Advanced Practice Provider Policy

Nationwide Children's Hospital

A Medical Staff Document

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DEFINITIONS

The following definitions shall apply to this Advanced Practice Provider Policy:

Advanced Practice Provider or APP means those physician assistants (PA), advanced practice registered nurses (APRN), optometrists, and other eligible allied health professionals set forth in **Exhibit A** who have applied for or who have applied for and been granted Privileges to practice at the Hospital either independently or in collaboration with or under the supervision of a Physician, Dentist, or Podiatrist, as applicable, with Medical Staff appointment and Privileges at the Hospital.

Adverse means a recommendation or action of the Medical Executive Committee or Board that denies, limits (*i.e.,* suspension, restriction, *etc.*) for a period in excess of fourteen (14) days, or terminates the Privileges of an APP on the basis of professional conduct or clinical competence, or as otherwise defined in this Policy.

Affiliate Hospital(s) means Nationwide Children's Hospital Toledo.

Board of Directors or **Board** means the governing body of the Hospital. A reference to the "Board of Directors" or "Board" shall include the Board's designee(s).

Chief Executive Officer or **CEO** means the individual appointed by the Board of Directors to act in its behalf in the overall management of the Hospital.

Chief Medical Officer or **CMO** means the individual appointed by the Hospital to be responsible for the clinical work, medical education, and quality of patient care delivered throughout the Hospital and its related companies.

Clinical Privileges or **Privileges** means the permission granted by the Board of Directors to a Practitioner or Advanced Practice Provider to render designated patient care, treatment, and/or services at/for the Hospital within defined limits based upon the Practitioner's or APP's professional license, education, training, experience, competence, ability, character, and judgment.

Dentist means an individual who has received a Doctor of Dental Surgery (D.D.S.) or Doctor of Dental Medicine (D.M.D.) degree; who is currently licensed to practice dentistry in the State of Ohio unless otherwise provided in the Medical Staff Bylaws or Policies; and whose practice is in the area of oral and maxillofacial surgery, general dentistry, or a specialty thereof.

Federal Healthcare Program means Medicare, Medicaid, TriCare, or any other federal or state program providing healthcare benefits that is funded directly or indirectly by the United States government.

Hospital means Nationwide Children's Hospital including all its clinical departments, programs, services, and provider-based locations.

Medical Executive Committee or MEC means the Executive Committee of the Medical Staff.

Medical Staff means those Medical Staff Members with such rights and responsibilities as defined in the Medical Staff category to which each has been appointed.

Medical Staff Bylaws or Bylaws means the articles, and amendments thereto, that constitute the basic governing document of the Medical Staff.

Medical Staff Department or Department means those clinical services designated as Medical Staff Departments as provided for in the Medical Staff Organizational Policy. Departments may be further divided into Sections led by Section Chiefs.

Medical Staff Department Chief or Department Chief means a Member of the active Medical Staff with Privileges appointed to serve as the administrative head of a Medical Staff Department and who reports to the CMO and, if applicable, the Surgeon-in-Chief.

Medical Staff Member or Member means a Practitioner who has been granted an appointment to the Medical Staff of the Hospital with or without Privileges. A Medical Staff Member must have applied for and been granted Privileges unless his/her appointment is to a Medical Staff category without Privileges or unless otherwise provided in the Medical Staff Bylaws or Policies. For purposes of the Bylaws or Policies, the term "membership" and "appointment/appointed" may be used interchangeably and shall have the same meaning.

Medical Staff Policy or Policy means those policies recommended by the Medical Executive Committee and approved by the Board that are generated to supplement the Medical Staff Bylaws. The Medical Staff Policies shall include, without limitation, this Advanced Practice Provider Policy.

Medical Staff President means a Member of the active Medical Staff elected to serve as the administrative leader of the Medical Staff.

Medical Staff Section Chief or **Section Chief** means a Member of the active Medical Staff with Privileges appointed to serve as administrative head of a Medical Staff Section subject to the authority of the Department Chief and CMO and, if applicable, the Surgeon-in-Chief**.**

Physician means an individual who has received a Doctor of Medicine ("M.D.") or Doctor of Osteopathic Medicine ("D.O.") degree and who is currently licensed to practice medicine in the State of Ohio unless otherwise provided in the Medical Staff Bylaws or Policies.

Professional Liability Insurance means professional liability insurance coverage of such kind, in such amount, and underwritten by such insurers as recommended by the MEC and approved by the Board.

Podiatrist means an individual who has received a Doctor of Podiatric Medicine (D.P.M.) degree and who is currently licensed to practice podiatry in the State of Ohio unless otherwise provided by the Medical Staff Bylaws or Policies.

Practitioner means an appropriately licensed Physician, Dentist, Podiatrist, or Psychologist.

Psychologist means an individual with a doctoral degree in psychology or school psychology, or a doctoral degree deemed equivalent by the Ohio State Board of Psychology, who is currently licensed to practice psychology in Ohio unless otherwise provided by the Medical Staff Bylaws or Policies.

Special Notice means written notice sent by (a) certified mail, return receipt requested; or (b) personal delivery service with signed acknowledgement of receipt.

RELATED INFORMATION

Not a Contract. This APP Policy is not intended to and shall not create any contractual rights between the Hospital and any APP or collaborating/supervising Practitioner. Any and all contracts of association or employment shall control contractual and financial relationships between the Hospital and its APPs and collaborating/supervising Practitioners.

Time Computation. Unless otherwise provided, in computing any period of time set forth in the Medical Staff governing documents, the date of the act from which the designated period of time begins to run shall not be included. The last day of the period shall be included unless it is a Saturday, Sunday, or legal holiday in which event the period runs until the end of the next day which is not a Saturday, Sunday, or legal holiday. When the period of time is less than seven (7) days, intermediate Saturdays, Sundays, and legal holidays shall be excluded. Unless otherwise specified herein (*e.g.*, a reference to "business days"), "days" shall mean "calendar days."

Use of a Designee. Whenever an individual is authorized to perform a duty by virtue of his/her position (*e.g.,* the CEO, CMO, Medical Staff President, Department Chief, *etc.*), then reference to the individual shall also include the individual's designee.

ARTICLE I
OVERVIEW

1.1 Applicability of Policy

1.1-1 This Policy is only applicable to APPs who have requested and/or been granted Privileges at the Hospital through the Medical Staff process.

1.1-2 All APPs who request Privileges at the Hospital must be credentialed through the Medical Staff consistent with this Policy and granted Privileges prior to providing care, treatment, and/or services to patients at the Hospital.

1.1-3 Attached hereto, and incorporated by reference herein, is Exhibit A which sets forth the APP occupations/professions that are credentialed, eligible for Privileges, and managed through the Medical Staff pursuant to this Policy.

1.1-4 Following consultation with the Advanced Practice Provider (APP) Credentials and Quality Committee and Medical Staff Credentials Committee, the Medical Executive Committee shall make recommendations to the Board, upon request, with respect to: (1) the APP occupations or professions that are eligible to request Privileges at the Hospital; (2) for each eligible APP occupation/profession, the mode of practice (*e.g.* independent, supervised, or collaborative) and scope of practice pursuant to State law, and applicable Privilege set for each; (3) whether any changes should be made to existing APP requirements (*e.g.,* qualifications, duties, privilege sets, *etc.*).

1.1-5 The Medical Staff will manage APPs with respect to the Clinical Privileges that are granted to such APPs through the Medical Staff.

1.2 Limitations

1.2-1 APPs are not granted appointment to the Medical Staff, may not hold Medical Staff office or serve as a Medical Staff officer, Department Chief, or Section Chief, and are not entitled to the fair hearing and appeal rights afforded to Medical Staff Members.

1.2-2 APPs may attend Medical Staff meetings but may not vote on Medical Staff matters. APPs may attend meetings of the Medical Staff Department/Section to which they are assigned but may not vote on Department/Section matters. APPs may serve on (and be removed from) Medical Staff committees as determined by the Medical Staff President with the right to vote on committee matters if so designated at the time of selection. An APP may also serve as chair of a committee as determined by the Medical Staff President.

1.2-3 APPs granted Privileges shall have such procedural due process rights, to the extent applicable, as set forth in Article VIII of this Policy.

1.2-4 APPs must comply with:

A. All limitations and restrictions imposed by their respective licenses, certificates, certifications, or other credentials required by Ohio law to practice;

B. The terms of their standard care arrangement, supervision agreement, or other required documentation (*e.g.,* pharmacist consult agreement, *etc.*), as applicable; and,

C. May only provide care, treatment, and services in accordance with this Policy, other applicable Hospital/Medical Staff policies, the Privileges granted to them, and applicable laws, rules, and regulations.

1.2-5 APPs may not admit patients to the Hospital except that Certified Nurse Practitioners (CNP), Clinical Nurse Specialists (CNS), Certified Nurse-Midwifes (CNM), and PAs may admit patients only to the extent such CNPs, CNSs, CNMs, and PAs are acting in compliance with Section 1.2-4 of this Policy. A CNP, CNS, CNM or PA with the Privileges to do so may only admit patients to the service of their collaborating or supervising Medical Staff Member.

1.3 Duties of Medical Staff Members who Supervise or Collaborate with an Advanced Practice Registered Nurse or a Physician Assistant

1.3-1 Those Medical Staff Members with Privileges at the Hospital who supervise or collaborate with an APRN or PA shall agree to:

A. Acquaint the APRN or PA with the APP Policy and other applicable policies of the Medical Staff/Hospital as well as the Practitioners, other APPs, and Hospital personnel with whom the APRN or PA will have contact.

B. Adhere to the requirements of any supervision agreement or standard care arrangement, as applicable, and otherwise provide appropriate supervision/collaboration consistent with this Policy, the APRN's or PA’s Privilege set, and applicable laws, rules, and regulations.

(1) It shall be the responsibility of each supervising Physician or Podiatrist and his/her PA to have and maintain a current, valid supervision agreement in accordance with applicable Ohio laws and State Medical Board of Ohio rules.

(2) It shall be the responsibility of each CNP, CNS, and CNM and his/her collaborating Physician or Podiatrist to have and maintain a current, valid, standard care arrangement in accordance with applicable Ohio laws and Ohio Board of Nursing rules.

C. Provide immediate notice to Medical Staff Services when a collaborating/supervising Practitioner receives notice of (i) any grounds for summary suspension or automatic suspension/automatic termination of the APRN's or PA's Privileges; or (ii) the occurrence of any action that establishes grounds for corrective action against the APRN or PA.

D. Provide immediate notice to Medical Staff Services when the standard care arrangement or supervision agreement expires or is terminated.

E. Provide immediate notice to Medical Staff Services when the Practitioner ceases to serve as the APRN's or PA's supervising or collaborating Practitioner.

F. Acknowledge and convey to the APRN or PA that the APRN's or PA's Privileges at the Hospital shall be automatically suspended or automatically terminated pursuant to the grounds set forth in Section 7.4 and Section 7.5 of this Policy.

1.3-2 Failure to properly supervise or collaborate with an APRN or PA, as applicable, shall be grounds for corrective action against a Medical Staff Member pursuant to the Medical Staff Bylaws.

1.4 Pharmacists

1.4-1 Qualified pharmacists may be granted Privileges to manage patients' drug therapy and order laboratory and diagnostic tests, including blood and urine tests, that are related to the drug therapy being managed, and evaluate the results of the tests that are ordered subject to applicable laws, rules, and regulations.

1.4-2 It shall be the responsibility of each pharmacist who is granted Privileges pursuant to Section 1.4-1 to have and maintain a current, valid consult agreement with those Physicians, APRNs (*i.e.,* CNMs, CNPs, and CNSs), and/or PAs whose patients' drug therapy is managed by the pharmacist in accordance with applicable Ohio laws and rules (*e.g.,* Ohio Board of Pharmacy, State Medical Board of Ohio, and Ohio Board of Nursing).

1.4-3 Pharmacists who are granted Privileges pursuant to Section 1.4-1 shall provide a copy of each consult agreement that he/she enters into, consistent with such Privileges, to the Medical Staff Office.

ARTICLE II
QUALIFICATIONS FOR CLINICAL PRIVILEGES & APP RESPONSIBILITIES

2.1 Nature of Privileges

2.1-1 Granting of Clinical Privileges at the Hospital is a privilege which shall be extended only to professionally competent APPs who continuously meet the qualifications, standards, and requirements set forth in this APP Policy.

2.1-2 No APP shall provide clinical care, treatment, and/or services to patients in the Hospital that require Privileges unless that APP has been granted appropriate Privileges in accordance with the procedures set forth in this Policy.

