CREDENTIALS MANUAL

Medical Staff
Fort Hamilton Hospital
Hamilton, Ohio

EFFECTIVE: 2/5/2019
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ARTICLE I: INTRODUCTION AND POLICY

1.1 Incorporation of Definitions.

This Credentials Manual adopts and incorporates by reference the definitions contained in the Medical Staff Bylaws, unless otherwise specified herein.

1.2 Application Policy.

As a general policy, this Hospital permits application to the Medical Staff from qualified Practitioners as described in Articles III and IV of the Medical Staff Bylaws. Qualified Practitioners and other qualified individuals may apply for Clinical Privileges without Medical Staff Appointment as described in this Manual. The credentials policies and procedures for AHPs are described in Article VI of this Manual; no other provisions of this Manual, except those in Article I and Article VI, applies to AHPs unless expressly stated. The KHN Centralized Credentialing Office (CCO) conducts credentialing for Kettering Health Network facilities as provided in Section 3.1 of the Bylaws.

1.3 Burden.

It is the burden of the applicant for appointment or Privileges to provide all information necessary to make reasonable and informed decisions on the application. An application is incomplete until deemed complete by the CCO and Medical Staff Services (in compliance with procedures that have been approved by the MEC and the Board), and accepted as complete by the Credentials Committee or Medical Executive Committee, which may remand an application to the CCO to be considered incomplete until identified information is received or questions resolved. Any intentional misrepresentation, misstatement, or omission from an applicant shall constitute cause for an immediate cessation of the processing of the application. In the event that an appointment and/or Privileges have been granted prior to the discovery of such intentional misrepresentation, misstatement, or omission, such discovery constitutes grounds for termination of appointment and Privileges. In such instances, the right to a hearing as set forth in the Bylaws shall be limited to the issue of whether the facts constitute an intentional misrepresentation, misstatement, or omission.

1.4 Non-Discrimination.

The non-discrimination provisions set forth in Section 3.2.3 of the Bylaws apply to decisions regarding the granting or denying of Medical Staff appointment or Clinical Privileges as described in this Manual.

ARTICLE II: PROCEDURES FOR APPOINTMENT, REAPPOINTMENT & PRIVILEGING

2.1 **Application Process.**

2.1-1 Application Content. All applications for Medical Staff appointment and/or Privileges shall be in writing (or electronic format as available), shall be signed or authenticated and dated by the Applicant, and shall be submitted on a form approved by the MEC. The application shall include all of the following:

(a) Medical Education and Post-Graduate Training. Documentation of satisfaction of the education and training qualifications set forth in the Bylaws including the name of the institution(s) and the dates attended, any degrees attained, course of study or program(s) completed; and, for all post-graduate training, the names of individuals responsible for reviewing the Applicant's performance.

(b) Licensure History. Documentation of satisfaction of the licensure qualifications set forth in the Bylaws including a copy of all current, valid professional licenses or certificates and Drug Enforcement Administration registration, the date of issuance and the license, certificate, registration or provider number(s); as well as all previous licenses held.

(c) Board Certification. Documentation of satisfaction of the board certification qualifications set forth in the Bylaws including records verifying any specialty or subspecialty board certification, recertification, or eligibility to sit for such board's examination.

(d) Professional References. The names of at least two (2) Practitioners in the Applicant's same professional discipline with personal knowledge of the Applicant's ability to practice. Peer and/or faculty recommendations shall include information regarding the Applicant's medical/clinical knowledge, technical/clinical skills, clinical judgment, interpersonal skills, communication skills and professionalism. Peer recommendations may be in the form of written documentation reflecting informed opinions on the 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. For reappointment applications, professional references shall include: (a) references from peers familiar with the Practitioner's practice of medicine in the clinical department area where privileges are sought (if volume is low, this may require review of procedure logs and/or competency reviews from other institutions to verify competency), (b) information regarding reviews under the Hospital's peer review activities, (c) information regarding reviews by the Hospital's Credentials Committee, Clinical Department Chair, and/or the MEC.

(e) Requests. Written request stating the Medical Staff category and/or Privileges for which the Applicant wishes to be considered.

(f) Continuing Education. Certification by the Applicant that he or she has completed the continuing education required for licensure as determined by the applicable state licensing board. The Hospital shall have the right, in its discretion, to audit any such educational activities.

(g) Professional Sanctions/ Issues. Information as to whether any of the following have ever been or are in the process of being (to Applicant's knowledge) investigated, denied, revoked, suspended, reduced, modified, not renewed, or voluntarily or involuntarily relinquished or terminated:

(i) Medical Staff appointment or privileges at this or any other hospital, health care institution, state or federal government program, or managed care panel.

(ii) Membership in local, state, or national professional organizations.

(iii) Specialty or sub-specialty board certification.

(iv) License/certificate to practice any profession in any jurisdiction.

(v) Drug Enforcement Administration registration or other controlled substance number.

(vi) Participation in any Federal Healthcare Program.

(vii) Faculty appointment at any professional school.

(viii) Professional Liability Insurance.

(ix) Request for return from any type of leave of absence.

(x) Termination of contractual relationship based on issues of clinical competency, impairment, professional or personal judgment, disruptive behavior, and/or moral turpitude.

If any of such actions has occurred or is pending, the Applicant shall provide a summary of the facts and any requested documents surrounding the inquiry and the outcome or status of the action.

(h) Professional Liability Insurance and History. Documentation verifying Professional Liability Insurance coverage meeting the qualifications set forth in the Bylaws and any relevant Hospital policies, including the name(s) of present insurance carrier(s), proof of continuous Professional Liability Insurance coverage (*e.g.* tail) and detailed information regarding the Applicant's malpractice/negligence claims' history and experience

during the past five (5) years from the insurance carrier. Minimum amount 1 million occurrence/ 3 million aggregate.

(i) Ability to Carry Out Privileges Requested. Statement of the Applicant's ability to fully and competently carry out the Privileges requested, with or without reasonable accommodation, with documentation confirming this statement. Each Applicant is expected to meet the criteria related to the privileges they are requesting on the privilege form. For initial applications, the confirmation must be from a currently licensed Practitioner approved by the Hospital, and including procedure logs with outcomes to support privilege requests for procedures not attested to in postgraduate references. For reappointment applications, the confirmation must come in the form of peer review.

(j) Legal Actions. A list of any lawsuits in which the Applicant has been named as a party with an explanation of the claims asserted against the Applicant, and an explanation (including the status and, if applicable, resolution) of any past or current criminal charges (other than minor traffic offenses) of which the Applicant was found guilty or to which the Applicant pled guilty or no contest.

(k) Affiliations. The name and address of any other health care organization, facility, or practice setting at which the Applicant has previously provided or is presently providing clinical patient care or including the location of the Applicant’s office(s); names and addresses of other Practitioners with whom the Applicant is or has been associated and the dates of the associations; names and locations of all healthcare institutions or organizations with which the Applicant had or has any association, employment, privileges or practice; and, the dates of each affiliation, status held, and general scope of privileges or duties.

(l) Regulatory Actions. Information as to whether the Applicant has been the subject of investigation by Medicare, Medicaid, or any other federal or state healthcare program and, if so, the outcome of such investigation.

(m) Conflict of Interest. Documentation of compliance with any Board approved conflict of interest policy as such policy may change from time to time.

(n) Criminal Background Investigation. Documentation of compliance with the Hospital's criminal background investigation requirements, including providing information regarding any felony convictions or other criminal history for the past seven (7) years, and authorization for the Hospital to conduct a criminal background check when necessary.

(o) Proof of Identity. Applicants must provide a form of government-issued photo identification to verify that he/she is, in fact, the individual requesting Privileges.

(p) Ethics and Relations. Other specifics about the Applicant's professional ethics, character, qualifications, interpersonal skills and ability that may bear on his/her ability to provide good patient care in the Hospital.

(q) Request for Hospital Affiliation. Request for primary hospital affiliation.

(r) Other. Such other information as the Board may determine is required from time to time.

2.1-2 Specific Acknowledgments and Agreements of Applicant. Statements in the application(s) for Medical Staff appointment and/or Privileges shall:

(a) Notify the Applicant of the scope and extent of the authorization, confidentiality, immunity, and release provisions of the Bylaws.

(b) Confirm the Applicant's agreement to fulfill the obligations of Medical Staff appointment and/or Privileges as set forth in the Bylaws and the applicable Medical Staff category/Privilege set.

(c) Confirm the Applicant's agreement that if an Adverse ruling is made with respect to his or her Medical Staff appointment, Medical Staff status, and/or Privileges, the Applicant will exhaust the administrative remedies afforded by the Medical Staff Bylaws, if applicable, before resorting to formal legal action.

(d) Confirm that the Applicant has received or has access to the Bylaws, has read or had an opportunity to read the Bylaws, and that he/she agrees to be bound by the terms thereof if the Applicant is granted appointment and/or Privileges and in all matters relating to consideration of the Applicant's application without regard to whether or not the Applicant is granted appointment and/or Privileges.

2.1-3 Effect of Application. By applying for Medical Staff appointment and/or Privileges, the Applicant:

(a) Acknowledges and attests that the application is correct and complete, and that any material misstatement or omission is grounds for a denial or termination of appointment and/or Privileges.

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

(c) Agrees to be bound by the authorization, immunity, confidentiality and release provisions of the Medical Staff Bylaws.

(d) Understands and agrees that if Medical Staff appointment and/or requested 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.

(e) Agrees to notify the Chief of Staff and President/CEO immediately if any information contained in the application changes. The foregoing obligation shall be a continuing obligation as long as the Applicant is an Appointee to the Medical Staff and/or has Privileges at the Hospital.

(f) Agrees to be bound by the terms of and to comply in all respects with the Medical Staff Bylaws, the Hospital's Code of Regulations as applicable, corporate compliance plan, ethical practice guidelines, notice of privacy practices and other applicable governing documents, policies and procedures, including but not limited to participation in Medical Staff functions, committee activity, educational, and Quality Assessment and Performance Improvement activities; and to comply with any health screening policies set forth by regulatory standards as well as medical staff policies and procedures. The policies of the Medical Staff shall not conflict with the Bylaws, Rules and Regulations, and to the degree that any incongruence is perceived, the Bylaws, Rules and Regulations are shall govern.

(g) Agrees to reside in the access area required of his/her category if so required.

2.1-4 Review of Qualifications. The Applicant will be given the opportunity to go through the qualification requirements with a Hospital or Medical Staff representative either in person, by telephone, electronically, or in writing. Upon receipt of the completed application and required application fee, if any, a credentials file will be created and maintained by the Hospital.

2.1-5 Burden of Proof. The Applicant shall have the burden of producing adequate information and documentation for a proper evaluation of his/her qualifications, and for resolving any doubts about these qualifications or any other concerns that the Medical Staff and/or Board may have.

2.2 **Hospital and Community Need; Ability to Accommodate**

2.2-1 In making recommendations to the Board regarding Medical Staff appointments and/or Privileges, the Medical Staff may consider any policies, plans, and objectives formulated by the Board concerning:

(a) The Hospital's current and projected patient care needs.

(b) The Hospital's ability to provide the physical (*e.g.* facilities and equipment), personnel, and financial resources that will be required if the application is acted upon favorably.

(c) The Hospital's strategic plan of development.

(d) The Hospital's decision to contract exclusively for the provision of certain medical services with a Practitioner or group of Practitioners other than the Applicant.

2.2-2 When an application is denied solely on the basis of this provision, to the extent the Applicant seeks and is entitled to have a hearing pursuant to Article XI of the Bylaws, such hearing shall be limited solely to the issue of whether evidence exists in support of the basis for denial. A hearing shall not be convened for the purpose of questioning the Hospital's use of resources or strategic planning. The following categories of practitioners are not eligible to request an application to the Medical Staff: (i) Practitioners who provide services currently provided under an exclusive hospital contract and who are not associated with the contracted group, and (ii) Practitioners who provide services not currently available at the Hospital.

2.3 **Processing the Application.**

2.3-1 Submission of Application. The application shall be submitted to the CCO, which shall review the application for completeness. The CCO shall be responsible for collecting all applicable materials, for verifying all qualification information received, and for promptly notifying the Applicant of any problems with obtaining required information. Upon notification of such problems, the Applicant must obtain and furnish the required information. If the Applicant fails to furnish the requested information within ninety (90) days of written request therefore, the application shall be deemed to have been voluntarily withdrawn, without right to a hearing or appellate review, and the Applicant shall be so informed.

