NATIONWIDE CHILDREN'S HOSPITAL TOLEDO MEDICAL STAFF CREDENTIALS POLICY

Revised: 10/31/2024

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ARTICLE I

DEFINITIONS & DESIGNEES

1.1 DEFINITIONS

1.1-1 The definitions set forth in the Medical Staff Bylaws shall apply to this Medical Staff Credentials Policy unless otherwise provided herein.

1.2 USE OF A DESIGNEE

1.2-1 Whenever an individual is authorized in the Medical Staff governing documents to perform a duty by virtue of his/her position, then reference to the individual shall also include the individual's authorized designee.

ARTICLE II

MEDICAL STAFF APPOINTMENT, REAPPOINTMENT, AND CLINICAL PRIVILEGES

2.1 NON-DISCRIMINATION

No Practitioner shall be denied Medical Staff appointment and/or 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 (provided that the applicant can competently exercise the Privileges requested with or without a reasonable accommodation); genetic information; veteran or military status; or any other characteristic(s) or class protected by applicable law.

2.2 NO ENTITLEMENT

No Practitioner shall be entitled to appointment to the Medical Staff and/or to the performance of Clinical Privileges at the Hospital merely by virtue of the fact that he or she holds a certain degree; is duly licensed to practice in this or any other state; is certified by any clinical board; is a member of any professional organization; had in the past, or presently has, medical staff appointment and/or similar privileges at another hospital or healthcare entity; or is employed by or contracts with the Hospital.

2.3 DURATION OF MEDICAL STAFF APPOINTMENT AND/OR PRIVILEGES

2.3-1 Granting of Medical Staff appointment, reappointment, and/or Privileges/regrant of Privileges shall be for a period of not more than two (2) years.

2.3-2 A Medical Staff appointment, reappointment, and/or grant/regrant of Privileges of less than two (2) years shall not be deemed Adverse for purposes of the Medical Staff governing documents.

2.4 RESOURCES

Requests for Medical Staff appointment and/or Privileges must be compatible with the policies, plans, and objectives formulated by the Board concerning: the Hospital's patient care needs (including current and projected needs) and the care, treatment, and/or services provided by the Hospital; the Hospital's ability to provide the facilities, equipment, personnel, and financial resources necessary if the application is approved; and the Hospital's decision to contract exclusively for the provision of certain medical/professional services with a Practitioner or group of Practitioners other than the applicant.

2.5 APPLICATION FOR MEDICAL STAFF APPOINTMENT AND/OR PRIVILEGES

2.5-1 Unless otherwise provided in the Medical Staff governing documents, an application for Medical Staff appointment and/or Privileges shall include the following, as applicable:

(a) Professional education and training, with specification as to pediatric training.

(b) ECFMG number.

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

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

(e) Current valid license to independently practice his/her respective profession in Ohio.

(f) Out-of-state licenses.

(g) Current, valid, Drug Enforcement Administration registration number as necessary for the Privileges requested.

(h) National Provider Identifier (NPI) number.

(i) Board certification status consistent with the requirements set forth in Article VII of this Policy.

(j) Affiliation with all local, state, and national professional societies.

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

(l) Designation of alternative coverage arrangements.

(m) Completion of the immunization status questionnaire form.

(n) Information as required by the Hospital's Tuberculosis Exposure Control Plan. Failure by the Practitioner to comply shall, as applicable, be deemed a voluntary withdrawal of a pending application or result in an automatic suspension of Medical Staff appointment and/or Privileges in accordance with the Medical Staff Bylaws.

(o) The Medical Staff category requested, the Privileges requested (if any), and completion of the applicable Delineation of Privileges form(s).

(p) Evidence of having met the continuing medical or other professional education requirements established by the applicable state licensure board as necessary to maintain current licensure.

(q) A statement of the Practitioner'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 Practitioner's ability to perform the Privileges requested and pediatric experience (*e.g.*, surgical/procedure/case logs from hospitals, ambulatory care facilities, and/or office procedures for which the Practitioner was the primary Practitioner, listed separately for each facility).

(1) Clinical case logs must be for the last two (2) years and are required to include name and signature, patient identifier (not to include patient names), facility name, type of procedures, date of procedures, and age or date of birth).

(r) Peer references from three (3) Practitioners 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 Chief and/or Department Chair). Peer recommendations include information regarding the applicant's medical/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 Practitioner-specific data collected from various sources for the purpose of validating current competence.

(2) Sources for peer recommendations may include the following: an organization's 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 chair/section chief; or an organization's medical executive committee.

(s) Information regarding previously successful or currently pending challenges to the applicant's licensure, board certification/eligibility, or DEA registration or the voluntary (while under investigation or to avoid investigation for a conduct or clinical competence matter) or involuntary

relinquishment of such licensure, board certification/eligibility, or DEA registration.

(t) Information regarding voluntary (while under investigation or to avoid investigation for a conduct or clinical competence matter) or involuntary limitation, reduction, suspension, or termination of the applicant's medical staff membership and/or 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.

(u) 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.

(v) Information as to whether the applicant has been the subject of investigation by a Federal Health Program and, if so, the status or outcome of the investigation.

(w) A recent photograph of the applicant.

(x) 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).

(y) Information necessary to complete a criminal background check pursuant to Section 6.3 including, but not limited to, a driver's license.

(z) A valid email address.

(aa) Such additional information as may be required by the application.

(bb) The applicant's dated signature on the completed application.

2.6 EFFECT OF APPLICATION

2.6-1 By signing and submitting an application for Medical Staff appointment and/or Privileges, the applicant:

(a) Attests that the application is correct and complete and acknowledges that any material misrepresentation, misstatement, or omission is grounds to cease processing an application or for termination of Medical Staff appointment and/or Privileges.

(b) Agrees to appear for interviews in support of his/her application.

(c) Agrees to the applicable provisions set forth in the Medical Staff Bylaws regarding confidentiality, immunity, and release of liability.

(1) Authorizes the Board, the Hospital, its Medical Staff, and their authorized representatives to consult with others who have been associated with the applicant and who may have information bearing on his/her qualifications for Medical Staff appointment and/or Privileges and releases the Board, the Hospital, its Medical Staff, and their representatives from liability for so doing.

(2) Authorizes the Board, the Hospital, its Medical Staff, and their authorized representatives to review all records and documents that may be material to an evaluation of the applicant's qualifications for Medical Staff appointment and/or Privileges and releases the Board, the Hospital, its Medical Staff, and their representatives from liability for so doing.

(3) Authorizes the Board, the Hospital, its Medical Staff, and their authorized representatives to provide to other hospitals, licensing boards, and other organizations concerned with provider performance and the quality and safety of patient care with information relevant to such matters that the Hospital may have concerning the Practitioner and releases the Board, the Hospital, its Medical Staff, and their representatives from liability for so doing.

(d) Agrees to fulfill Medical Staff responsibilities if Medical Staff appointment and/or Privileges are granted.

(e) Acknowledges receiving access to the Medical Staff governing documents.

(1) Agrees to be bound by the terms of and to comply in all respects with the Medical Staff governing documents in all matters related to consideration of the applicant's application whether or not Medical Staff appointment and/or Privileges are granted.

(2) Agrees to be bound by the terms of and to comply in all respects with the Medical Staff governing documents as well as applicable Hospital policies (*e.g.*, corporate compliance plan, notice of privacy practices, conflict of interest policies, *etc.*) if granted Medical Staff appointment and/or Privileges at the Hospital.

(f) Agrees that if an Adverse recommendation or action is made/taken with respect to Medical Staff appointment and/or Privileges, the applicant will exhaust the administrative remedies afforded by the Bylaws and Fair Hearing Policy before resorting to formal legal action.

(g) Understands and agrees that if Medical Staff appointment and/or Privileges are denied based upon the applicant's competence or conduct,

the applicant may be subject to reporting to the National Practitioner Data Bank and/or state authorities.

(h) Agrees to promptly notify the Medical Staff Office, in writing, within ten (10) days following any changes to the information set forth in the applicant's Medical Staff application. The foregoing obligation shall be a continuing obligation of the applicant so long as he/she has an application pending for Medical Staff appointment and/or Privileges or holds Medical Staff appointment and/or Privileges at the Hospital.

(i) 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). The applicant recognizes and understands that any and all information (including peer review information) relative to Medical Staff appointment and/or Privileges that is maintained, received, and/or generated by the Hospital or Affiliate Hospital(s) may be shared between/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 performance improvement activities and can form the basis for corrective action.

