CREDENTIALS POLICY MANUAL
OF
THE PROFESSIONAL STAFF OF
GRANDVIEW/SOUTHVIEW HOSPITAL

APPROVED by Grandview/Southview
Medical Executive Committee: June 21, 2017, March 20, 2018
Hospital Board of Trustees: June 23, 2017, March 30, 2018

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INTRODUCTION AND POLICY

SECTION 1.1. Incorporation of Definitions

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

SECTION 1.2. Application Policy

As a general policy, this Hospital permits application to the Medical Staff from qualified Practitioners as described in the Medical Staff Bylaws. Qualified Practitioners and other qualified individuals may apply for Clinical Privileges without Medical Staff Appointment as described in this Policy Manual. The credentials policies and procedures for AHPs are described in Article 4 of Policy Manual; no other provisions of this Policy Manual, except those in Article 1 and Article 4 unless expressly stated. The KHN Centralized Credentialing Office (COO) conducts credentialing for Grandview/Southview Hospital as provided in the Bylaws.

SECTION 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 Department (in compliance with procedures that have been approved by the MEC and the Board), and accepted as complete by the 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.

SECTION 1.4. Non-Discrimination

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

ARTICLE 2.
PROCEDURES GOVERNING APPOINTMENT, REAPPOINTMENT, PRIVILEGING

SECTION 2.1. Application

2.1.1. Information. Applications for appointment to the Professional Staff and the granting/re-granting of Privileges shall be in writing (or electronic format as available), and shall be signed or authenticated and dated by the applicant, and shall be submitted to the CCO. The application shall require detailed information concerning the applicant's professional qualifications, and shall include all of the following primary queries:

(a) Medical Education and Post-Graduate Training. Documentation of satisfaction of the professional 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 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 three (3) Practitioners in the applicant's same professional discipline with personal knowledge of the applicant's current competencies and 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 service area where privileges are sought in order to verify current competency and the ability to perform the privileges requested (if volume is low, this may require review of procedure logs with outcomes and/or competency reviews from other

institutions to support privilege requests for procedures not attested to in postgraduate references to verify current competency and the ability to perform the privileges requested), (b) information regarding reviews under the Hospital's peer review activities, (c) information regarding reviews by the Hospital's Credentials Committee, Chair of the appropriate Clinical Department or Section, and/or the MEC (if the Appointee has inadequate activity at the Hospital, this may require review of procedure logs with outcomes and/or competency reviews from other institutions to support privilege requests for procedures to verify current competency and the ability to perform the privileges requested). Appointees do not need to provide letters of reference but are subject to routine review (clinical peer review, medical records review, credentials function, MEC review, and a current clinical competency review).

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

(f) Continuing Education. A listing or provision of documentation of continuing medical education as currently required by the State Medical Board of Ohio and as delineated by the privilege profile, or the minimum required to maintain certification as deemed necessary by the individual's respective subspecialty. 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 offenses that involve a lack of professional characteristics relevant to the practice of medicine.

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.

(i) Current Ability to Carry Out Privileges Requested. Statement of the applicant's current ability to fully and competently carry out the Privileges requested (including but not limited to physical and mental health in relation to the privileges requested (health status), 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 an individual with the same professional credential; and if such individual is not available, then from a person in the same practice area who can speak to the applicant's professional current competence and ethical standards, including persons who meet this criteria who are the director of a training program, the chief of staff at another hospital at which the applicant holds Clinical Privileges, or 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 (e.g., current clinical competence review, clinical peer review, medical records review, credentials function, MEC Committee).

(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, at any time, the subject of investigation by or exclusion from Medicare, Medicaid, or any other federal or state healthcare program, as well as the outcome of any 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 (or such other period of time as currently required by law or accrediting standards), and authorization for the Hospital to conduct a criminal records check.

(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. An applicant shall present himself/herself to the CCO and/or Medical Staff Services personnel for face to face verification of the submitted government-issued identification prior to providing care at the Hospital.

(p) Healthcare Employment History. Applicants must provide healthcare related employment/appointment history (work history).

(q) 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.

(r) Request for Hospital Affiliation. Select primary hospital affiliation.

(s) Releases. The application shall have written releases whereby the applicant (i) authorizes and requests the release of all information relevant to his/her application, including any incidents or occurrences, for use by the Staff and Hospital, (ii) waives all rights that s/he might have against any person, institution, or organization conveying such information, and

(iii) agrees to abide by all applicable provisions of the Bylaws, related manuals and policies with respect to confidentiality, immunity, and releases.

(t) Application Processing Fee. Processing of the application requires payment of a non-refundable application processing fee. An application submitted without the processing fee shall be deemed incomplete.

(u) Other. Such other information as may be deemed appropriate in light of the Staff category, Clinical Department assignment, and Privileges requested, and as the Board may determine is required from time to time.

SECTION 2.2. Undertakings

2.2.1. Contents. Every application for Professional Staff appointment shall contain:

(a) the applicant's specific acknowledgement of the obligation upon appointment to the Professional Staff to provide continuous care and supervision to all patients within the Hospital for whom the applicant has responsibility;

(b) the applicant's agreement to abide by all such bylaws and policies of the Hospital, including all the Bylaws and the Rules and Regulations of the Professional Staff and the Clinical Department and Sections of which the applicant seeks to be a member as shall be in force during the time the applicant is appointed to the Professional Staff of the Hospital;

(c) the applicant's agreement to accept committee assignments (associate active and active staff only) and such other reasonable duties and responsibilities as shall be assigned to the applicant by the Hospital Board and the Professional Staff;

(d) a statement that the applicant has received and read a copy of such bylaws of the Hospital, the Bylaws and the Rules and Regulations of the Professional Staff as are in force at the time of the application, or as amended from time to time, and that the applicant has agreed to be bound by the terms thereof in all matters relating to consideration of the application regardless of whether or not the applicant is granted appointment to the Professional Staff and/or Clinical Privileges;

(e) a statement of the applicant's willingness to appear for personal interviews in regard to the application.

2.2.2. Statements. 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.

(e) Confirm that the Applicant agrees to participate in a centralized credentialing/recredentialing program and authorizes the CCO to perform centralized credentialing/verification functions including, but not limited to, the sharing of Applicant's credentialing/recredentialing and other information with other participating KHN entities, as relevant.

2.2.3. Acknowledgements. 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/or Medical Staff Services Department (via the CCO if applicable) immediately if any information contained in the application changes. The foregoing obligation shall be a continuing obligation of the Applicant so long as he/she 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 its Bylaws, Rules and Regulations, and to the degree that any incongruence is perceived, the Bylaws, Rules and Regulations shall govern.

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

SECTION 2.3. Effect of Application

2.3.1. 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 other communication technologies, 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.

2.3.2. Burden of Providing Information. 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, and for providing evidence that all the statements made and information given on the application are factual and true.

2.3.3. Hospital and Community Need; Ability to Accommodate. 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.

(e) 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 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.

SECTION 2.4. Processing the Application.

2.4.1. 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 thirty (30) 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.

2.4.2. Primary Source Verification/Data Repository Queries. The CCO shall perform primary source verification. The credentials of all Applicants shall be checked through the data repositories as necessary prior to granting membership and/or Privileges (each query to the National Practitioners Data Bank (NPDB) is facility specific and is performed by the facility). The CCO shall 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.

2.4.3. MSS Review and Queries. Upon the completion of the collection and primary verification process, the CCO shall transmit the application and all supporting documents to the medical staff services (MSS) department. The MSS department will then be responsible for performing a comprehensive review, competency evaluation for the privileges requested, and shall query the NPDB. When the application is considered complete by the MSS department's review, it is forwarded to the Credentials Committee.

2.4.4. Incomplete Application. An application that is incomplete, deficient, or for which the CCO or MSS Department is unable to develop the evidence initially required to support the qualifications and other informational elements contained therein, shall not be processed. The CCO or MSS department shall notify the Applicant of the deficiencies it finds. Unless the time within which to obtain information is

extended by the Chief of Staff and the Hospital President/CEO or designee, the Applicant's failure to respond or to furnish the information requested in connection with an application within thirty (30) calendar days of such request shall constitute a waiver of the Applicant's rights, if any, to further processing of the application and to any subsequent review to which the Applicant might otherwise be entitled, and the application shall be automatically deemed to be withdrawn. At any time during the review process, the application may be deemed incomplete by the CCO, or the Medical Staff Services department, or the applicable Department or Section, or the Credentials Committee, or the Medical Executive Committee, or any of the respective Chairs of the foregoing, or the Board. No application shall be considered to be complete until it has been reviewed by the appropriate Department or Section Chair, Credential Committee and by the Medical Executive Committee. If the Applicant fails to submit the requested information or documentation within thirty (30) calendar days after being requested to do so, the application shall be deemed to be incomplete and automatically withdrawn, unless the time to obtain the information is extended as provided in this Section.