2.3-2 Primary Source Verification/Data Repository Queries. The CCO shall perform primary source verification. The CCO shall also check the OIG Cumulative Sanction report, the General Services Administration List of Parties Excluded from Federal Procurement and Non-Procurement Programs and any other appropriate sources to determine whether the Applicant has been convicted of a healthcare related offense, or debarred, excluded or otherwise made ineligible for participation in a federal healthcare program.

2.3-3 Upon completion of the collection and verification process, the CCO shall transmit the completed application and all supporting documents to the applicable MSP.

2.3-4 The credentials of all Applicants shall be checked through the National Practitioner Data Bank and other data repositories as necessary prior to granting

Privileges by the MSP. Each query to the NPDB is facility specific. The MSP will collate the application and verify case logs, continuing education and any other criteria outlined on the requested Delineation of Privileges.

2.4 **Appointment and Privileging Process.**

2.4-1 Credentials Records. A separate credentials record shall be maintained for each Practitioner requesting initial appointment, reappointment and/or Privileges.

2.4-2 Clinical Department Chair Review and Recommendation. Once the application is complete, the application shall be forwarded for review by the Clinical Department Chair of the appropriate section in which the Applicant seeks Privileges. The Clinical Department Chair has the right to meet with the Applicant to discuss any aspect of the application, his or her qualifications and experience, and requested Privileges. Upon completion of this review, the Clinical Department Chair shall make recommendations to the Credentials Committee regarding whether the Applicant should be (1) appointed to the Medical Staff and/or granted Privileges with or without limitation, (2) rejected in whole or in part for Medical Staff appointment and/or Privileges, or (3) deferred for further consideration. All recommendations to appoint must specifically include, if applicable, recommendations for the delineated Privileges to be granted.

2.4-3 Credentials Committee Review and Recommendation. Upon receipt of recommendations from the Clinical Department Chair the application shall be reviewed by the Credentials Committee. The Credentials Committee has the right to meet with the Applicant to discuss any aspect of the application, his or her qualifications and experience, and requested Privileges. Upon completion of this review, the Credentials Committee shall make recommendations to the MEC regarding whether the Applicant should be (1) appointed to the Medical Staff and/or granted Privileges with or without limitation, (2) rejected in whole or in part for Medical Staff appointment and/or Privileges, or (3) deferred for further consideration. All recommendations to appoint must specifically include, if applicable, recommendations for the delineated Privileges to be granted based on the individual Practitioner's qualifications and competency at the time the privileges are requested.

If the Credentials Committee does not receive a Clinical Department Chair's recommendation within thirty (30) days after the Clinical Department Chair's receipt of the completed application, the Credentials Committee may (after notifying the Clinical Department Chair of the Credential Committee's intent and allowing one week, or other less amount of time in order to ensure that the Credentials Committee's recommendation is received by the MEC within 60 days of the CCO deeming the application to be complete) make a recommendation to the MEC on the Credentials Committee's own initiative using the same type of criteria considered by the Clinical Department Chair.

2.4-4 Medical Executive Committee Review and Recommendation. Upon receipt of recommendations from the Credentials Committee, the application shall be reviewed by the MEC. The MEC has the right to meet with the Applicant to discuss any aspect of the application, his or her qualifications and experience, and requested Privileges. Upon completion of its review, the MEC shall determine whether to recommend that the Applicant be (1) appointed to the Medical Staff and/or granted Privileges with or without limitation, (2) rejected in whole or in part for Medical Staff appointment and/or Privileges, or (3) deferred for further consideration. All recommendations to appoint must specifically include, if applicable, the delineated Privileges to be granted.

(a) Defer Recommendation. When the recommendation of the MEC is to defer the application for further consideration, that recommendation must be followed within thirty (30) days, except for good cause, by a subsequent recommendation as to approval or denial of, or special limitations on, appointment, Medical Staff category and/or Privileges. The President/CEO shall promptly send the Applicant Special Notice of a decision to defer action on his/her application.

(b) Favorable MEC Recommendation. When the recommendation of the MEC is favorable to the Applicant, the Chief of Staff shall promptly forward the MEC's written recommendation, together with all supporting documentation, to the Board.

(c) Adverse MEC Recommendation. When the recommendation of the MEC is deemed Adverse to the Applicant, the provisions of Article XI of the Bylaws, if applicable, shall apply. The President/CEO shall notify the Applicant of the recommendation, by Special Notice, and the Applicant's right, if any, to the procedural rights provided for in Article XI of the Bylaws. 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 right, if any, to a hearing as provided for in Article XI of the Bylaws.

2.4-5 Action by the Board of Directors.

(a) Favorable MEC Recommendation. The Board may adopt or reject any portion of the MEC's recommendation that was favorable to an Applicant or refer the recommendation back to the MEC for additional consideration, but must state the reason(s) for the requested reconsideration and set a time limit within which a subsequent recommendation must be made. If the Board's decision is favorable, the action shall be effective as its final decision. If the Board's decision is Adverse to the Applicant, the Board shall so notify the Applicant by Special Notice and the Applicant shall be entitled to the procedural rights, if any, provided for in Article XI of the Bylaws.

(b) Without Benefit of MEC Recommendation. If the Board does not receive a MEC recommendation within thirty (30) days after the MEC's receipt of the completed application (or an additional thirty (30) days thereafter if the MEC defers the application as permitted in Section 2.4-4(a) above), the Board may, after notifying the MEC of the Board's intent and allowing a reasonable period of time for response by the MEC, take action on the Board's own initiative using the same type of criteria considered by the MEC. If the Board's action is favorable, the application shall become effective as the final decision of the Board. If such action is Adverse, the President/CEO shall promptly notify the Applicant of such Adverse decision, by Special Notice, and hold its decision in abeyance until the Applicant has exercised, or has been deemed to have waived, his or her rights, if any, under Article XI of the Bylaws. The fact that the Adverse decision is held in abeyance shall not be deemed to confer Privileges when none existed before.

(c) Adverse MEC Recommendation. If the Board is to receive an Adverse MEC recommendation, the President/CEO shall withhold the recommendation and not forward the application to the Board for action until after the President/CEO notifies the Applicant, by Special Notice, of the MEC's recommendation and the Applicant's right to the procedural rights, if any, provided for in Article XI of the Bylaws and the Applicant either exercises or waives such rights.

2.4-6 Joint Conference Committee/ Medical Staff Administration (MSA). Whenever the Board's proposed decision is contrary to the recommendation of the MEC, there shall be a further review of the recommendation by the Joint Conference Committee/MSA. This Committee shall, after due consideration and within thirty (30) days after receipt of the MEC's recommendation and the Board's proposed decision, make its report to the Board. The Board may then render a final decision.

2.4-7 Final Board Decision. When the Board's decision is final, the Board shall send notice of such decision through the President/CEO to the MEC and, by Special Notice, to the Applicant. All decisions to appoint shall include, as applicable, the Medical Staff category to which the Applicant is appointed, the Privileges that may be exercised, and any special conditions related thereto.

2.5 **Application for Appointment Only**.

Due to the limited nature of an appointment to the Associate Medical Staff - Membership Only, and without Privileges, such Applicants shall only be required to provide such information as the MEC and Board deem necessary. If time constraints so require, an application for appointment to the Associate Medical Staff - Membership Only, and without Privileges, may be acted upon by the Board upon recommendation of the MEC chair. Denial of an application for appointment without Privileges shall not trigger

procedural due process rights nor create a reportable event for purposes of federal or state law.

2.6 **Process for Reappointment/Regrant of Privileges.**

2.6-1 Criteria for Review. A Practitioner shall be notified no later than 180 days prior to the date of expiration of his/her appointment and/or Privileges. No later than 150 days before the expiration date, the Practitioner must furnish to the CCO the following materials in writing and on a form approved by the MEC. Each assessment concerning the biennial reappointment of a Medical Staff Appointee and/or the regranting of Privileges shall be based upon:

(a) Updates to the information provided in the Practitioner's application, from the time of the Practitioner's initial appointment/privileging or last reappointment/privileging, that are necessary to bring the Practitioner's file current.

(b) Data from periodic appraisals by the Hospital and other organizations that currently privilege the Practitioner, if available.

(c) When regranting Privileges, review of the Practitioner's performance within the Hospital.

(d) Relevant Practitioner specific data as compared to aggregate data, when available.

(e) Morbidity and mortality data, when available.

(f) Fulfillment/satisfaction of Medical Staff responsibilities, including but not limited to, attendance at Medical Staff meetings and participation in Medical Staff affairs, including participation in Hospital and Medical Staff committees.

(g) Proof of continuing medical and/or professional training and education completed outside the Hospital during the current appointment/Privilege period as requested.

(h) Any requests for additional or reduced Privileges, or for Medical Staff category changes and the basis therefore.

(i) Such other information as the MEC and Board deem necessary.

Under no circumstances shall Medical Staff appointment and/or Privileges extend beyond the expiration date of the current appointment/Privilege period.

2.6-2 Review and Recommendation. The CCO shall verify the information provided on the application for reappointment and/or regrant of Privileges as with an initial application for appointment and/or Privileges, and notify the Practitioner of any

deficiencies or verification problems. The Practitioner has the burden of producing adequate information and resolving any doubts about the data. After the application for reappointment and/or regrant of Privileges has been declared complete by the CCO, the same process as set forth above with respect to initial applications for appointment and/or Privileges shall be followed.

2.6-3 Failure to Submit an Application for Reappointment/Privileges. Failure, without good cause, to submit a timely application for reappointment and/or a regrant of Privileges shall be deemed a voluntary resignation from the Medical Staff and shall result in termination of appointment and Privileges at the expiration of the Practitioner's current term. A Practitioner whose appointment and/or Privileges are so terminated shall not be entitled to the procedural rights provided in Article XI of the Bylaws except, if applicable, for the sole purpose of determining the issue of good cause. A Practitioner seeking to reapply after a voluntary resignation shall be required to submit an application for initial appointment and/or Privileges; provided, however, that the Practitioner may submit an application for reappointment and/or regrant of Privileges for up to six (6) months after a voluntary resignation.

2.7 **Requests for Modification of Appointment Status and/or Privileges.**

2.7-1 Request. A Practitioner may, either in connection with reappointment and/or a regrant of Privileges, or at any other time during an appointment/Privilege period, request modification of his/her Medical Staff category and/or Privileges by submitting a written request to the CCO on the prescribed form. Such request shall be processed in substantially the same manner as provided in Section 2.6 for reappointment/regrant of Privileges. A Practitioner whose request for modification has been denied may not submit a similar request for a period of not less than one (1) year from the date of the prior denial.

2.8 **Timeframe**.

2.8-1 Guidelines. All individuals and groups required to act on an application for Medical Staff appointment/reappointment and/or Privileges should do so in a timely manner. Unless the application is incomplete, requires additional information, or for other good cause, the following timeframe guidelines will be used as a goal in which to process the application:

INDIVIDUAL/GROUP	TIME
CCO Verification	Generally within thirty (30) days of submission of the application. However, if additional information is required from the Applicant, the Applicant will have ninety (90) days to respond to requests for such information. The time spent awaiting a response from the

	Applicant shall not count towards the verification process time. Once an application is deemed complete, the application is then forwarded to the appropriate Clinical Department Chair.
Clinical Department Chair Evaluation	Generally should be completed within thirty (30) days of receipt of completed application from the CCO.
Credentials Committee Evaluation	At the next scheduled meeting after receipt of recommendations from the Clinical Department Chair, but a recommendation shall be made to the MEC within 60 days of receipt of a completed application.
MEC Evaluation	At the next scheduled meeting after receipt of recommendations from the Credentials Committee. May be deferred beyond such meeting but will generally be completed within thirty (30) days of such meeting.
Board Evaluation	At the next scheduled meeting after receipt of recommendations from the MEC. May be deferred beyond such meeting, but will generally be completed within thirty (30) days of such meeting.

These time periods are only guidelines and are not directives. Nevertheless, a recommendation shall be made to the MEC within 60 days of receipt of an application once deemed complete. The timeframe guidelines in this section do not create any rights for a Practitioner to have an application processed within these precise periods. The burden of providing all necessary information and providing such information in a timely manner remains at all times with the Practitioner.

If, for any reason, the provisions of Hearing and Appeal procedures of the Bylaws are applicable to an Appointee or Applicant, the time requirements provided in the Bylaws supersede and control the processing of the application.

2.9 **Resignations and Terminations.**

2.9-1 Resignation of Medical Staff Appointment and/or Privileges. Resignation of Medical Staff appointment and/or Privileges, and the reason for such resignation,

shall be submitted in writing. Notification of the resignation will be forwarded to the MEC and Board.