2.2 Qualifications for Privileges

2.2-1 Unless otherwise provided in this APP Policy, in order for an APP to be eligible for Privileges at the Hospital an APP must meet the following qualifications:

A. Have and maintain a current, valid license issued by the State of Ohio to practice his/her respective profession and meet the continuing education requirements established by the applicable State licensure board.

B. Have and maintain Ohio prescriptive authority (as part of the APP's license) and a current, valid Drug Enforcement Administration registration number as necessary for the Privileges requested.

C. Provide documentation of completion of professional education and training as required by the applicable State licensing entity and such additional education and training as may be set forth in the applicable Delineation of Clinical Privileges.

D. Provide, if applicable, documentation of board certification (*e.g.,* national nursing specialty certification for advanced practice registered nurses, *etc.*) and maintain certification in his/her area(s) of practice at the Hospital by the appropriate professional board(s).

E. Have and maintain current, valid Professional Liability Insurance in an amount no less than one million dollars ($1,000,000,000) per incident and three million dollars ($3,000,000,000) annual aggregate.

F. Be able to participate in Federal Healthcare Programs.

G. Have and maintain a provider number for Medicare issued by the United States Department of Health & Human Services and a provider

number for Medicaid issued by the Ohio Department of Medicaid, as necessary for the Privileges requested.

H. Have not been convicted of or pled guilty to any of the violations described in division (A)(4) of section 109.572 of the Ohio Revised Code which disqualify the applicant from employment or being granted Privileges at a children's hospital pursuant to section 2151.86 of the Ohio Revised Code. In the event an applicant seeks to request a waiver of this qualification on the grounds that the applicant meets the rehabilitation standards as provided for in Ohio Revised Code 109.572(A)(4), the applicant shall follow the waiver procedure set forth in Section 2.2-2 below.

I. Designate an appropriate Practitioner with Medical Staff appointment and Privileges at the Hospital to supervise or collaborate with the APRN or PA.

J. Have and maintain a current, valid supervision agreement (for PAs) or standard care arrangement (for CNPs, CNSs, and CNMs) with his/her supervising or collaborating Physician or Podiatrist, as required by Ohio law, and provide a copy of such agreement/arrangement, and any amendments thereto, to the Hospital.

K. Have and maintain a current, valid consult agreement(s) (for Pharmacists) in accordance with Section 1.4 and provide a copy of such consult agreement(s), and any amendments thereto, to the Hospital.

L. Satisfy such other qualifications as set forth in the applicable Privilege set.

M. Agree to fulfill, and fulfill, the responsibilities, as applicable, set forth in this Policy.

N. Provide such other information as set forth in this Policy or as required by the APP application.

2.2-2 Waiver of Qualifications for Privileges

A. A written request for a waiver of a qualification for Privileges may be submitted by the APP for consideration by the MEC and Board. Qualifications for Privileges may be waived, at the sole discretion of the Board, based upon exceptional circumstances and a Board determination that such waiver will serve the best interests of patient care. The MEC will make a recommendation to the Board regarding whether to grant or deny the request for a waiver. Upon receipt of the MEC's recommendation, the Board shall either grant or deny the

waiver request. Once a waiver is granted, it shall remain in effect from the time it is granted until the APP's resignation or termination of Privileges unless a shorter time period is recommended by the MEC and approved by the Board. The APP must thereafter reapply for the waiver.

B. No APP is entitled to a waiver. A determination by the Board not to grant an APP's request for a waiver; or, the Hospital's inability to process an application; or, termination of an APP's Privileges based upon failure to satisfy the qualifications for Privileges does not give rise to any procedural due process rights nor does it create a reportable event for purposes of federal or state law.

2.3 No Entitlement to Privileges

2.3-1 No APP shall be entitled to exercise particular Clinical Privileges in the Hospital merely by virtue of the fact that he/she: holds a certain degree; is duly licensed to practice his/her profession in this or in any other state; is a member of a professional organization or certified by a clinical board; had in the past, or presently has, privileges at this Hospital or another hospital; or is contracted with or employed by this Hospital.

2.4 Nondiscrimination

2.4-1 No applicant shall be denied Privileges on the basis of: race; color; sex (including pregnancy); sexual orientation; gender identity; gender expression; transgender status; age (40 and older); religion; marital, familial, or health status; national origin; ancestry; disability; genetic information; veteran or military status; or any other characteristic(s) or class protected by applicable law.

2.5 Basic Responsibilities of APPs Granted Privileges

2.5-1 Unless otherwise provided in this APP Policy, the ongoing responsibilities of APPs with Privileges at the Hospital shall include:

A. Providing patients with quality of care meeting the professional standards of the Hospital's Medical Staff.

B. Abiding by this APP Policy and other applicable Medical Staff and Hospital policies (including, but not limited to, the Hospital's corporate compliance program, conflict of interest policies, if applicable, and Notice of Privacy Practices distributed to patients as required by federal patient privacy regulations), and applicable accreditation standards, laws, rules, and regulations.

C. Discharging such APP functions for which he/she is responsible.

D. Preparing and completing in a timely fashion the medical and other required records for all patients he/she provides care, treatment, or services for in the Hospital.

E. Providing continuous care and supervision of his/her patients or otherwise arranging a suitable alternate to provide such care and supervision.

F. Calling for consultation and/or assistance, as needed, in the care of patients; and, providing consultation and assistance in his/her respective area of expertise and for which he/she has Clinical Privileges when requested.

G. Satisfying any continuing professional education requirements necessary to maintain his/her licensure or that may otherwise be established by the Medical Staff.

H. Complying with such notification requirements as set forth in this APP Policy.

I. Working in a cooperative, professional manner and refraining from any conduct or activity that is disruptive to Hospital operations.

J. Participating in, and cooperating with, peer review, quality improvement, and utilization review activities, whether related to the APP or others, as requested by the Medical Staff.

K. Cooperating in any relevant or required review of the APP's or others' credentials, qualifications, clinical performance, or as otherwise required by this APP Policy and refraining from directly or indirectly interfering, obstructing, or hindering any such review, whether by threat of harm or liability, by withholding information, by refusing to perform or participate in assigned responsibilities, or otherwise.

L. Conducting himself/herself consistent with Hospital and Medical Staff policies regarding conflicts of interest and otherwise acting in such a manner that potential conflicts of interest are specifically stated prior to discussions and/or action on issues where such a conflict may exist.

M. Adhering to applicable professional ethical practice guidelines.

N. Participating in and completing the applicable Department orientation for new APPs.

O. Discharging such other APP obligations as may be recommended by the Medical Executive Committee and approved by the Board.

P. Complying with Hospital health screening and immunization requirements (or be granted an exemption thereto) as set forth in the applicable Hospital policies and/or Medical Staff Policies.

2.5-2 Failure to satisfy any of the aforementioned responsibilities may be grounds for denial of regrant of Privileges or corrective action pursuant to this APP Policy.

2.6 Duration of Privileges

2.6-1 Initial granting of Privileges, modification of Privileges, and regrant of Privileges shall be for a period of not more than two (2) years.

2.6-2 A grant of Privileges for less than two (2) years shall not be deemed Adverse for purposes of this APP Policy.

ARTICLE III
PROCESSING APPLICATIONS FOR INITIAL GRANT OF CLINICAL PRIVILEGES

3.1 Responsibility of Producing Information

3.1-1 In connection with all applications for Privileges, the APP shall have the responsibility of producing information for a proper evaluation of the APP's qualifications and for resolving any doubts about his/her qualifications for Privileges.

3.2 Application Content

3.2-1 Application for Clinical Privileges shall be made in writing, on a prescribed original form, and submitted to Medical Staff Services.

3.2-2 Unless otherwise provided in this APP Policy, a completed application shall document, at a minimum, the following information, as applicable:

A. Professional education and training, with specification as to pediatric training.

B. Current and prior affiliations with hospitals, surgery centers, ambulatory care centers, faculty/teaching appointments, *etc.*

C. Other affiliations such as private practice, partnerships, corporations, military assignments, government agencies, *etc.*

D. Current valid license (to include prescriptive authority/prescriber number, as applicable) issued by the State of Ohio to practice his/her respective profession.

E. Out-of-state licenses.

F. Current, valid, Drug Enforcement Administration registration number as necessary for the Privileges requested.

G. Board certification, as applicable (*e.g.,* national nursing specialty certification for advanced practice registered nurses, *etc.*).

H. Affiliation with all local, state, and national professional societies.

I. Documentation of Professional Liability Insurance coverage in an amount not less than $1 million per incident and $3 million per annual aggregate.

J. Designation of alternative coverage arrangements.

K. Completion of the immunization status questionnaire form.

L. Information as required by the Hospital's Tuberculosis Exposure Control Plan. Failure by the APP to comply shall, as applicable, be deemed a voluntary withdrawal of a pending application or result in an automatic suspension of Privileges.

M. The Privileges requested and completion of the applicable delineation of Privileges form(s).

N. Evidence of having met the continuing professional education requirements established by the applicable State licensure board as necessary to maintain current licensure.

O. A statement of the APP's ability to safely and competently exercise the Privileges requested, with or without a reasonable accommodation, according to accepted standards of professional performance as supported by evidence of current competence verifying the APP's ability to perform the Privileges requested and pediatric experience.

(1) If the APP requests an accommodation, the procedure outlined in Section 3.3 below will be followed.

P. Peer references from three (3) Practitioners or APPs in the applicant's same professional discipline who are personally knowledgeable about the applicant's ability to practice (*e.g.,* training, professional competence, and character) and who have known the applicant for at least one (1) year (additional letters may be requested at the discretion of the Section and/or Department Chief(s)). Peer recommendations include information regarding the applicant's clinical knowledge, technical and clinical skills, clinical judgment, interpersonal skills, communication skills, and professionalism.

(1) Peer recommendations are to be in the form of written documentation reflecting informed opinions on each applicant's scope and level of performance; or, a written peer evaluation of APP-specific data collected from various sources for the purpose of validating current competence.

(2) Sources for peer recommendations may include the following: an organization performance improvement committee, the majority of whose members are the applicant's peers; reference letter(s)/form(s) or other written documentation; documented follow-up telephone conversation(s) about the applicant's written peer reference(s); a department or major clinical service chair who is a peer; or an organization's medical executive committee.

Q. Information regarding previously successful or currently pending challenges to the applicant's licensure, board certification/eligibility, or DEA registration or the voluntary or involuntary relinquishment of such licensure, board certification/eligibility, or DEA registration.

R. Information regarding voluntary or involuntary limitation, reduction, suspension, or termination of the applicant's clinical privileges at another hospital/healthcare facility or involuntary suspension or removal from a managed care organization's panel as a result of patient harm.

S. Information regarding the applicant's involvement in professional liability actions (pending claims, judgements, or settlements); list all carriers used for the last ten (10) years.

T. Information as to whether the applicant has been the subject of investigation by a Federal Healthcare Program and, if so, the status or outcome of the investigation.

U. A recent photograph of the applicant.

V. Information as to whether the applicant has ever been named as a defendant in a criminal action and/or convicted of, or pled no contest to, or pled guilty to a crime (other than minor motor vehicle violations).

W. Information necessary to complete a criminal background check including, but not limited to, a driver's license.

X. A valid email address.

Y. A copy of the current, valid standard care arrangement (for CNPs, CNS, and CNMs) or supervision agreement (for PAs) and any amendments thereto. A copy of the current, valid consult agreement(s) (for Pharmacists) and any amendments thereto, in accordance with Section 1.4.

Z. The name of the Practitioner(s) with Medical Staff appointment and Privileges at the Hospital who will supervise or collaborate with the APRN or PA.

AA. The applicant's signature on the completed application.

3.3 Requests for Accommodation

3.3-1 Requests for a reasonable accommodation from applicants for, or APPs with, Privileges at the Hospital shall be forwarded to the Hospital's General Counsel/Legal Services for review and resolution. The General Counsel may consult with the Chief Medical Officer, Medical Staff President, other

appropriate Medical Staff leaders, and/or the Chief Nursing Officer, as needed, in making a determination with respect to such request.

3.3-2 When the Wellness Committee determines that an APP is suffering from an impairment that may be amenable to a reasonable accommodation, the committee shall forward the matter to the Hospital's General Counsel/Legal Services for review and resolution. The General Counsel may consult with the Wellness Committee, as needed, in deciding how the matter should be handled.

3.4 Effect of Signing/Submitting an Application for Privileges

3.4-1 If requested, an applicant shall be given the opportunity to go through the qualifications and other requirements for Privileges with a Hospital representative in person, by telephone, or in writing.

3.4-2 Upon receipt of the application and required application fee, a credentials file shall be created and maintained for the applicant.

3.4-3 By signing and submitting an application for Privileges, the applicant:

A. Acknowledges and attests that the application is correct and complete, and further acknowledges that any material misstatement or omission is grounds for a denial or termination of Privileges.