SECTION 2.5. Appointment and Privileging Process and Procedures

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

2.5.2. Credentials Committee Initial Procedure. Upon the application being determined to be complete by the MSS department review criteria, such application for Professional Staff appointment shall be submitted by the MSS department with all supporting materials to the Credentials Committee for evaluation. Upon receipt of the application from the MSS department, the Credentials Committee shall:

(a) inform the Chair of each Clinical Department or Section to which the applicant seeks Clinical Privileges of the pending application, and provide the application for each Chair to review, after conferring with Clinical Department or Section members, and provide written recommendations;

(b) post the name of the applicant so that each member of the Professional Staff may have an opportunity to submit to the Credentials Committee, in writing, information bearing on the applicant's qualifications for Professional Staff appointment. In addition, any person currently holding an appointment to the Professional Staff shall have the right to appear in person before the Credentials Committee to discuss in private and in confidence any concerns he or she may have about the applicant.

2.5.3. Clinical Department or Section Chair Procedure. The Chair of each Clinical Department or Section in which the applicant seeks Clinical Privileges shall provide the Credentials Committee with specific written recommendations for approving, disapproving, or deferring for further consideration the application,

and for delineating the applicant's Clinical Privileges based on the individual applicant's qualifications and competency at the time the privileges are requested. These recommendations shall be made a part of the Credentials Committee's report. As part of the process of making this recommendation, the Clinical Department or Section Chair has the right to meet with the applicant to discuss any aspect of the applicant's application, qualifications, and requested Clinical Privileges. In the event a request is submitted for which no criteria have been created the request will be tabled until the Credentials Committee formulates the necessary criteria and the criteria are approved by the Credentials Committee, Staff Executive Staff and Hospital Board. The Credentials Committee may reference national guidelines and solicit input from the appropriate Chair of the Clinical Department or Section or committee.

SECTION 2.6. Subsequent Credentials Committee Procedure

2.6.1. Review of Supporting Evidence and Recommendations. The Credentials Committee shall examine the evidence of the licensure, character, current professional competence, judgment, professional qualifications (including specific training and experience), prior behavior, ethical standing of the applicant, and health considerations to determine, through information contained in references given by the applicant and from peer review and other sources available to the committee, including an appraisal from the Chair of the Clinical Department or Section in which privileges are sought, whether the applicant has established and meets all of the necessary qualifications for the Professional Staff category and/or Clinical Privileges requested by the applicant. As part of the Credentials Committee process in its review of the evidence, the Credentials Committee may meet with the applicant to discuss any aspect of the submitted application or the applicant's qualifications or Clinical Privileges.

2.6.2. Credentials Committee Report and Recommendation. Not later than sixty (60) days from receipt of the application with supporting documentation from the MSS department, the Credentials Committee shall make a written report and recommendation regarding the applicant to the Medical Executive Committee, including, as relevant, its recommendation for Clinical Department or Section assignments and Clinical Privileges, as applicable. An application must include responses and necessary verifications of the primary queries for appointment to the Medical Staff as may be enumerated in the Bylaws and this Policy Manual. The Credentials Committee shall have the authority to determine if primary source verification is satisfactory for any provided information.

The report of the Credentials Committee shall include the written recommendations of the Chair of each Clinical Department or Section in which privileges were requested. If the Clinical Department or Section Chair(s) does not send his/her recommendation to the Credentials Committee within fourteen (14) days of the receipt of the application, the Credentials Committee may proceed to make a recommendation to the MEC on its own initiative (after notifying the Clinical Department or Section Chair of the Credentials Committee's

intent, and allowing one week, or other less amount of time, but must ensure that the Credentials Committee's recommendation is received by the MEC within 60 days of the MSS deeming the application to be complete by its criteria).

The Credentials Committee shall transmit to the Medical Executive Committee the complete application and its recommendation that the applicant be appointed to the Professional Staff and/or granted Privileges with or without limitation, that his/her application be deferred for further consideration, or that s/he be rejected in whole or in part for Professional Staff appointment and/or Privileges. All recommendations to appoint must specifically include, if applicable, recommendations for each delineated Privilege to be granted based on the individual Practitioner's qualifications and current competency at the time each such Privilege is requested. The Chair of the Credentials Committee or the Vice President of Medical Affairs, or their designee, shall be available to the Medical Executive Committee to answer any questions that may be raised with respect to the recommendation.

2.6.3. Medical Executive Committee Procedure

(a) At its next regular meeting after receipt of the application and report and recommendation of the Credentials Committee, the Medical Executive Committee shall review the application. 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 appointed to the Professional Staff and/or granted Privileges with or without limitation, that his/her application be deferred for further consideration, or that he or she be rejected in whole or in part for Professional Staff appointment and/or Privileges. All recommendations to appoint must specifically include, if applicable, recommendations for each delineated Privilege to be granted based on the individual Practitioner's qualifications, health considerations, and current competency at the time each such Privilege is requested.

(b) When the recommendation of the Medical Executive Committee is favorable to the applicant, the Hospital President shall promptly forward the MEC's written recommendation, together with all supporting documentation, to the Hospital Board for its review and recommendation. All recommendations to appoint must also specifically recommend the Clinical Privileges to be granted, which may be qualified by any probationary conditions relating to such Clinical Privileges.

(c) When the recommendation of the Medical Executive Committee is to defer the application for further consideration, it must be followed up within thirty (30) days (except for good cause), with a subsequent recommendation for appointment to the Professional Staff with specified Clinical Privileges as applicable, or for rejection of the application for Professional Staff

appointment and/or Privileges. The Hospital President or the Vice President of Medical Affairs shall promptly notify the applicant by certified mail, return receipt requested, of a decision to defer action on his/her application.

(d) When the recommendation of the Medical Executive Committee is adverse to the applicant in respect to either appointment or Clinical Privileges, the Hospital President or the Vice President of Medical Affairs shall promptly so notify the applicant and describe the applicant's right, if any, to the procedural rights provided for in the Bylaws. The Notice shall be sent by certified mail, return receipt requested. No such adverse recommendation shall 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 the Bylaws. If the applicant requests a hearing, the recommendation of the Hearing Committee shall be forwarded to the MEC.

(e) If, after the Medical Executive Committee has considered the report and recommendation of the Hearing Committee and the hearing record, the Medical Executive Committee's reconsidered recommendation is favorable to the applicant, the Hospital President or the Vice President of Medical Affairs shall promptly forward it, together with all supporting documentation, to the Hospital Board for their review and recommendation. If recommendation of the Medical Executive Committee continues to be adverse, the Hospital President or the Vice President of Medical Affairs shall promptly so notify the applicant, by certified mail, return receipt requested. The Hospital President or the Vice President of Medical Affairs shall then forward such recommendation, together with all supporting documentation, to the Hospital Board for their review and recommendation.

(f) The Medical Executive Committee, after consideration of the recommendations of the Clinical Departments or Sections as transmitted through the Credentials Committee, shall recommend initial Clinical Departmental or Sectional assignments for all Appointees to the Professional Staff as applicable and for all other approved individuals with Clinical Privileges.

2.6.4. Hospital Board Procedure

(a) At its next regularly scheduled meeting, the Hospital Board shall make the final decision on the application for appointment to the Professional Staff membership and/or privilege determination. Should conflict exist between the Medical Executive Committee's recommendation and the Board's proposed decision, an ad hoc Joint Conference Committee of equal members from the MEC and the Board shall be convened. The Board members shall be selected by the chair of the Board and the MEC

members by the president of the medical staff. Through the collaboration of the Board chair and the Medical Staff president, a time table will be established for resolution. This Committee shall make its report to the Board within 30 days after receipt of the issue. The Board will then render a final decision. All decision to appoint shall include, as applicable, the Medical Staff category to which the Applicant is appointed, the Privileges that he/she may exercise as applicable, and any special conditions related thereto. When the Board's decision is final, it shall send notice through the Hospital President to the MEC, and also to the Applicant by certified mail, return receipt requested or personal delivery as specified for Special Notice.