2.7 MEDICAL STAFF APPOINTMENT AND PRIVILEGING PROCESS

2.7-1 APPLICANT'S BURDEN

(a) An application and appropriate documents will be sent to interested applicants upon request.

(b) A completed application for Medical Staff appointment and/or Privileges must be submitted to the Medical Staff Office by the applicant electronically on the Hospital-approved form, signed by the applicant, and accompanied by the full amount of the non-refundable application fee.

(c) Upon receipt of the application and required non-refundable application fee, a credentials file will be created and maintained for each applicant by the Hospital.

(d) The applicant shall have the burden of producing adequate information for a proper evaluation of his/her qualifications for Medical Staff appointment and/or Privileges and for resolving any doubts about such qualifications.

(e) The applicant shall be responsible for providing a complete application. An application shall be considered incomplete if the need arises at any time for new, additional, or clarifying information.

(f) Until the applicant has provided all information requested, the application for Medical Staff appointment and/or Privileges will be deemed incomplete and will not be processed.

(g) Failure, without good cause, by an applicant to respond to a request for additional information regarding his/her pending application within thirty (30) days after written request for such additional information may be deemed a voluntary withdrawal of the application and the applicant's file will be closed.

(h) For any future consideration for Medical Staff appointment and/or Privileges, the applicant must request and submit a new initial application including application fee.

2.7-2 CREDENTIALING COLLECTION AND VERIFICATION PROCESS

(a) The Medical Staff Office is responsible for collection and verification of applications, and accompanying materials, for Medical Staff appointment and/or Privileges. The Medical Staff Office shall:

(1) Query and review the AMA Physician Masterfile or the American Osteopathic Association Physician Profile Report regarding Physician applicants.

(2) Query and review reports from the National Practitioner Data Bank regarding the applicant.

(3) Review results of the applicant's criminal background check.

(4) Query the appropriate sources (*e.g.*, Office of Inspector General's Cumulative Sanction report, General Services Administration List of Parties Excluded from Federal Procurement and Non-Procurement Programs, *etc.*) to determine whether the applicant has been convicted of a health care related offense, or debarred, precluded, excluded, or otherwise made ineligible for participation in a Federal Health Program.

(b) Applications will not be forwarded for review and action until the Medical Staff Office has deemed the application to be properly completed and all verifications have been obtained.

(c) When the application is complete and the collection and verification process is finished, the Medical Staff Office shall notify the Department Chair (and Section Chief, as applicable) that the application and all accompanying materials are available for review.

2.7-3 REVIEW BY DEPARTMENT CHAIR/SECTION CHIEF AND CHIEF MEDICAL OFFICER

(a) The chair of the Medical Staff Department (and, as applicable, the chief of the Section) in which the applicant seeks Clinical Privileges will review the application and accompanying materials to assess the applicant's qualifications for Medical Staff appointment and/or Privileges.

(b) The Department Chair, Section Chief, and/or the Chief Medical Officer may, at their discretion, interview the applicant.

(c) Following such review and interview, if any, the Department Chair (and Section Chief, as applicable) will provide a written recommendation(s) as to approval or denial of the applicant's request for Medical Staff appointment and/or Privileges to the Chief Medical Officer for review and submission to the Medical Executive Committee.

2.7-4 RECOMMENDATION BY MEDICAL EXECUTIVE COMMITTEE

(a) At its next regular meeting after receipt of a recommendation from the Department Chair (Section Chief, as applicable) and the Chief Medical Officer, the MEC shall consider any such recommendations, review the application and accompanying materials, and may take any of the following actions (which may be set forth in the MEC's meeting minutes):

(1) Deferral: The MEC may table a recommendation on the application and note in the MEC minutes the deferral and the reason(s) therefore. A decision by the MEC to defer the application for further consideration must be revisited at the next regularly scheduled MEC meeting, except for good cause, at which point the MEC shall issue its recommendation as to approval or denial of Medical Staff appointment and/or Privileges.

(2) Favorable Recommendation: If the recommendation of the MEC is favorable to the applicant, the MEC shall forward its recommendation to the Board for action.

(3) Adverse Recommendation: If the recommendation of the MEC is Adverse to the applicant, the Medical Staff President shall notify the applicant of the Adverse recommendation, by Special Notice, and of the applicant's right, as applicable, to request a hearing. No such Adverse recommendation shall be forwarded to the Board until after the applicant has exercised or has been deemed to have waived his or her right, as applicable, to a hearing as provided for in the Fair Hearing Policy.

2.7-5 BOARD ACTION

At its next regular meeting after receipt of a recommendation from the MEC, the Board may take any of the following actions:

(a) Deferral: The Board may table a decision on the application and note in the Board minutes the deferral and the reason(s) therefore.

(b) Favorable MEC Recommendation: If the Board receives a favorable MEC recommendation, the Board may:

(1) Refer the matter back to the MEC for additional consideration. The Board must state the reason(s) for the requested reconsideration and set a time limit within which a subsequent MEC recommendation to the Board must be made.

(2) Grant Medical Staff appointment and/or Privileges as recommended by the MEC. If the Board's decision is favorable to the applicant, the action shall be effective as the Board's final decision.

(3) Reject or modify the MEC's favorable recommendation in whole or in part. If the Board's proposed decision is contrary to the MEC's favorable recommendation, the matter shall be referred to the Joint Conference Committee pursuant to subsection 2.7-6 below.

(i) If the Board's determination is Adverse to the applicant following such referral (and provided the applicant has not previously been granted a hearing on the application by the MEC) the Chief Operating Officer shall notify the applicant, by Special Notice, and the applicant shall be entitled, if applicable, to the procedural due process rights provided for in the Fair Hearing Policy upon proper and timely request therefore.

(ii) Such Adverse decision shall be held in abeyance until the applicant has exercised or been deemed to have waived his/her procedural due process rights, if any, under the Fair Hearing Policy.

(iii) The fact that the Adverse decision is held in abeyance shall not be deemed to confer Medical Staff appointment and/or Privileges where none existed before.

(c) Without Recommendation from MEC

(1) If the Board, in its determination, does not receive a recommendation from the MEC within an appropriate time frame, the Board may, after informing the MEC of the Board's intent and allowing a reasonable period of time for response by the MEC, make its own determination using the same type of criteria considered by the MEC.

(2) If the Board's decision is favorable to the applicant, the Board action shall be effective as its final decision.

(3) If the Board's decision is Adverse to the applicant, the Chief Operating Officer shall inform the applicant, by Special Notice, and the applicant shall be entitled, if applicable, to the procedural due process rights provided for in the Fair Hearing Policy.

(i) Such Adverse decision shall be held in abeyance until the applicant has exercised or been deemed to have waived his/her procedural due process rights, if any, under the Fair Hearing Policy.

(ii) The fact that the Adverse decision is held in abeyance shall not be deemed to confer Medical Staff appointment and/or Privileges where none existed before.

(d) Adverse MEC Recommendation

(1) If the Board is to receive an Adverse MEC recommendation, the Medical Staff President shall withhold the recommendation and not forward it to the Board until after the applicant either exercises or waives his/her right, if any, to the procedural due process rights set forth in the Fair Hearing Policy.

(2) The Board shall thereafter take final action in the matter as provided for in the Fair Hearing Policy.

2.7-6 REFERRAL TO JOINT CONFERENCE COMMITTEE

(a) Whenever the Board's proposed decision is contrary to the recommendation of the MEC, there shall be a review of the matter by the Joint Conference Committee.

(b) The Joint Conference Committee shall, after due consideration, make its written recommendation to the Board within seven (7) days after referral to the committee. Thereafter, the Board may act. Such action by the Board may include accepting, rejecting, or modifying, in whole or in part, the recommendation of the Joint Conference Committee.

2.7-7 FINAL DECISION

(a) The Board, through the Chief Operating Officer, shall give notice of the Board's final decision to the applicant and to the Medical Staff President. The Medical Staff and Hospital personnel shall be notified, as appropriate.

(b) A notice regarding a grant of Medical Staff appointment and/or Privileges shall include, as applicable: the Medical Staff category to which the

applicant is appointed; the Department/Section to which he/she is assigned; the Privileges he/she may exercise; and any special conditions attached to the appointment and/or Privileges.

2.8 TIME PERIOD GUIDELINES FOR PROCESSING

2.8-1 All individuals and groups required to act on an application for Medical Staff appointment and/or Privileges must do so in a timely and good faith manner.