B. Agrees to appear for personal interviews, if requested, in support of his or her application.

C. Acknowledges the scope and extent of those provisions in Article XII which relate to authorization to obtain and release information, confidentiality of information, immunity for reviews and actions taken, and the right to obtain releases for obtaining and sharing information.

D. Agrees to fulfill APP responsibilities including, but not limited to, practicing in an ethical manner and providing (or arranging for) continuous care of his/her patients.

E. Agrees to notify Medical Staff Services immediately if any information contained in the application changes. The foregoing obligation shall be a continuing obligation of the applicant so long as he or she has Privileges at the Hospital.

F. Acknowledges that he/she has been provided (or has access to) a copy of this APP Policy; that he or she agrees to be bound by and comply with the terms thereof, as well as by/with other applicable Medical Staff Policies, in addition to the Hospital's Code of Regulations and applicable Hospital policies and procedures including, but not limited to, the Hospital's Corporate Integrity Plan if

he or she is granted Privileges; and, to be bound by and comply with the terms thereof in all matters relating to consideration of his or her application without regard to whether the applicant is granted Privileges.

G. Agrees that when an Adverse recommendation or action is made with respect to his or her request for or exercise of Privileges, the applicant will exhaust the administrative remedies afforded by this APP Policy before resorting to formal legal action.

H. Acknowledges that the Hospital and Affiliate Hospital(s) are part of a healthcare system and that information is shared among the Hospital and Affiliate Hospital(s). As a condition of grant of Privileges, the applicant recognizes and understands that any and all information (including peer review information) relative to his/her exercise of Privileges that is maintained, received, and/or generated by the Hospital or Affiliate Hospital(s) may be shared among the Hospital and Affiliate Hospital(s). The applicant further understands that this information may be used as part of the respective Hospital's/Affiliate Hospital's quality assessment and improvement activities and can form the basis for corrective action.

3.5 Credentials Verification Process

3.5-1 Upon receipt of a completed application, Medical Staff Services shall obtain the appropriate documents for review. The information on the application will be verified by the primary source whenever possible. The applicant shall be notified of any problems in obtaining the information required and it shall be the applicant's obligation to obtain the required information. Failure to provide the requested documentation within thirty (30) days after a request therefore will result in the application being incomplete and may be deemed a voluntary withdrawal of the application.

3.5-2 Medical Staff Services shall also:

A. Query and review reports from the National Practitioner Data Bank regarding the applicant.

B. Review results of the applicant's criminal background check.

C. Query appropriate sources (*e.g.,* Office of Inspector General, *etc.*) to determine whether the applicant has been convicted of a healthcare related offense or debarred, suspended, excluded, or otherwise made ineligible for participation in a Federal Healthcare Program.

3.5-3 When collection and verification of materials is accomplished, Medical Staff Services shall transmit the application and all accompanying materials to the appropriate Department and/or Section Chief for review.

3.5-4 Applications will not be forwarded for review and action until Medical Staff Services has deemed the application to be properly completed and all verifications have been obtained.

3.5-5 An interview with the applicant may be conducted as part of the privileging process, at the sole discretion, of the applicable Medical Staff Department Chair or Section Chief, the APP Credentials and Quality Committee, the Medical Staff Credentials Committee, and/or the MEC. If conducted, a written record of the interview will be completed and placed in the applicant's credentials file. If the applicant refuses an interview, the application process may be stopped.

3.6 Procedure for Review and Action on Initial Applications for Privileges

3.6-1 Action by Department and/or Section Chiefs

A. All applications and accompanying materials must be referred to the appropriate Department and/or Section Chief(s) for review and submission to the APP Credentials and Quality Committee.

3.6-2 Action by APP Credentials and Quality Committee

A. Upon receipt of feedback from the Department and/or Section Chief(s), the APP Credentials and Quality Committee shall, at its next regular meeting, review the completed application, accompanying material, and recommendations.

B. Upon completion of its review, the APP Credentials and Quality Committee shall submit its findings (which may be reflected in meeting minutes) to the Credentials Committee for review. The APP Credentials and Quality Committee findings shall include a recommendation that the applicant's request for Privileges be deferred, approved, or denied. A recommendation for approval shall specify the Clinical Privileges recommended.

3.6-3 Action by Credentials Committee

A. Upon receipt of feedback from the APP Credentials and Quality Committee, the Credentials Committee shall, at its next regular meeting, review the completed application, accompanying material, and recommendations.

B. Upon completion of its review, the Credentials Committee shall submit its findings (which may be reflected in meeting minutes) to the Medical Executive Committee for review. The Credentials Committee findings shall include a recommendation that the applicant's request for Privileges be deferred, approved, or denied. A recommendation for approval shall specify the Clinical Privileges recommended.

3.6-4 Action by Medical Executive Committee

A. Upon receipt of the report of the Credentials Committee (which may be reflected in meeting minutes), the Medical Executive Committee will, at its next regular meeting, review the application, the accompanying documentation, and the feedback provided by the Department and/or Section Chief(s), the APP Credentials and Quality Committee, and the Credentials Committee regarding the applicant. Upon completion of its review, the Medical Executive Committee shall take one of the following actions.

(1) Deferral: A decision by the Medical Executive Committee to defer action regarding the application for further consideration will be considered at the next regular meeting of the Medical Executive Committee. Absent unusual circumstances in which the Medical Executive Committee believes that a request for additional information is appropriate, the MEC will proceed with a recommendation to grant or deny the request for Privileges. The Medical Staff President shall promptly send the applicant written notice of a decision by the Medical Executive Committee to defer action on the application.

(2) Favorable Recommendation: When the recommendation of the Medical Executive Committee is favorable to the applicant, the written recommendation (which may be reflected in meeting minutes) regarding the Department/Section assignment, Privileges, and any special conditions to be attached to the Privileges shall be forwarded to the Board.

(3) Adverse Recommendation: When the recommendation of the Medical Executive Committee is Adverse to the applicant, the Medical Staff President shall so inform the applicant, by Special Notice, and the applicant shall then be entitled to the procedural rights, if applicable, set forth in Article VIII of this APP Policy. No such Adverse recommendation shall be required to be forwarded to the Board until after the applicant has exercised, or has been deemed to have waived, his/her procedural due process rights, if any, as provided for in Article VIII.

3.6-5 Action by Board of Directors

A. The Board may take any of the following actions with regard to an application for Privileges:

(1) Favorable MEC Recommendation: The Board may adopt or reject, in whole or in part, a favorable recommendation of the MEC or refer the recommendation back to the MEC for further consideration stating the reasons for such referral back and setting a time limit within which a subsequent recommendation shall be made.

(a) If the Board's decision is favorable to an applicant, it shall be effective as the final decision of the Board and the applicant shall be so informed as set forth in Section 3.6.7 below.

(b) If the Board's decision following a favorable recommendation by the MEC is Adverse to the applicant (and provided that the applicant has not previously been granted or waived his/her procedural due process rights on the application), the Chief Executive Officer shall so notify the applicant, by Special Notice, and the applicant shall be entitled to the procedural rights, if applicable, set forth in Article VIII of this APP Policy.

(2) Without Benefit of MEC Recommendation: If the Medical Executive Committee does not forward a recommendation to the Board within sixty (60) days of the receipt of the Credentials Committee report, the Board may take action on its own initiative following notice to the Medical Executive Committee of the Board's intent to act.

(a) If the Board's decision is favorable to the applicant, it shall be effective as the final decision of the Board and the applicant shall be so informed as set forth in Section 3.6.7 below.

(b) If the Board's decision is Adverse to the applicant, the Chief Executive Officer shall so inform the applicant, by Special Notice, and the applicant shall be entitled, if applicable, to the procedural due process rights set forth in Article VIII of this APP Policy.

(3) After Exercise or Waiver of Procedural Rights: In the case of an Adverse MEC recommendation or an Adverse Board decision, the Board shall take final action in the matter only after the applicant has exhausted or waived his/her procedural rights, if any, as provided for in Article VIII of this APP Policy.

3.6-6 Review by the Joint Conference Committee

A. Whenever the Board's decision is contrary to the recommendation of the MEC, there shall be review of the matter by the Joint Conference Committee prior to final action by the Board.

B. The Joint Conference Committee shall, after due consideration, make its written recommendation (which may be reflected in meeting minutes) to the Board within ten (10) day after referral to the committee.

C. The Board may thereafter take final action. Such action by the Board may include accepting, rejecting, or modifying, in whole or part, the recommendation of the Joint Conference Committee.

3.6-7 Notice of Final Decision

A. Notification of the final decision of the Board of Directors will be sent by the Chief Executive Officer to the Department and/or Section Chief(s), to the applicant, by Special Notice, and as otherwise appropriate.

B. A notice to grant Privileges shall include, as applicable:

(1) The Department/Section to which the APP is assigned.

(2) The Privileges which the APP has been granted.

(3) Information regarding any special conditions attached to the Privileges

3.7 Time Guidelines

3.7-1 The following time periods are considered guidelines and do not create any rights for an applicant to have his/her application processed within these precise periods; provided; however, that this provision shall not apply to the time periods contained in Article VIII of this APP Policy. When the procedure set forth in Article VIII is activated by an Adverse recommendation or action as provided herein, the time requirements set forth therein shall govern the continued processing of the application.

Individual/Group	Time
Medical Staff Services	90 days
Department/Section Chief	15 days
APP Credentials/Quality Committee	Next regular meeting

Credentials Committee	Next regular meeting
MEC	Next regular meeting
Board of Directors	Next regular meeting

ARTICLE IV
PROCEDURE FOR REGRANT OF PRIVILEGES

4.1 Application for Regrant of Privileges

4.1-1 Unless otherwise provided herein, APPs desiring to maintain Clinical Privileges are expected to complete an application packet for regrant of Privileges and submit it to Medical Staff Services by the date set forth on the APP's regrant application.

4.1-2 Failure to file the completed application packet on or before the date set forth on the APP's regrant application may result in the Hospital's inability to process the APP's request for regrant of Privileges by the end of the APP's current Privilege period.

4.2 Content of Application for Regrant of Privileges

4.2-1 Review of requests for regrant of Privileges shall include, but not be limited to, consideration of the following information with respect to each APP since the time of the last grant/regrant of Privileges.

A. Continued satisfaction of the qualifications set forth in Section 2.2 and any additional information with respect to Section 3.2 and Section 3.4 of this Policy as necessary to update the APP's credentials file since the last grant/regrant of Privileges subject to the following:

(1) Additional peer recommendations in accordance with the requirements set forth in Section 3.2.3 (P) of this Policy when insufficient APP-specific data is available.

B. Satisfaction and evidence of continued willingness to satisfy APP responsibilities.

C. The Privileges requested and the reason for any changes thereto. Completion of the applicable delineation of Privileges form(s).

D. Data contained in each APP's Quality Improvement Profile including, but not limited to, focused and ongoing professional practice evaluation data.

E. Timely return of completed information forms when required.

F. Any other criteria which, in the opinion of the Department and/or Section Chief(s) is information necessary for them and the APP

Credentials and Quality Committee, Credentials Committee, MEC, or Board to be able to evaluate the request for regrant of Privileges.

4.3 Processing Applications for Regrant of Privileges

4.3-1 Information with respect to applications for regrant of Privileges shall be collected and verified by Medical Staff Services in accordance with the procedure set forth in Section 3.5 of this Policy

4.3-2 The applicable Department/Section Chief, the APP Credentials and Quality Committee, the Credentials Committee, the MEC, and the Board shall review and act upon applications for regrant of Privileges in accordance with the procedure set forth in Section 3.6 of this Policy.

4.3-3 For purposes of regrant of Privileges, the terms "applicant" and “Privileges” as used in Section 3.5 and Section 3.6 of this Policy shall be read, as "APP" and “regrant of Privileges," respectively.

4.4 Time Periods for Processing Applications for Regrant of Privileges

4.4-1 All individuals and groups required to act on an application for regrant of Privileges must do so in a timely and good faith manner.

4.4-2 If an application for regrant of Privileges has not been fully processed by the expiration date of the APP’s current Privilege period, the APP’s Privileges shall terminate as of the last date of his/her current Privilege period. An APP whose Privileges are so terminated shall not be entitled to the procedural due process rights provided in Article VIII of this APP Policy.

4.4-3 If an APP submits an application within ninety (90) days after termination of his/her Privileges, the application will be treated as an application for regrant of Privileges. If an APP submits an application thereafter, such application shall be treated as an initial application for Privileges.