(b) Due to the limited nature of an appointment to the Community Based Physician Staff category without Privileges, Applicants requesting this category shall be required to provide primary query information related to membership only, and other information deemed necessary by the MEC and Board. If time constraints so require, an application for appointment to this category 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 shall it create a reportable event for purposes of federal or state law.

SECTION 2.7. Timeframe

2.7.1. 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 processing 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 thirty (30) 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 the CCO has completed its collection and verification process, the CCO shall forward the application to the MSS department.

MSS Department Review, Competency, Evaluation, NPDB query	Generally should be completed within fourteen (14) days of receipt of the application from the CCO.
Chair of Clinical Department or Section Evaluation	Generally should be completed within fourteen (14) days of receipt of application from the MSS department.
Credentials Committee Evaluation	At the next scheduled meeting after receipt of recommendations from the Department or Section Chair, but a recommendation shall be made to the MEC within 60 days of receipt of an application deemed complete by the MSS department's criteria.
MEC Evaluation	At the next scheduled meeting after receipt of recommendations from the Credentials Committee, a recommendation shall be made to the Board. 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, a final decision is made. 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 by the Credentials Committee within 60 days of its receipt of an application from the MSS department that is deemed complete according to the MSS department's criteria. 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 the responsibility of 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.

SECTION 2.8. Temporary Privileges

2.8.1. General. The granting of temporary Privileges is not precipitous and 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 as part of the process of granting temporary privileges by the Chair of the appropriate Clinical Department or Section and/or Hospital President or designee acting on behalf of the Board. Except for Emergency/Disaster Privileges, the Practitioner requesting temporary Privileges must agree in writing to abide by the Bylaws, governing documents, and applicable policies and procedures; and whether or not such written agreement is obtained, the Bylaws and policies control all matters relating to the exercise of Clinical Privileges. The President (or Chief of Staff or VPMA acting as the President's designee) acting on behalf of the Board and adhering to State law, may, upon the recommendation of the Chair of the appropriate Clinical Department or Section, grant temporary Privileges in the following situations:

(a) Temporary Clinical Privileges for Initial Applicants. On a case by case basis, based upon the information then available which may reasonably be relied upon, temporary admitting and Clinical Privileges may be granted to the initial applicant for Professional Staff appointment whose application is clean, complete, verified and awaiting review and approval by the Medical Executive Committee and Board of Directors; and at a minimum, there is positive verification of current medical licensure, Drug Enforcement Administration (DEA) certificate, proof of current and continuous professional liability insurance, and at least one recent positive reference (specific to the applicant's current competence to perform the Privileges requested) from a previous hospital, chief/chair of a department or service. Time limited Temporary Privileges may be granted in this circumstance only when sufficient evidence exists that the granting of such Temporary Privileges is prudent, and shall continue, unless terminated, until action on the application is taken by the Board, but in no event shall exceed 120 days. In exercising such Temporary Privileges, the applicant shall act under the supervision of the Chair (or the Chair's designee) of the Clinical Department or Section in which the applicant has requested primary Privileges. If not involved in the recommendation, the Chair of the appropriate Clinical Department or Section shall be notified within two (2) weeks of said temporary appointment and concur in such action; and otherwise the temporary appointment and Privileges shall be discontinued. Provisional status will commence at the time of temporary appointment.

(b) Temporary Privileges may not be used where the Practitioner fails to provide all information necessary to the processing of his or her reappointment in a timely manner.

2.8.2. Temporary Clinical Privileges to Care for Specific Patients. On a case by case basis, based upon the information then available which may reasonably be relied upon, temporary admitting and Clinical Privileges may be granted to an individual who is not an applicant for appointment for the purpose of rendering care to a specifically identified patient(s), or for other similarly limited circumstances. Examples include, but are not limited to:

(a) A practitioner who has necessary skills to provide care to a specific patient(s) that a currently privileged Practitioner does not possess;

(b) For the proctoring of a Medical Staff member, when proctoring by a current Medical Staff member cannot be done;

(c) Court ordered evaluation of a Hospital patient;

(d) A requested second opinion.

This shall be done in the same manner and under the same conditions as set forth in the Bylaws for initial applicants for temporary privileges, provided that the individual acknowledges in a signed writing that he or she has received and read copies of the Hospital bylaws, the Medical Staff Bylaws, the Medical Staff governing manuals, and the Rules and Regulations which are then in force and that the individual agrees to be bound by the terms thereof in all matters relating to the temporary Clinical Privileges. Such privileges shall be restricted to the specifically identified patients or circumstances for which they were granted. 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(s). Temporary Privileges granted under this circumstance may be granted no more than three (3) times in any 12 month period. If not involved in the recommendation, the Chair of the appropriate Clinical Department or Section shall be notified within two (2) weeks of said temporary appointment and concur in the action; and otherwise the temporary appointment and Privileges shall be discontinued.

2.8.3. Temporary Clinical Privileges for Locum Tenens. On a case by case basis, based upon the information then available which may reasonably be relied upon, temporary admitting and Clinical Privileges may be granted to an individual who applies to serve in a locum tenens capacity for specific periods of time, which are not typically sequential so as to bypass the need for application for appointment. Unless otherwise stated herein, this shall be done in the same manner and under the same conditions for initial applicants for Temporary Privileges provided that the locum tenens acknowledges in a signed writing that the locum tenens has received and read copies of the Hospital bylaws, the Medical Staff Bylaws, the Medical Staff governing manuals, and the Rules and Regulations which are then in force; and that the locum tenens agrees to be bound by the terms thereof in all matters relating to the temporary Clinical Privileges. An approved application for Temporary 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 process.

2.8.4. Temporary Clinical Privileges For Emergency or Disaster.

(a) In an emergency, any Practitioner, to the degree permitted by his/her license and certification regardless of Staff status or Clinical Privileges, or the lack thereof, shall be permitted by the Hospital President (or Chief of Staff or VPMA acting as the President's designee), upon recommendation of the Chair of the relevant Department, to do, and shall be assisted in doing, everything possible to save the life/limb of a patient in the Hospital, using Hospital resources as necessary, including calling for any necessary consultation. A documented phone call to the practitioner's hospital regarding identification and licensure shall act as primary source verification for purposes of Emergency Privileges. While an attempt must be made to both obtain approval from the Chair of the relevant Department and to document the verification call, such attempts should not act to delay emergent care and may be performed after the situation is under control. When the circumstances necessitating Emergency Privileges are no longer present, said practitioner must either request Temporary Privileges to continue to treat the patient, or transfer the care of the patient to a Professional Staff member holding the appropriate Clinical Privileges 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 or limb is in immediate danger and delay in administering treatment could increase the danger or harm. In the event such requested Temporary Privileges are denied or the emergency practitioner does not request such Privileges, the patient shall be assigned to an appropriate person currently appointed to the Professional Staff, giving all possible consideration to the wishes of the patient. The granting of Emergency Temporary Privileges is not utilized to "cover" a practitioner who has failed to follow Medical Staff guidelines in applying for privileges.

(b) In a disaster, Temporary Disaster Privileges may be granted to licensed or certified volunteer practitioners to perform services within the scope of their license or certification 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 primary source identification from the volunteer's hospital (A documented phone call is acceptable); and, in addition to, at least one (1) of the following:

(i) verification of a valid government-issued picture identification;

(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.

The granting of Temporary Disaster Privileges shall be done in the same manner as initial Temporary Privileges, except that primary source verification of licensure and competency may be performed after the situation is under control and as circumstances allow. 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.

If verification cannot be completed within seventy-two (72) hours due to extraordinary circumstances (for example, no means of communication or lack of resources), such extraordinary circumstances shall be documented and verification shall be performed as soon as reasonably possible. 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. It is anticipated that these Disaster Privileges may be granted to state-wide and out-of-state volunteer practitioners as necessary.

All practitioners who receive Disaster Privileges must at all times while at the Hospital wear an identification badge issued by the Hospital or one with photograph from the facility at which they otherwise hold privileges, if possible.

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 (e.g., the Chief of Emergency Services). Disaster Privileges shall cease upon alleviation of the circumstances of disaster as determined by the Hospital President.

2.8.5. Telemedicine Privileges.

(a) The practice of telemedicine is defined in Ohio as the practice of medicine in this State through the use of any communication, including oral, written or electronic communication, by a physician located outside this State. Physicians who are licensed in Ohio may examine and diagnose patients through the use of any communication, including oral, written, or electronic, without obtaining a telemedicine certificate from Ohio. The practice of medicine is deemed to occur in the state in which the patient is located and receiving care and is defined as the originating site. The distant site is the site from which the prescribing or treating services are provided. Any practitioner using telemedicine to regularly provide medical services to patients located in Ohio must either be licensed to practice medicine in Ohio or have a telemedicine certificate.