2.8-2 The following time periods will be used as a guideline:

(a) Department Chair/Section Chief/Chief Medical Officer: Within 30 days following notification from the Medical Staff Office that the complete application is available for review.

(b) Medical Executive Committee: Next regular meeting after receipt of a recommendation from the Department Chair (Section Chief, as applicable) and Chief Medical Officer.

(c) Board: Next regular meeting after receipt of a recommendation from the MEC.

2.8-3 This timeline is a guideline and shall not create any rights for the applicant to have an application processed within these time periods.

2.8-4 If additional information is needed from the applicant, the time awaiting a response from the applicant shall not count towards the applicable time period guideline.

2.8-5 If the provisions of the Fair Hearing Policy are activated, the time requirements provided therein govern the continued processing of the application.

2.9 RESIGNATIONS

2.9-1 A Practitioner who desires to voluntarily resign his/her Medical Staff appointment and/or one (1) or more of the Privileges granted shall submit a written resignation to the Medical Staff Office. Notification of the resignation will be communicated by the Medical Staff Office as appropriate.

2.9-2 A resignation should be submitted sufficiently in advance to assure that there is continuity of patient care and no disruption in services. A Practitioner who resigns his/her Medical Staff appointment and/or Privileges is obligated to complete all medical records for which he/she is responsible prior to the effective date of the resignation. In the event a Practitioner fails to do so, consideration may be given by the Hospital to contacting the applicable state licensing board regarding the Practitioner's actions.

2.10 REAPPLICATION

2.10-1 Except as otherwise provided in the Medical Staff governing documents, or as otherwise determined by the Board upon recommendation of the Medical Executive Committee in light of exceptional circumstances:

(a) A Practitioner whose Medical Staff appointment and Privileges are automatically terminated pursuant to Section 7.5.1 (a), (b), (d), or (e) of the Medical Staff Bylaws shall not be eligible to reapply for Medical Staff appointment and/or Privileges for a period of at least two (2) years following the effective date of the automatic termination.

(b) A Practitioner who has received a final Adverse decision regarding Medical Staff appointment/reappointment and/or Privileges/regrant of Privileges shall not be eligible to reapply for Medical Staff appointment and/or Privileges for a period of at least two (2) years following the latter of the date of the notice of the final Adverse decision or final court decision.

(c) A Practitioner who has resigned his/her Medical Staff appointment and/or Privileges or who fails to seek reappointment/regrant of Privileges while under investigation or to avoid an investigation for professional conduct or clinical competency concerns shall not be eligible to reapply for Medical Staff appointment and/or Privileges for a period of at least two (2) years following the effective date of the resignation.

(d) A Practitioner who has withdrawn an initial application for Medical Staff appointment and/or Privileges for professional conduct or clinical competency concerns shall not be eligible to reapply for Medical Staff appointment and/or Privileges for a period of at least two (2) years following the date of the withdrawal.

2.10-2 Any such reapplication shall be processed as an initial application, in accordance with the applicable procedures set forth Section 2.7 and the Practitioner must submit such additional information as may be reasonably required to demonstrate that the basis for the automatic termination, Adverse decision, resignation, or 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.

ARTICLE III

MEDICAL STAFF REAPPOINTMENT/REGRANT OF PRIVILEGES

3.1 APPLICATION FOR MEDICAL STAFF REAPPOINTMENT/REGRANT OF PRIVILEGES

3.1-1 Unless otherwise provided herein, Practitioners desiring to maintain Clinical Privileges and/or Medical Staff membership are expected to complete an application packet for Medical Staff reappointment and/or regrant of Privileges and submit it to the Medical Staff Office by the date set forth on the Practitioner's reappointment/regrant application. The Practitioner must sign the application for Medical Staff reappointment/regrant of Privileges and in so doing accepts the same conditions as set forth in Section 2.6.

3.1-2 A Practitioner who is required to pay Medical Staff dues that has unpaid dues at the end of the Practitioner's current Medical Staff appointment and/or Privilege period shall not be eligible to apply for Medical Staff reappointment and/or regrant of Privileges until such time as the dues are paid.

3.1-3 The Practitioner has the burden of producing adequate information for a proper evaluation of his/her qualifications for Medical Staff reappointment and/or regrant of Privileges, of resolving any doubts about such qualifications, and of satisfying requests for additional information or clarification made by authorized Medical Staff or Hospital representatives as set forth in Section 2.7-1.

3.1-4 Failure to return an application for Medical Staff reappointment and/or regrant of Privileges by the expiration date of the Practitioner's current appointment/Privilege period is deemed a voluntary resignation and results in automatic termination of the Practitioner's Medical Staff appointment and Privileges at the expiration of his/her current appointment/Privilege term. For any future consideration for Medical Staff appointment and/or Privileges, the Practitioner will need to submit a new initial application, including application fees.

3.1-5 Review of requests for Medical Staff reappointment and/or regrant of Privileges shall include, but not be limited to, consideration of the following information with respect to each Practitioner since the time of the last Medical Staff appointment/reappointment and/or grant/regrant of Privileges:

(a) Continued satisfaction of the qualifications for Medical Staff appointment and/or Privileges as set forth in Section 2.2 of the Medical Staff Bylaws and the applicable Medical Staff category and/or Privilege set.

(b) Updated information provided by the Practitioner with respect to Section 2.5 as necessary to bring the Practitioner's credentials file current.

(c) Satisfaction of the Medical Staff responsibilities set forth in the Section 2.3 of the Medical Staff Bylaws and the applicable Medical Staff category.

(d) Completion of the applicable Delineation of Privileges form(s) if Privileges are requested.

(e) Results of the Medical Staff's peer review and focused and ongoing professional practice evaluations (FPPE and OPPE) and relevant findings from other quality assessment/performance improvement activities.

(f) Request for changes, if any, in Medical Staff appointment category and/or Clinical Privileges and the reason for any changes thereto.

(g) Timely return of completed information forms when required.

(h) Additional information which, in the opinion of the MEC, is necessary to evaluate the request for Medical Staff reappointment and/or regrant of Privileges.

3.1-6 A Practitioner seeking Medical Staff reappointment and/or regrant of Privileges who has had minimal activity at the Hospital must submit such professional practice evaluation data/quality assessment information from the Practitioner's primary hospital, if applicable, and/or such other supplemental information (*e.g.*, additional peer references, *etc.*) as may be requested, before the Practitioner's application for reappointment and/or regrant of Privileges shall be considered complete and processed further.

3.2 PROCESSING APPLICATIONS FOR MEDICAL STAFF REAPPOINTMENT AND/OR REGRANT OF PRIVILEGES

3.2-1 An application for Medical Staff reappointment and/or regrant of Privileges shall be processed as follows:

(a) The Medical Staff Office verifies the information provided on the application for Medical Staff reappointment/regrant of Privileges working with the same authorities and generally in the same manner, to the extent applicable, as provided for in the initial application process set forth in Section 2.7-2.

(b) Applications for Medical Staff reappointment and/or regrant of Privileges shall be reviewed and acted upon in accordance with the procedure set forth in Section 2.7-3 through Section 2.7-7.

(c) For purposes of Medical Staff reappointment and/or regrant of Privileges, the terms "applicant" and "appointment" and "Privileges" as used in Article II shall be read, as "Practitioner" and "reappointment" and "regrant of Privileges," respectively.

(d) All individuals and groups required to act on an application for Medical Staff reappointment and/or regrant of Privileges must do so in a timely and good faith manner.

3.2-2 If an application for Medical Staff reappointment and/or regrant of Privileges has not been fully processed by the expiration date of the Practitioner's current appointment and/or Privilege period, the Practitioner's Medical Staff appointment and Privileges shall terminate as of the last date of his/her current appointment/Privilege period. A Practitioner whose Medical Staff appointment and Privileges are so terminated shall not be entitled to the procedural due process rights provided in the Fair Hearing Policy. If the Practitioner qualifies, he/she may be granted temporary Privileges pursuant to Section 5.1-4.

3.3 MODIFICATION OF MEDICAL STAFF APPOINTMENT AND/OR PRIVILEGES

3.3-1 A Practitioner may, either in connection with Medical Staff reappointment and/or regrant of Privileges or at any other time, request modification of his/her Medical Staff appointment category (*i.e.*, a transfer from one Medical Staff category to another) and/or Clinical Privileges by submitting a written request to the Medical Staff Office.