4.5 Changes in Privileges

4.5-1 An APP may, either in connection with regrant of Privileges or at any other time, request modification of his/her Clinical Privileges by submitting a written request (to include the reasons for such request) to Medical Staff Services. Appropriate documentation must accompany the request (*e.g.,* additional education, training, experience, *etc.*).

4.5-2 A modification request shall be processed in substantially the same manner as an application for regrant of Privileges.

4.5-3 In the event additional Privileges are granted, such Privileges shall be subject to a Focused Professional Practice Evaluation period.

ARTICLE V
PROFESSIONAL PRACTICE EVALUATIONS; APP PRIVILEGE SETS; EMERGENCY, DISASTER, AND TEMPORARY CLINICAL PRIVILEGES

5.1 Professional Practice Evaluation

5.1-1 APPs granted Privileges at the Hospital shall exercise such Privileges consistent with accepted and prevailing standards of care.

5.1-2 The Hospital's focused professional practice evaluation ("FPPE") process shall be set forth in detail in the Practitioner/APP Effectiveness Policy and shall be implemented for all: (1) APPs requesting initial Privileges (2) existing APPs requesting additional Privileges during the course of a current Privilege period; and (3) in response to concerns regarding an APP's ability to provide safe, quality patient care. The FPPE period shall be used to determine the APP's current clinical competence and ability to perform the requested Privileges.

5.1-3 Upon conclusion of the FPPE period, ongoing professional practice evaluation ("OPPE") shall be conducted on all APPs with Privileges. The Hospital's OPPE process shall be set forth in detail in the Practitioner/APP Effectiveness Policy and requires the Hospital to gather, maintain, and review data on the performance of all APPs with Privileges on an ongoing basis.

5.2 Considerations and Privilege Criteria

5.2-1 The Board shall determine the Hospital's scope of patient care services based upon recommendations from Hospital administration and in consultation with the MEC; and, thereafter delegates to the MEC the responsibility of developing the appropriate Privilege set for such services.

5.2-2 Overall considerations for establishing new services and procedures (and for recognizing new techniques with respect to existing procedures) include, but are not limited to:

A. The Hospital's available resources and staff (*e.g.,* equipment required, staff skills/training required, *etc.*).

B. The Hospital's ability to appropriately monitor and review the competence of the Practitioner(s) or APP(s) exercising such Privilege(s) (*e.g.,* risks to patients *etc.*).

C. The availability of another/other qualified Practitioner(s) or APP(s) with Privileges at the Hospital to provide coverage for the service or procedure when needed and/or to provide coverage for the care of patients after the procedure or service is rendered.

D. The quality and availability of training programs.

E. Whether such service or procedure currently, or in the future, would be more appropriately provided through a contractual arrangement with the Hospital.

F. Whether there is a community need for the service or procedure.

5.3 Procedure for APP Request for Recognition of a New Service or Procedure/Technique

5.3-1 Requests by APPs for recognition of a new service or procedure/technique that has not yet been recognized by the Board shall be processed as follows:

A. The APP must submit a written request for recognition of a new service or procedure/technique to Medical Staff Services. The request should include the new service or procedure/technique being requested, the reason why the APP believes the Hospital should recognize such service or procedure/technique and any additional information that the APP believes may be of assistance to the Hospital in evaluating the request.

B. The applicable Department Chief, with involvement of the Section Chief as appropriate, will review requests for new services or procedures/techniques taking into account the considerations set forth in Section 5.2 as well as what types of APPs are likely to request such services or procedures/techniques, positions of specialty societies/certifying boards, and criteria with respect to the services or procedures/techniques by other hospitals with similar resources and staffing (*e.g.,* indications for use, *etc.*). An *ad hoc* committee may be convened to assist with this review.

(1) If the Department Chief recommends that the requested service or procedure/technique be recognized at the Hospital, the Department Chief will prepare a written report including the recommended standards to be met with respect to the following: education; training; board certification; experience; and, the type of professional practice evaluation (*e.g.* whether proctoring/monitoring should be required and, if so, the number of cases/procedures to be included/performed during a Privilege period to establish current competency) required to perform the new service or procedure/technique.

(2) If the Department Chief recommends that the new service or procedure/technique be included in an existing Privilege set, the Department Chief will provide the basis for such determination.

(3) If the Department Chief recommends that the new service or procedure/technique not be offered at the Hospital, the Department Chief will prepare a written report detailing the findings.

C. The Department Chief shall forward a report containing the input of the Department Chief, to the APP Credentials and Quality Committee. Upon receipt of the Department Chief's report, the APP Credentials and Quality Committee will act. The opinion of the APP Credentials and Quality Committee, whether favorable or not favorable, will be forwarded to the Credentials Committee for consideration. The opinion of the Credentials Committee, whether favorable or not favorable, will be forwarded to the MEC for review and action.

5.4 Amendment of Existing Privilege Sets

5.4-1 Proposed amendments to existing Privilege sets shall be reviewed by the applicable Department/Section Chief, the APP Credentials and Quality Committee, and the Credentials Committee and approved by the MEC.

5.4-2 A decision by the MEC not to approve proposed amendments to an existing Privilege set does not constitute an appealable event for purposes of Article VIII of this APP Policy.

5.5 Emergency Privileges

5.5-1 In the case of emergency, any APP, to the degree permitted by his/her license, shall be expected to do everything possible to save the life of a patient, using every facility of the Hospital necessary, including calling for any consultation necessary. Emergency Privileges automatically terminate upon alleviation of the emergency situation. When an emergency situation no longer exists, such APP must request the Privileges necessary to continue to treat the patient. In the event such Privileges are denied or he/she does not desire to request the applicable Privileges, the patient shall be assigned to another APP with Privileges at the Hospital or to a Member of the Medical Staff with appropriate Privileges. An APP who exercises emergency Privileges is not entitled to the procedural due process rights set forth in Article VIII of this APP Policy.

5.5-2 For the purpose of this section, an "emergency" is defined as a condition in which serious permanent harm would result to a patient absent action; or, in which the life of a patient is in immediate danger and any delay in administering treatment would add to that danger.

5.5-3 Any use of emergency Privileges must be reported to Medical Staff Services within three (3) business days by the responsible APP and will be subject to automatic review by the Medical Staff officers, the APP Credentials and Quality Committee, and the Credentials Committee.

5.6 Disaster Privileges

5.6-1 Disaster Privileges may be granted to a licensed, volunteer Ohio APP (subject to applicable Ohio licensure laws, rules, and regulations) who does not otherwise have Privileges at the Hospital when the Hospital's emergency management plan has been activated in response to a disaster and the Hospital is unable to handle immediate patient needs. For purposes of this section, a "disaster" is an emergency that, due to its complexity, scope, or duration, threatens the Hospital's capabilities and requires outside assistance to sustain patient care, safety, or security functions.

5.6-2 Disaster Privileges may be granted, on a case-by-case basis, for up to thirty (30) days at the discretion of one of the following:

A. Chief Executive Officer;

B. Chief Medical Officer;

C. Medical Staff President;

D. Incident Commander (following consultation with the Chief Executive Officer or Chief Medical Officer or Medical Staff President)

5.6-3 Disaster Privileges may be granted following:

A. Verification of a current, valid government-issued picture identification in addition to presentation of at least one (1) of the following:

(1) Current license to practice the applicable profession.

(2) A current photo identification card from a healthcare organization that clearly identifies professional designation.

(3) Confirmation by a Practitioner with current Medical Staff appointment and/or Privileges at the Hospital with personal knowledge regarding the volunteer APP's identity and qualifications.

(4) Identification indicating that the APP is a member of a Disaster Medical Assistance Team (DMAT), the Medical Reserve Corps (MRC), the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP), or other recognized state or federal response organization or group.

(5) Identification indicating that the APP has been granted authority by a government entity to render patient care, treatment, or services in disaster circumstances.

(6) Primary source verification of licensure.

B. Completion of a query of appropriate sources (OIG, *etc.*) to determine whether the volunteer has been convicted of a healthcare related offense or debarred, suspended, excluded, or otherwise made ineligible for participation in a Federal Healthcare Program.

C. Completion and review of a criminal background check.

D. Unless otherwise provided by applicable Ohio licensure laws, rules, and regulations, receipt of the name of the volunteer PA's or APRN's collaborating or supervising Practitioner(s), as applicable, (who must also apply for and be granted disaster Privileges at the Hospital in order for the volunteer APP to be granted disaster Privileges) and receipt of a current, valid supervision agreement (for PAs) or standard care arrangement (for CNPs, CNS, and CNMs) and any amendments thereto.

E. A copy of the current, valid consult agreement(s) (for Pharmacists), and any amendments thereto, in accordance with Section 1.4.

5.6-4 The Medical Administrative Specialist, or designee, is required to present to Medical Staff Services a list of volunteer APP names and copies of the documents listed above (or documentation of the volunteer APP's presentation thereof). A primary source verification of licensure (*i.e.,* through the applicable state licensing board) shall be conducted as soon as the immediate situation is under control or within seventy-two (72) hours from the time the volunteer APP presents to the Hospital, whichever comes first. If primary source verification of licensure cannot be completed within seventy-two (72) hours of the APP's arrival at the Hospital (due to, for example, no means of communication or lack of resources), the Hospital will document all of the following:

A. Reason(s) primary source verification of licensure could not be performed within 72 hours of the APP's arrival at the Hospital.

B. Evidence of the APP's demonstrated ability to continue to provide adequate care, treatment, and services.

C. Evidence of the Hospital's attempt to perform primary source verification of licensure as soon as possible.

5.6-5 In addition to the primary source verification of licensure, the Medical Administrative Specialist will also attempt to:

A. Obtain copies of the volunteer APP's current professional license, a photo identification card from a facility at which the volunteer APP currently practices, and the volunteer APP's driver's license if such

copies were not otherwise initially provided by the volunteer APP pursuant to Section 5.6.2 above.

B. Contact the primary facility at which the volunteer APP practices to verify that he/she is in good standing.

C. Verify the volunteer APP's professional liability insurance coverage.

5.6-6 All volunteer APPs who receive disaster Privileges must, at all times while at the Hospital, wear an identification badge, with photograph, from the facility at which they otherwise hold Privileges. If the volunteer APP does not have such identification, he or she will be issued a badge identifying him or her and designating the APP as an emergency provider.

5.6-7 The activities of volunteer APPs who receive disaster Privileges shall be monitored by the Chief Medical Officer or applicable Department/Section Chief in collaboration with, as applicable, the volunteer APP's supervising or collaborating Practitioner. Based upon oversight of each volunteer APP, a reassessment must be made within seventy-two (72) hours of the volunteer APP's arrival at the Hospital to determine if granted disaster Privileges should continue.

5.6-8 The disaster Privileges shall cease upon alleviation of the circumstances of disaster as determined by the Chief Executive Officer.

5.7 Temporary Privileges

Temporary Privileges may be granted on a case by case basis by the appropriate Hospital leadership as set forth in this section. Temporary Privileges may be granted to APPs under the following circumstances:

5.7-1 Important Patient Care Need

A. To fulfill an important patient care need that mandates an immediate authorization to practice, for a limited period of time, not to exceed ninety (90) days.

B. Temporary privileges for an important patient care need may not exceed two (2) requests during any 12-month period. After two (2) requests for temporary Privileges to meet an important patient care need in a twelve (12) month period, the APP must apply for Privileges at the Hospital through the routine credentialing and privileging process. Temporary Privileges to meet an important patient care need shall be explicitly curtailed by a date of expiration.

C. Temporary Privileges may be granted for an important patient care need upon receipt and verification of a:

(1) Current letter of reference from the APP's primary hospital attesting to his/her character, qualifications, professional standing, and current competence. The letter is required to be from appropriate medical leadership and include the date of grant of privileges at the primary hospital.

(2) Copy of current valid license (to include prescriptive authority/prescriber number, as applicable) authorizing the APP to practice in Ohio.

(3) Copy of current valid DEA certificate, if applicable.

(4) Documentation of current Professional Liability Insurance coverage.

(5) Completion of a query and evaluation of the National Practitioner Data Bank information and such other queries as required by Section 3.5-2 (*e.g.,* OIG, *etc.*).

(6) Information as required by the Hospital's Tuberculosis Exposure Control Plan.

(7) Completion of immunization documentation form.

(8) Criminal background check.

(9) Copy of current curriculum vitae.

(10) The name of the PA's or APRN's collaborating or supervising Practitioner(s) (who must hold Medical Staff appointment and Privileges at the Hospital) and receipt of a current, valid supervision agreement(s) (for PAs) or standard care arrangement(s) (for CNPs, CNSs, and CNMs) and any amendments thereto.

(11) A copy of the current, valid consult agreement(s) (for Pharmacists), and any amendments thereto, in accordance with Section 1.4.