(b) Episodic services, consultations on an irregular or infrequent basis, provided on the request of a member of the medical staff solely for the purpose of offering an expert opinion and/or to advise the treating Practitioner, but not directing the patient's care, are not telemedicine services for the purposes of credentialing Practitioners under the Bylaws and this Policy Manual. Similarly, informal consultation performed outside the context of a contractual relationship and on an irregular or infrequent basis without the expectation or exchange of direct or indirect compensation, is not telemedicine.

(c) The Board will determine the clinical services to be provided through telemedicine after considering the recommendations of the appropriate Department/Section Chair, the Credentials Committee and the Medical Executive Committee. Practitioners providing Hospital patients with clinical services that include prescribing care or otherwise treating such patients via the practice of telemedicine must be credentialed and privileged by the Hospital in accordance with the Bylaws, this Policy Manual, accreditation requirements, and applicable law. If the Hospital has a pressing clinical need and a Practitioner can supply that service through a telemedicine link, the Practitioner may be evaluated for temporary Privileges as set forth in the Bylaws and this Policy Manual.

(d) Individuals applying for telemedicine privileges must meet the applicable qualifications for medical staff appointment outlined in the Bylaws and this Policy Manual, including current professional liability coverage, but shall be excepted from any requirements related to geographic residency, coverage arrangements, and/or emergency call responsibilities. Qualified applicants may be granted telemedicine privileges but will not be

appointed to the Medical Staff or have the rights afforded to its Members. However, Practitioners must comply with all provisions of the Bylaws and Medical Staff policies and procedures applicable to the exercise of their clinical privileges at the Hospital.

(e) Applications for telemedicine privileges will be processed in accordance with the provisions of the Bylaws and this Policy Manual in the same manner as for any other applicant, except that the Hospital may use the credentialing information provided by the applicant's primary hospital if that hospital is a Medicare-participating hospital that is obligated to comply with CMS requirements of 42 CFR 482.12(a) (1-7) and 42 CFR 482.22(a)(1-2), and such hospital provides: (1) a list of all privileges granted to the practitioner; (2) information indicating that the applicant has exercised such privileges in a competent manner; and (3) a signed attestation that the information is complete, accurate, and up to-date. The Board must ensure that, when telemedicine services are furnished to Hospital patients through an agreement with a distant-site hospital, the agreement is written and specifies that it is the responsibility of the governing body of the distant-site hospital to meet the CMS requirements of 42 CFR 482.12(a) (1-7) with regard to that hospital's physicians and practitioners providing telemedicine services. Information regarding the telemedicine practitioner's quality of care, including, at least, any information related to adverse outcomes resulting from sentinel events occurring at the distant-site hospital and this Hospital as a result of the telemedicine services, shall be provided each to the other for consideration in the credentialing and re-credentialing process of both hospitals.

(f) Telemedicine privileges, if granted, will be for a period of not more than two years. Individuals seeking to renew telemedicine privileges will be required to complete an application and, upon request, provide the Hospital with evidence of current clinical competence. This information may include, but is not limited to, a quality profile from the applicant's primary practice affiliation and an evaluation form(s) from a qualified supervisor(s). If all requested information is not received by dates established by the Hospital, the individual's telemedicine privileges will expire at the end of the current term. Once all information is received and verified, an application to renew telemedicine privileges will be processed as set forth in the Bylaws and this Policy Manual.

(g) Individuals granted telemedicine privileges will be subject to the Hospital's quality assessments and performance improvement initiatives, ongoing periodic appraisals, and peer review activities.

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

2.8.6. Termination of Temporary or Telemedicine Clinical Privileges

(a) The Hospital President (acting on behalf of the Board) or designee, upon consultation with the Chief of Staff (or their respective designee), may at any time terminate any or all of a Practitioner's temporary admitting and Clinical Privileges effective immediately or as of the discharge from the Hospital of all the individual's patients then under such individual's care. 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.

(b) In the event of a summary termination of temporary Clinical Privileges, the appropriate Clinical Department or Section Chair or, in his/her absence, the Chief of Staff, or his/her designee, shall assign to a staff Appointee the responsibility for the care of such terminated individual's patients until they are discharged from the Hospital, giving consideration wherever possible to the wishes of the patient in the selection of the substitute.

(c) The granting of any temporary admitting and/or temporary clinical or telemedicine privileges is a courtesy on the part of the Hospital and neither the granting, denial, reduction, restriction, suspension, modification, monitoring of, termination, or failure to renew of such privileges shall entitle the individual concerned to any of the procedural rights provided herein with respect to hearings or appeals. A Practitioner who has been granted initial 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.

2.8.7. Process for Reappointment/Regrant of Privileges. A Practitioner shall be notified by the CCO no later than 180 days prior to the date of expiration of his/her appointment and/or Privileges. No later than one hundred twenty (120) days before the expiration date, the Practitioner must furnish to the CCO the required documentation.

(a) Renewal Application. Appointees seeking reappointment shall be responsible for reviewing their initial application forms and reporting on the reappointment application prescribed forms any material changes in the information previously given, particularly with regard to any professional disciplinary action taken or pending elsewhere. Each person shall submit any change in status and shall submit proof of professional liability insurance coverage, documentation indicating he or she has met mandatory continuing medical education credit, as well as a copy of all current medical licenses to practice medicine, dentistry, podiatry or psychology.

Failure, without good cause, to submit a timely application for reappointment and/or 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 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 he/she may submit an application for reappointment and/or regrant of Privileges for up to six (6) months after a voluntary resignation. Under no circumstances shall Medical Staff appointment and/or Privileges extend beyond the expiration date of the current appointment/Privilege period.

Any Appointee, who at the time of processing bi-annual reappointments to the Professional Staff, does not desire reappointment, shall so indicate on the appropriate application form submitted to the CCO on the appropriately cycled due date.

(b) Factors to be Considered. Each assessment concerning the biennial reappointment of a Medical Staff Appointee and/or the regranting of Privileges or a change in staff category, where applicable shall be based upon:

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

(ii) Data from periodic appraisals and other relevant documentation regarding clinical activity demonstrating current clinical competence and clinical judgment in the treatment of patients by the Hospital and/or other organizations that currently privilege the Practitioner, if available;

(iii) Relevant Practitioner specific data as compared to aggregate data, if available;

(iv) Morbidity and mortality data, if available;

(v) Professional ethics, the person's physical and mental capacity to treat patients, information from the National Practitioner Data Bank, and criminal records check information;

(vi) For Active and Associate Active Staff, attendance at Professional Staff meetings and participation in Professional Staff affairs, including participation in Hospital and Medical Staff committees;

(vii) Compliance with the Hospital bylaws, policies, directives and the Professional Staff Bylaws, Rules and Regulations;

(viii) Behavior and cooperation with Hospital personnel;

(ix) Use of the Hospital's facilities for patients, cooperation and relations with other practitioners, and general attitude toward patients, the Hospital and the public;

(x) Proof of satisfactory completion of such continuing education requirements as may be imposed by law and this Hospital;

(xi) Any requests for changes in Medical Staff category and/or Privileges;

(xii) Peer review (clinical peer review, medical records review);

(xiii) Such other information as the MEC and/or Board deem necessary; and

(xiv) Recommendations from the Quality Assessment and Performance Improvement Committee and/or other Staff committees based on peer review findings.

The CCO shall verify the information provided on the application for reappointment and/or regrant of Privileges, perform the same queries as with an initial application for appointment and/or Privileges, and notify the Practitioner of any deficiencies or verification problems. Reapplicants do not need to provide letters of reference. The Practitioner has the burden of producing adequate information and resolving any doubts about the data. After such application has been declared complete by the CCO's primary verification review, the same process as set forth with respect to initial applications for appointment and/or Privileges shall be followed.

2.8.8. Department/Section Procedure

(a) Immediately after receiving the application for reappointment from the CCO, the CCO shall forward such application with supporting documentation to the MSS department which shall generally complete its review, competency evaluation, and NPDB query within 14 days of receipt and shall forward the same to the Chair of each Clinical Department or Section, together with the Clinical Privileges such applicant holds. The MSS department shall also forward to the Chair of each Clinical Department or Section those applications of persons who have applied for

a change in Clinical Privileges or for a change in Professional Staff category.