3.3-2 A modification request shall be processed in substantially the same manner as an application for Medical Staff reappointment and/or regrant of Privileges.

3.3-3 A request for new Privileges during a current Medical Staff appointment/Privilege period requires documentation of appropriate education, training, and experience supportive of the request and will be subject to focused professional practice evaluation if granted.

ARTICLE IV

LEAVE OF ABSENCE PROCEDURE

4.1 NOTICE OF LEAVE

4.1-1 In the event that a Practitioner will be absent from practice and unable to exercise his/her Privileges for a period in excess of sixty (60) days, he/she shall notify the Medical Staff Office in the manner set forth in Section 4.1-2.

4.1-2 A Practitioner may, for good cause (which may include, but is not limited to, illness, injury, military duty, or educational sabbatical), take a voluntary leave of absence by giving written notice to the Medical Staff Office who shall communicate receipt of such notification to others as appropriate. The notice must state the reason for the leave and the approximate period of time of the leave which may not exceed two (2) years except for military service.

4.1-3 In the event that a leave of absence takes place within the Practitioner's existing Medical Staff appointment and/or Privilege period, Section 4.1-4 does not apply and the Practitioner maintains his/her existing Medical Staff appointment/category and/or Privileges, as granted, which cannot be exercised during the leave subject to Section 4.1.5.

4.1-4 In the event that a leave of absence extends beyond the final date of the Practitioner's current Medical Staff appointment and/or Privilege period, the Practitioner may:

(a) Resign his/her Medical Staff appointment and/or Privileges at the end of the current appointment and/or Privilege period and subsequently reapply if/when able to do so; or,

(b) Apply for reappointment to a Medical Staff category without Privileges while on leave; or

(c) Apply for Medical Staff reappointment and a regrant of Clinical Privileges while on leave which, if granted, will be subject to an FPPE to assess current clinical competency upon return from leave.

4.1-5 A Practitioner on a leave of absence shall not be entitled to exercise his/her Clinical Privileges or the rights of Medical Staff appointment at the Hospital.

4.1-6 Prior to taking a leave of absence, the Practitioner shall have made arrangements for the care of his/her patients during the leave of absence.

4.2 TERMINATION OF LEAVE OF ABSENCE, REINSTATEMENT OF MEDICAL STAFF APPOINTMENT & REINSTATEMENT/NEW GRANT OF PRIVILEGES

4.2-1 In order to qualify for reinstatement of Medical Staff appointment and, as applicable, reinstatement or a new grant of Privileges following a leave of absence, the Practitioner must maintain Professional Liability Insurance coverage during the leave or purchase tail coverage for all periods during which the Practitioner held Privileges at the Hospital. The Practitioner shall provide information to demonstrate satisfaction of continuing Professional Liability Insurance coverage or tail coverage as required by this provision upon request for reinstatement of Medical Staff appointment and, as applicable, reinstatement or a new grant of Privileges upon termination of the leave.

4.2-2 A Practitioner may request reinstatement of his/her Medical Staff appointment and, as applicable, reinstatement or a new grant of Privileges by sending a written notice to the Medical Staff Office.

4.2-3 The Practitioner must submit a written summary of relevant activities during the leave as well as such additional information as is reasonably necessary to reflect that the Practitioner is qualified for reinstatement of Medical Staff appointment and, as applicable, reinstatement or a new grant of Privileges.

(a) If a Practitioner is returning from a medical leave of absence, the Practitioner may also be asked to obtain a physical examination and/or mental evaluation addressing the Practitioner's capability to resume clinical practice.

(b) The MEC may recommend reinstatement of Privileges subject to a Focused Professional Practice Evaluation (FPPE) period to assess current clinical competency upon return from a leave of absence; provided, however, that a regrant of Clinical Privileges while on leave (pursuant to Section 4.1-4 (c) above) shall be subject to FPPE upon the Practitioner's return A new grant of Privileges is subject to initial FPPE.

4.2-4 When the Practitioner's request for reinstatement of Medical Staff appointment and, as applicable, reinstatement or a new grant of Privileges is deemed complete, the applicable procedure set forth in Article II or Article III will be followed in evaluating and acting on such request.

4.3 FAILURE TO RETURN FROM LEAVE

4.3-1 If a Practitioner fails to request reinstatement of Medical Staff appointment and, as applicable, reinstatement or a new grant of Privileges upon termination of the leave of absence, the MEC shall make a recommendation to the Board as to how such failure should be construed.

4.3-2 If such failure is deemed by the Board to be a voluntary resignation, it shall not give rise to any procedural due process rights pursuant to the Fair Hearing Policy.

ARTICLE V

TEMPORARY, EMERGENCY, DISASTER, AND TELEMEDICINE PRIVILEGES & OTHER PRIVILEGE RELATED MATTERS

5.1 TEMPORARY PRIVILEGES

5.1-1 CONDITIONS

Temporary Privileges may be granted only in the circumstances and under the conditions described in this Section 5.1. Special requirements of consultation and reporting may be imposed by the applicable Department Chair or Section Chief. Under all circumstances, the Practitioner requesting temporary Privileges shall agree to abide by the Medical Staff governing documents and applicable Hospital policies in all matters relating to his/her activities at the Hospital.

5.1-2 GROUNDS FOR TEMPORARY PRIVILEGES

(a) The Chief Operating Officer or CMO may grant temporary Clinical Privileges on a case-by-case basis, upon the grounds (and satisfaction of the corresponding requirements) set forth in Section 5.1-3 or Section 5.1-4 following receipt of a written recommendation from the:

(1) Applicable Department Chair (or Section Chief); and

(2) Medical Staff President (or authorized designee).

5.1-3 PENDENCY OF REVIEW OF A COMPLETE APPLICATION

(a) Temporary Privileges are not to be automatically granted to all applicants. Temporary Privileges may be granted to applicants for new Privileges awaiting application review and action by the Medical Executive Committee and Board upon written request by the applicant for such temporary Privileges and satisfaction of the following:

(1) Receipt of a complete application that raises no concerns.

(2) Review and verification of:

(i) Current licensure;

(ii) Relevant training /experience;

(iii) Current competence;

(iv) Ability to perform the Privileges requested with or without a reasonable accommodation; and

(v) Such other information as set forth in Section 2.2 of the Medical Staff Bylaws and Section 2.5 of this Policy.

(3) Completion of a query and evaluation of the National Practitioner Data Bank information and such other queries as required by Section 2.7-2.

(4) Confirmation that the applicant has no current or previously successful challenges to his/her licensure or registration.

(5) Confirmation that the applicant has not been subject to the involuntary termination of his/her medical staff appointment at another organization.

(6) Confirmation that the applicant has not been subject to the involuntary limitation, reduction, denial, or loss of his/her clinical privileges.

(b) Applicants for new Privileges include a Practitioner applying for Privileges at the Hospital for the first time; a Practitioner currently holding Privileges who is requesting one or more additional Privileges during his/her current Medical Staff appointment and/or Privilege period; and a Practitioner who is in the Medical Staff reappointment and/or regrant process and is requesting one or more additional Privileges.

(c) Temporary Privileges may be granted in this circumstance for a period not to exceed the pendency of the application (*i.e.*, completion of review and action on the application by the Medical Executive Committee and Board) or one hundred twenty (120) days, whichever is less. Under no circumstances may temporary Privileges be granted if the application is pending because the applicant has not responded in a satisfactory manner to a request for clarification of a matter or for additional information.

5.1-4 IMPORTANT/URGENT PATIENT CARE, TREATMENT, OR SERVICE NEED

(a) Temporary Privileges for an important/urgent patient care, treatment, or service need may be granted upon:

(1) Receipt of a written request by the applicant for the specific temporary Clinical Privileges desired and verification of the Practitioner's:

(i) Current licensure;

(ii) Current competence relative to the temporary Privileges being requested (confirmed by a current letter of reference from an appropriate medical staff leader at the hospital

and/or other healthcare location(s) at which the Practitioner currently practices);

(iii) DEA registration, if required for the Privileges requested;

(iv) Professional Liability Insurance; and

(v) Board certification status.

(2) Query of the National Practitioner Data Bank and such other queries as required by Section 2.7-2.

(3) Receipt of information as required by the Hospital's Tuberculosis Exposure Control Plan.

(4) Completion of the Hospital's immunization documentation form.