D. Upon written request therefore and subject to Section 5.7-1 (A)-(C), temporary Privileges to meet an important patient care need may be granted by the Chief Executive Officer or Chief Medical Officer upon recommendation of the Medical Staff President.

5.7-2 Pendency of a Completed Application

A. Temporary Privileges may be granted to an applicant for new Privileges while awaiting review and action on the APP's application by the Medical Executive Committee and Board provided the:

(1) APP has submitted a completed application consistent with the requirements set forth in Section 2.2 and 3.2 of this Policy.

(2) Application raises no concerns upon completion of the verification by Medical Staff Services set forth in Section 3.5 of this Policy and following review by the Department/Section Chief(s), APP Credentials and Quality Committee, and Credentials Committee pursuant to Sections 3.6-1, 3.6-2, and 3.6-3 of this Policy.

(3) APP has no current or previously successful challenge to licensure; and, has not been subject to the involuntary limitation, reduction, denial, or loss of clinical privileges.

B. Upon written request therefore and provided the requirements in Section 5.7-2 (A) are met, temporary Privileges to applicants for new Privileges may be granted by the Chief Executive Officer or Chief Medical Officer upon recommendation of the Medical Staff President.

C. Temporary Privileges for applicants for new Privileges may be granted for a limited period of time not to exceed the pendency of the application or one hundred and twenty (120) days, whichever is less. For purposes of this section an "applicant for new Privileges" includes an APP applying for Privileges at the Hospital for the first time, an APP currently holding Privileges who is requesting one or more additional Privileges; and an APP who is in the reprivileging process and is requesting one or more additional Privileges.

D. Temporary Privileges should be granted only when the information available reasonably supports a favorable determination regarding the applicant's request for new Privileges. Under no circumstances may temporary Privileges be granted if the application is still pending because the APP has not responded in a satisfactory manner to a request for clarification of a matter or for additional information.

5.7-3 Additional Information

A. Written notification of a grant of temporary Privileges will be sent by Medical Staff Services to the APP, the appropriate Department and/or Section Chief(s), and other Hospital departments, as appropriate.

B. The APP will be restricted to the specific delineations for which the temporary Privileges are granted. While exercising temporary Privileges, the APP will be monitored by the Department/Section

Chief(s), in cooperation with the APP's supervising or collaborating Practitioner, as applicable.

C. APPs exercising temporary Privileges must agree to abide by this APP Policy and other applicable Medical Staff and Hospital policies.

5.8 TERMINATION OF TEMPORARY OR DISASTER PRIVILEGES

5.8-1 Termination

A. The Chief Executive Officer, the Chief Medical Officer, or the Medical Staff President may, at any time, terminate all, or any portion, of an APP's temporary or disaster Privileges.

B. Where the life or well-being of a patient is determined to be endangered, the APP's temporary or disaster Privileges may be terminated by any person entitled to impose a summary suspension pursuant to this APP Policy.

5.8-2 Procedural Due Process Rights

A. An APP who has been granted temporary or disaster Privileges is not a Member of the Medical Staff and is not entitled to the procedural due process rights afforded to Medical Staff Members.

B. An APP shall not be entitled to the procedural due process rights set forth in Article VIII of this APP Policy because the APP's request for temporary or disaster Privileges is refused, in whole or in part, or because all or any portion of such Privileges are terminated, not renewed, restricted, suspended, or otherwise limited, modified or monitored in any way.

5.8-3 Patient Care

A. In the event an APP's temporary or disaster Privileges are revoked, the APP's patients then in the Hospital shall be assigned to another APP or Practitioner with appropriate Privileges by the Medical Staff President and/or CMO. The wishes of the patient will be considered, where feasible, in choosing a substitute Practitioner or APP.

ARTICLE VI
APP CONDUCT AND IMPAIRMENT MATTERS

6.1 APP Conduct

6.1-1 APPs with Privileges at the Hospital are expected to conduct themselves in a professional and courteous way so as to reflect a respect for the rights of others and foster quality patient care and in accordance with the Medical Staff Practitioner/APP Effectiveness Policy. Actions of APPs that fall below accepted standards of professional conduct or courtesy will be considered misconduct and will not be tolerated. This shall include conduct which has the purpose or effect of interfering with an individual's work performance, interfering with Hospital activities, or creating an intimidating, hostile, or offensive work environment.

6.1-2 The procedure for addressing APP conduct matters is set forth in the Medical Staff Practitioner/APP Professional Conduct Policy located in the Medical Staff Practitioner/APP Effectiveness Policy.

6.2 APP Impairment

6.2-1 The procedure for addressing APP impairment is set forth in the Medical Staff Practitioner/APP Impairment Policy located in the Medical Staff Practitioner/APP Effectiveness Policy.

ARTICLE VII
COLLEGIAL INTERVENTION; CORRECTIVE ACTION; SUMMARY SUSPENSION; AUTOMATIC SUSPENSION; AUTOMATIC TERMINATION

7.1 Informal Collegial Intervention

7.1-1 Collegial Intervention

A. Prior to initiating corrective action against an APP for professional conduct or clinical competency concerns, the Vice President of the Medical Staff may elect, but is not obligated, to attempt to resolve the concern(s) informally.

B. Any such informal/collegial attempts shall be documented and retained in the APP's quality file. If the person of concern is the Vice President of the Medical Staff, then the Medical Staff President shall be the appropriate person to attempt informal resolution.

7.1-2 No Obligation

A. Nothing in this Section shall be construed as obligating the Hospital or Medical Staff leaders to engage in collegial intervention prior to implementing formal corrective action on the basis of a single incident.

B. The Vice President of the Medical Staff/Medical Staff President, may in his/her discretion, involve other Medical Staff leaders, the Chief Medical Officer, and/or the Chief Nursing Officer, to participate in the process and/or may delegate the process to a Department/Section Chief.

C. Collegial intervention efforts may include review of documents and meetings with appropriate individuals, including the APP of concern. All such collegial intervention activities, including implementation of any processes to resolve the problem (all of which must be voluntary), are documented in the APP's quality file.

D. The informal procedures described in this section will continue for as long as reasonable, generally not to exceed 120 days. If the informal procedures described in this section fail to resolve the concern to the satisfaction of the Vice President of the Medical Staff/Medical Staff President, a request for formal corrective action should be initiated.

7.2 Formal Corrective Action Procedure

7.2-1 Grounds for Corrective Action. Corrective action against an APP may be initiated whenever the APP acts, either within or outside the Hospital, in a manner that is or is reasonably likely to be:

A. Contrary to this APP Policy or other applicable Medical Staff Policies, the Hospital's governing documents, or applicable Hospital policies and/or procedures.

B. Detrimental to patient safety or to the quality or efficiency of patient care in the Hospital.

C. Disruptive to Hospital operations.

D. Damaging to the Medical Staff's or the Hospital's reputation.

E. Below the applicable standard of care.

7.2-2 Authorization to Initiate. Any of the following may request that corrective action be initiated:

A. An officer of the Medical Staff.

B. The APP's Department/Section Chief

C. MEC or any other standing Medical Staff committee (or chair thereof)

D. Chief Executive Officer

E. Chief Medical Officer

F. Chief Nursing Officer

G. Board or chair thereof

7.2-3 Initiation, Requests, Notices. All requests for corrective action shall be submitted to the MEC in writing, which writing may be reflected in minutes. The request must include reference to the specific action(s) that constitute(s) the grounds for the request. In the event the request for corrective action is initiated by the MEC, it shall reflect the basis for its recommendation in its minutes.

7.2-4 Investigation. Upon receipt of the request for corrective action, the MEC shall act on the request. The MEC may:

A. Determine that no corrective action is warranted and close the matter.

B. Determine that no corrective action is warranted and remand the matter for collegial intervention consistent with the Medical Staff governing documents.

C. Initiate a formal corrective action investigation in accordance with the requirements set forth in this §7.2.

7.2-5 A matter is under formal investigation upon the following events, whichever occurs first:

A. The APP is notified by an authorized Hospital or MEC representative (either verbally or upon proof of receipt of Special Notice) that a request for corrective action has been submitted to the MEC.

B. The start of an MEC meeting at which a request for corrective action is being presented.

7.2-6 For the sole purpose of determining whether there is a potential reportable event, the matter is under formal corrective action until the end of the MEC meeting at which the issue is presented; provided, however, that if the MEC determines to proceed with a formal corrective action investigation, the matter shall remain under a formal corrective action investigation until such time as the MEC rejects the request for corrective action, closes the investigation, or a final decision is rendered by the Board.

7.2-7 The Medical Staff President shall provide the affected APP with written notice of a determination by the MEC to go forward with a corrective action investigation. Medical Staff Services shall notify the CMO, Chief Nursing Officer, Department Chief and Section Chief of an MEC determination to go forward with a correction action investigation.

7.2-8 The MEC may conduct such investigation itself; assign the task to a Medical Staff officer, a Department Chief, or a standing or *ad hoc* Medical Staff committee; or, may refer the matter to the Board for investigation and resolution.

7.2-9 This investigative process shall not entitle the APP to the procedural due process rights provided in Article VIII of this APP Policy.

7.2-10 The investigating individual/group will proceed with its investigation in a prompt manner. The investigative process may include, without limitation, a meeting with the APP involved who may be given an opportunity to provide information in a manner and upon such terms as the investigating individual/group deems appropriate; with the individual or group who made the request; and/or with other individuals who may have knowledge of or information relevant to the events involved.

7.2-11 If the investigation is conducted by a group or individual other than the MEC or the Board, that group or individual shall submit a written report of the investigation, which may be reflected by minutes, to the MEC as soon as is practical after its receipt of the assignment to investigate. The report should contain such detail as is necessary for the MEC to rely upon it including recommendations for appropriate corrective action or no action at all (and the basis for such recommendations).

7.2-12 MEC Action. As soon as practical following completion of its report (which may be reflected by minutes), or receipt of a report from the investigating individual or group, the MEC shall act upon the request for corrective action. Its action may include, without limitation, the following:

A. A determination that no corrective action be taken.

B. Issuance of a verbal warning or a letter of reprimand.

C. Imposition of a focused professional practice evaluation period with retrospective review of cases and/or other review of professional behavior but without requirement of prior or concurrent consultation or direct supervision.

D. Imposition of prior or concurrent consultation or direct supervision or other form of focused professional practice evaluation that limits the APP's ability to continue to exercise previously exercised Privileges for a period up to fourteen (14) days.

E. Imposition of reduction, limitation/restriction, or suspension of all or any part of the APP's Privileges for a period up to fourteen (14) days.

F. Other actions deemed appropriate under the circumstances that will result in a limitation or reduction of the APP's Privileges for a period up to fourteen (14) days.

G. Recommendation of imposition of prior or concurrent consultation or direct supervision or other form of focused professional practice evaluation that limits the APP's ability to continue to exercise previously exercised Privileges for a period in excess of fourteen (14) days.

H. Recommendation of reduction, limitation/restriction, or suspension of all or any part of the APP's Privileges for a period in excess of fourteen (14) days.

I. Recommendation of revocation of all or any part of the APP's Privileges.

J. Recommendation of other actions deemed appropriate under the circumstances that will result in a limitation or reduction of the APP's Privileges for a period in excess of fourteen (14) days.

K. Referral to Board for action.

7.2-13 Effect of MEC Action

A. The APP shall be notified of the MEC's determination or recommendation.

B. Adverse Recommendation. If the recommendation of the MEC is Adverse to the APP, the recommendation shall be forwarded to the Medical Staff President who shall promptly notify the affected APP, in writing, by Special Notice. The Medical Staff President shall then hold the MEC recommendation until the APP has exercised or waived the procedural due process rights set forth in Article VIII of this APP Policy after which the final MEC recommendation, together with all accompanying information, shall be forwarded to the Board for action.

C. Referral to Board; Failure of MEC to Act. If the MEC (i) refers the matter to the Board for investigation; or (ii) fails to act on a request for corrective action within an appropriate time as determined by the Board, the Board may proceed with its own investigation or determination, as applicable to the circumstances. In the case of (ii), the Board shall make such determination after informing the MEC of the Board's intent and allowing a reasonable period of time for response by the MEC.

(1) If the Board's decision is not Adverse to the APP, the action shall be effective as its final decision and the President of the Medical Staff shall inform the APP of the Board's decision by Special Notice.

(2) If the Board's decision is Adverse to the APP, the President of the Medical Staff shall inform the APP, by Special Notice, and the APP shall be entitled, upon timely and proper request, to the procedural due process rights set forth in Article VIII of this APP Policy.

7.2-14 Other Action. The commencement of corrective action procedures against an APP shall not preclude the summary suspension, automatic suspension, or automatic termination of all, or any portion, of the APP's Privileges in accordance with the procedures set forth in Sections 7.3, 7.4, or 7.5.