2.9-2 Termination of Medical Staff Appointment and/or Privileges. In those cases when a Practitioner moves away from the area without submitting a forwarding address or the Practitioner's written intentions with regard to his/her Medical Staff appointment and/or Privileges, the Practitioner's Medical Staff appointment and/or Privileges shall be terminated after approval by the MEC and the Board. If a forwarding address is known, the Practitioner will be asked his/her intentions with regard to Medical Staff appointment and/or Privileges and, if the Practitioner does not respond within thirty (30) days, the Practitioner's name will be submitted to the MEC and Board for approval of termination. Consideration may also be given to contacting the applicable state licensing board regarding the Practitioner's actions. The President/CEO will inform the Practitioner of the approved termination by Special Notice.

2.9-3 No Right to Hearing. Provided a resignation or termination pursuant to this Section 2.9 is determined by the Board to be voluntary, such resignation or termination shall not give rise to any procedural due process rights pursuant to Article IX of the Bylaws.

2.10 **Impact of Final Adverse Decision or Automatic Termination**

2.10-1 A Practitioner who has received a final Adverse decision regarding appointment/reappointment, Medical Staff category, or Privileges may not reapply for Medical Staff appointment and/or Privileges for a period of at least one (1) year from the later of (a) the date of the notice of the final Adverse decision; or (b) the final court decision, as applicable.

2.10-2 A Practitioner whose appointment and/or Privileges are terminated pursuant to the Corrective Action Article of the Medical Staff Bylaws may not reapply for Medical Staff appointment and/or Privileges for a period of at least one (1) year from the date of the automatic termination.

Applications submitted after the required one (1) year waiting period will be processed as an initial application, and the Practitioner must submit such additional information as required by the Medical Executive Committee or Board to show that any basis for the earlier Adverse decision or automatic termination has been resolved.

ARTICLE III: CLINICAL PRIVILEGES

3.1 **Exercise of Privileges.**

3.1-1 Limitation on Privileges. Every Practitioner practicing at this Hospital shall, in connection with such practice, be entitled to exercise only those Privileges that have been determined to be within the individual's scope of demonstrated competency, based on Hospital capabilities, and specifically granted to the Practitioner by the Board upon recommendation of the Medical Staff through its credentialing process as delineated in the Medical Staff Bylaws and governing documents, policies and procedures.

3.1-2 Request for Privileges. Every application for Medical Staff appointment and Privileges, for Privileges only, for reappointment and regranting of Privileges, or for new/modified Privileges must contain a request for the specific delineated Privileges desired by the Practitioner. The evaluation of such request shall be based upon the qualifications set forth in the Medical Staff Bylaws and this Credentials Manual in addition to the Practitioner's competency in the following areas: patient care, medical/clinical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice.

The Practitioner shall have the burden of establishing his or her current qualifications and competency for the Privileges requested. Privileges must be defined and delineated as clearly as possible, avoiding broad and general terms. Standards for obtaining clinical Privileges are developed by the Medical Staff in collaboration with Clinical Services, and may include core privilege delineation and/or specific categories or levels of specialty privileges as defined by education, training, experience, demonstrated clinical competency, patient types or diseases, major treatment areas and degree of complexity, and may use components as recommended by national associations or specialty accrediting bodies. Standards for obtaining clinical privileges must be approved by the Medical Staff and the Board.

3.1-3 Dentists, Oral Surgeons, Podiatrists, and Psychologists. Oral Surgeons and Podiatrists may admit patients to the Hospital. Dentists may co-admit. Psychologists may neither admit nor co-admit patients to the Hospital but may treat patients who have been admitted by a Practitioner with admitting Privileges provided the Psychologist maintains a consultative relationship with the attending Practitioner during the course of treatment of the patient.

Privileges exercised by Dentists and Oral Surgeons shall be under the overall supervision of the Clinical Department Chair of Surgery. Privileges exercised by Podiatrists shall be under the overall supervision of the Clinical Department Chair of Surgery. Privileges exercised by Psychologists shall be under the overall supervision of the Clinical Department Chair of Medicine.

At the time of the admission of a dental (other than the admission of a patient by an Oral Surgeon) or podiatric patient with pre-existing medical problems, a Physician Medical Staff Appointee with admitting Privileges shall be responsible for completing the admission history and physical examination, and caring for any medical problem that may be present at the time of admission or that may arise during hospitalization. If a medical problem exists, the Physician shall determine the risk and effect of the proposed surgical procedure on the health of the patient. At or before the time of admission of such patients, the Dentist, Oral Surgeon (if not otherwise Privileged to do so) or Podiatrist is responsible for obtaining medical consultation in accordance with the above provisions. An Oral Surgeon, if granted the Privilege to do so, may perform the admitting history and physical for his/her patients. The Chair of the relevant Clinical Department (or the Chief of Staff if the Chair of the Clinical Department is not available) shall decide any disputed issue.

The Dentist, Podiatrist, or Psychologist is solely responsible for completion of the dental, podiatric, or psychological history, examination, diagnosis, operative report, discharge summary and such other components of the medical record related to his/her care of the patient that are within his/her scope of licensure and granted Privileges. If there is a medical problem, the attending Physician shall participate in the discharge of the patient and the completion of the medical records.

3.2 **Allied Health Professional Services**. Requests for AHPs to perform specified patient care services from AHP supervising Practitioners are processed in the manner specified in this Credentials Manual. An AHP may, subject to any State licensure or certificate requirements or other limitations, exercise independent judgment within their areas of individual professional competence and participate directly in the management of patients under appropriate supervision in accordance with Hospital policy.

These practitioners provide medical care under the supervision of a licensed physician as requested on their delineation of privileges and granted through the credentialing process outlined in this manual. Applicable laws, codes or regulations which govern the scope of practice for each AHP are available through the medical staff services office.

Effective May 20, 2014, a CNS, CNM, or CNP may admit patients to the hospital in accordance with ORC 3727.06 if all of the following conditions are met:
(i) The CNS, CNM, or CNP has a standard care arrangement entered into pursuant to ORC 4723.431 with a collaborating physician or podiatrist who is a member of the medical staff that lists admitting privileges; and (ii) The patient will be under the medical supervision of the collaborating doctor or podiatrist; and (iii) The hospital has implemented applicable privilege sets and computer systems/process to enable it to grant such privileges; and (iv) The CNS, CNM or CNP has been granted admitting privileges and appropriate credentials under these bylaws.

Effective May 20, 2014, a PA/C may admit patients to the hospital in accordance with ORC 3727.06 if all of the following conditions are met: (i) The PA/C is listed on a

supervision agreement approved under ORC 4730.19 for a physician or podiatrist who is a member of the hospital's medical staff; and (ii) The patient will be under the medical supervision of the supervising doctor or podiatrist; and (iii) The hospital has implemented applicable privilege sets and computer systems/process to enable it to grant such privileges; and (iv) The hospital has granted the PA/C admitting privileges and appropriate credentials under these bylaws. The collaborating doctor or podiatrist must be an active member of the medical staff in good standing.

Prior to admitting a patient, CNS, CNM, or CNP, or PA/C shall notify the collaborating or supervising physician or podiatrist of the planned admission.

3.3 **Recognition of New Service or Procedure:** A Privilege set must be approved by the Board for all new services and procedures except for those that are clinically or procedurally similar to an existing modality.

3.3-1 The Board shall determine the Hospital's scope of patient care services based upon recommendation from the MEC. 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 another qualified Practitioner(s) with Privileges at the Hospital to provide coverage for the procedure/service 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.

3.3-2 Requests for Privileges for a service or procedure that has not yet been recognized by the Board shall be processed as follows:

(a) The Practitioner must submit a written request for Privileges to the MEC. The request shall 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 to the MEC in evaluating the request.

(b) The MEC will establish an *ad hoc* committee to develop criteria and to submit such criteria to the MEC within thirty (30) days of receiving the request. For good cause shown, the *ad hoc* committee may be granted additional time in which to complete its task. The criteria should be based

upon a determination as to what specialties are likely to request the Privilege; the positions of specialty societies, certifying boards, etc.; the available training programs; and criteria required by other hospitals with similar resources and staffing. If the *ad hoc* committee decides to recommend that the Privilege be recognized at the Hospital, the *ad hoc* committee must provide in its report the recommended standards to be met with respect to the following: education, training, fellowship/board status; experience; whether proctoring/monitoring should be required and, if so, the number of cases/procedures to be included; and, if possible, the number of cases/procedures that should be performed during an appointment/Privilege period to establish current competency. If the *ad hoc* committee determines that the service or procedure can or should be included in an existing Privilege set, the *ad hoc* committee will provide the basis for its determination.

(c) Upon receipt of the *ad hoc* committee's report, the MEC shall act. The recommendation of the MEC regarding the new service or procedure, whether favorable or not favorable, shall be forwarded to the Board for approval. If the Board approves the Privilege, the requesting Practitioner(s) may be granted Privileges consistent with the terms set forth in the Bylaws and related Manuals. If the Board does not approve the Privilege, the requesting Practitioner(s) will be so notified. A decision by the Board not to recognize a new service or procedure does not constitute an appealable event for purposes of Article XI of the Bylaws.

3.4 **Types of Privileges.**

3.4-1 Temporary Privileges. Temporary clinical Privileges may be granted only in the circumstances and under the conditions set forth in this section. Special requirements of consultation and reporting may be imposed by the Chief of Staff. In all cases, the Practitioner requesting temporary Privileges must agree in writing to abide by the Medical Staff Bylaws, governing documents, and applicable policies and procedures. The President/CEO (acting on behalf of the Board and adhering to State law) may, upon recommendation of the Chief of Staff, grant temporary Privileges on a case by case basis in the following circumstances:

(a) Pendency of a Completed Application. Temporary Privileges for new Applicants may be granted upon verification of the following information:

(i) Current licensure, DEA certificate and insurance.

(ii) Relevant training and experience.

(iii) Current competence.

(iv) Ability to perform the Privileges requested.

(v) Satisfaction of other criteria required by the Bylaws.

(vi) Completion of a query and evaluation of the National Practitioner Data Bank information.

(vii) Satisfactory completion of application.

(viii) No current or previously successful challenge to licensure/registration.

(ix) That the Applicant has not been subject to the involuntary termination of his/her medical staff appointment at another organization.

(x) That the Applicant has not been subject to the involuntary limitation, reduction, denial or loss of his/her clinical Privileges.

(xi) One recent reference from a previous hospital or department chair.

Temporary Privileges may be granted in this circumstance only when sufficient evidence exists that the granting of such Privileges is prudent and for a period not to exceed the pendency of the application or one hundred twenty (120) days, whichever is less. Any such renewal shall be made by the President/CEO and may be made only when the information available continues to support a favorable determination regarding the Practitioner's application for clinical Privileges. Under no circumstances may temporary Clinical Privileges be initially granted or renewed if the application is still pending because the Applicant has not responded in a satisfactory manner to a request for clarification of a matter or for additional information.

(b) Important Patient Care Need. Temporary Privileges may be granted to a Practitioner to meet an important patient care need (*e.g.,* for the immediate care of a specific patient) but only after verification of the Practitioner's current licensure**,** DEA certificate, insurance, and current competence relative to the Privileges being requested as evidenced by at least one recent reference from a previous hospital, or department chair. Temporary Privileges may be granted in this circumstance for an initial period of thirty (30) days and may be renewed for additional thirty (30) day periods as necessary for the care of a particular patient.

(c) Guest Privileges**.** Guest practitioners are typically involved in the care of a specific patient for a specific procedure or admission and are under the direction of an existing member of the Active Medical Staff. Practitioners who have been invited to participate in the care of a specific patient at Fort Hamilton Hospital and who would otherwise have no need to obtain medical staff membership and/or clinical privileges. (i.e. geographical reasons) may be granted temporary guest privileges. Such individual may include visiting faculty or others who come to Fort Hamilton Hospital to

perform or assist an existing member of the medical staff in a select procedure or serve in a role of definitive scope.

(i.) Applicant must submit an application requesting temporary privileges to fulfill an important patient care need.

(ii.) The Medical Staff Professional assigned to the application is responsible for verifying the following elements:

- Valid Ohio medical license and/or other state medical licenses
- Verification of membership, clinical privileges and demonstrated clinical competence from primary hospital
- Confidential physician evaluation from professional reference. Professional reference must be a clinician who can attest to clinical competence to perform the privileges being requested or management of care being provided to the patient.
- Verification of current professional liability and claims history
- AMA/AOA profile as appropriate
- National Practitioner Data Bank Query
- OIG Query
- Copy of DEA Certificate

(iii.) If the Applicant is requesting to assist another physician on the Fort Hamilton Hospital Medical Staff, a letter from that physician indicating their agreement to supervise the requesting physician is required.

