent with applicable state statutes and regulations and any other policies adopted by the Hospital. The Supervising Physician will make all appropriate filings with the Division of Allied Health Professions of the Medical Board of California (or other appropriate agency) regarding the supervision and responsibilities of the Advanced Practice Professional, to the extent that such filings are required.

(d) It will be the responsibility of the Supervising Physician to provide, or to arrange for, professional liability insurance coverage for the Advanced Practice Professional in amounts required by the Board. The insurance must cover any and all activities of the Advanced Practice Professional in the Hospital. The Supervising Physician will furnish evidence of such coverage to the Hospital. The Advanced Practice Professional will act in the Hospital only while such coverage is in effect.

ARTICLE 9

CONFLICTS OF INTEREST

(a) When performing a function outlined in this Policy, the Bylaws, applicable policies, or the Medical Staff Rules and Regulations, if any member has (or reasonably could be perceived as having) a conflict of interest or a bias, that member will not participate in the final discussion or voting on the matter, and will be excused from any meeting during that time. However, the member may provide relevant information and may answer any questions concerning the matter before leaving.

(b) Any member with knowledge of the existence of a potential conflict of interest or bias on the part of any other member may call the conflict of interest to the attention of the Chief of Staff (or the Chief of Staff-Elect if the Chief of Staff is the person with the potential conflict), the applicable department chair, or the applicable committee chair. The Chief of Staff, applicable department chair, or applicable committee chair will make a final determination as to whether the provisions in this Article should be triggered.

(c) The fact that a department chair or a member is in the same specialty as a member whose performance is being reviewed does not automatically create a conflict. In addition, the assessment of whether a conflict of interest exists will be interpreted reasonably by the persons involved, taking into consideration common sense and objective principles of fairness. No member has a right to compel disqualification of another member based on an allegation of conflict of interest.

(d) The fact that a department or committee member or Medical Staff Leader chooses to refrain from participation, or is excused from participation, will not be interpreted as a finding of actual conflict.

(e) Specific guidelines that implement the principles of this Article are located in Appendix E of the PPE Policy.

ARTICLE 10

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) A request for appointment, reappointment or clinical privileges, 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 management personnel to assist with employment decisions.

(c) 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 management personnel. However, nothing herein will require the individual's employer to follow this Policy.

Adopted by the Medical Executive Committee on May 19, 2025.

Adopted by the Board on June 11, 2025.

APPENDIX A

LICENSED INDEPENDENT PRACTITIONERS
AND ADVANCED PRACTICE
PROFESSIONALS

Licensed Independent Practitioners practicing at the Hospital are as follows:

Nurse Practitioner, Certified Nurse Midwife

Advanced Practice Professionals practicing at the Hospital are as follows:

Physician Assistant, Registered Nurse First Assist