7.3 Summary Suspension

7.3-1 Whenever an APP's conduct is of such a nature as to require immediate action to protect, or to reduce the substantial likelihood of injury or imminent danger to the life, health, or safety of any individual at the Hospital (*e.g.,* patient, employee, visitor, *etc.*), or may interfere with the safe and orderly operation of the Hospital, the following shall have the authority to summarily suspend all, or any portion, of the Privileges of such APP:

A. Chief Medical Officer in consultation with the Medical Staff President

B. Physician-in-Chief in consultation with the Chief Medical Officer and the Medical Staff President

C. Surgeon-in-Chief in consultation with the Chief Medical Officer and the Medical Staff President

D. Chief Executive Officer

E. Chief Nursing Officer in consultation with the Medical Staff President

F. Board or Board chair

G. MEC or Medical Staff President in consultation with the CMO

7.3-2 A summary suspension is effective immediately upon imposition. The person or group imposing the summary suspension shall immediately inform the President of the Medical Staff of the suspension and the President of the Medical Staff shall promptly give Special Notice thereof to the APP. The Medical Staff President will also notify the CMO (to the extent the CMO did not otherwise impose such summary suspension) and the APP's Department Chief/Section Chief of the summary suspension.

7.3-3 As soon as possible, but in no event later than five (5) days after a summary suspension is imposed, the MEC, if it did not impose the summary suspension, shall convene to review and consider the need, if any, for corrective action pursuant to the procedure set forth in Section 7.2. The MEC may modify, continue, or terminate a summary suspension provided that the summary suspension was not imposed by the Board or the CEO.

7.3-4 In the case of a summary suspension imposed by the Board or CEO, the MEC shall give its recommendation to the Board/CEO as to whether such summary suspension should be modified, continued, or terminated. The Board/CEO may accept, modify, or reject the MEC's recommendation.

7.3-5 Not later than fourteen (14) days following the original imposition of the summary suspension, the APP shall be advised, by Special Notice, of the MEC's determination; or, in the case of a summary suspension imposed by the Board or the CEO, of the MEC's recommendation as to whether such summary suspension should be modified, continued, or terminated and of the APP's rights, if any, pursuant to Article VIII of this APP Policy.

7.3-6 A summary suspension that is lifted within fourteen (14) days of its original imposition on the grounds that the summary suspension was not required shall not be deemed an Adverse action for purposes of Article VIII of this APP Policy.

7.4 **Grounds for Automatic Suspension of Privileges**

7.4-1 The following events shall result in an automatic suspension or limitation of an APP's Privileges, as applicable, without recourse to the procedural due process rights set forth in Article VIII of this APP Policy.

A. License

(1) Whenever an APP's license is suspended, the APP's Clinical Privileges shall be likewise automatically suspended as of the date such action becomes effective and throughout its term.

(2) Whenever an APP's license is limited or restricted by the applicable licensing authority, the APP's Clinical Privileges shall be automatically limited or restricted in a similar manner as of the date such action becomes effective and throughout its term.

(3) Whenever an APP is placed on probation by the applicable licensing authority, his/her Clinical Privileges shall automatically become subject to the same terms and conditions of the probation as of the date such action becomes effective and throughout its term.

B. DEA Registration

(1) In the event of action by the Drug Enforcement Administration (DEA) or other controlled substances authority suspending an APP's DEA registration number the APP's Privileges shall be automatically suspended as of the date of such action and throughout its term.

(2) In the event of action by the DEA or other controlled substances authority restricting or imposing probation on an APP's DEA registration number the APP's right to prescribe medications covered by the registration shall automatically and correspondingly be limited or made subject to the terms of the probation as of the date of such action and throughout its term.

C. Professional Liability Insurance. If an APP's Professional Liability Insurance coverage lapses, falls below the required minimum, is terminated, or otherwise ceases to be in effect, in whole or in part, the APP's Privileges shall be automatically suspended until Professional Liability Insurance coverage is restored or the matter is otherwise resolved pursuant to Section 7.5-1 (C). Medical Staff Services shall be provided with a copy of the insurance certificate from the insurance company and a written statement explaining the circumstances of the APP's non-compliance with the Hospital's Professional Liability Insurance requirements, any limitation on the new policy, and a

summary of relevant activities during the period of non-compliance. For purposes of this section, the failure of an APP to provide proof of Professional Liability Insurance shall constitute a failure to meet the requirements of this provision.

D. Documentation of TB Test. Failure to adhere to tuberculosis screening requirements as set forth in the Hospital's Tuberculosis Exposure Control Plan shall result in automatic suspension of the APP's Privileges.

E. Delinquent Medical Records. Whenever an APP fails to complete medical records as provided for in applicable Hospital/Medical Staff policies, the APP's Privileges shall be automatically suspended or limited to the extent and in the manner provided for in such Hospital/Medical Staff policies.

F. Federal Healthcare Program. Whenever an APP is suspended from participating in a Federal Healthcare Program, the APP's Privileges shall be likewise immediately and automatically suspended.

G. Investigations, Charges, Indictment. At such time as the Hospital learns through a reliable source that an APP is under investigation by a federal, state, or local law enforcement agency or has been charged or indicted for a violent crime, a crime against a child, or improper prescribing of a controlled substance, the APP's Privileges will be automatically suspended.

H. Suspension/Termination of Supervising or Collaborating Practitioner's Appointment/Privileges. Lapse, suspension, or termination of a PA's or APRN's supervising or collaborating Practitioner's Medical Staff appointment and/or Privileges, for any reason, shall result in an automatic suspension of the APP's Privileges unless the APP has more than one (1) supervising or collaborating Practitioners with Medical Staff appointment and Privileges at the Hospital.

I. Termination/Expiration of Standard Care Arrangement/Supervision Agreement. Termination or expiration of the standard care arrangement (for CNPs, CNSs, and CNMs) or supervision agreement (for PAs) shall result in an automatic suspension of the APP's Privileges unless the APP has more than one (1) current, valid standard care arrangement or supervision agreement with an appropriate Physician or Podiatrist with Medical Staff appointment and Privileges at the Hospital on file in Medical Staff Services.

J. Termination/Expiration of Consult Agreement. Termination or expiration of a Pharmacist's consult agreement shall result in an

automatic suspension of the Pharmacist's Privileges unless the Pharmacist has more than one (1) current, valid consult agreement on file at the Hospital.

K. Immunization/Health Screenings. Failure to provide documentation of required immunizations and/or health screenings (or an approved exemption) in accordance with the requirements set forth in the applicable Hospital policies and/or Medical Staff Policies will result in an automatic suspension of the APP's Privileges subject to Section 7.5-1(I) below.

7.4-2 Impact of Automatic Suspension or Limitation of Privileges

A. With the exception of Section 7.4-1 (E) regarding delinquent medical records, during such period of time when an APP's Privileges are automatically suspended or limited, he/she may not, as applicable, exercise his/her Privileges at the Hospital.

B. An APP whose Privileges are automatically suspended or limited pursuant to Section 7.4-1 (E) for delinquent medical records is subject to the same limitations except that such APP may:

(1) Conclude the management of any patient under his or her care in the Hospital at the time of the effective date of the automatic suspension/limitation of Privileges.

(2) Attend to the management of patients under his or her care requiring emergency care and intervention.

7.4-3 Action Following Imposition of Automatic Suspension

A. At its next regular meeting (or sooner if the Medical Executive Committee deems it appropriate) after the imposition of an automatic suspension, the Medical Executive Committee shall convene to determine if corrective action is necessary in accordance with the procedure set forth in Section 7.2.

B. The lifting of the action or inaction that gave rise to an automatic suspension of Privileges shall result in the automatic reinstatement of the APP's Privileges, as applicable; provided, however, that the APP shall be obligated to provide such information/documentation as Medical Staff Services may reasonably request to assure that the situation that gave rise to the automatic suspension/limitation has been appropriately resolved and that all information in the APP's credentials file is current.

C. Medical Staff Services will notify, as applicable, the Medical Staff President, CMO, and the APP's Department Chief/Section Chief of an

automatic suspension of the APP's Clinical Privileges and the automatic reinstatement thereof.

D. Written notification of an automatic suspension and of reinstatement of Privileges following an automatic suspension shall be given to the affected APP (and his/her collaborating/supervising Practitioner, as applicable) by the Medical Staff President or Chief Medical Officer or Chief Nursing Officer.

7.5 Automatic Termination of Privileges

7.5-1 Imposition of Automatic Termination. The following events shall result in an automatic termination of Privileges without recourse to the procedural due process rights set forth in Article VIII of this APP Policy.

A. Licensure. Action by any applicable licensing authority terminating an APP's professional license shall result in automatic termination of the APP's Privileges.

B. DEA Registration. In the event of action by the DEA or other controlled substances authority revoking an APP's DEA registration number, the APP's Privileges shall automatically terminate.

C. Professional Liability Insurance. If an APP's Professional Liability Insurance coverage lapses, falls below the required minimum, is terminated or otherwise ceases to be in effect for a period greater than thirty (30) days, the APP's Privileges shall automatically terminate as of the thirty-first (31st) day. For purposes of this section, the failure of an APP to provide proof of Professional Liability Insurance shall constitute a failure to meet the requirements of this paragraph.

D. Federal Healthcare Program. Whenever an APP is excluded from participating in a Federal Healthcare Program, the APP's Privileges shall be automatically terminated.

E. Plea of Guilty to Certain Offenses. If an APP pleads guilty or no contest to, or is found guilty of a felony or other serious offense that involves (i) violence or abuse upon a person, conversion, embezzlement or misappropriation of property; (ii) fraud, bribery, evidence tampering or perjury; (iii) a drug offense; or (iv) as otherwise required by Ohio law, the APP's Privileges shall be automatically terminated.

F. Supervising/Collaborating Practitioner. If the APP's Privileges are suspended pursuant to §7.4.1 (H) and the APP does not make arrangements for supervision by/collaboration with an appropriate Practitioner with Medical Staff appointment and Privileges at the

Hospital within thirty (30) days after the automatic suspension, the APP's Privileges at the Hospital shall automatically terminate as of the thirty-first (31st) day.

G. Failure to Submit New Standard Care Arrangement/Supervision Agreement. If the APP's Privileges are suspended pursuant to §7.4.1 (I) and the APP does not submit a new, executed standard care arrangement (for CNPs, CNSs, and CNMs) or supervision agreement (for PAs) with an appropriate Physician or Podiatrist with Medical Staff appointment and Privileges at the Hospital within thirty (30) days after the automatic suspension, the APP's Privileges shall automatically terminate as of the thirty-first (31st) day.

H. Failure to Submit New Consult Agreement. If a Pharmacist's Privileges are suspended pursuant to §7.4.1 (J) and the Pharmacist does not submit a new, executed consult agreement within thirty (30) days after the automatic suspension, the Pharmacist's Privileges shall automatically terminate as of the thirty-first (31st) day.

I. Immunizations/Health Screenings. In the event that documentation of required immunizations and/or health screenings (or an approved exemption) is not provided within sixty (60) days following the date of an automatic suspension of Privileges pursuant to Section 7.4-1(K), then the APPs Privileges shall automatically terminate as of the sixty-first (61st) day.

7.5-2 Medical Staff Services will notify, as applicable, the Medical Staff President, CMO, and the APP's Department Chief/Section Chief of an automatic termination of the APP's Clinical Privileges.

7.5-3 Written notification of an automatic termination of Privileges shall be given to the affected APP (and his/her collaborating/supervising Practitioner, as applicable) by the Medical Staff President or Chief Medical Officer

7.6 Alternate Coverage

Immediately upon the imposition of a summary suspension, automatic suspension, or automatic termination, the Chief Medical Officer, after consultation with the applicable Department Chief, shall have authority to provide for alternative coverage for the patients of the APP who remain in the Hospital at the time of such summary suspension or automatic suspension/termination. The wishes of the patients shall be considered, when feasible, in the selection of such alternative Practitioner or APP. The affected APP shall confer with the covering Practitioner/APP to the extent necessary to safeguard the patient(s).

7.7 Consistency of Action Between Hospital and Affiliate Hospital(s)

7.7-1 So that there is consistency between the Hospital and Affiliate Hospital(s) regarding corrective action and the status of privileges considering that the Hospital and the Affiliate Hospital(s) are part of the same healthcare system and that the Hospital and the Affiliate Hospital(s) have agreed to share information regarding appointment and privileges, the following automatic actions shall occur:

A. With the exception of an automatic suspension for delinquent medical records, if an APP's privileges are automatically suspended or automatically terminated, in whole or in part, at Affiliate Hospital(s), the APP's Privileges at Hospital shall automatically become subject to the same action without recourse to the procedural due process rights set forth in Article VIII of this APP Policy.