(b) Within fourteen (14) days after receipt of these applications for reappointment, the Chair of the Clinical Department or Section shall review, confer with the Clinical Department or Section members (if the Clinical Department or Section Chair so chooses), and shall transmit to the Credentials Committee the applications of the Clinical Department or Section members recommended for reappointment in the same Professional Staff category with the same Clinical Privileges they then hold. If the applicant's volume is low, procedure logs and competency evaluation data from other institution may be reviewed. In addition, the Chair shall submit individual recommendations, and the reasons therefore, for any changes in Professional Staff category, in Clinical Privileges, or for non-reappointment of those who applied for changes and those who did not.

(c) Recommendations for increase or decrease of Clinical Privileges by the Clinical Department or Section Chair shall be based upon relevant recent training, the trainer's recommendations and acknowledgement of the trainer's direct observation of patient care provided by the applicant, review of the records of patients treated in this or other hospitals, review of all other records of the Hospital or the Professional Staff which evaluate the individual's participation in the delivery of medical care and review of information obtained from the National Practitioner Data Bank. Any Clinical Privileges granted an individual which have not been used during the term of such individual's appointment shall automatically be reviewed by the appropriate Clinical Department or Section, should the applicant delineate a request for such Privileges.

2.8.9. Credentials Committee/MEC Procedure

(a) The Credentials Committee, after receiving recommendations from the Chair of the applicable Clinical Department or Section, shall review all pertinent information available including all information provided from other committees of the Professional Staff and from Hospital management for the purpose of determining its recommendations for Professional Staff reappointment, for change in Professional Staff category, and for the regranting of the same and any new Clinical Privileges for the ensuing two (2) years.

(b) The Credentials Committee shall prepare and submit to the Medical Executive Committee its report and recommendation that the reappointment be: (i) renewed; (ii) renewed with changes in Staff category, Department or Service assignment or Clinical Privileges; or (iii) terminated. Where non-reappointment or a change in Privileges is recommended, the reason therefore shall be stated. A Practitioner may,

but need not, be invited to attend a meeting of the Credentials Committee for a discussion of the Practitioner's requested reappointment. If, as a result of such meeting or otherwise, an agreement is reached changing or reducing the Privileges of such Practitioner, or withdrawing the Practitioner's application for reappointment, it shall be written and signed by the Practitioner and the Chair of the Credentials Committee, and shall not be deemed to adversely affect the Practitioner.

(c) When appropriate, the Medical Executive Committee may require that a person currently seeking reappointment procure an impartial physical or mental examination at the applicant's expense either as part of the reapplication process or during the appointment year to aid it in determining whether Clinical Privileges should be granted or continued and shall make results available for the committee's consideration. Failure of the person seeking reappointment to procure such an examination within a reasonable time after being requested to do so in writing by the Medical Executive Committee shall constitute a relinquishment of all Professional Staff rights and Clinical Privileges until such time as the Medical Executive Committee has received the examination results and has had a reasonable opportunity to evaluate them and make a recommendation thereon.

(d) Recommendations for an increase in Clinical Privileges made to the Hospital Board shall be based upon relevant recent training, the trainer's recommendation and acknowledgement of his/her direct observation of patient care provided by the Applicant, review of the records of patients treated in this or other hospitals and review of all other records and information from applicable Clinical Departments or Sections of the Professional Staff which evaluate the individual's participation in the delivery of medical care that justify increased Privileges. The recommendation for such increased Privileges may carry with it such requirements for supervision or consultation for such period of time as are thought necessary.

(e) The Medical Executive Committee shall transmit its report and recommendations to the Hospital Board through the Hospital President or the Vice President of Medical Affairs in time for the Hospital Board to consider reappointments at its next scheduled meeting. Any recommendation by the Medical Executive Committee denying reappointment, denying a requested change in Professional Staff category or Clinical Privileges or recommending reduction of existing Clinical privileges shall entitle the affected individual to the procedural rights provided in the Bylaws. The Hospital President or the Vice President of Medical Affairs shall then promptly notify the individual of the recommendation by Special Notice. The recommendation shall not be forwarded to the Hospital Board until the individual has exercised or has been deemed to have waived his/her right to a hearing as provided in the

Bylaws, after which the Hospital Board shall be given the MEC's final recommendation and shall act on it.

SECTION 2.9. Periodic Appraisals

(a) The medical staff, through its periodic appraisal process, will regularly and periodically conduct appraisals of the qualifications of all Practitioners currently appointed to the medical staff/granted medical staff privileges, as well as the qualifications of any other credentialed providers. Such appraisals shall be conducted approximately every 24 months for each Practitioner, or at other times as warranted. The purpose of the appraisal is to determine the suitability of continuing, discontinuing, revising or otherwise changing the medical staff membership or privileges of each individual Practitioner. Such appraisal procedure will evaluate qualifications and current demonstrated competencies to perform each task or activity within the applicable scope of practice or privileges for that type of Practitioner for which he/she has been granted privileges by evaluating at least: current work practice, special training, quality of specific work, patient outcomes, education, maintenance of continuing education, adherence to medical staff rules, certifications, appropriate licensure, and currency of compliance with licensure requirements.

(b) Any requested procedure/task/activity/privilege that goes beyond the specified list of privileges for that particular category of practitioner requires an appraisal by the medical staff through its appraisal process and approval of the Board. Such appraisal must consider evidence of qualifications and competencies specific to the nature of the request and whether the activity/task/procedure is one that the Hospital can support if conducted within the Hospital. Privileges will not be granted for and procedure/task/activity this is not conducted within the Hospital, regardless of the individual Practitioner's ability to perform such.

SECTION 2.10. Procedure For Leave of Absence

2.10.1. Request for and Grant of Leave of Absence. Persons appointed to the Professional Staff may, for good cause, be granted leaves of absence by the Hospital Board for a definitively stated period of time, but no longer than a two (2) year period. Requests for leaves of absence shall be made to the Chair of the Clinical Department or Section in which the individual applying for leave has his/her primary Clinical Privileges, and shall state the purpose and the beginning and anticipated ending dates of the requested leave. The Clinical Department or Section Chair shall transmit the request together with his/her recommendation to the Medical Executive Committee which shall make a report and a recommendation and transmit it to the Hospital President for action by the Hospital Board. 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 he/she must continue to pay Medical Staff dues 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 person 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.

2.10.2. Expiration of Appointment and/or Privileges During Leave. In the event an Appointee's appointment and Privilege period ends during the Appointee's leave of absence, he/she may apply for reappointment to the Medical Staff. For purposes of a leave of absence, an Appointee can be reappointed to his/her Medical Staff category without being granted Privileges and without otherwise having to meet the privileging requirements applicable to his/her appointment category. If the Appointee fails to reapply for reappointment, his/her appointment shall terminate at the end of the current appointment term without recourse to the procedural due process rights set forth in the Bylaws or governing documents. An Appointee may not apply for a regrant of Privileges during the leave of absence and the Appointee's Privileges shall terminate at the end of his/her current Privilege period without recourse to the procedural due process rights set forth in the Bylaws or governing documents.

2.10.3. Request for Return and Reinstatement. Prior to the return from the leave of absence, the Professional Staff member shall submit a written request to the applicable Clinical Department or Section Chair (who in turn shall transmit the request to the Vice President of Medical Affairs), that the leave of absence be terminated as of a specified date, as well as such additional information as is reasonably necessary to reflect the Professional Staff member 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.

2.10.4. Report and Recommendation. The Clinical Department or Section Chair shall transmit the request together with his/her recommendation to the Medical Executive Committee which shall make a report and a recommendation and transmit it to the Hospital President for action by the Hospital Board.

ARTICLE 3.
MODIFICATION, RESIGNATIONS OR TERMINATION OF APPOINTMENT STATUS AND/OR PRIVILEGES.

SECTION 3.1. Modification

An Appointee 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 the Bylaws and the Policy Manual for reappointment/regrant of Privileges. An Appointee 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.

SECTION 3.2. Resignations

Resignation of Medical Staff appointment and/or Privileges, and the reason for such resignation, shall be submitted in writing to the Chief of Staff through the Medical Staff Services Department. Notification of the resignation shall be forwarded to the Hospital President, CCO and all appropriate Hospital personnel. The Hospital President will notify the Practitioner of the Board's receipt of his/her resignation. Provided such resignation is determined by the Board to be voluntary, the action shall not give rise to any procedural due process rights as outlined in the Bylaws.