(5) Completion of a criminal background check pursuant to Section 6.3.

(6) Receipt of a copy of a current curriculum vitae.

(b) The important/urgent patient care, treatment, or service need that supports the request for temporary Privileges pursuant to this ground shall be documented at the time temporary Privileges are requested and retained in the Practitioner's credentials file.

(c) Temporary Clinical Privileges may be granted for an important/urgent patient care, treatment, or service need for an initial period of up to 120 days and may be extended for an additional period of up to 60 days if extenuating circumstances arise and there remains an important/urgent patient care, treatment, or service need which requires the Practitioner to maintain temporary Clinical Privileges. After such time period(s), the Practitioner must apply for Medical Staff appointment and Privileges in order to continue to practice at the Hospital.

5.2 EMERGENCY PRIVILEGES

5.2-1 For purposes of this section, "emergency" is defined as a situation in which the life of a patient is in immediate danger or serious permanent harm is imminent.

5.2-2 In the case of an emergency, any Practitioner is authorized and shall be assisted to render care, treatment, and/or services to attempt to save a patient's life, or to save a patient from serious harm, as permitted within the Practitioner's scope of practice and notwithstanding the Practitioner's Medical Staff category or Privileges.

5.2-3 A Practitioner exercising emergency Privileges must obtain all consultative assistance deemed necessary and arrange for appropriate post-emergency care.

5.2-4 Emergency Privileges automatically terminate upon alleviation of the emergency situation. A Practitioner who exercises emergency Privileges shall not be entitled to the procedural due process rights set forth in the Fair Hearing Policy.

5.2-5 Any use of emergency Privileges must be reported to the CMO as soon as practicable and to the Medical Staff Office within three (3) business days by the responsible Practitioner and will be subject to automatic review by the Medical Staff officers.

5.3 DISASTER PRIVILEGES

5.3-1 In circumstances of disaster when the Hospital's emergency management plan has been activated and the Hospital is unable to meet immediate patient needs, the Hospital may choose to rely on volunteer Practitioners to help meet these needs subject to applicable state licensure laws, rules, and regulations.

5.3-2 Under such circumstances, if the usual credentialing and privileging process cannot be followed, the Chief Operating Officer, CMO, or Medical Staff President may grant such disaster Privileges on a case-by-case basis after the Hospital obtains from the volunteer Practitioner a valid government-issued photo identification (*e.g.*, a driver's license or passport) and at least one of the following:

(a) Primary source verification of licensure.

(b) A current license to practice.

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

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

(e) A current picture identification card from a health care organization that clearly identifies the volunteer Practitioner's professional designation.

(f) Confirmation by a current Medical Staff Member(s) with Privileges at the Hospital who has/have personal knowledge regarding the volunteer Practitioner's current clinical competence/professional ability.

5.3-3 In order to be granted disaster Privileges, a volunteer Practitioner must also, upon request, satisfy such other qualifications as required by Section 5.1-4 (a)(1)-(6) for a grant of temporary Privileges for an important patient care need.

5.3-4 If not initially verified pursuant to Section 5.3-2, primary source verification of licensure occurs as soon as the disaster is under control or within seventy-two (72) hours from the time the volunteer Practitioner presents to the Hospital, whichever comes first. In extraordinary circumstances where primary source verification of a volunteer Practitioner's licensure cannot be completed within 72 hours after the Practitioner's arrival, and provided the individual has been exercising disaster Privileges, the Medical Staff Office must document:

(a) The reason(s) primary source verification could not be performed in the required time frame.

(b) Evidence of a demonstrated ability by each volunteer Practitioner granted disaster Privileges to continue to provide adequate care, treatment, and services.

(c) Evidence of the Hospital's attempt to perform primary source verification as soon as possible.

5.3-5 Primary source verification of licensure is not required if the volunteer Practitioner has not provided care, treatment, or services at the Hospital under the disaster Privileges.

5.3-6 The activities of volunteer Practitioners who receive disaster Privileges shall be managed by and under the supervision of the CMO, the Department Chair, a Section Chief, or an appropriate designee.

5.3-7 Within seventy-two (72) hours after a volunteer Practitioner's arrival at the Hospital, the Chief Operating Officer, CMO, or Medical Staff President must make a decision, based upon the information obtained during that time, related to the continuation of the disaster Privileges initially granted.

5.3-8 All volunteer Practitioners who receive disaster Privileges must, at all times while at the Hospital, wear a photo identification badge from the facility at which they otherwise hold Privileges. If a Practitioner does not have such identification, he/she will be issued a badge at the Hospital (with photo, if possible under the circumstances) identifying him/her and designating the Practitioner as a volunteer disaster privileged provider.

5.3-9 Disaster Privileges shall cease upon alleviation of the circumstances of disaster as determined by the Chief Operating Officer.

5.4 TELEMEDICINE PRIVILEGES

5.4-1 Section 5.4 applies to distant-site telemedicine Practitioners who do not practice on-site at the Hospital.

5.4-2 Distant-site Practitioners who are responsible for the patient's care, treatment, and/or services via a telemedicine link shall be credentialed (which may be by proxy) and privileged to do so by the Hospital in accordance with the Medical Staff Bylaws and this Credentials Policy, accreditation standards, and applicable laws, rules, and regulations.

5.4-3 Prior to a distant-site Practitioner providing telemedicine services to patients at the Hospital, the distant-site Practitioner must be appropriately credentialed (which may be by proxy) and granted Privileges by the Hospital. A distant-site Practitioner providing services via a telemedicine link shall be credentialed and privileged in one of the following ways:

(a) The Hospital may fully credential and grant Privileges to each distant-site Practitioner using the routine credentialing and privileging process as set forth in Article II of this Policy; **OR,**

(b) The credentialing information and privileging decision from the distant-site may be relied upon by the Hospital Medical Staff and Board in making its telemedicine privileging recommendations/decisions for the Hospital regarding each distant-site Practitioner provided that the Hospital has entered into a written agreement with the distant-site and all of the following requirements are met:

(1) The distant-site is a Medicare-participating hospital; **OR**, a facility that qualifies as a distant-site telemedicine entity. A "distant-site telemedicine entity" is defined as an entity that (1) provides telemedicine services, (2) is not a Medicare-participating hospital, and (3) provides contracted services in a manner that enables hospitals using its services to meet all applicable conditions of participation, particularly those requirements related to the credentialing and privileging of practitioners providing telemedicine services to the patients of the hospital.

(i) When the distant-site is a Medicare-participating hospital, the written agreement shall specify that it is the responsibility of the distant-site hospital to meet the credentialing requirements of 42 C.F.R. 482.12 (a)(1)-(a)(7), as such provisions may be amended from time to time, with regard to the distant-site hospital Practitioners providing telemedicine services.

(ii) When the distant-site is a distant-site telemedicine entity, the written agreement shall specify that the distant-site

telemedicine entity is a contractor of services to the Hospital and, as such, furnishes the contracted services in a manner that permits the Hospital to comply with all applicable conditions of participation for the contracted services including, but not limited to, 42 C.F.R. 482.12 (a)(1)-(a)(7) with regard to the distant-site telemedicine entity Practitioners providing telemedicine services. The written agreement shall further specify that the distant-site telemedicine entity's medical staff credentialing and privileging process and standards will, at minimum, meet the standards at 42 C.F.R. 482.12 (a)(1)-(a)(7) and at 42 C.F.R. 482.22 (a)(1)-(a)(2), as those provisions may be amended from time to time.

(2) The distant-site is a TJC accredited or a Medicare-participating organization.

(3) Each distant-site Practitioner is privileged at the distant-site for those services to be provided at the Hospital and the distant-site provides the Hospital with a current list of each distant-site Practitioner's privileges at the distant-site.

(4) Each distant-site Practitioner holds an appropriate license issued by the appropriate licensing entity in the state in which the Hospital whose patients are receiving the telemedicine services is located in addition to meeting the licensing standards, as applicable, in the state in which the Practitioner is located.

(5) The Hospital maintains documentation of its internal review of the performance of each distant-site Practitioner and sends the distant-site such performance information for use in the distant-site's periodic appraisal of the distant-site Practitioner. At a minimum, this information must include:

(i) All adverse events that result from the telemedicine services provided by the distant-site Practitioner to Hospital patients.

(ii) All complaints the Hospital receives about the distant-site Practitioner.