B. If an APP's privileges are summarily suspended or if an APP voluntarily agrees not to exercise privileges while undergoing an investigation at Affiliate Hospital(s), such summary suspension or voluntary agreement not to exercise privileges shall automatically and equally apply to the APP's Privileges at Hospital and shall remain in effect until such time as Affiliate Hospital(s) render(s) a final decision or otherwise terminate(s) the process.

C. If an APP's privileges are limited, suspended, or terminated at Affiliate Hospital(s), in whole or in part, based on professional conduct or clinical competency concerns, the APP's Privileges at Hospital shall automatically and immediately become subject to the same decision without recourse to the procedural due process rights set forth in Article VIII of this Policy unless otherwise provided in the final decision at Affiliate Hospital(s).

D. If an APP resigns his/her privileges or fails to seek regrant of privileges at Affiliate Hospital(s) while under investigation or to avoid investigation for professional conduct or clinical competency concerns, such resignation shall automatically and equally apply to the APP's Privileges at Hospital without recourse to the procedural due process rights set forth in Article VIII of this Policy.

7.7-2 If a Practitioner withdraws an initial application for privileges at Affiliate Hospital(s) for professional conduct or clinical competency concerns, such application withdrawal shall automatically and equally apply to applications for Privileges at Hospital without recourse to the procedural due process rights set forth in Article VIII of this Policy.

ARTICLE VIII
PROCEDURAL DUE PROCESS RIGHTS

8.1 APPLICABILITY

8.1-1 The procedural due process rights set forth in this Policy are only applicable to APPs requesting or granted Privileges through the Medical Staff process.

8.1-2 The provisions in the Medical Staff Bylaws and Fair Hearing Policy setting forth the procedural rights of Medical Staff applicants and Medical Staff Members do not apply to APPs.

8.2 PROCEDURAL DUE PROCESS RIGHTS FOLLOWING RECOMMENDATION OF DENIAL OF APPLICATION FOR PRIVILEGES

8.2-1 When the MEC proposes to make a recommendation to deny an APP's application for Privileges based upon professional conduct or clinical competence concerns, the APP shall be provided written notice, by Special Notice, of the MEC's proposed recommendation.

8.2-2 The APP shall then have five (5) days in which to submit a written response to the MEC as to why such Adverse recommendation should be withdrawn and a favorable recommendation made. The APP may meet with the MEC (or a subcommittee of the MEC) upon request. After reviewing the APP's written response and meeting with the APP (if applicable), the MEC shall, within a reasonable timeframe, make its final recommendation to the Board. The APP will be advised, by Special Notice, of the MEC's final recommendation; and, if applicable, the APP's right to appeal.

8.2-3 If the MEC's recommendation continues to be Adverse to the APP, the APP shall have five (5) days in which to submit a written appeal to the Board. At the Board's discretion, it may meet (or have a committee of the Board meet) with the APP. During this meeting, the basis of the Adverse recommendation that gave rise to the appeal will be reviewed with the APP and the APP will have the opportunity to present any additional information the APP deems relevant to the review and appeal of the MEC's Adverse recommendation. After reviewing the Adverse recommendation of the MEC, the APP's written response/appeal, and the results of meetings with the APP, if any, the Board shall take action within a reasonable timeframe.

8.2-4 Whenever the Board determines that it will decide a matter contrary to the recommendation of the MEC, and the matter has not previously been submitted to the Joint Conference Committee, the matter will be submitted to such committee for review and recommendation before the Board makes its final decision.

8.2-5 The APP will receive written notice, by Special Notice, of the Board's final decision.

8.3 PROCEDURAL DUE PROCESS RIGHTS FOLLOWING CORRECTIVE ACTION OR SUMMARY SUSPENSION

8.3-1 The APP shall have five (5) days in which to submit a written response to the MEC as to why such limitation, suspension, or termination of the APP's Privileges should, as applicable, be lifted, rescinded, or not take place. The APP may meet with the MEC (or a subcommittee of the MEC) upon request. After reviewing the APP's written response and meeting with the APP (as applicable), the MEC shall, within a reasonable timeframe, make a recommendation regarding the limitation, suspension, or termination of the APP's Privileges to the Board. The APP shall be advised, by Special Notice, of the MEC's recommendation, the basis for such recommendation; and, if applicable, the APP's right to appeal.

8.3-2 If the MEC recommendation is Adverse to the APP, the APP shall have five (5) days in which to submit a written appeal to the Board. At the Board's discretion, it may meet (or have a committee of the Board meet) with the affected APP. During this meeting, the basis of the Adverse recommendation/action that gave rise to the appeal will be reviewed with the APP and the APP will have the opportunity to present any additional information the APP deems relevant to the review and appeal of the MEC's recommendation. After reviewing, as applicable, the recommendation of the person/group that imposed a summary suspension, the recommendation of the MEC, the APP's written response/appeal, and the results of meetings with the APP, if any, the Board shall take action within a reasonable timeframe.

8.3-3 Whenever the Board determines that it will decide a matter contrary to the recommendation of the MEC, and the matter has not previously been submitted to the Joint Conference Committee, the matter will be submitted to such committee for review and recommendation before the Board makes its final decision.

8.3-4 The APP will receive written notice, by Special Notice, of the Board's final decision.

8.4 EMPLOYER NOTIFICATION

When an APP's Privileges are suspended, terminated, or otherwise curtailed, the APP's employer (if applicable) shall be notified of such action.

ARTICLE IX
LEAVE OF ABSENCE

9.1 Requests for LOA

9.1-1 Requests for a leave of absence (LOA), and extensions thereto, shall be submitted in writing to the APP Credentials and Quality Committee. The APP Credentials and Quality Committee shall review the request for a LOA and make a recommendation to the Credentials Committee. A LOA may be granted to APPs for any reason deemed appropriate by the Credentials Committee, for a specified period of time. Upon a LOA exceeding 365 days, the APP Credentials and Quality Committee will review the LOA for continued appropriateness. Notwithstanding the foregoing, a LOA for an APP may not extend beyond the last date of the APP's current Privilege period.

9.1-2 The APP Credentials and Quality Committee and/or the Credentials Committee may recommend placing an APP on a LOA when said APP is under medical care or convalescence.

9.1-3 Prerogatives During LOA

A. An APP on LOA shall not exercise Privileges in the Hospital during the LOA and APP responsibilities shall be inactive.

B. He/she shall be excused from all meetings during the period of the LOA.

9.1-4 Request for Reinstatement Following LOA

A. At least thirty (30) days prior to termination of the LOA, an APP wishing to return from the LOA and have his/her Privileges reinstated shall submit a summary of relevant activities during the LOA to the APP Credentials and Quality Committee.

(1) An APP returning from a military LOA will be required to submit proof of military status.

(2) An APP returning from medical LOA will be required to submit a Practitioner's report on the APP's ability to resume practice and competently exercise the Privileges requested, with or without a reasonable accommodation, according to accepted standards of professional performance.

(3) APP's returning from an academic LOA shall be required to submit a summary of the educational activities undertaken and evidence of completed training from the appropriate program director.

B. In order to qualify for reinstatement following a LOA, the APP must maintain Professional Liability Insurance coverage during the LOA or purchase tail coverage for all periods during which the APP held Privileges at the Hospital. The APP shall provide information to demonstrate satisfaction of continuing Professional Liability Insurance coverage or tail coverage as required by this provision upon request for reinstatement.

C. Reinstatement of Privileges following a LOA must be approved by the APP's Department/Section Chief(s), the APP Credentials and Quality Committee, Credentials Committee, Medical Executive Committee, and the Board of Directors.

9.2 Failure to Request Reinstatement following a LOA

9.2-1 If an APP fails to request reinstatement of his/her Privileges upon termination of the LOA and is not then under investigation by the Medical Staff, such failure will be deemed a voluntary resignation of the APP's Privileges and shall not give rise to any procedural rights pursuant to Article VIII of this APP Policy.

ARTICLE X
RESIGNATION, TERMINATION, AND REAPPLICATION

10.1 Resignation

10.1-1 Resignation of Privileges shall be submitted in writing at least thirty (30) days in advance of departure to the respective Department Chief (or designated Section Chief) and copies made available to the Chief Medical Officer, Medical Staff Services, and Health Information Management Department.

10.1-2 It is the responsibility of the APP to complete all medical records prior to his/her departure. In the event an APP is deceased, the responsibility of medical record completion will be assumed by the Department Chief (or designated Section Chief).

10.1-3 The name of the APP will be removed from the central mailing system. For information purposes, notice of the resignation will be provided to the APP Credentials and Quality Committee, the Credentials Committee, the Medical Executive Committee, the Board of Directors, and appropriate Hospital personnel, as applicable.

10.2 Termination

10.2-1 In those cases where an APP moves away from the Hospital's service area without submitting a forwarding address, within sixty (60) days of moving, or his/her written intentions with regard to his/her Privileges, the APP's Privileges shall be terminated upon review by the APP Credentials and Quality Committee, the Credentials Committee, recommendation of the Medical Executive Committee, and approval by the Board of Directors.

10.2-2 If a forwarding address is known, the APP will be asked his/her intentions with regard to his/her Privileges; and, if he/she does not respond within thirty (30) days, such failure to respond shall be construed as a voluntary termination of Privileges.

10.3 Report to State Licensing Board

10.3-1 When appropriate, consideration may be given by the Hospital, after consultation with one (1) or more Medical Staff officers, to notifying the applicable State licensing board regarding an APP's actions (*e.g.,* for failure to complete patient records, abandonment, *etc*.).

10.4 Nature of Resignation/Termination

10.4-1 Provided a resignation or termination pursuant to Section 10.1 or Section 10.2 is determined by the Board, following a recommendation of the MEC,

to be voluntary, such resignation or termination shall not give rise to any procedural due process rights set forth in Article VIII of this APP Policy.

10.5 Reapplication and Waiting Periods

10.5-1 Except as otherwise provided in this APP Policy, or as otherwise determined by the Board upon recommendation of the MEC in light of exceptional circumstances, an APP:

A. Whose Privileges are automatically terminated pursuant to Section 7.5-1(A)-(F) may not reapply for Privileges for a period of at least one (1) year from the effective date of the automatic termination.

B. Who has received a final Adverse decision regarding Privileges/regrant of Privileges may not reapply for Privileges for a period of at least two (2) years from the latter of the date of the notice of the final Adverse decision or final court decision.

C. Who has resigned his/her Privileges (to include withdrawal of an application for regrant of Privileges) while under investigation or to avoid an investigation for professional conduct or clinical competency concerns OR who has withdrawn an application for Privileges following an Adverse recommendation by the Medical Executive Committee may not reapply for Privileges for a period of at least two (2) years after the effective date of the resignation or application withdrawal.

10.5-2 Any such reapplication shall be processed as an initial application in accordance with the applicable procedures set forth in this APP Policy, and the APP must submit such additional information as the applicable authorities of the Medical Staff and the Board may reasonably require in demonstrating that the basis of the automatic termination, Adverse decision, or resignation/withdrawal has been resolved or no longer exists. If such information is not provided, the reapplication will be considered incomplete and voluntarily withdrawn and will not be further processed.

No APP may submit or have in process at any given time more than one application for the same Privileges.

ARTICLE XI
CRIMINAL BACKGROUND CHECKS; INTERNAL CONFLICTS OF INTEREST

11.1 Criminal Background Checks

11.1-1 Purpose

A. To promote a safe environment for patients, employees, visitors and the general public by conducting criminal background checks (hereafter "background check") as part of the credentialing process for all APPs.

11.1-2 Procedure

A. A criminal background check shall be performed on APPs applying for Privileges and at the time of each regrant of Privileges. No APP may provide care, treatment, and/or services for patients at the Hospital until all credentialing requirements have been met, including results of a criminal background check, and the APP has been granted Privileges to provide such care, treatment, and/or services.

B. APPs will be required to sign a waiver/consent for a background check. Refusal to provide adequate information on the initial application or regrant form, or to provide consent/waiver for the background check, will result in the Hospital's inability to process the APP's application or termination of Privileges for failure to meet baseline qualifications.

C. The background check process will be initiated by Medical Staff Services and will not be performed until the signed consent/waiver is received by Medical Staff Services.

D. Background checks will be conducted by a third party vendor who will be instructed to provide results to Medical Staff Services personnel only.

E. Background check results will be evaluated and processed in accordance with the Medical Staff procedure for credentialing and will be used for initial credentialing and recredentialing purposes. The following information will be evaluated, as applicable, to determine what action should be taken:

(1) Whether the criminal activity occurred recently.