SECTION 3.3. 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 automatically terminated after approval by the MEC and the Board. If a forwarding address is known, the Practitioner will first 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 Hospital President will attempt to inform the Practitioner of the approved termination by Special Notice. Provided a termination pursuant to this Section is determined by the Board to be voluntary, such termination shall not give rise to any procedural due process rights as outlined in the Bylaws.

ARTICLE 4.
ALLIED HEALTH PRACTITIONERS

SECTION 4.1. General

(a) All allied health practitioners (AHPs) that provide medical care or conduct surgical procedures either directly or under supervision, whether employed by the Hospital or an Appointee or other entity or contracted provider, must be individually credentialed based on their own current individual qualifications (education, current experience, training, certifications, and compliance with Medical Staff and Hospital rules as relevant, etc.) and demonstrated current competencies (actual practice). This Article addresses those AHPs who are permitted to provide services at the Hospital through the Medical Staff credentialing process, but this Article is not intended to and shall not create any contractual rights between the Hospital and any AHP or supervising or collaborating Practitioner(s). Any and all contracts of association or employment shall control contractual and financial relationships between the Hospital and AHPs or Practitioners. 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. The AHP staff, as associates to the Medical Staff, is not entitled to the status or rights accorded to membership of the Medical Staff but, rather, AHP individuals are granted privilege delineation rights and responsibilities via Medical Staff mechanisms. This Article also describes dependent, non-privileged positions that do not fall within the AHP category of practitioners, but for which an application, approval and continued adherence to the requirements outlined in the approved position description and this Article are required in order to serve a physician in the Hospital.

(b) Any privileges which are granted to an individual AHP shall in no circumstances be deemed to supersede or exceed the scope of the AHP's licensure and governing documents, including but not limited to a Utilization Plan, a Standard Care Arrangement or such other agreement between the AHP and the responsible physician. To the extent that privileges delineated hereinafter are beyond the scope of the AHP's licensure or agreement with a responsible physician, those privileges shall not be deemed to have been granted. Likewise, to the extent the AHP's licensure or agreement with a responsible physician permits the AHP to perform activities or functions beyond the privileges delineated herein, the AHP is strictly prohibited from exercising such activities and functions in this Hospital and is limited to only those privileges granted and delineated according to the procedures herein.

(i) The Allied Health Practitioner category is created for the purpose of providing a mechanism for the Professional Staff and the Hospital to document and verify the credentials of persons who, under their license, certificate or other legal credentials, are permitted by Ohio law to provide patient care in the Hospital as an adjunct to treatment by Practitioners who are members of the Professional Staff. The Hospital Board determines the appropriate professions and practice parameters of AHPs to be included in the category of AHPs permitted to perform certain services at the Hospital, taking into consideration the recommendations of the Medical Executive Committee, the Credentials Committee, the Allied Health Practitioners Credentials Subcommittee, appropriate Staff Departments and Sections, and in keeping with Ohio statutes and accreditation standards..

(ii) An individual who possesses a license, certificate or other legal credential required by Ohio law to provide direct or supervised patient care in a hospital setting, but who is not a member of the Professional Staff, may apply to be an Allied Health Practitioner authorized to practice his/her profession in the Hospital (provided that such individual is applying to practice an AHP professional category recognized by the Hospital as a permitted category.

(iii) The CCO and MSS department are responsible for the administrative duties related to verifying the credentials, and processing an AHP application in a manner as set forth in Article II. The Medical Staff shall make recommendations to the Board with respect to: (1) the categories of AHPs, based upon occupation or profession, that shall be eligible for privileges at the Hospital; (2) for each eligible AHP category, the scope of practice and applicable privilege set or position description for each; (3) whether any changes should be made to existing AHP categories; and (4) which AHP categories should be credentialed and managed through the Medical Staff or the Human Resources Department.

(iv) Allied Health Practitioners have no authority to admit or co-admit patients to the Hospital, except to the extent provided by Ohio law, Medicare Conditions of Participation, standards of accrediting bodies such as the Healthcare Facilities Accreditation Program (HFAP) and other law and regulations as relevant. Relevant law and regulations are kept in a central file or online within the Medical Staff Services department. AHPs are not eligible for Professional Staff membership, to hold Professional Staff offices, or to vote on Professional Staff affairs. They may serve on standing committees of the Professional Staff when specifically authorized by the Chief of Staff.

(v) Each Allied Health Practitioner will be assigned to a Clinical Department and will be under the supervision of a member of the Professional Staff.

(vi) All services rendered by Allied Health Practitioners must be under the supervision and direction of, and subject to any policies, procedures, privileges and restrictions adopted by, the applicable Clinical Department or Professional Staff member.

(vii) Allied Health Practitioners may only perform services in accordance with provisions relating to their respective professions contained in Appendix A (attached hereto and incorporated into this Article), and performance of those services must comply with all limitations and restrictions imposed by the Allied Health Practitioners' respective licenses, certifications, or legal credentials required by Ohio law. 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 APN 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.

(viii) Separate credential and privilege files for each Allied Health Practitioner will be maintained and available for review by members of the Professional Staff upon request to and oversight by the Credentials Committee.

(ix) If an Allied Health Practitioner wishes to apply for additional privileges or procedures, the Allied Health Practitioner shall follow the processes and procedures as set forth in this Policy Manual.

(x) 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 it does not have, in its sole opinion, the financial resources, physical space, community need, or actual clinical need for the services offered under that particular license or certification, or any

other consideration that the Hospital, in its sole discretion, may factor into its decision.

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

SECTION 4.2. Descriptions and Limitations of Allied Health Practitioners.

(a) Allied Health Practitioners shall be permitted to practice their professions in the Hospital only in accordance with the descriptions for the respective professions contained in Appendix A of this Policy Manual, except as defined in Section 4.3 below. 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.

(b) The Hospital Board, may, at any time, make modifications, additions or deletions to the descriptions contained in Appendix A without amendment to the Bylaws acting with consideration of the recommendations of the Medical Executive Committee, the Credentials Committee, the Allied Health Practitioners Credentials Subcommittee, appropriate Staff Departments and Sections, and in keeping with Ohio statutes.

SECTION 4.3. Categories of Allied Health Practitioners

4.3.1. Independent Allied Health Practitioners

(a) This category of practitioners will consist of persons defined by State law and designated by Board with consideration of the recommendations of the Medical Executive Committee, the Credentials Committee, the Allied Health Practitioners Credentials Subcommittee, appropriate Staff Departments and Sections, and in keeping with Ohio statutes.

(b) Independent Allied Health Practitioners may provide patient care services within the limits of their license and their professional skills and abilities. The degree of participation of independent Allied Health Practitioners in patient care shall be determined according to protocol or privileges as delineated in Appendix A and with consideration of the recommendations of the Medical Executive Committee, the Credentials Committee, the Allied Health Practitioners Credentials Subcommittee, appropriate Staff Departments and Sections, and in keeping with Ohio statutes, accrediting standards, and approved by the Hospital Board.

(c) Independent Allied Health Practitioners shall:

(i) Exercise independent judgment in their areas of competence participating directly in the management and care of patients,

provided that an active member of the Professional Staff shall have the ultimate responsibility for patient care, except as regards areas of expertise provided by the Independent Allied Health Practitioner;

(ii) Record reports and progress notes on the patients' records and write orders for treatment to the extent established in the Rules and Regulations of the Professional Staff, provided that the ability to write such orders are within the scope of his/her license, certificate or other legal credentials;

(iii) Not admit or discharge Hospital patients; and

(iv) Not vote on Medical Staff matters except within committees when the right to vote is specified at the time of committee assignment.

(d) Dependent Allied Health Practitioners

(i) This category shall consist of those Allied Health Practitioners who are employees of the Hospital or employees of a member of the Professional Staff (or a corporation controlled by a member of the Professional Staff) and who performs a major portion of their professional responsibilities within the Hospital.

(ii) The employer of the individual who is seeking approval as a dependent Allied Health Practitioner shall present a written statement of the clinical duties and responsibilities of said individual to the Allied Health Practitioner Credentials Subcommittee for review and recommendation prior to utilizing said individual within the Hospital. The employer shall complete such forms as may be requested by the Allied Health Practitioner Credentials Subcommittee.

(iii) The employer of the dependent Allied Health Practitioner shall assume full responsibility, and be fully accountable for the conduct of said individual within the Hospital. It is the further responsibility of the employer of the dependent Allied Health Practitioner to acquaint said individual with the applicable Rules and Regulations of the Professional Staff and the Hospital, as well as appropriate members of the Professional Staff and Hospital personnel with whom said individual shall have contact at the Hospital.