5.5 MOONLIGHTING PRIVILEGES

5.5-1 QUALIFICATIONS

Moonlighting Privileges may be granted to medical residents and fellows who:

(a) Obtain prior written approval from the director of the applicable fellowship or residency program.

(b) Are in good standing in his/her residency or fellowship program as confirmed by the program director.

(c) Are requesting Privileges to provide clinical care, treatment, and/or services to patients at the Hospital (or a provider-based location thereof) outside of the time periods that the resident or fellow is participating in their residency or fellowship training education/program.

(d) Have and maintain a current valid license (not a training certificate) to practice medicine in Ohio and meet the continuing education requirements necessary to maintain such medical license as determined by the State Medical Board of Ohio.

(e) Have and maintain, if necessary for the Privileges requested, a current valid Drug Enforcement Administration (DEA) registration.

(f) Document successful completion of professional education.

(g) Possess current, valid Professional Liability Insurance coverage in such form and amount as determined by the Board.

(h) Are able to participate in Federal Health Programs.

(i) Document and demonstrate an ability to work with others in a positive, professional, cooperative, and collegial manner.

(j) Document and demonstrate current ability to competently perform the Privileges requested with or without a reasonable accommodation.

(k) Are able to provide patient care, treatment, and/or services at an acceptable level of quality and efficiency and consistent with available resources and applicable standards of care.

(l) Document and demonstrate adherence to the applicable code of professional ethics and good character/judgment.

(m) Comply with Board or Hospital conflict of interest policies, if any, as applicable.

(n) Comply with Medical Staff requirements regarding criminal background checks.

(o) Satisfy such other qualifications as are set forth in the applicable Privilege set and as may be otherwise recommended by the Medical Executive Committee and approved by the Board.

5.5-2 CONDITIONS

(a) Fellows and residents on a J-1 visa or as otherwise prohibited by applicable laws, rules, and/or regulations are not permitted to moonlight. Fellows employed under an H1-B visa may be able to moonlight in limited situations provided certain conditions are met.

(b) PGY-1 and PGY-2 residents are not permitted to moonlight.

(c) A moonlighting resident or fellow must request and be granted Clinical Privileges prior to providing any clinical care, treatment, and/or services to patients at the Hospital (or a provider-based location thereof) outside of the time periods that the resident or fellow is participating in their residency or fellowship training education/program.

(1) A moonlighting resident or fellow will be subject to Focused and Ongoing Professional Practice Evaluation (FPPE/OPPE) with respect to the moonlighting Privileges granted.

(d) Special requirements of consultation and reporting may be imposed at such time as moonlighting Privileges are granted.

(e) A moonlighting resident or fellow must agree, in writing, to abide by the Medical Staff governing documents and the policies of the Hospital in all matters relating to his/her moonlighting activities at the Hospital.

(f) Moonlighting is not required and must not interfere with the resident's or fellow's residency or fellowship clinical training/education.

(g) All moonlighting hours must be reported and counted towards work duty hour requirements.

(h) Permission to moonlight may be withdrawn if the residency or fellowship program director determines that the resident's or fellow's education/training is adversely impacted by such moonlighting activities.

5.5-3 PROCESSING A REQUEST FOR MOONLIGHTING PRIVILEGES

(a) A request for moonlighting Privileges shall be processed in accordance with the credentialing and privileging process (as applicable) set forth in Article II (for initial grant of privileges) or Article III (for regrant of privileges) of this Policy.

(b) Moonlighting Privileges may be granted/regranted for a period of up to two (2) years as recommended by the MEC and approved by the Board.

5.6 TERMINATION OF TEMPORARY, DISASTER, TELEMEDICINE, OR MOONLIGHTING PRIVILEGES

5.6-1 The Chief Operating Officer, CMO, or Medical Staff President may terminate a Practitioner's temporary, disaster, or telemedicine Privileges (or a resident's/fellow's moonlighting Privileges) at any time.

5.6-2 Where the life or well-being of a patient is determined to be endangered, the Practitioner's temporary, disaster, or telemedicine Privileges (or a resident's/fellow's moonlighting Privileges) may be terminated by any person entitled to impose a summary suspension pursuant to the Medical Staff Bylaws.

5.6-3 In the event a Practitioner's temporary, disaster, or telemedicine Privileges (or a resident's/fellow's moonlighting Privileges) are revoked, the Practitioner's patients shall be assigned to another Practitioner by the Medical Staff President or applicable Department Chair/Section Chief. The wishes of the patient will be considered, where feasible, in choosing a substitute Practitioner.

5.6-4 A Practitioner who has been granted temporary, disaster, or telemedicine Privileges (or a resident or fellow who has been granted moonlighting Privileges) is not a Medical Staff Member and is not entitled to the procedural due process rights afforded to Medical Staff Members.

5.6-5 A Practitioner (or resident/fellow) shall not be entitled to the procedural due process rights set forth in the Medical Staff Bylaws or Fair Hearing Policy because the Practitioner's request for temporary, disaster, or telemedicine Privileges (or the resident's/fellow's request for moonlighting 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.

5.7 RECOGNITION OF A NEW SERVICE OR PROCEDURE; ADOPTION & AMENDMENT OF PRIVILEGE SETS

5.7-1 The Board shall determine the Hospital's scope of patient care services based upon recommendations from the Medical Executive Committee. Overall considerations for establishing new services and procedures include, but are not limited to:

(a) The Hospital's available resources and staff.

(b) The Hospital's ability to appropriately monitor and review the competence of the performing Practitioner(s).

(c) The availability of other qualified Practitioners with Privileges at the Hospital to provide coverage for the new service or procedure when needed.

(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.

5.7-2 Requests for Privileges for a new service or procedure at the Hospital that has not yet been recognized by the Board shall be processed as follows:

(a) The Practitioner must submit a written Privilege request for a new service or procedure to the Medical Staff Office. The request should include a description of the Privileges being requested, the reason why the Practitioner believes the Hospital should recognize such Privileges, and any additional information that the Practitioner believes may be of assistance in evaluating the request.

(b) The Department Chair (with involvement of the applicable Section Chief, as appropriate) and the Chief Medical Officer will review requests for a new service or procedure taking into account the considerations set forth in 5.7-1.

(1) If the Department Chair (with involvement of the applicable Section Chief, as appropriate) and the Chief Medical Officer determine that the new service or procedure should not be recognized at the Hospital, the Department Chair will provide a written recommendation to the Medical Executive Committee.

(2) If the Department Chair (with involvement of the applicable Section Chief, as appropriate) and the Chief Medical Officer determine that the new service or procedure should be included in an existing Privilege set, then the Department Chair will prepare and submit a written recommendation to the Medical Executive Committee.

(3) If the Department Chair (with involvement of the applicable Section Chief, as appropriate) and the Chief Medical Officer determine that the new service or procedure should be recognized at the Hospital and that a new Privilege set is required, the Department Chair (who may consult with the applicable Section Chief, as necessary) after consultation with the Chief Medical Officer, shall develop and submit to the Medical Executive Committee a new Privilege set based upon:

(i) A determination as to what specialties are likely to request the Privileges.

(ii) The positions of specialty societies, certifying boards, *etc.*

(iii) The available training programs.

(iv) Recommended standards to be met with respect to the following: education; training; board certification; experience; focused professional practice evaluation requirements to establish current competency, etc.

(v) Criteria required by other hospitals with similar resources and staffing.

(c) Upon receipt of a recommendation from the Department Chair, the Medical Executive Committee shall review the matter and forward its recommendation to the Board:

(1) If the Board approves the new service or procedure (and new or amended Privilege set), the requesting Practitioner(s) may apply for such Privilege(s) consistent with the credentialing and privileging process set forth in Article II.

(2) If the Board does not approve the new service or procedure, the requesting Practitioner(s) shall be so notified. A decision by the Board not to recognize a new service or procedure does not give rise to the procedural due process rights provided in the Fair Hearing Policy.

5.7-3 Adoption and amendment of Delineation of Privileges (*i.e.*, Privilege sets) for care, treatment, and/or services provided at the Hospital requires review by the Department Chair, the applicable Section Chief, and the Chief Medical Officer, a recommendation from the MEC, and approval of the Board.

5.8 PROFESSIONAL PRACTICE EVALUATION

5.8-1 Practitioners granted Privileges at the Hospital shall exercise such Privileges consistent with acceptable and prevailing standards of care.