(iv.) Once the application is deemed complete by the Medical Staff Professional the application shall be forwarded to the appropriate Clinical Department Chair for review of clinical qualifications and determination of clinical competence.

(v.) The Chief of Staff and/or designee will review and provide recommendation to the President/CEO of the Hospital and/or designee who has the authority to grant the temporary privileges. (Note: President/CEO designee could be the CFO or, if unavailable, the Vice President of Clinical Services or the CMO.

(vi.) These privileges are time limited and expire upon discharge of the patient. The application is considered current for a period not to

exceed twelve (12) months. Such privileges shall be granted no more than three times during the twelve-month period.

3.4-2 *Locum Tenens*. A Practitioner seeking Privileges as a *locum tenens* shall submit an application for such Privileges and shall have such application processed in accordance with Article II of this Credentials Manual. Privileges shall be granted for a period of time as determined by the Chief of Staff, to include extensions of such Privileges provided, however, that no single extension shall be for a period in excess of thirty (30) days. An approved application for Privileges as a *locum tenens* shall be valid for a period of two (2) years. In the event a Practitioner seeks to act in the capacity of a *locum tenens* more than once during this two (2) year period, the Practitioner will not be required to submit a new application; rather, the Practitioner will only be required to update the information given in the prior approved application and such other information as is deemed necessary by the Chief of Staff similar to the reappointment/Privilege regranting process. In exceptional circumstances, as determined by the President/CEO (acting on behalf of the Board and adhering to State law) and the Chief of Staff in their sole discretion, a *locum tenens* Practitioner may initially qualify for temporary Privileges pursuant to Section 3.3-1.

3.4-3 Emergent Privileges. In the case of an emergency, any Practitioner/AHP, to the degree permitted by the Practitioner's license, shall be permitted and assisted to do everything possible to save the life of a patient using Hospital resources as necessary, including the calling of any consultation necessary and desirable. When the extraordinary circumstances necessitating this action are no longer present, said Practitioner must relinquish care of the patient to the Practitioner of record or arrange for appropriate post-emergency care. For purposes of this section, "emergency" is defined as a situation where serious permanent harm is imminent or in which an individual's life is in immediate danger and delay in administering treatment could increase the danger or harm. This practice is not utilized to "cover" a practitioner who has failed to follow Medical Staff guidelines in applying for privileges.

3.4-4 Disaster Privileges.

(a) Disaster Privileges may be granted to licensed volunteer Practitioners when the Hospital's emergency operations plan is activated in response to a disaster and the Hospital is unable to meet immediate patient needs. The President/CEO or Chief of Staff may grant such disaster Privileges on a case-by-case basis after verification of a valid government-issued picture identification in addition to at least one (1) of the following:

(i) primary source verification (A documented phone call is acceptable);

(ii) a current license to practice;

(iii) a current picture identification card from a health care organization that identifies professional designation;

(iv) identification indicating the individual 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;

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

(vi) confirmation of the identity of the volunteer Practitioner and his/her qualifications by a Hospital employee or Practitioner with Hospital Privileges.

(b) The granting of disaster Privileges shall be done in the same manner as temporary Privileges, except that primary source verification of licensure and competency may be performed after the situation is under control and as circumstances allow.

(i) A primary source verification of licensure shall be conducted as soon as the immediate situation is under control, or within seventy-two (72) hours from the time the volunteer Practitioner presents to the organization, whichever comes first.

(ii) If verification cannot be completed within seventy-two (72) hours due to extraordinary circumstances (for example, no means of communication or lack of resources), verification shall be performed as soon as possible. In such event, the Hospital shall document all of the following: the reasons primary source verification could not be performed within seventy-two (72) hours of the volunteer Practitioner's arrival at the Hospital; evidence of the volunteer Practitioner's demonstrated ability to continue to provide adequate care, treatment and services; and, evidence of the Hospital's attempt to perform primary source verification as soon as possible.

(iii) A reassessment/decision must be made within seventy-two (72) hours after initial disaster Privileges have been granted to determine if there should be a continuation of disaster Privileges for that Practitioner.

(c) It is anticipated that these disaster Privileges may be granted to state-wide and out-of-state volunteer Practitioners as necessary.

(d) All Practitioners 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 Practitioner does not have such identification, the Practitioner will be issued a badge identifying and designating the Practitioner as an emergency provider.

(e) The activities of Practitioners who receive disaster Privileges shall be managed by and under the supervision of the Chief of Staff or an appropriate designee of the incident commander.

(f) Disaster Privileges shall cease upon alleviation of the circumstances of disaster as determined by the President/CEO.

3.4-5 Telemedicine Privileges.

Telemedicine is defined as the use of medical information exchanged between practitioners at an originating site Hospital, (the site where the patient is physically located at the time of service) and a distant-site (the site where the Practitioner providing the professional service is located) through electronic communications for the purpose of providing patient care, treatment and services at the originating site, including education services for the Practitioner. For purposes of this manual, telemedicine would not include services that are strictly interpretive in nature, such as reading of images or specimens, or consultations in which a practitioner is simply offering advice to a treating practitioner that typically occur over the phone, unless such physician services were not available through the Medical Staff to meet the patient care needs. Practitioners shall be credentialed and privileged to provide telemedicine by the Hospital in accordance with the Bylaws and this manual, accreditation requirements, and applicable law. If the Hospital has a pressing clinical need and the Practitioner can supply that service through a telemedicine link, the Practitioner may be evaluated for temporary Privileges as set forth in this manual.

Distant-site Practitioners providing telemedicine may be credentialed in accordance with CMS. If telemedicine services are to be furnished through an agreement with a distant-site hospital or telemedicine entity, the Hospital shall be in compliance with the Medicare Conditions of Participation (CoP) set forth at C.F.R. 482.12(a)(8)&(a)(9), regarding credentialing and privileging based on the Board's approval of its medical staff recommendations in compliance with such CoP. The Hospital Board retains overall responsibility and authority for services furnished under a contract and ensures that the nature and scope of contracted services are defined in writing and meet applicable federal, Ohio State law, accrediting standards, and Hospital Bylaws and policies. The Hospital shall evaluate the contracted care, treatment, and services to determine whether such is being provided according to the contract and level of safety and quality that the Hospital expects.

The Hospital may credential and privilege distant-site Practitioners providing telemedicine services to the Hospital in accordance with the Bylaws, governing manuals, accreditation requirements, Medicare Conditions of Participation, and applicable current federal and Ohio law through one of the following mechanisms:

(a) The Medical Staff may independently review and make privileging recommendations for each telemedicine Practitioner in accordance with CFR 482.22 (a)(1) through 482.22 (a)(2) using the same credentialing and privileging process required of all applicants to the Medical Staff in accordance with the Bylaws and governing manuals, policies and procedures; or

(b) The Medical Staff may rely upon the credentialing and privileging decisions made and information provided by the distant-site hospital/telemedicine entity pursuant to a written contractual agreement with the distant-site hospital or telemedicine entity, which complies with Ohio law and requirements at CFR 482.22 (a)(1) and 482.22 (a)(2) and accreditation standards, so long as the Hospital's Board ensures through that agreement all of the following provisions are met:

a. The distant-site hospital is a Medicare-participating hospital that has granted privileges to the Practitioners who are providing telemedicine services to the Hospital's patients, and the distant-site hospital is obligated to comply with the requirements of CFR 482.12 (a)(1) through (a)(7) and CFR 482.22 (a)(1) through (a)(2); or the distant-site telemedicine entity providing the telemedicine services has granted privileges to the Practitioners providing telemedicine services to the Hospital's patients through a medical staff credentialing and privileging process with standards that satisfy the requirements of CFR 482.12 (a)(1) through (a)(7) and CFR 482.22 (a)(1) through (a)(2).

b. The individual distant-site hospital/telemedicine entity provides the Hospital with a current list of the distant-site Practitioners and a copy of the current privileges which each Practitioner can exercise at the distant-site. Any and all information released for telemedicine purposes will be per written consent from the individual Practitioner providing such services.

c. The individual distant-site Practitioner must have a current, valid Ohio license to practice medicine or a current, valid, Ohio telemedicine certificate issued by the State Medical Board of Ohio.

d. The Hospital provides to and receives from the distant-site information concerning the internal review of the distant-site Practitioner's performance of current Privileges at the Hospital and at the distant-site

hospital/telemedicine entity for use in privileging, performance improvement, and the periodic appraisal of the distant-site Practitioner. (NOTE: This exchange of information occurs in a way consistent with any Hospital policies or procedures intended to preserve any confidentiality or privilege of the information as established by applicable law.) Practitioners providing telemedicine services must be successfully evaluated pursuant to ongoing periodic appraisals. At a minimum, this information would include:

i. All adverse outcomes and events that result from the telemedicine services provide by the distant-site Practitioner to Hospital patients, including adverse outcomes, and
ii. Complaints about the distant-site Practitioner from patients, other licensed independent practitioners, or staff related to telemedicine services.

e. The Medical Staff at both the Hospital and distant-sites determine and recommend the clinical services that are to be provided by the Practitioner through telemedicine at their respective sites which can be appropriately delivered through this medium, and are consistent with commonly accepted quality standards. Clinical privileging decisions encompass consideration of the appropriate use of telemedicine equipment by the telemedicine Practitioner. The Medical Executive Committee will make its recommendation to the Board based on

(c) The Medical Executive Committee will make recommendations to the Board based on credentialing and privileging information provided by the distant-site hospital/telemedicine entity in accordance with the requirements of Ohio law, accreditation standards, and in full compliance with the requirements in CFR 482.12 (a)(8) and (a)(9) and 4822.12 (a)(3) and (a)(4).

(d) Unless otherwise stated in a contractual agreement, the granting of clinical privileges will be for the same period of time as the granting of privileges by the distant-site hospital or telemedicine entity, but no less frequently than every two (2) years. Upon presentation of evidence of the extension or renewal of privileges granted by the distant-site hospital or telemedicine entity, the Medical Executive Committee will make its recommendation to the Board based on the credentialing and privileging reappointment decisions made by the distant-site hospital or telemedicine entity.

(e) Distant-site Practitioners receiving Clinical Privileges at the Hospital to perform telemedicine services will not be members of the Medical Staff and will have no rights that are afforded its members. However, telemedicine Practitioners must comply with all provisions of the Medical Staff Bylaws, Credentials Manual and Medical Staff policies and

procedures applicable to the exercise of such Clinical Privileges at the Hospital.

(f) Distant-site telemedicine Practitioners are required to carry and submit proof of having and maintaining current professional liability coverage in amounts as required by the Board.

(g) Distant-site Practitioners will provide telemedicine services in accordance with their scope of licensure or telemedicine certificate, as applicable, and shall have an appropriate professional relationship with a Member of the Active or Courtesy Staff who shall be responsible for the service provided to the Hospital's patients.

(h) The Hospital shall evaluate the following elements prior to granting privileges to distant-site Practitioners:

a. Current State license (if other than Ohio, the state of current practice and Ohio telemedicine certificate)
b. Challenges to any licensure or registration
c. Voluntary and involuntary relinquishment of any license or registration
d. Voluntary and involuntary termination of medical staff membership
e. Voluntary and involuntary limitation, reduction or loss of clinical privileges
f. Any evidence of an unusual pattern or an excessive number of professional liability actions resulting in a final judgment against the applicant
g. Documentation as to the applicant's health status as affects performance of the privileges requested
h. Relevant practitioner-specific data as compared to aggregate data, when available
i. Performance measurement data, including morbidity and mortality data, when available

Practitioners on the Hospital's Medical Staff may provide telemedicine services to patients at remote locations, functioning as the distant-site Practitioner. When Hospital is acting as the distant-site, the chair of each department/section that offers telemedicine services will delineate which clinical services are appropriately delivered via a telemedicine link, consistent with commonly accepted quality standards.

(a) Practitioners who have responsibility through a telemedicine link are credentialed and privileged by the medical staff of Hospital and the medical staff of the originating site.

(b) Performance of services by a Hospital practitioner will be evaluated as part of privileging and as a part of the reappraisal conducted at the time of reappointment or renewal or revision of clinical privileges.