(2) Number of offenses.

(3) Nature of each offense.

(4) Rehabilitation efforts.

(5) Seriousness of the matter.

(6) Relevance of the matter to the APP's practice.

F. The APP may be asked to provide a written response regarding the report, meet with the applicable Section/Department Chief(s), meet with the APP Credentials and Quality Committee and/or the Credentials Committee, and/or may be required to have a fingerprint check. Failure to respond or agree may result in:

(1) A determination by the Hospital that the application will not be processed because it is incomplete; or,

(2) Referral for corrective action.

G. Reasonable efforts will be made to ensure that results of criminal background checks are kept as confidential as possible with a limited number of individuals authorized to review the results.

H. The APP may review the results of his/her own background check by contacting Medical Staff Services in writing. A copy of the report shall be provided to the APP upon his/her written request directed to Medical Staff Services.

11.2 Internal Conflicts of Interest

11.2-1 In any instance where an APP has or reasonably could be perceived to have a conflict of interest with another Practitioner or APP in any matter that comes before the Medical Staff, a Department/Section, or Medical Staff committee, the APP is expected to disclose the conflict to the individual in charge of the meeting. The APP may be asked and is expected to answer any questions concerning the conflict. The committee (or, in the absence of a committee, the individual in charge of the meeting) is responsible for determining whether a conflict exists and, if so, whether the conflict rises to the level of precluding the APP from participating in the pending matter.

11.2-2 A Department/Section Chief shall have the duty to delegate review of applications to another member of the Department/Section if the Department/Section Chief could reasonably be perceived as not being able to review such application objectively.

11.2-3 For purposes of this section, the fact that APPs (or their supervising or collaborating Practitioners, as applicable) are competitors, partners, or employed in the same group shall not, in and of itself, automatically disqualify such APPs from participating in the review of applications or other Medical Staff matters with respect to their colleagues.

11.3 Adoption & Amendment of APP Policy

This APP Policy shall be adopted, and may be amended, in accordance with the procedure for adoption and amendment of Medical Staff Policies set forth in the Medical Staff Bylaws.

ARTICLE XII
CONFIDENTIALITY, IMMUNITY, RELEASES, & PEER REVIEW

12.1 Definitions

12.1-1 For the purposes of this Article, the following definitions shall apply:

A. Information means minutes, records, reports, memoranda, statements, recommendations, data, and other disclosures whether in written or oral form relating to any of the subject matter specified in this Policy.

B. Representative means the Board and any officer, trustee/director, or committee thereof; the Hospital and the Hospital CEO or CMO; the Medical Staff organization and any officer, Department/Department Chief, Section/Section Chief, or committee thereof; and any individual(s) (*e.g.,* designated Hospital employees, Practitioners, APPs, *etc.*) authorized by any of the foregoing to carry out assigned duties on its behalf.

C. Third Parties means both individuals and organizations providing Information to any Representative.

12.2 Authorizations and Conditions

12.2-1 By applying for, or exercising, Clinical Privileges at the Hospital, an APP:

A. Authorizes Representatives (and Third Parties, as applicable) to solicit, provide, and act upon Information bearing on his/her professional ability and qualifications.

B. Agrees to be bound by the provisions of this Article and to waive all legal claims against any Representative (and Third Party, as applicable) who acts in accordance with the provisions of this Article.

C. Acknowledges that the provisions of this Article are express conditions to his/her application for and grant/regrant of Clinical Privileges at the Hospital.

12.3 Confidentiality of Information

12.3-1 Information with respect to any APP submitted, collected, or prepared by any Representative of this Hospital or any other health care facility or organization or medical staff for the purpose of: evaluating, monitoring, or improving the quality, appropriateness, and efficiency of patient care; reducing morbidity and mortality; evaluating the qualifications, competence, and performance of an APP or acting upon matters relating to corrective action; contributing to teaching or clinical research; determining that

healthcare services are/were professionally indicated and performed in accordance with the applicable standards of care; or establishing and enforcing guidelines to help keep healthcare costs within reasonable bounds shall, to the fullest extent permitted by law, be confidential. Such Information shall not be disclosed or disseminated to anyone other than a Representative or other healthcare facility or organization or medical staff engaged in an official, authorized activity for which the Information is needed; nor, be used in any way except as provided herein or except as otherwise required**/**permitted by law.

12.3-2 Such confidentiality shall also extend to information of like kind that may be provided by/to Third Parties. This information shall not become part of any particular patient's file or of the general Hospital records.

12.3-3 It is expressly acknowledged by each APP that violation of the confidentiality provisions provided herein is grounds for corrective action.

12.4 Immunity From Liability

12.4-1 For Action Taken. No Representative (or Third Party, as applicable) shall be liable to an APP for damages or other relief for any action taken or statement or recommendation made within the scope of his/her duties as a Representative or Third Party provided that such Representative or Third Party does not act on the basis of false Information knowing such Information to be false.

12.4-2 For Providing Information. No Representative or Third Party shall be liable to an APP for damages or other relief by reason of providing Information, including otherwise privileged or confidential information, to a Representative or to any other health care facility or organization or medical staff concerning an APP who is or has been an applicant for Privileges or who did or does exercise Clinical Privileges at the Hospital provided that such Representative or Third Party does not act on the basis of false Information knowing such Information to be false.

12.5 Activities and Information Covered

12.5-1 The confidentiality and immunity provided by this Article shall apply to all Information in connection with the activities of the Hospital/Medical Staff or the activities of any other health care facility or organization or medical staff concerning, but not limited to:

A. applications for Clinical Privileges

B. periodic reappraisals for regrant of Privileges

C. corrective actions

D. procedural due process

E. quality assessment and performance improvement activities

F. utilization reviews

G. other Hospital, Medical Staff, Department/Section, or committee activities related to monitoring and maintaining quality patient care and appropriate professional conduct

12.5-2 The Information referred to in this Article may relate to an APP's professional qualifications including, but not limited to, clinical ability, judgment, the ability to safely and competently exercise the Clinical Privileges requested and to sufficiently demonstrate professional competence, character, professional ethics, or any other matter that might directly or indirectly affect patient care.

12.6 Releases

12.6-1 Each APP shall, upon request of the Hospital, execute general and specific releases in accordance with the nature and intent of this Article, subject to applicable law.

12.6-2 Execution of such releases shall not be deemed a prerequisite to the effectiveness of this Article.

12.7 Cumulative Effect

Provisions in this APP Policy and in application forms relating to authorizations, confidentiality of information, releases, and immunity from liability shall be in addition to other protections provided by law and not in limitation thereof. In the event of conflict, the applicable law shall be controlling.

12.8 Peer Review Files

12.8-1 Peer Review Files

A. This section applies to peer review files maintained by the Medical Staff Services Office and documentation generated by or on behalf of a peer review committee.

B. It is the expectation of the Hospital that appropriate documentation will be maintained in peer review files and/or committee minutes with respect to all actions involving APPs. In the event that peer review files in addition to the standard credentials and quality files are generated (*e.g.,* corrective action investigations, *etc.*), a memo should be placed in the standard credentials or quality file (as appropriate)

referencing the fact of the other file and providing a summary of the facts of the matter, nature of the concern, and conclusions reached.

C. Information with respect to any APP that is submitted, collected, or prepared by any representative of the Hospital or any other health care facility, organization, or medical staff for the purpose of achieving and maintaining the quality of patient care and provided to the APP Quality and Credentials Committee or the Credentials Committee or such other committee whose purpose it is to review and access quality information or otherwise perform quality improvement functions shall, to the fullest extent permitted by law, be held in confidence and not be disseminated except as provided herein or except as otherwise required by law.

D. Any committee as described above shall be considered a peer review committee as described in Ohio Revised Code Section 2305.25 *et seq*.

E. A breach of confidentiality by any Medical Staff representative would include, but not be limited to, the unauthorized release or exchange of any oral or written peer review protected information to any person/group/agency and may violate provisions of the Ohio Revised Code, imposing civil liability. If it is determined that such a breach has occurred, the individual may be subject to corrective action as deemed appropriate by the Medical Staff leadership.

F. Subject to Section 12.8.2., a request for dissemination of information contained in peer review files and committee minutes shall be presumed to require a subpoena. All subpoenas shall be referred to the Legal Services Department. The Legal Services Department will advise and consult with the Medical Staff President and the Chief Medical Officer regarding the particular situation.

12.8-2 Access to Peer Review Files

A. The following individuals shall be authorized representatives with access to Medical Staff peer review files, to the extent necessary to perform official functions, subject to the requirement that confidentiality be maintained:

(1) Medical Staff Services Office Personnel

(2) Respective Section Chiefs and/or Department Chiefs(s)

(3) Officers of the Medical Staff

(4) Chief Medical Officer

(5) Chief Nursing Officer

(6) APP Credentials and Quality Committee and Credentials Committee chairs and committee members

(7) Legal Counsel for Hospital

(8) Credential committee chair of related organizations which have contracted with Nationwide Children's Hospital for credentialing and peer review related services

(9) Peer review committee members appointed and consultants retained by the CMO and/or Medical Staff President for credentialing and peer review purposes

(10) Chief Executive Officer of Hospital

B. The authorized representatives shall have viewing access only in the presence of Medical Staff Services Office personnel and will not be allowed to remove the peer review files from Hospital premises.

C. An APP will be permitted access to all information in the APP's peer review file submitted by the APP. Subject to Section 12.8-2(D), an APP shall not have access to any other information in the APP's peer review file.

D. Subject to the access rights described hereinabove, information contained in the peer review files of any APP may be disclosed only with the written consent of the APP and only after approval by the CMO and President of Medical Staff in consultation with Hospital legal counsel.

E. Requests for credentialing information from external organizations shall be in writing, include the reasons for the information, and a statement signed by the APP releasing from liability all those providing the information.

F. Requests for information from third parties regarding clinical evaluation, restriction of Privileges, or Adverse actions will be referred to the respective Section Chief and/or Department Chief(s) for completion along with a signed release of liability from the APP. The Chief(s) will return a copy of completed requests to the Medical Staff Services Office.

G. No information will be released to third parties by telephone except for confirmation of the APP's name and respective Department Chiefs(s) and/or Section Chief(s).

H. Accreditation surveyors shall be entitled to inspect Medical Staff credential files on the Hospital premises in the presence of Medical Staff Services Office personnel.

I. Individuals representing managed care organizations shall have limited access to the Medical Staff peer review files, in the presence of Medical Staff Services Office personnel, with a signed release of liability from the APP. Documents contained in the files are viewable only and cannot be copied.

12.8-3 Location and Security Precautions

A. All Medical Staff peer review files shall be maintained in the Medical Staff Services Office. Such files shall be secured and under the supervision of the Medical Staff Services Office Manager. The files shall be secured except during such times as the Medical Staff Services Office personnel are physically present and able to monitor access.

B. Medical Staff peer review files will not be removed from the Medical Staff Services Office unless under the supervision of Medical Staff Services Office personnel.

12.8-4 Medical Staff Peer Review Committee and Department/Section Minutes

A. Dissemination to third parties of Medical Staff peer review committee minutes or the peer review portion of Department and/or Section minutes, related documents, and appendages shall only be made where expressly required by law.

B. Access to minutes by persons performing official Hospital or Medical Staff functions shall be permitted only to the extent necessary to perform said functions upon approval of the Medical Staff President, CMO, and Hospital legal counsel.

C. Provisions shall be taken to protect all peer review minutes from disclosure as follows:

(1) Minutes shall be restricted to those actually involved in the peer review process.

(2) Minutes distributed at a meeting may be collected at the conclusion of a meeting. Otherwise, it is the committee member’s responsibility to maintain confidentiality of all minutes.

(3) Minutes shall be stamped “Confidential Peer Review Information Protected by Law” under Ohio Revised Code 2305.25, *et seq*.

D. Accreditation surveyors shall be entitled to inspect Medical Staff committee minutes or Department and/or Section minutes in the presence of Medical Staff Services Office personnel.

ADOPTION AND APPROVAL

This Advanced Practice Provider Policy shall replace any previous policies with respect to Advanced Practice Providers, and shall become effective when adopted by the Medical Executive Committee and approved by the Board of Directors.

ADOPTED BY THE MEDICAL EXECUTIVE COMMITTEE: November 16, 2021

APPROVED BY THE BOARD OF DIRECTORS: November 16, 2021

EXHIBIT A

Advanced Practice Providers Eligible for Clinical Privileges

Certified Nurse Practitioners
Certified Nurse-Midwives
Clinical Nurse Specialists
Certified Registered Nurse Anesthetists
Pharmacists (limited to those Pharmacists who have or will enter into Pharmacist consult agreements)
Physician Assistants
Optometrists