5.8-2 The Hospital's focused professional practice evaluation (FPPE) process is set forth, in detail, in the Medical Staff Practitioner/APP Effectiveness Policy and shall be implemented for all: (i) Practitioners granted initial Privileges; (ii) existing Practitioners granted new Privileges during the course of an appointment/Privilege period; and (iii) in response to concerns regarding a Practitioner's ability to competently exercise the Privileges granted. The FPPE period shall be used to assess the Practitioner's current clinical competence.

5.8-3 Upon conclusion of the initial FPPE period, ongoing professional practice evaluation ("OPPE") shall be conducted on all Practitioners with Privileges. The Hospital's OPPE process is set forth, in detail, in the Medical Staff

Practitioner/APP Effectiveness Policy and requires the Hospital to gather, maintain, and review data on the performance of all Practitioners with Privileges on an ongoing basis.

5.9 DENTISTS, PODIATRISTS, AND PSYCHOLOGISTS

5.9-1 ADMITTING PRIVILEGES

(a) Dentists and Podiatrists may be granted Privileges to admit patients to the Hospital.

(b) Psychologists may not admit or co-admit patients to the Hospital but may treat patients who have been admitted by a Physician with admitting Privileges provided the Psychologist maintains a consultative relationship with the attending Physician during the course of treatment of the patient.

5.9-2 MEDICAL CONSULTATION

(a) It is the responsibility of an admitting Podiatrist or Dentist to obtain a medical consultation from a Physician Medical Staff Member with appropriate Privileges for the care and treatment of any medical condition that is present at the time of hospitalization of the Podiatrist's or Dentist's patient, or that may arise during the patient's hospitalization, that is outside the scope of practice of the Podiatrist or Dentist.

(b) As appropriate, the Physician consulted shall determine the medical risk and effect of a surgical procedure on the health of the patient.

5.9-3 MEDICAL HISTORY & PHYSICAL

(a) It is the responsibility of a Dentist to arrange for a Physician Medical Staff Member with appropriate Privileges to complete the medical history and physical examination (H&P), update thereto (when required), or outpatient assessment, as applicable, for the Dentist's patients.

(b) Dentists who are Oral Surgeons and Podiatrists may perform and document the H&P for their patients provided that the Oral Surgeon or Podiatrist has been privileged to do so and that such H&P, update thereto (when required), or outpatient assessment, as applicable, is within his/her scope of practice.

(c) Additional requirements with respect to H&Ps, updates, and outpatient assessments, as applicable, are set forth in the Medical Staff Bylaws and/or applicable Hospital or Medical Staff policies.

5.9-4 DOCMENTATION

(a) The Dentist/Oral Surgeon, Podiatrist, or Psychologist is responsible for documentation of, as applicable, the dental, podiatric, or psychological history, examination, diagnosis, operative report, and relevant portion of the discharge summary and for completion of the medical record as relates to his/her care of the patient.

(b) If there is a medical problem, the consulting Physician shall participate in the discharge of the Podiatrist's, Dentist's/Oral Surgeon's patient and the completion of the medical record such as relates to the Physician's care of the patient.

ARTICLE VI

CONFLICTS OF INTEREST; CONTRACTED PROVIDERS; AND CRIMINAL BACKGROUND CHECKS

6.1 CONFLICTS OF INTEREST

6.1-1 In any instance where a Practitioner has or reasonably could be perceived to have a conflict of interest in any matter that comes before the Medical Staff, a Department/Section, or a Medical Staff committee, the Practitioner is expected to disclose the conflict to, as applicable, the Medical Staff President, the Department Chair/Section Chief, or committee chair. The Practitioner may be asked and is expected to answer any questions concerning the conflict. The Medical Staff President, Department Chair/Section Chief, or committee chair is responsible for determining whether a conflict exists and, if so, whether the conflict rises to the level of precluding the Practitioner from participating in the pending matter.

6.1-2 For purposes of this Section 6.1, the fact that Practitioners are competitors, partners, or employed in the same group shall not, in and of itself, automatically disqualify such Practitioners from participating in the review of applications or other Medical Staff matters with respect to their colleagues.

6.1-3 All Practitioner nominees for election or appointment to a position on the Board, a Board committee, as a Medical Staff officer, Department Chair, Section Chief, or member of the Medical Executive Committee shall not have a disqualifying conflict of interest as determined by the Board (or Chief Operating Officer and CMO as the Board's authorized designees).

6.2 CONTRACTED PRACTITIONERS

6.2-1 A Practitioner who is or who will be providing specified professional services pursuant to a contract with the Hospital (or for a group holding a contract with the Hospital) is subject to all qualifications for Medical Staff appointment/reappointment and/or Privileges/regrant of Privileges and must meet all of the responsibilities of Medical Staff appointment and/or Privileges as set forth in the Medical Staff governing documents for any other Practitioner.

6.2-2 The effect of the expiration or termination of a Practitioner's contract with the Hospital (or the expiration or termination of a Practitioner's association with the group holding the contract with the Hospital) upon a Practitioner's appointment and/or Privileges at the Hospital will be governed solely by the terms of the Practitioner's contract with the Hospital (or with the group holding the contract with the Hospital). If the contract is silent on the matter, then contract expiration or termination alone (or the expiration or termination of the Practitioner's association with the group holding the contract with the Hospital) will not affect the Practitioner's appointment or Clinical Privileges at the Hospital with the exception set forth in subsections 6.2-3 and 6.2-4 below.

6.2-3 In the absence of language in the contract to the contrary, if an exclusive contract under which such Practitioner is engaged is terminated or expires (or if the relationship of the Practitioner with the group that has the exclusive contractual relationship with the Hospital is terminated or expires) then the Practitioner's Medical Staff appointment and those Privileges covered by the exclusive contract shall also be terminated and the procedural due process rights afforded by the Fair Hearing Policy shall not apply; provided, however, that the Board in its sole discretion may waive this automatic termination result.

6.2-4 If the Hospital enters into an exclusive contract for a particular service(s), any Practitioner who previously held Privileges to provide such service(s), but who is not a party to the exclusive contract (or otherwise employed by or contracted with the group that holds the exclusive contract with the Hospital), may not provide such service(s) as of the effective date of the exclusive contract irrespective of any remaining time on his/her appointment, reappointment, and/or Privilege term.

6.3 CRIMINAL BACKGROUND CHECKS

6.3-1 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 Practitioners.

6.3-2 Procedure

(a) A criminal background check shall be performed on Practitioners applying for initial appointment and/or Privileges and at the time of each reappointment and/or regrant of Privileges. No Practitioner 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 Practitioner has been granted Privileges to provide such care, treatment, and/or services.

(b) Practitioners will be required to sign a waiver/consent/release for a background check. Refusal to provide adequate information on the initial application or reappointment/regrant form, or to provide consent/waiver/release for the background check, will result in the Hospital's inability to process the Practitioner's application or termination of Medical Staff appointment and/or Privileges for failure to meet baseline qualifications.

(c) The background check process will be initiated by the Medical Staff Office and will not be performed until the signed consent/waiver/release is received by the Medical Staff Office.

(d) Background checks will be conducted by a third-party vendor who will be instructed to provide results to the Medical Staff Office.

(e) If the background check identifies any criminal activity not disclosed on the initial application for Medical Staff appointment and/or Privileges or on the application for Medical Staff reappointment and/or regrant of Privileges, the Practitioner will be notified and additional information from the Practitioner will be requested. Failure to disclose all previous convictions (with the exception of minor traffic/motor vehicle violations) is considered falsification of records. Pursuant to Section 2.6-1 (a), a material misrepresentation, misstatement, or omission with respect to an application for Medical Staff appointment/reappointment and/or grant/regrant of Privileges is grounds to cease processing the application or for termination of Medical Staff appointment and/or Privileges.

(f) 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 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 practice of medicine/other applicable profession.

(g) The Practitioner may be asked to provide a written response regarding the report, meet with the Department Chair and/or applicable Section Chief and/or may be required to have a fingerprint check. Failure to cooperate may result in the Hospital's inability to process (or continue to process) the Practitioner's application or termination of Medical Staff appointment and Privileges for failure to meet baseline criteria.

(h) 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.

(i) A copy of the background report may be provided to the Practitioner upon his/her written request directed to the Medical Staff Office.