(c) Any and all credentialing documentation that can be released to the originating site hospital will be per written consent for release of information for telemedicine purposes from the individual independent licensed practitioner, including copies of the following information:

i. Initial Application or Reappointment Application
ii. Current approved Privileges
iii. Ohio medical license
iv. DEA certificate verification
v. Fluoroscopy / X-ray Certificate verification, if applicable
vi. Current Professional Liability Coverage, if applicable

3.5 **Termination of Temporary, Locum Tenens, Emergent, Disaster, or Telemedicine Privileges.**

3.5-1 Termination. The President/CEO or the Chief of Staff may, at any time, terminate any or all of a Practitioner's temporary, *locum tenens*, emergency, disaster or telemedicine Privileges. Where the life or well-being of a patient is determined to be endangered, the Practitioner's Privileges may be terminated by any person entitled to impose a summary suspension pursuant to the Bylaws Section 10.7.

3.5-2 Due Process Rights. A Practitioner who has been granted temporary, *locum tenens*, emergency, disaster or telemedicine Privileges is not an Appointee to the Medical Staff and is not entitled to the procedural due process rights afforded to Appointees. A Practitioner shall not be entitled to the procedural due process rights set forth herein because the Practitioner's request for temporary, *locum tenens*, emergency, disaster or telemedicine Privileges are 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.

3.5-3 Patient Care. In the event a Practitioner's Privileges are terminated, the Practitioner's patients then in the Hospital shall be assigned to another Practitioner by the Chief of Staff. The wishes of the patient will be considered, where feasible, in choosing a substitute Practitioner.

3.6 **Return/Re-Entry to Clinical Practice**

3.6.1 Purpose. To provide a pathway for applicants who wish to return to active clinical practice in their respective trained discipline after a period of absence from clinical activity. To ensure that Practitioners have retained current clinical competence and to enhance, broaden, and/or develop clinical/medical skills, the Return to Practice Program delineates guidelines to be monitored through established focused professional evaluation processes, in addition to the specific

processes to be completed during the provisional appointment period and/or reappointment cycle. Practitioners granted membership and privileges under this program will meet existing standards and requirements delineated within the Medical Staff Bylaws, Manuals and governing documents including specialty-specific delineation of privileges criteria.

3.6.2 Process. Applicants requesting return to practice will be required to meet with the Medical Staff leadership prior to formal application and/or approval of their return to practice. Clinical Department Chairs will be responsible for developing the plan with the Practitioner to address specific needs. Program guidelines are outlined on the "Return to Practice" grid below, based on the following components:

- Number of years out of active clinical practice
- Education requirements
- Supervision / proctoring requirements
- Period of evaluation
- Program supervisor
- Competency evaluation
- Program monitoring / feedback

Years out of Practice	**Education**	**Supervision/ Proctoring**	**Period of Evaluation**	**Supervision**	**Competency Evaluation**
<1	Ongoing relevant continuing education	Established focused professional evaluation for initial Applicants/ procedure	3 months	Clinical Department Chair	Retrospective review based on established criteria
1 to 2	Equivalent of 50% of specialty specific continuing education as required for State of Ohio licensure within the previous 12 months or equivalent education	Established focused professional evaluation for initial Applicants/procedure	6 months	Clinical Department Chair	Retrospective review based on established criteria
>2	Equivalent of 100% of specialty specific continuing education as required for State	Established focused professional evaluation for Applicants/procedure Concurrent proctoring in accordance with plan	6 months	Clinical Department Chair and Medical Staff Proctor	Focused professional evaluation forms completed by proctor

	licensure within the previous 24 months or equivalent education such as board review courses	developed by the focused professional evaluation by active Medical Staff Appointee willing to facilitate RTP			Retrospective review based on established criteria

3.7 **Assignment.**

Each member of the Medical Staff shall be assigned membership in one Clinical Department. The exercise of Privileges and specified services within each Clinical Department shall be subject to the rules and regulations therein and to the authority of the Clinical Department and its Chair. Physicians sharing common interests or skills and/or limit their professional activities to a single, sometimes general, medical or surgical specialty. The following are Clinical Department with specialties as may be assigned within such Clinical Department, subject to change from time to time in accordance with the Bylaws procedures:

The current Clinical Departments include:

Anesthesiology

Pain Management

Emergency Medicine

Medicine

Allergy & Immunology

Anticoagulation Clinic

Cardiology

Dermatology

Endocrinology

Family Practice

Gastroenterology

Glycemic Control

Hematology/Oncology

Hospital Medicine (Hospitalist)

Infectious Disease

Internal Medicine

Nephrology

Neurology

Palliative Care

Psychiatry

Pulmonary/Critical Care

Rheumatology

Sleep Medicine

Wound Care

Obstetrics/Gynecology & Pediatrics

Neonatology

Urogynecology

Gynecologic Oncology

Radiology

Radiation Oncology

Interventional Radiology

Neuroradiology

Nuclear Medicine

Diagnostic Radiology

Women's Imaging and Mammography

Musculoskeletal Radiology

Surgery

Breast Surgery

Endoscopy

General Surgery

Neurosurgery

Ophthalmology

Oral & Maxillofacial Surgery

Orthopedic Surgery

Otolaryngology (ENT)

Pathology

Plastic Surgery

Podiatry

Thoracic Surgery

Urology

Vascular Surgery

3.8 **Periodic Appraisals**.

The Hospital's periodic appraisal process is set forth in the Peer Review Policy, as such policy may change from time to time. Periodic appraisals shall be used to determine the Practitioner's clinical competence and ability to perform the requested Privileges.

ARTICLE IV: LEAVE OF ABSENCE

4.1 Grant of Leave of Absence

4.1-1 At the discretion of the MEC (with notice to the Board), an Appointee may, for good cause shown (such as for personal reasons related to the birth of a child, illness of a family member, participation in extended mission project, to pursue additional education, to fulfill required military services, or for medical conditions which are anticipated to impair the Appointee for a period of at least two (2) months), be granted a voluntary leave of absence from the Medical Staff by submitting a written request to the MEC (with physician certification regarding any medical condition warranting a leave) stating the approximate period of time of the leave which may not exceed one (1) year. The time period for consideration of reappointment shall be stayed during the leave of absence.

4.1-2 During a leave of absence, the Appointee is not entitled to exercise Privileges at the Hospital and has no appointment Prerogatives and responsibilities, with the exception that the Appointee must continue to pay Medical Staff dues, if applicable, unless otherwise waived by the MEC. He or she shall not be an Officer or serve on any committee of the Medical Staff or vote on any Medical Staff matter. Prior to a leave of absence being granted, the Appointee shall have made arrangements acceptable to the MEC and Board for the care of his/her patients during the leave, and shall have completed all delinquent medical records, except in emergency circumstances.

4.2 Termination of Leave of Absence and Reinstatement

4.2-1 The Appointee must submit to the MEC, at least thirty (30) days prior to termination of the leave of absence or at any earlier time, a written request for reinstatement as well as such additional information as is reasonably necessary to reflect that the Appointee is qualified for reinstatement or as may otherwise be requested by the MEC, including but not limited to:

(a) A physician's report on the Appointee's ability to resume practice if the Appointee is returning from a medical leave of absence.

(b) A statement summarizing any educational activities undertaken by the Appointee if the leave of absence was for educational reasons.

(c) Proof of military discharge or status if the leave of absence was for military reasons.

(d) Proof of continuing professional liability insurance coverage (or tail coverage) satisfactory to the Hospital evidencing proof of coverage for professional liability claims that occur or are reported during the period of the leave of absence.

(e) A written summary of relevant clinical activities engaged in during the leave of absence if the MEC so requests**.**

4.2-2 For good cause and upon notice received not less than thirty (30) days prior to expiration of a leave, an Appointee's leave may be extended by the MEC (with notice to the Board) for an additional period of up to 12 months so long as the leave period does not exceed a total of eighteen (18) months.

4.2-3 Reinstatement of membership and clinical privileges previously held may be granted subject to monitoring and/or proctoring as determined by the MEC. The proctoring may be voluntary or mandatory.

4.2-4 Once the Appointee's request for reinstatement is deemed complete the MEC shall, at its next regular meeting, take action on the request in accordance with the procedure set forth in this Article, and shall make such recommendation to the Board for final determination.

4.2-5 Upon reinstatement following a leave of absence, the Appointee shall return to the same clinical service, in the same Staff category, and with the same clinical privileges that existed upon commencement of the leave. However, a leave of absence due to any physical, medical, psychological or other impairment that interferes or has interfered with the Appointee's ability to practice medicine necessitates review by the appropriate Clinical Department Chair before prior clinical privileges are restored.

4.2-6 If an Appointee fails to request reinstatement upon the termination of a leave of absence, the MEC shall make a recommendation to the Board as to how the failure to request reinstatement should be construed**.** A Member who is deemed to have automatically relinquished his/her membership and Privileges as set forth in this Article shall not be entitled to the procedural rights provided under the Bylaws; and a request for Medical Staff membership subsequently received from such Member shall be treated and processed as an application for initial appointment.

ARTICLE V: PRACTITIONER PROVIDING CONTRACTUAL SERVICES

5.1 Exclusivity Policy

If the Hospital adopts a policy involving a closed Clinical Service or an exclusive arrangement for a particular service or services, any Practitioner who holds Privileges to provide such services, but who is not a party to the exclusive contract/arrangement, may not provide such services as of the effective date of the closure of the Clinical Service or start of the exclusive arrangement, irrespective of any remaining time on his/her appointment, reappointment and/or Privilege term.

5.2 Qualifications

The Medical Staff Appointment or Privileges of a Practitioner who is or will be providing specified professional services pursuant to a contract with the Hospital are subject to the same qualifications, credentialing process, and requirements/obligations as any other Medical Staff Appointee or Practitioner.

5.3 Effect of Termination of Appointment/Privileges

The Medical Staff Appointment/Privileges or any Practitioner providing specified professional services pursuant to a contract with the Hospital are subject to the same corrective action provisions as set forth in the Bylaws for all Appointees and Practitioners. How such actions affect a contract entered into by the Hospital shall be controlled by the contract, but no Practitioner may engage in services at the Hospital without appropriate Clinical Privileges.

5.4 Effect of Contract Expiration or Termination

The effect of expiration or other termination of a contract for professional services entered into by the Hospital with a Practitioner will generally be governed solely by the terms of the Practitioner's contract with the Hospital. If a Practitioner who is serving under the terms of an exclusive contract is reassigned on a permanent basis to a different facility by the group contractor, such Practitioner's Medical Staff membership and Privileges shall automatically terminate with no due process rights. If the contract is silent on the matter, then contract expiration or other termination alone will not affect the Practitioner's Medical Staff appointment status or Clinical Privileges.

ARTICLE VI: ALLIED HEALTH PROFESSIONALS

6.1 General Scope

All practitioners that provide medical care or conduct surgical procedures either directly or under supervision, whether employed by the Hospital or an Appointee, must be individually credentialed based on their own current individual qualifications and demonstrated competencies (actual practice). This Article VI addresses those AHPs who are permitted to provide services at the Hospital. This Article sets forth the credentialing process and the general practice parameters for these individuals, as well as guidelines for determining the need for additional categories of AHPs at the Hospital.

AHPs are not eligible for appointment to the Medical Staff. AHPs shall not be entitled to any of the rights or prerogatives of appointment to the Medical Staff, including but not limited to the right to vote on Medical Staff matters at any level or to hold any Medical Staff office. The AHP staff is created for the purpose of providing patient care in the Hospital as an adjunct to treatment by Practitioners who are Appointees to the Medical Staff.

All services rendered by AHPs must be performed pursuant to the Clinical Privileges granted and under the supervision, collaboration and/or direction of an Appointee as described in this Manual. All services rendered by AHPs are subject to any policies, procedures, privileges, and restrictions adopted by the Board or its Medical Staff Committee or Board Committee delegate and/or as otherwise provided in position descriptions or scopes of practice. AHPs shall provide services pursuant to approved narrative or checklist privilege lists or defined scopes of practice submitted by the Appointee. Supervision requirements of AHPs shall be in compliance with law and regulations and be specifically defined on any applicable privilege lists or defined scopes of practice.

The ratio of supervising physician to particular AHP shall be as defined by the Ohio Revised Code and Ohio Administrative Code.

All AHPs authorized to provide care will have an annual competence/skill assessment and other relevant quality monitoring.