(iv) The clinical duties and responsibilities of an Allied Health Practitioner within the Hospital shall terminate if the Professional Staff appointment of the employer is terminated for any reason, or shall be restricted to the same extent as if the employer's Clinical Privileges are curtailed.

4.3.2. Hospital-Recognized Categories of Licensed/Certified Allied Health Professionals

(a) The Board, in consultation with the Medical Staff, has determined that the following categories of licensed/certified AHPs are recognized and may apply for Privileges as AHPs, or in the case of unlicensed employees, for services permitted in the Hospital, all as further defined at Appendix A:

(i) Certified registered nurse anesthetist (CRNA)

(ii) Certified physician assistant (PA)

(iii) Speech pathologists and Audiologists

(iv) Certified nurse midwives (CNM)

(v) Certified nurse practitioner (CNP)

(vi) Clinical nurse specialist (CNS)

(vii) Registered nurse first assistants in surgery (RNFA)

(viii) Neonatal nurse practitioner

(ix) Perfusionists

(x) Surgical assistants

(xi) Limited specialty surgical scrub/assistant

(xii) Radiologist assistant

(xiii) Medical assistants

(xiv) Hospital administrative assistants (unlicensed Appointee's employee)

(xv) Medical Scribes (unlicensed, uncredentialed non-AHP private Appointee's employee)

SECTION 4.4. Qualification for Appointment

Appointment as an Allied Health Practitioner will be granted to professionally competent individuals who meet the qualifications, standards and requirements of their respective licensure, certification, or other legal authorization, and the criteria established through the Allied Health Practitioner Credentials Subcommittee of the Hospital and approved by the Hospital Board.

Only individuals who can document the following shall be qualified for appointment as an Allied Health Practitioner:

(a) current license, certification, or other legal credentials required by Ohio law and/or Hospital policy;

(b) education (including appropriate professional continuing education and any specific orientation requirements of the Hospital), training, demonstrated professional background and experience, and professional competence for the Privileges requested;

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

(d) the names of at least four (4) members of the same profession, as appropriate, who have had extensive experience in observing and working with the applicant and who can provide adequate references pertaining to the applicant's current professional competence, judgment, character, and mental and physical health in relation to privileges requested. Two (2) of these references shall be individuals other than current associates of the applicant;

(e) information as to whether the applicant's Clinical Privileges at any other hospital or health care facility have ever been voluntarily or involuntarily revoked, suspended or reduced;

(f) information as to whether the applicant's membership in local, state or national professional societies or the applicant's license to practice any profession in any state, or the applicant's Drug Enforcement Administration license has ever been suspended, modified or terminated, if applicable. The submitted application shall include a copy of all the applicant's current licenses to practice, and if applicable, the Drug Enforcement Administration license;

(g) information concerning the applicant's malpractice experience including information with respect to professional liability actions which resulted in pending or final settlements or judgments within the last five (5) years;

(h) ability to work with members of the Professional Staff and Hospital employees;

(i) written documentation from the applicant verifying that the applicant has adequate professional malpractice insurance coverage as established by the Hospital Board; and

(j) any other information deemed necessary by the Credentials Committee.

SECTION 4.5. Conditions of Acceptance

An individual accepting appointment as an Allied Health Practitioner agrees to the following terms and conditions:

(a) the Allied Health Practitioner has read the Bylaws of the Professional Staff of the Hospital and agrees to abide by all applicable terms of such Bylaws and any applicable Rules and Regulations, including any subsequent amendments thereto, and any applicable Hospital policies the Hospital may from time to time put into effect;

(b) the Allied Health Practitioner grants full immunity from liability pursuant to the provisions of the Bylaws regarding this subject matter, and by submitting an application for Clinical Privileges or renewal of Clinical Privileges or by providing specified patient care services at the Hospital, each Allied Health Practitioner agrees to, authorizes, and acknowledges all of the provisions, statements, and commitments of the Bylaws in connection with Confidentiality, Immunity & Release.

(c) the Allied Health Practitioner shall not deceive a patient as to the identity of himself or herself as other than an Allied Health Practitioner providing treatment or service in the Hospital;

(d) the Allied Health Practitioner shall not make any statement or take any action that might cause a patient to believe that the Allied Health Practitioner is a member of the Professional Staff;

(e) the Allied Health Practitioner shall not perform any patient care in the Hospital that is not permitted under the Bylaws or Allied Health Practitioner's license, certification, or other legal credential required under Ohio law;

(f) the Allied Health Practitioner shall continue to maintain in force malpractice insurance in an amount that will not be less than that specified by the Hospital Board; and

(g) the ratio of supervising physician to AHP shall be as defined by Ohio law.

All AHPs will have an annual competency/skill assessment and other relevant quality monitoring.

SECTION 4.6. Action on Appointment

Persons seeking Clinical Privileges as an AHP shall apply in the same manner as provided in the Bylaws for Practitioners; noting that none of the hearing and appeal provisions granted Practitioners are applicable to AHPs. Upon receipt of an application for appointment as an Allied Health Practitioner, the CCO and MSS department shall initially perform their respective reviews of the application

for completeness, and verify information such as licenses, education, references and other information identified by the Credentials Committee as being important to the credentialing process. An incomplete application will be returned to the applicant for completion and resubmission.

Upon receipt of an application considered complete by the CCO and MSS department according to their criteria, the application together with supporting documentation will be forwarded to the AHP Credentials Subcommittee for review. The Allied Health Practitioner Credentials Subcommittee will proceed to review, and where it is deemed appropriate, investigate the character, qualification and current professional competence of the applicant. Not later than thirty (30) days from receipt of the application form from the AHP Credentials Subcommittee, the application and the recommendation of the Allied Health Practitioner Credentials Subcommittee will then be forwarded to the Credentials Committee for review.

Upon receipt of an application considered to be complete by the AHP Credentials Subcommittee and the recommendation of such Subcommittee, the Credentials Committee, to the extent it deems necessary, shall proceed to:

(a) further review and investigate the character, qualification and current professional competence of the applicant;

(b) further verify the accuracy of the information contained in the application through primary sources as necessary; and

(c) consider the specific Department or Section comments and the written comments received from members of the Professional Staff.

(d) Not later than sixty (60) days from receipt of the completed application form with the written recommendations of the Allied Health Practitioner Credentials Subcommittee and the Credentials Committee, the Credentials Committee shall forward the application with its recommendation to the Medical Executive Committee. The Chair of the Credentials Committee and the Chair of the Allied Health Practitioner Credentials Subcommittee, or their designee shall be available to the Medical Executive Committee to answer any questions that may be raised with respect to the recommendations.

(e) At its next regular meeting after receipt of the recommendations of the Credentials Committee and the Allied Health Practitioner Credentials Subcommittee, the Medical Executive Committee shall determine whether to recommend to the Hospital Board that the applicant be granted Privileges as an Allied Health Practitioner and, if recommended, the scope of Privileges.

(f) The Hospital President or the Vice President of Medical Affairs shall forward the recommendation of the Medical Executive Committee, together with all supporting documentation, to the Hospital Board for their review and recommendation. The applicant shall receive written notification of the decision of the Hospital Board.

(g) There shall be no right of appeal of an adverse decision.

SECTION 4.7. Temporary Appointment to AHP Category with Privileges

The Hospital President, or the Vice President of Medical Affairs as designated by the Hospital President (or such other designee), with the concurrence of either the Chief of Staff or the Chair of the appropriate Clinical Department or Section, or their designee, may temporarily appoint a person as an Allied Health Practitioner with Privileges under the following circumstances:

(a) when the circumstances warrant granting a temporary appointment to the AHP category during the processing of a person's completed AHP application;

(b) to a person who has not applied for appointment to the AHP category, but has been requested to assist a member of the Professional Staff in the care of a specific patient.

(c) Special requirements of supervision and reporting will be imposed by the Hospital President, the Vice President of Medical Affairs, the Chair of the Allied Health Practitioner Credentials Subcommittee, or any Chair of any Department concerned regarding a person granted temporary appointment as an Allied Health Practitioner.

(d) The Chair of the appropriate Clinical Department or Section shall be notified within two (2) weeks of said temporary appointment and concur. Otherwise the temporary appointment will be discontinued.

(e) No Privileges shall be granted, however, until there is verification of applicable licensure, certification and registration, current and continuous professional liability insurance, and at least one reference from a facility or chief or department chair of the facility where the applicant has privileges or has had privileges in the past.