ARTICLE VII

BOARD CERTIFICATION

7.1 QUALIFICATION

7.1-1 Unless otherwise provided herein, all Physicians, Podiatrists, and Dentists shall be board certified (or board eligible) in the specialty in which the Practitioner seeks Privileges at the time of initial application for Medical Staff appointment and/or Privileges as follows:

(a) **Physicians**: By the American Board of Medical Specialties board applicable to the Physician's specialty/sub-specialty; or, by the American Osteopathic Board; or, by the Royal College of Physicians and Surgeons of Canada. A Physician who is board certified in a subspecialty is not required to also maintain certification with the primary board (*e.g.,* a Physician who is board certified in gastroenterology is not also required to maintain internal medicine board certification) unless otherwise required by the applicable certifying board or Delineation of Privileges.

(b) **Podiatrists**: By the American Board of Podiatric Medicine or the American Board of Foot and Ankle Surgery.

(c) **Dentists**: By the American Board of Pediatric Dentistry; the American Board of General Dentistry; the American Board of Oral & Maxillofacial Surgery; or the American Board of Orthodontics.

7.1-2 A Physician, Podiatrist, or Dentist who is a qualified candidate for board certification at the time of initial application for Medical Staff appointment and/or Privileges shall have the time period as set by the applicable certifying board following the date of completion of residency or fellowship training to become board certified.

(a) If the applicable certifying board does not specify a time period for board certification, the Physician, Podiatrist, or Dentist shall have five (5) years following the date of completion of residency or fellowship training to become certified.

7.1-3 Physicians, Podiatrists, and Dentists for whom board certification is required shall continuously maintain board certification in accordance with the requirements of the applicable certification board unless a waiver is otherwise granted by the Board.

7.2 WAIVER OF BOARD CERTIFICATION

7.2-1 A waiver to allow additional time to attain board certification/recertification or to waive the board certification requirement may be requested by a Practitioner in the following instances:

(a) Any Practitioner who is required to be board certified and who fails to attain or who is ineligible for board certification, but possesses equivalent qualifications, may request a waiver. The Practitioner requesting the waiver bears the burden of demonstrating exceptional circumstances and that his or her qualifications are equivalent.

(b) Any Practitioner who is required to be board certified and who fails to maintain board certification may request a waiver. The Practitioner requesting the waiver bears the burden of demonstrating exceptional circumstances and that the waiver is in the best interest of the Hospital and patient care. A Practitioner's impending retirement within two (2) years of a recertification deadline may be considered as an exceptional circumstance.

7.2-2 A written request for a waiver of the board certification requirement may be submitted by the Practitioner to the Medical Staff Office for consideration in accordance with the waiver procedure set forth in the Medical Staff Bylaws.

7.2-3 Unless a waiver is requested and subsequently granted in accordance with the procedure set forth in the Medical Staff Bylaws, a Practitioner's failure to:

(a) Satisfy the requirement of board certification (or board eligibility, as applicable) at the time of initial application shall result in the Hospital's inability to process the application as a result of the Practitioner's failure to meet baseline qualifications.

(b) Continuously satisfy the board certification (or board eligibility, as applicable) requirement following attainment of Medical Staff appointment and/or Privileges shall result in an automatic termination of Medical Staff appointment and/or Privileges for failure to meet baseline qualifications.

ARTICLE VIII

PEER REVIEW INFORMATION

8.1 PEER REVIEW INFORMATION

8.1-1 This section applies to electronic and paper peer review files maintained by the Medical Staff Office and peer review privileged communication, information, and documentation (*e.g.,* meeting minutes, *etc.*) generated by or on behalf of a peer review committee (collectively "Peer Review Information").

8.1-2 It is the expectation of the Hospital that appropriate documentation will be maintained in peer review files with respect to all actions involving Practitioners and Advanced Practice Providers [APP(s)].

8.1-3 Peer Review Information shall be held in confidence and not disseminated except as provided in the Medical Staff governing documents or as otherwise required by applicable laws, rules, and/or regulations.

8.1-4 A breach of confidentiality by a member/agent of a peer review committee includes, but is not limited to, the unauthorized release or exchange of Peer Review Information to any person/group/agency not otherwise entitled to receive such protected information and may violate provisions of the Ohio Revised Code, imposing civil liability. If it is determined that such a breach has occurred, the Practitioner or APP may be subject to corrective action.

8.1-5 Subpoenas received for Peer Review Information shall be referred to the Legal Services Department. The Legal Services Department will advise and consult with the Medical Staff President, Chief Medical Officer, and/or Chief Operating Officer regarding the subpoena.

8.2 ACCESS TO PEER REVIEW INFORMATION

8.2-1 Peer Review Information is available to:

(a) Members/agents of a Medical Staff or Hospital peer review committee.

(b) Authorized Hospital staff, Practitioners, and/or APPs who require access to such information as part of the protected peer review process.

8.2-2 A Practitioner or APP will be permitted access to all information in the Practitioner's or APP's own peer review file(s) submitted by the Practitioner or APP. A Practitioner or APP shall be given access to other information in the Practitioner's or APP's peer review file(s) during the course of a fair hearing proceeding (or similar procedural due process proceeding as applicable to APPs) if an Adverse recommendation or action is based on such information.

(a) A request by a Practitioner or APP to review his/her own peer review file(s) should be made to the Medical Staff Office in advance. The review will be held at the Hospital in the presence of a designated Hospital/Medical Staff peer review agent.

(b) A Practitioner or APP does not have the right to a copy of his/her peer review file(s) unless the file(s) is/are produced as part of a fair hearing proceeding (or similar procedural due process proceeding as applicable to APPs).

8.2-3 Requests from Accrediting Entities/Regulatory Agencies

(a) Subject to authorization from the Legal Services Department, access to Peer Review Information may be made available to accrediting entities and/or regulatory agencies on the Hospital premises in the presence of a designated Hospital/Medical Staff peer review agent.

8.2-4 Other Third Party Requests for Peer Review Information

(a) No information will be released to third parties by telephone except for confirmation of the Practitioner's or APP's name and the name of the applicable Department Chair and Section Chief.

(b) Requests from third parties for Practitioner or APP credentialing information shall be in writing, include the reasons for the information, and a statement signed by the Practitioner releasing from liability all those providing the information.

(c) Requests from third parties for clinical evaluations regarding a Practitioner or APP will be referred to the respective Section Chief and/or Department Chair for completion along with a signed release of liability from the Practitioner or APP. The Section Chief and/or Department Chair will return a copy of completed requests to the Medical Staff Office.

(d) As required by law (*e.g.*, criminal matter; federal EEOC claim, *etc.*).

8.2-5 With the exception of the limited access described in Section 8.2-1 through Section 8.2-4, Peer Review Information may otherwise be disclosed only with approval of the Chief Operating Officer or CMO in consultation with Hospital legal counsel.

8.3 LOCATION AND SECURITY PRECAUTIONS

8.3-1 Practitioner and APP peer review files shall be maintained by the Medical Staff Office electronically or in a paper file in the Medical Staff Office. Peer review files shall be secured.

8.3-2 Practitioner and APP paper peer review files (including copies of such files and/or information contained within) will not be removed from the Medical Staff Office or the Hospital unless permitted pursuant to this Article or by the Chief Operating Officer or CMO for an authorized purpose. Access to review information contained within paper peer review files shall be in accordance with this Article.

8.3-3 Access to review electronic peer review files will be permitted as set forth in this Article. Copies of electronic peer review files (or information contained within the electronic peer review files) may not be made unless requested for an authorized purpose in accordance with this Article.

8.4 MEDICAL STAFF PEER REVIEW COMMITTEE MINUTES

8.4-1 Documentation of peer review activities shall be kept separately in a peer review committee's meeting minutes and materials. Such peer review committee minutes and materials are designated and maintained as protected peer review documents.

8.4-2 Dissemination to third parties of Medical Staff peer review committee minutes and materials is not permitted with the exception of the limited access rights set forth in this Article regarding peer review files/information.

8.4-3 Provisions shall be taken to protect all peer review committee minutes and materials from disclosure as follows:

(a) Access to peer review committee minutes and materials shall be restricted to those participating in the peer review process (*e.g.* peer review committee members/agents, *etc.*) or as otherwise permitted by this Article.

(b) Peer review minutes and materials distributed at a peer review committee meeting may be collected at the conclusion of a meeting. Otherwise, it is the peer review committee member's/agent's responsibility to maintain confidentiality of all peer review committee minutes and materials.

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

CERTIFICATION OF ADOPTION AND APPROVAL

Adopted by the Medical Executive Committee on: 10/30/2024

Approved by the Board on: 10/31/2024