All AHPs must comply with all limitations and restrictions imposed by their respective licenses, certifications, or legal credentials required by Ohio law, and may only perform services in accordance with provisions relating to their respective professions and contained the applicable provisions of to this Article. Prior to an AHP performing services within the Hospital, the Appointee must file with the Medical Staff a scope of practice or services to be performed at the Hospital, specific to the individual AHP that he or she supervises. For holders of a Certificate to Prescribe (CTP), a description of the scope of prescriptive practice shall be included with any limitations and/or exclusions, which shall be in compliance with the formulary index and rules promulgated by Ohio regulations specific to the licensee. An APRN CPT holder's standard care arrangement

must specify whether the collaborating physician must personally examine the patient or if the drug may be prescribed without consultation which must be consistent with the CPT holder's scope of practice and the practice specialty of the supervising physician. The supervising Appointee must attest that his/her practice oversight ratio does not and will not exceed State limitations.

Notwithstanding anything to the contrary contained in this Article, the Hospital is under no obligation to accept or favorably act upon a proposal or an application provided under the terms and conditions of this Article. The Hospital is not required to accept an application if the Hospital does not have, in its sole opinion, the financial resources, physical space, community need, or actual clinical need for that particular license or certification, or any other consideration that the Hospital, in its sole discretion, may factor into its decision.

Nothing in this Article prohibits the Hospital from hiring an AHP as an employee.

6.2 **Categories of Licensed Allied Health Professionals**

The Board, in consultation with the Medical Staff, has determined that the following **c**ategories of licensed AHPs are recognized and may apply for Privileges as AHPs:

(a) Certified registered nurse anesthetist (CRNA)

(b) Certified nurse practitioner (CNP)

(c) Clinical nurse specialist (CNS)

(d) Certified nurse midwife (CNM)

(e) Dietitian

(f) Genetics Counselor

(g) Physician assistant (PA)

(h) Mental Health Therapists

6.2-1 Active Allied Health Professional Staff

6.2.1.1 Qualifications. Practitioners to this category must:

(a) Meet all qualifications for Allied Health Professional Staff appointment as set forth in Section 6.4.

(b) Actively participate in Allied Health Professional Staff activities and responsibilities, such as committee and Clinical Service assignments.

(c) Provide evidence of clinical performance at all other hospitals in which they practice in such form as the Hospital may reasonably request. In addition, they shall provide other information as the Hospital may reasonably require in order to be able to appropriately evaluate the Appointee's qualifications.

6.2.1.2 Prerogatives. Practitioners to this category may:

(a) Treat and consult on patients, in accordance with the Privileges granted, except as otherwise provided in the Medical Staff policies and manuals or by specific privilege restriction.

(b) Participate in Hospital education programs as appropriate.

6.2.1.3 Responsibilities. Appointees to this category:

(a) Must pay all application fees, dues and assessments that are enacted by the Medical Executive Committee.

6.2-2 Associate Allied Health Professional Staff

6.2.2.1 Qualifications. Practitioners to this category shall:

(a) Consist of those practitioners who desire to be affiliated with the Hospital, but who do not intend to provide patient care at the Hospital. The primary purpose of the Associate Allied Health Professional Staff is to promote professional and educational opportunities and to allow such practitioners to refer patients to the Hospital's diagnostic and treatment facilities. Practitioners to this category must meet the general qualifications but shall not be required to provide documentation establishing current clinical competence.

6.2.2.2 Prerogatives. Practitioners to this category may:

(a) Refer patients to the Hospital's diagnostic and treatment facilities.

(b) Review patient's medical records of their collaborating/supervising physician, but may not write orders, make medical record entries, or otherwise actively participate in the provision or management of care to patients.

(c) Not be granted privileges and may not admit or treat patients at the Hospital.

6.2.2.3 Responsibilities. Appointees to this category must:

(a) Pay all application fees, dues and assessments that are enacted by the Medical Executive Committee.

6.3 Guidelines for Determining the Need for New Categories of AHPs

6.3-1 New Categories and Determination of Need. All requests for recognition of a new AHP category shall be reviewed by the Credentials Committee. The CCO shall assist in gathering information as deemed necessary or appropriate which may include, but not be limited to: information from the appropriate specialty group or trade association; information from the supervising or collaborating Appointee of the Medical Staff, and information from other hospitals, health care facilities, consultants and other appropriate sources. The Credentials Committee shall make a recommendation to the MEC whether or not to proceed with creating such new category. The MEC shall then review the recommendation, all information compiled, and any other information deemed necessary and shall make a recommendation to the Board whether or not to proceed with creating such new category.

6.2-2 Revision of Article VI. Upon recommendation of the MEC and approval by the Board to create a new category of AHP, the MEC shall prepare revisions to this Manual and Article VI as necessary to establish the qualifications, requirements, and duties of the AHP category, similar to those for other categories contained in this Article VI. These revisions shall be adopted pursuant to Article VII.

6.4 Application, Qualifications, and Privileges

6.4-1 General. Appointment as an AHP is a privilege that will only be granted to professionally competent individuals who meet the qualifications, standards, and requirements of their respective licensure, certification, other legal authorization, and this Manual.

6.4-2 General Qualification for Licensed AHPs. Only individuals who can document the following shall be qualified for appointment as an AHP:

(a) Current license, certification, certificate to prescribe, or other legal credentials required by Ohio law as relevant to the practice and AHP category;

(b) Education, training, professional background and experience, and professional competence;

(c) Adherence to the ethics of the profession for which an individual holds a license, certification, or other legal credential required by Ohio law;

(d) Good personal and professional reputation as established by appropriate references (at least one reference must be from a professional with the same legal credentials);

(e) Ability to fully and competently carry out the Clinical Privileges requested and work cooperatively with Appointees to the Medical Staff and Hospital employees;

(f) Proper, current, and valid supervision agreements or collaboration arrangements, if applicable to the AHP category, with an Appointee to the Medical Staff in good standing; and

(g) Job description or full listing of job related responsibilities.

This documentation must be presented with sufficient adequacy to assure the Medical Staff and the Hospital that any patient cared for by the person seeking appointment as an AHP will be given quality care.

6.4-3 Conditions of Acceptance. An individual accepting Privileges as an AHP agrees to the following terms and conditions:

(a) To provide patient care in the Hospital in accordance with this Article VI, all applicable Hospital policies and procedures, and the scope of his or her granted Clinical Privileges;

(b) To have read and agreed to abide by this Article VI and any other applicable Medical Staff and Hospital policies that may from time to time be amended or put into effect;

(c) To have and maintain proper, current, and valid supervision or collaboration arrangements, if applicable to the AHP category, with an Appointee to the Medical Staff in good standing;

(d) To agree to confidentiality requirements, to grant immunity from liability, and authorize release of information as required by and provided in Section 6.5;

(e) To properly identify themselves as an AHP when providing treatment or service in the Hospital;

(f) To agree that that every patient must be under the supervision of an Appointee and that an Appointee is responsible for the care of each patient;

6.4-4 Application for Clinical Privileges. Persons seeking Clinical Privileges as an AHP shall make application in the same manner as provided in Article II addressing Practitioners; provided, however, that none of the hearing and appeal provisions in Article II apply, but rather, any adverse action against an AHP applicant is processed pursuant to Section 6.4-6. The Clinical Privileges of an AHP may be granted for any period up to two (2) years. Applications for renewal

of Clinical Privileges shall be processed in the same manner as provided for Practitioners as provided in Section 2.6; provided, however, that none of the hearing and appeal provisions in Article II apply, but rather, any adverse action against an AHP applicant is processed pursuant to Section 6.4-6 of this Manual.

If the Hospital hires a clinical nurse specialist, certified nurse-midwife, or certified nurse practitioner as an employee, the Hospital shall negotiate a standard care arrangement on behalf of the employee in compliance with division (E) of Section 4723.431 of the Ohio Revised Code and paragraphs (C) and (E) of OAC 4723-8-04; and such standard care arrangement shall be in accordance with the policies and procedures of the Board and the Bylaws, policies, and procedures of the Medical Staff. The Hospital may determine to process initial applications or renewal applications through the Human Resources Department in accordance with the procedures of the Human Resources Department and applicable law.

A copy of a Licensed Advanced Practice Registered Nurse (APRN) Standard Care Arrangements, as required by the Ohio Administrative Code, chapter 4723-8-04 (as set forth at Appendix A of this Manual) shall be submitted to the Hospital by the Appointee as part of the initial and renewal applications, noting any restrictions applicable to care of patients in the Hospital. Such standard care arrangements shall be reviewed annually in compliance with the above stated Code and a signed copy shall be timely submitted to the Hospital Medical Staff Services or Human Resources, as applicable, for inclusion in the APRN's credentials file.

Supervision requirements, whether direct or indirect, for APRNs shall be in accordance with this Manual and applicable law as further set forth at Appendix A, as may be amended from time to time. Definitions applicable to APNs are as set forth at ORC 472301 at Appendix A.

All orders written by an APRN or physician assistant (PA) must be signed, timed and dated.

6.4-5 Temporary Clinical Privileges. Licensed AHPs may apply for and be granted Temporary Privileges in the same manner as for Practitioners as provided in Section 3.3-1.

6.4-6 Corrective Action and Due Process.

(a) The provisions of Article XI of the Bylaws setting forth the due process rights of Medical Staff Appointees specifically do not apply to AHPs. Rather, all due process rights, if any, are as set forth in this Article VI.

(b) Either the President/CEO or the Chief of Staff may limit Clinical Privileges, up to and including suspension or termination, at any time when, in the judgment of the President/CEO or the Chief of Staff, the AHP has violated this Article VI, the AHP has ceased to be qualified

pursuant to this Article VI, or such action is in the best interest of patient care or Hospital operations.

(c) In the event the President/CEO or the Chief of Staff seeks to recommend a suspension or termination of Clinical Privileges, the AHP shall be advised, by Special Notice, of the recommendation and the basis for such recommendation. The AHP shall have five (5) days in which to submit a written response to the individual recommending the action as to why such suspension or termination should not take place. The President/CEO and the Chief of Staff shall discuss the information and the Chief of Staff shall provide input and recommendation on final action. The President/CEO shall then make a final decision and shall notify the Board and MEC of the action taken including advising the Board of the written response, if any, of the AHP and the contents of such response.

(d) In the event the President/CEO or the Chief of Staff summarily suspends or immediately terminates an AHP's Privileges, such action shall become effective immediately but shall be followed by written notice of such action, given to the AHP by Special Notice. The AHP shall have five (5) days in which to submit a written response to the individual taking such action as to why such suspension should be lifted or termination rescinded. The President/CEO and the Chief of Staff shall discuss the information and the Chief of Staff shall provide input and recommendation on final action. The President/CEO shall then make a final decision and shall notify the Board and MEC of the action taken including advising the Board of the written response, if any, of the AHP and the contents of such response.

(e) When an AHP's Clinical Privileges are curtailed and/or the AHP is terminated, the employer (if applicable) shall be notified as to the reasons for such action.

(f) An AHP's Clinical Privileges shall be automatically suspended and reinstated for the same reasons as set forth in the Medical Staff Bylaws for automatic suspensions of Clinical Privileges of Practitioners. Such an automatic suspension shall not give rise to any due process rights to the AHP.

6.5 Confidentiality, Immunity & Release

By submitting an application for Clinical Privileges or renewal of Clinical Privileges or by providing specified patient care services at the Hospital, each AHP agrees to, authorizes, and acknowledges all of the provisions, statements, and commitments in Article XIV of the Bylaws, reading such Article with the term "AHP" replacing "Practitioner."

6.6 Certified registered nurse anesthetist (CRNA)

A certified registered nurse anesthetist may provide to nursing care that requires knowledge and skill obtained from advanced formal education and clinical experience. In this capacity as an advanced practice nurse with scope of services defined under division (B) of Section 4723.43 of the Ohio Revised Code, a nurse authorized to practice as a CRNA, with the supervision and in the immediate presence of a physician, podiatrist, or dentist, may administer anesthesia and perform anesthesia induction, maintenance, and emergence, and may perform with supervision preanesthetic preparation and evaluation, post-anesthesia care, and clinical support functions, consistent with the nurse's education and certification, and in accordance with rules adopted by the Ohio Board of Nursing. In accordance with Ohio law, a CRNA is not required to obtain a certificate to prescribe in order to provide the anesthesia care. The physician, podiatrist, or dentist supervising a certified registered nurse anesthetist must be actively engaged in practice in Ohio. When a certified registered nurse anesthetist is supervised by a podiatrist, the nurse's scope of practice is limited to the anesthesia procedures that the podiatrist has the authority under section 4731.51 of the Revised Code to perform. When a certified registered nurse anesthetist is supervised by a dentist, the nurse's scope of practice is limited to the anesthesia procedures that the dentist has the authority under Chapter 4715. of the Revised Code to perform.

6.7 Certified nurse practitioner (CNP)

A certified nurse practitioner may provide nursing care that requires knowledge and skill obtained from advanced formal education and clinical experience. In this capacity as an advanced practice nurse with scope of services defined under division (C) of Section 4723.43 of the Ohio Revised Code, a nurse authorized to practice as a CNP, in collaboration with one or more physicians or podiatrists, may provide preventive and primary care services and evaluate and promote patient wellness within the nurse's nursing specialty, consistent with the nurse's education and certification, and in accordance with rules adopted by the Ohio Board of Nursing. A CNP who holds a certificate to prescribe issued under section 4723.48 of the Revised Code may, in collaboration with one or more physicians or podiatrists, prescribe drugs and therapeutic devices in accordance with section 4723.481 of the Revised Code. When a CNP is collaborating with a podiatrist, the nurse's scope of practice is limited to the procedures that the podiatrist has the authority under section 4731.51 of the Revised Code to perform.

6.8 Clinical nurse specialist (CNS)

A clinical nurse specialist may provide nursing care that requires knowledge and skill obtained from advanced formal education and clinical experience. In this capacity as an advanced practice nurse with scope of services defined under division (D) of Section 4723.43 of the Ohio Revised Code, a nurse authorized to practice as a CNS, in collaboration with one or more physicians or podiatrists, may provide and manage the care of individuals and groups with complex health problems and

provide health care services that promote, improve, and manage health care within the nurse's nursing specialty, consistent with the nurse's education and in accordance with rules adopted by the Ohio Nursing Board. A CNS who holds a certificate to prescribe issued under section 4723.48 of the Revised Code may, in collaboration with one or more physicians or podiatrists, prescribe drugs and therapeutic devices in accordance with section 4723.481 of the Revised Code. When a CNS is collaborating with a podiatrist, the nurse's scope of practice is limited to the procedures that the podiatrist has the authority under section 4731.51 of the Revised Code to perform.

6.9 Certified nurse midwife (CNM)

A CNM may provide nursing care that requires knowledge and skill obtained from advanced formal education and clinical experience. In this capacity as an advanced practice nurse with scope of services defined under division (A) of Section 4723.43 of the Ohio Revised Code, a nurse authorized to practice as a CNM, in collaboration with one or more physicians, may provide the management of preventive services and those primary care services necessary to provide health care to women antepartally, intrapartally, postpartally, and gynecologically, consistent with the nurse's education and certification, and in accordance with rules adopted by the Ohio Board of Nursing. No CNM may perform version, deliver breech or face presentation, use forceps, do any obstetric operation, or treat any other abnormal condition, except in emergencies. A CNM may perform episiotomies, normal vaginal deliveries, and/or repair vaginal tears. A CNM who holds a certificate to prescribe issued under section 4723.48 of the Revised Code may, in collaboration with one or more physicians, prescribe drugs and therapeutic devices in accordance with section 4723.481 of the Revised Code.

6.10 Physician Assistant (PA)

A physician assistant (PA) is defined as a skilled person qualified by academic and clinical training to provide services to patients as a physician assistant under the supervision, control, and direction of one or more Ohio-licensed doctors of allopathic or osteopathic medicine and surgery or podiatrists, who are responsible for the physician assistant's performance in compliance with chapter 4730 of the Ohio Revised Code. A supervising physician shall provide Medical Staff Services a current copy of each physician supervisory plan and supervision agreement applicable to the PA, which the Hospital shall provide upon request of an individual practicing with a PA in the Hospital in accordance with section 4730.22(B) of the Ohio Revised Code.

Except when the on-site supervision requirements specified in section 4730.45 of the Ohio Revised Code are applicable, the supervising physician shall be continuously available for direct communication with the physician assistant by either being physically present at the location where the physician assistant is practicing, or being readily available to the physician assistant through some means of telecommunication and being in a location that under normal conditions is not more than sixty minutes travel time away from the location where the physician assistant is practicing. A physician may not supervise more than three (3) PAs at any one time.

A PAs is authorized to provide (i) assistance in surgery in surgery in the Hospital, (ii) any and all of the services specified in Ohio law (iii) in accordance with Hospital's defined core scope of practice and supplemental privileges applicable to each particular specialty service line, but so long as such assistance or provision of services are not prohibited by any applicable law as amended, or otherwise restricted by the supervising physician or Hospital's grant of Privileges to a particular PA. A PA who holds a certificate to prescribe issued under Chapter 4730 of the Ohio Revised Code may prescribe drugs in accordance with Ohio Administrative Code chapter 4730-2-06 and any restrictions placed on the PA's prescriptive authority by the supervising physician or Hospital's grant of Privileges to a particular PA.

In the case of a PA's practice within the Emergency Department, if the supervising physician routinely practices in the emergency department, the supervising physician shall provide on-site supervision of the PA when the PA practices in the emergency department. If the supervising physician does not routinely practice in the emergency department, the supervising physician may, on occasion, send the physician assistant to the emergency department to assess and manage a patient. In supervising the PA's assessment and management of the patient, the supervising physician shall determine the appropriate level of supervision in compliance with law, except that the supervising physician must be available to go to the emergency department to personally evaluate the patient and, at the request of an emergency department physician, the supervising physician shall go to the emergency department to personally evaluate the patient.

6.11 Private Dependent Non-Privileged Practitioners

Appointees may request that dependent practitioners be permitted to serve in the Hospital for the Appointee without clinical privileges, such as RN Private Scrubs, Licensed Practical Nurses, RN Clinical Coordinator/Assistant, Scrub Assistants/Surgical Technicians, etc. Such persons authorized to perform services at the Hospital pursuant to an approved application including an attached job description shall represent, receive supervision from, report to, and be held accountable to the Appointee. Such approved dependent practitioners may assist at surgical, diagnostic, or therapeutic procedures for which the Appointee requires assistance and as approved by the Medical Staff. All such dependent practitioners shall wear identification while providing services in the Hospital, and shall be required to adhere to all policies of the Hospital and related regulatory requirements.

No application will be accepted or processed under this section 6.11 if the Appointee's employee/contractee is also a physician. A private dependent non-privileged practitioner is not entitled to any appeal process, including the due process rights as set forth at section 6.4-6 of this Manual. At no time will an application be processed if it will permit the Appointee's employee/contractee to perform billable procedures and/or services that are in themselves isolated from direct personal assistance to the physician; or which are available at the Hospital.

If approved duties of Private Dependent Non-Privileged Practitioners are exceeded or abused, permission to provide services at the Hospital will be immediately revoked by the President/CEO or Chief of Staff.

ARTICLE VII: ANNUAL REVIEW, ADOPTION AND AMENDMENT

7.1 Annual Review

The Credentials Committee will review this Credentials Manual on an annual basis.

7.2 Adoption and Amendment

This Credentials Manual shall be adopted and amended, in whole or in part, as set forth in the Medical Staff Bylaws in the Article regarding Review, Revision, Adoption and Amendment.

CERTIFICATION OF ADOPTION AND APPROVAL

Adopted by the Medical Executive Committee on
January 11, 2019
Annual Review- no revisions March 13, 2020

_____
Linda Reilman, MD
Chief of Staff

Approved by the Board of Directors on March 17, 2020

after receipt of a recommendation by the Medical Executive Committee

_____
Ronald Connovich
President/CEO

SIGNED DOCUMENT KEPT IN MEDICAL STAFF OFFICE

APPENDIX A to Credentials Manual
(applicable to Article VI regarding Allied Health Professionals)

Ohio Board of Nursing Rules, including recently adopted rule, can be found at : http://www.nursing.ohio.gov/Law_and_Rule.htm under "Laws and Rules" with the Nurse Practice Act found at the Ohio Revised Code, Chapter 4723 and implementing administrative rules found at Ohio Administrative Code, Chapter 4723, copies of which may also be obtained from Hospital Medical Staff Services.

Ohio State Medical Board Rules governing a PA's can be found at http://www.med.ohio.gov/ under "Physician Assistant", and are found at the Ohio Revised Code, Chapter 4730 and implementing administrative rules found at Ohio Administrative Code, Chapter 4730, copies of which may also be obtained from Hospital Medical Staff Services.

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ORC 4723.01 Nurse Definitions

As used in this chapter:

(A) "**Registered nurse**" means an individual who holds a current, valid license issued under this chapter that authorizes the practice of nursing as a registered nurse.

(B) "**Practice of nursing as a registered nurse**" means providing to individuals and groups nursing care requiring specialized knowledge, judgment, and skill derived from the principles of biological, physical, behavioral, social, and nursing sciences. Such nursing care includes:

(1) Identifying patterns of human responses to actual or potential health problems amenable to a nursing regimen;

(2) Executing a nursing regimen through the selection, performance, management, and evaluation of nursing actions;

(3) Assessing health status for the purpose of providing nursing care;

(4) Providing health counseling and health teaching;

(5) Administering medications, treatments, and executing regimens authorized by an individual who is authorized to practice in this state and is acting within the course of the individual's professional practice;

(6) Teaching, administering, supervising, delegating, and evaluating nursing practice.

(C) "**Nursing regimen**" may include preventative, restorative, and health-promotion activities.

(D) "Assessing health status" means the collection of data through nursing assessment techniques, which may include interviews, observation, and physical evaluations for the purpose of providing nursing care.

(E) "**Licensed practical nurse**" means an individual who holds a current, valid license issued under this chapter that authorizes the practice of nursing as a licensed practical nurse.

(F) "**The practice of nursing as a licensed practical nurse**" means providing to individuals and groups nursing care requiring the application of basic knowledge of the biological, physical, behavioral, social, and nursing sciences at the direction of a licensed physician, dentist, podiatrist, optometrist, chiropractor, or registered nurse. Such nursing care includes:

(1) Observation, patient teaching, and care in a diversity of health care settings;

(2) Contributions to the planning, implementation, and evaluation of nursing;

(3) Administration of medications and treatments authorized by an individual who is authorized to practice in this state and is acting within the course of the individual's professional practice, except that administration of intravenous therapy shall be performed only in accordance with section 4723.17 or 4723.171 of the Revised Code. Medications may be administered by a licensed practical nurse upon proof of completion of a course in medication administration approved by the board of nursing.

(4) Administration to an adult of intravenous therapy authorized by an individual who is authorized to practice in this state and is acting within the course of the individual's professional practice, on the condition that the licensed practical nurse is authorized under section 4723.17 or 4723.171 of the Revised Code to perform intravenous therapy and performs intravenous therapy only in accordance with those sections;

(5) Delegation of nursing tasks as directed by a registered nurse;

(6) Teaching nursing tasks to licensed practical nurses and individuals to whom the licensed practical nurse is authorized to delegate nursing tasks as directed by a registered nurse.

(G) "**Certified registered nurse anesthetist**" means a registered nurse who holds a valid certificate of authority issued under this chapter that authorizes the practice of nursing as a certified registered nurse anesthetist in accordance with section 4723.43 of the Revised Code and rules adopted by the board of nursing.

(H) "**Clinical nurse specialist**" means a registered nurse who holds a valid certificate of authority issued under this chapter that authorizes the practice of nursing as a clinical nurse specialist in accordance with section 4723.43 of the Revised Code and rules adopted by the board of nursing.

(I) "**Certified nurse-midwife**" means a registered nurse who holds a valid certificate of authority issued under this chapter that authorizes the practice of nursing as a certified nurse-midwife in accordance with section 4723.43 of the Revised Code and rules adopted by the board of nursing.

(J) "**Certified nurse practitioner**" means a registered nurse who holds a valid certificate of authority issued under this chapter that authorizes the practice of nursing as a certified nurse practitioner in accordance with section 4723.43 of the Revised Code and rules adopted by the board of nursing.

(K) "**Physician**" means an individual authorized under Chapter 4731. of the Revised Code to practice medicine and surgery or osteopathic medicine and surgery, except as used in divisions (C) and (D) of section 4723.482 of the Revised Code.

(L) "**Collaboration" or "collaborating**" means the following:

(1) In the case of a clinical nurse specialist, except as provided in division (L)(3) of this section, or a certified nurse practitioner, that one or more podiatrists acting within the scope of practice of podiatry in accordance with section 4731.51 of the Revised Code and with whom the nurse has entered into a standard care arrangement or one or more physicians with whom the nurse has entered into a standard care arrangement are

continuously available to communicate with the clinical nurse specialist or certified nurse practitioner either in person or by radio, telephone, or other form of telecommunication;
(2) In the case of a certified nurse-midwife, that one or more physicians with whom the certified nurse-midwife has entered into a standard care arrangement are continuously available to communicate with the certified nurse-midwife either in person or by radio, telephone, or other form of telecommunication;
(3) In the case of a clinical nurse specialist who practices the nursing specialty of mental health or psychiatric mental health without being authorized to prescribe drugs and therapeutic devices, that one or more physicians are continuously available to communicate with the nurse either in person or by radio, telephone, or other form of telecommunication.
(M) "**Supervision**," as it pertains to a certified registered nurse anesthetist, means that the certified registered nurse anesthetist is under the direction of a podiatrist acting within the podiatrist's scope of practice in accordance with section 4731.51 of the Revised Code, a dentist acting within the dentist's scope of practice in accordance with Chapter 4715. of the Revised Code, or a physician, and, when administering anesthesia, the certified registered nurse anesthetist is in the immediate presence of the podiatrist, dentist, or physician.

(N) "**Standard care arrangement**" means a written, formal guide for planning and evaluating a patient's health care that is developed by one or more collaborating physicians or podiatrists and a clinical nurse specialist, certified nurse-midwife, or certified nurse practitioner and meets the requirements of section 4723.431 of the Revised Code.

(O) "**Advanced practice nurse**" means a certified registered nurse anesthetist, clinical nurse specialist, certified nurse-midwife, or certified nurse practitioner.

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OAC 4723-8-04 Standard care arrangement for a certified nurse-midwife, certified nurse practitioner, and clinical nurse specialist. (Effective 2-1-2011)
e-copy at: http://www.registerofohio.state.oh.us/pdfs/4723/0/8/4723-8-04_PH_FF_A_RU_20110113_1031.pdf

(A) Prior to engaging in practice, a standard care arrangement shall be entered into with each physician or podiatrist with whom the certified nurse-midwife, certified nurse practitioner, or clinical nurse specialist collaborates.

(1) The standard care arrangement shall be revised to reflect the addition or deletion
of a physician or podiatrist with whom the nurse collaborates within that employment setting. Under these circumstances, a new standard care arrangement is not necessary.

(2) A new standard care arrangement shall be executed when the nurse is employed
at a different setting and engages in practice with a different collaborating physician or podiatrist.

(B) A certified nurse-midwife, certified nurse practitioner, or clinical nurse specialist engaged in the practice of the nurse's specialty, shall enter into a written standard care arrangement with one or more collaborating physicians or podiatrists whose practice is the same or similar to the nurse's practice. In accordance with division (D) of section 4723.431 of the Revised Code, a clinical nurse specialist without a certificate to prescribe whose nursing specialty is mental health or psychiatric mental health is not required to enter into a standard care arrangement.

(C) The standard care arrangement shall include at least:

(1) The signatures of each nurse, and each collaborating physician, or the physician's designated representative, or each podiatrist with whom the certified nurse-midwife, certified nurse practitioner, or clinical nurse specialist primarily collaborates indicating review of and agreement to abide by the terms of the standard care arrangement.; the date when the arrangement is initially executed; and the date of the most recent review of the arrangement. For purposes of this rule, a physician's designated representative means a physician who serves as the department or unit director or chair, within the same institution, organization or facility department or unit, and within the same practice specialty, that the nurse practices, and with respect to whom the physician has executed a legal authorization to enter collaborating agreements on the physicians' behalf;

(2) The date when the arrangement is initially executed;

(3) The date of the most recent review of the arrangement;

(4) The complete name, specialty and practice area, business address, and business phone number or number at which the individual can be reached at any time for:

(a) Each collaborating physician or podiatrist with whom the certified nurse-midwife, certified nurse practitioner, or clinical nurse specialist primarily collaborates and who is a party to the standard care arrangement; and

(b) Each certified nurse-midwife, certified nurse practitioner, or clinical nurse specialist who is a party to the standard care arrangement;

(5) A statement of services offered by the certified nurse-midwife, certified nurse practitioner, or clinical nurse specialist consistent with section 4723.43 of the Revised Code and this chapter. For holders of a certificate to prescribe, there shall also be a description of the scope of prescriptive practice.

(6) A plan for incorporation of new technology or procedures consistent with the applicable scope of practice as set forth in section 4723.43 of the Revised Code and this chapter;

(7) Quality assurance provisions, including at least:

(a) A schedule for periodic review and reapproval of the standard care arrangement. The standard care arrangement shall be reviewed at least annually. Each nurse who is a party to the arrangement and at least one collaborating physician or podiatrist shall sign and date the annual review of the standard care arrangement;

(b) Criteria for referral of a client by the certified nurse-midwife, certified nurse practitioner, or clinical nurse specialist to a collaborating physician or podiatrist, including, for the certified nurse-midwife, a plan for referral of breech or face presentation or any other abnormal condition identified as such in the standard care arrangement;

(c) A process for the certified nurse-midwife, certified nurse practitioner, or clinical nurse specialist to obtain consultation from the physician or podiatrist;

(d) A procedure for regular review of referrals made by the certified nurse-midwife, certified nurse practitioner, or clinical nurse specialist to other health care professionals, and the care outcomes for a representative sample of all clients seen by the nurse; and

(e) A process for chart review in accordance with rule 4723-8-05 of the Administrative Code if the nurse's practice includes any direct client care, education, or management;

(8) A policy for care of infants up to age one and recommendations for collaborating physician visits for children from birth to age three, if the nurse is providing services to infants;

(9) A plan for coverage of clients in instances of emergency or planned absences of either the certified nurse-midwife, certified nurse practitioner, or clinical nurse specialist, or the collaborating physician or podiatrist;

(10) A process for resolution of disagreements regarding matters of patient management; and

(11) An arrangement regarding reimbursement under the medical assistance program as set forth in division (C) of section 5111.02 of the Revised Code and in accordance with any rules adopted under division (B) of section 5111.02 of the Revised Code.

(12) For nurses with a current valid certificate to prescribe, the following quality assurance provisions shall include at least:

(a) Provisions to ensure timely direct, personal evaluation of the client with a collaborating physician or the physician's designee when indicated;

(b) Additional prescribing parameters for those drugs or therapeutic devices established in the formulary, including:

(i) Provisions for use of drugs with non-food and drug administration (FDA) approved indications;

(ii) Provisions for use of drugs approved by the FDA and reviewed by the committee on prescriptive governance subsequent to the date of the standard care arrangement; and

(iii) Provisions for use of drugs previously reviewed by the committee on prescriptive governance but approved by the FDA for new indications subsequent to the date of the standard care arrangement.

(c) A procedure for the nurse and the collaborating physician, or a designated member of a quality assurance committee, composed of physicians, of the institution, organization, or agency where the nurse has practiced during the period covered by the review, to conduct a periodic review, at least semiannually, of a representative sample of prescriptions written by the nurse; and

(13) Quality assurance standards consistent with Provisions as set forth in rule 4723-8-05 of the Administrative Code.

(D) The most current copy of the standard care arrangement, and any legal authorization
signed by a physician according to paragraph (C)(1) of this rule, shall be retained and be available upon request at each site where practice of the certified nurse-midwife, certified nurse practitioner, or clinical nurse specialist occurs. Upon request of the board, the certified nurse-midwife, certified nurse practitioner, or clinical nurse specialist shall immediately provide a copy of the standard care arrangement to the board.

(E) When a hospital negotiates a standard care arrangement in accordance with division (E) of section 4723.431 of the Revised Code and this chapter, the standard care arrangement shall be developed in accordance with paragraph (C) of this rule. Review and approval of the standard care arrangement shall be in accordance with the policies and procedures of the hospital governing body and the bylaws, policies, and procedures of the hospital medical staff.

(F) A certified nurse-midwife, certified nurse practitioner, or clinical nurse specialist shall notify the board of the identity of a collaborating physician or podiatrist not later than thirty days after engaging in practice.

(G) A certified nurse-midwife, certified nurse practitioner, or clinical nurse specialist shall notify the board of any change in the identity of a collaborating physician or podiatrist not later than thirty days after the change takes effect.

(H) A clinical nurse specialist who does not hold a certificate to prescribe and whose nursing specialty is mental health or psychiatric mental health is exempt from the requirement of executing a standard care arrangement in accordance with division (D)(1) of section 4723.431 of the Revised Code. The clinical nurse specialist who does not hold a certificate to prescribe and whose nursing specialty is mental health or

psychiatric mental health shall identify one or more physicians with whom the nurse collaborates in accordance with division (D)(1) of section 4723.431 of the Revised Code.

(I) A clinical nurse specialist who holds a certificate to prescribe and whose nursing specialty is mental health or psychiatric mental health shall enter into a standard care arrangement in accordance with division (D)(2) of section 4723.431 of the Revised Code.

Ohio Revised Code § 4730.21. Supervisory duties of physician; number of agreements; quality assurance system.
(A) The supervising physician of a physician assistant exercises supervision, control, and direction of the physician assistant. In supervising a physician assistant, all of the following apply: (1) Except when the on-site supervision requirements specified in section 4730.45 of the Revised Code are applicable, the supervising physician shall be continuously available for direct communication with the physician assistant by either of the following means: (a) Being physically present at the location where the physician assistant is practicing; (b) Being readily available to the physician assistant through some means of telecommunication and being in a location that under normal conditions is not more than sixty minutes travel time away from the location where the physician assistant is practicing. (2) The supervising physician shall personally and actively review the physician assistant's professional activities. (3) The supervising physician shall regularly review the condition of the patients treated by the physician assistant. (4) The supervising physician shall ensure that the quality assurance system established pursuant to division (F) of this section is implemented and maintained. (5) The supervising physician shall regularly perform any other reviews of the physician assistant that the supervising physician considers necessary. (B) A physician may enter into supervision agreements with any number of physician assistants, but the physician may not supervise more than two physician assistants at any one time. A physician assistant may enter into supervision agreements with any number of supervising physicians, but when practicing under the supervision of a particular physician, the physician assistant's scope of practice is subject to the limitations of the physician supervisory plan that has been approved under section 4730.17 of the Revised Code for that physician or the policies of the health care facility in which the physician and physician assistant are practicing. (C) A supervising physician may authorize a physician assistant to perform a service only if the service is authorized under the physician supervisory plan approved for that physician or the policies of the health care facility in which the physician and physician assistant are practicing. A supervising physician may authorize a physician assistant to perform a service only if the physician is satisfied that the physician assistant is capable of competently performing the service. A supervising physician shall not authorize a physician assistant to perform any service that is beyond the physician's or the physician assistant's normal course of practice and expertise. (D) (1) A supervising physician may authorize a physician assistant to practice in any setting within which the supervising physician routinely practices. (2) In the case of a health care facility with an emergency department, if the supervising physician routinely practices in the facility's emergency department, the supervising physician shall provide on-site supervision of the physician assistant when the physician assistant practices in the emergency department. If the supervising physician does not routinely practice in the facility's emergency department, the supervising physician may, on occasion, send the physician assistant to the facility's emergency department to assess and manage a patient. In supervising the physician assistant's assessment and management of the patient, the supervising physician shall determine the appropriate level of supervision in compliance with the requirements of divisions (A) to (C) of this section, except that the supervising physician must be available to go to the emergency department to personally evaluate the patient and, at the request of an emergency department physician, the supervising physician shall go to the emergency department to personally evaluate the patient. (E) Each time a physician assistant writes a medical order, including prescriptions written in the exercise of physician-delegated prescriptive authority, the physician assistant shall sign the form on which the order is written and record on the form the time and date that the order is written. When writing a medical order, the physician assistant shall clearly identify the physician under whose supervision the physician assistant is authorized to write the order. (F) (1) The supervising physician of a physician assistant shall establish a quality assurance system to be used in supervising the physician assistant. All or part of the system may be applied to other physician assistants who are supervised by the supervising physician. The system shall be developed in consultation with each physician assistant to be supervised by the physician. (2) In establishing the quality assurance system, the supervising physician shall describe a process to be used for all of the following: (a) Routine review by the physician of selected patient record entries made by the physician assistant and selected medical orders issued by the physician assistant; (b) Discussion of complex cases; (c) Discussion of new medical developments relevant to the practice of the physician and physician assistant; (d) Performance of any quality assurance activities required in rules adopted by state medical board pursuant to any recommendations made by the physician assistant policy committee under section 4730.06 of the Revised Code; (e) Performance of any other quality assurance activities that the supervising physician considers to be appropriate. (3) The supervising physician and physician assistant shall keep records of their quality assurance activities. On request, the records shall be made available to the board and any health care professional working with the supervising physician and physician assistant. (3) The supervising physician and physician assistant shall keep records of their quality assurance activities. On request, the records shall be made available to the board and any health care professional working with the supervising physician and physician assistant. *effective 5-17-06*