SECTION 4.8. Term of Appointment/Sponsoring Member's Hearing

(a) The Clinical Privileges of the AHP may be granted for any period up to two (2) years. Notwithstanding anything herein contained to the contrary, Allied Health Practitioners as may be granted appointment hereunder shall not be considered for any purpose to be Appointees to the Medical Staff, do not possess any of the rights or prerogatives that come with such medical staff appointment, and are not entitled to the due process

hearings or appeals afforded to Medical Staff members pursuant to Article II of the Bylaws. Notwithstanding the foregoing, however, should an adverse action be proposed against an AHP of the Medical Staff, the sponsoring member of such AHP may petition the Credentials Committee for a hearing at which the sponsoring member may respond to such proposed adverse action. Following such hearing, should the Credentials Committee continue to recommend any adverse action against the AHP, the AHP's sponsor may request a hearing by the Medical Executive Committee. The Medical Executive Committee shall consider the request for a hearing, and may choose to grant or not grant such hearing, in its sole and absolute discretion. The decision of the Medical Executive Committee (or, in the event the Medical Executive Committee chooses not to grant a hearing) shall be final.

(b) The appointment or temporary appointment of a person as an Allied Health Practitioner can be terminated at any time, with or without cause, by the Hospital President, the Vice President of Medical Affairs, the Chief of Staff, the Medical Executive Committee, or the Chair of the Hospital Board. The Hospital specifically does not create any property interest or expectation of continuing appointment in any person appointed as an Allied Health Practitioner.

(c) The provisions of the Bylaws governing the Appointment to the Professional Staff specifically do not apply to Allied Health Practitioners, and there is no right to appeal the denial of an appointment to the AHP category or the termination of such appointment.

SECTION 4.9. Reappointment

(a) On at least a biannual basis, and on an appropriately cycled due date, the COO or MSS Department shall notify Allied Health Practitioners providing patient care in the Hospital to submit an application for reappointment to the AHP category. The application for reappointment shall require each Allied Health Practitioner to update his/her initial application for appointment to include all current information. The application for reappointment shall include information regarding continuing education credits required by both the laws of Ohio and the applicable accrediting body. Any Allied Health Practitioner who at the time of processing biannual reappointments wishes to be considered for a change in Clinical Privileges, or who does not desire reappointment, shall so indicate on the application for reappointment.

(b) Within thirty (30) days of such notice, each Allied Health Practitioner shall provide the application for reappointment to the CCO. Failure to provide the application for reappointment may result in termination of appointment.

(c) The CCO shall forward an application with supporting documentation to the MSS department which shall review and complete any necessary primary verifications before forwarding the appropriately cycled set of applications for reappointment to the Allied Health Practitioner Credentials Subcommittee for review and recommendation. The Allied Health Practitioner Credentials Subcommittee shall consider all pertinent information available, including recommendations from the Chair of any concerned Department or Section, in determining its recommendations for reappointment and for the granting of Clinical Privileges for the ensuing two (2) years. The recommendations of the Allied Health Practitioner Credentials Subcommittee shall then be forwarded to the Credentials Committee.

(d) The Credentials Committee shall proceed to further review and investigate the applicants for reappointment and then prepare and submit to the Medical Executive Committee a list of Allied Health Practitioners recommended for reappointment without change in Clinical Privileges. Recommendations for non-reappointment and for changes in Privileges shall be handled individually.

(e) The Medical Executive Committee shall transmit its report and recommendations to the Hospital Board through the Hospital President or the Vice President of Medical Affairs, and the Hospital Board shall make the final determination regarding reappointments.

(f) The Allied Health Practitioner shall receive written notification of his/her reappointment or non-reappointment, and a copy of such notification shall be maintained in the Hospital's records.

(g) There shall be no right of appeal of an adverse decision.

SECTION 4.10. Guidelines for Determining the Need for New Categories of AHPs

(a) All requests for recognition of a new AHP category shall be reviewed by the Allied Health Practitioners Credentials Subcommittee and 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 Allied Health Practitioners Credentials Subcommittee shall make a recommendation to the Credentials Committee which 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.

(b) Upon recommendation of the MEC and approval by the Board to create a new category of AHP, the MEC shall prepare revisions to this Article and Appendix A as necessary to establish the qualifications, requirements, and duties of the AHP category, similar to those for other categories contained in this Article, which shall be recommended to the Board for final approval.

(c) The Board shall transmit its decision through the Hospital President or Vice President Medical Affairs to the MEC.

SECTION 4.11. Medical Scribes

Appointees may request that their medical scribe be permitted to serve in a clerical capacity in the Hospital for the Appointee without clinical privileges. Medical Scribes are not AHPs and may never provide direct patient care. Such persons may be authorized to fulfill the primary secretarial and non-clinical functions for the Appointee at the Hospital pursuant to an approved application (including an attached position description that specifies duties allowed at the Hospital, expectations and accountability). A Scribe is an unlicensed person who is present during the Appointee's performance of a clinical service and enters information into the electronic medical record or chart at the direction of an Appointee to document (on behalf of the Appointee) the Appointee's dictation and/or activities. However, a scribe may not enter an Appointee's orders or test interpretations into the medical record or other clinical logs. Medical record entries made by a scribe must be signed (name and title), dated and timed {Example: "Scribed for Dr. [name of physician] by [name and title of scribe], [date and time of entry]}. Scribes may gather laboratory results, faxed radiology reports, medical records and other data for review by the Appointee. Scribes may make and answer calls for the Appointee, but may not give or take medical data over the phone. A scribe may not communicate medical advice, information, or care plans of any kind to the patient or patient's family/friends, but may communicate waits and delays as directed by the Appointee. Scribes may not bring patients food or water or assist others with their clinical roles. Scribes may not have access to narcotic prescription blanks or lock box. Scribes may not disposition patients. While serving at the Hospital, a scribe must at all times be supervised by, report to, and is held accountable to the Appointee. Such approved scribe 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, including all information management, HIPAA, HITECH, confidentiality, and patient rights standards. A private scribe is not entitled to any appeal process, including the due process rights as set forth in the Bylaws or other Bylaws' governing documents. If approved duties of a scribe are exceeded or abused, permission to provide services at the Hospital will be immediately revoked by the President/CEO, VPMA, or Chief of Staff.

ARTICLE 5.
ADOPTION, AMENDMENT, OR REPEAL

This Credentials Policy Manual may be adopted, amended, or repealed, in whole or in party, as provided in the Medical Staff Bylaws.

CERTIFICATION OF ADOPTION AND APPROVAL

Originally adopted by the Medical Executive Committee on November 23, 1999
Revisions adopted by the Medical Executive Committee on October 19, 2010
Re-adopted by the Medical Executive Committee on November 6, 2012
Manual adopted by the Medical Executive Committee on August 20, 2013
Re-adopted by the Medical Executive Committee on November 15, 2016
Re-adopted by the Medical Executive Committee on June 20, 2017
Revisions adopted by the Medical Executive Committee on March 20, 2018.
Revisions adopted by the Medical Executive Committee on March 19, 2019.

_____
Chief of Staff

Originally approved by the Board of Trustees on December 8, 1999 and included in Bylaws, after receipt of a recommendation by the Medical Executive Committee. Revisions approved by the Board of Trustees on November 9, 2010, after receipt of recommendations by the Medical Executive Committee. Re-adopted by the Board of Trustees on November 6, 2012 after receipt of a recommendation by the Medical Executive Committee. Separated from the Bylaws proper and integrated and incorporated thereto as a governing manual thereof on August 19, 2014.

Re-adopted by the Board of Trustees on November 15, 2016 after receipt of a recommendation by the Medical Executive Committee.

Re-adopted by the Board of Trustees on June 23, 2017 after receipt of a recommendation by the Medical Executive Committee.

Re-adopted by the Board of Trustees on March 30, 2018 after receipt of a recommendation by the Medical Executive Committee.

Re-adopted by the Board of Trustees on March _____, 2019 after receipt of a recommendation by the Medical Executive Committee.

_____
Hospital President

APPENDIX A
DESCRIPTION OF ALLIED HEALTH PRACTITIONERS

(applicable to Article 4 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 department.

A. Certified Registered Nurse Anesthetists (CRNA)

(Source: Section 4723.41, Section 4723.43 and Section 4731.35 of the Ohio Revised Code; Chapter 4723 of the Ohio Administrative Code)

(1) Certified registered nurse anesthetist may provide that nursing care that requires knowledge and skill obtained from advanced formal education and clinical experience. In this capacity as an advanced practice registered 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, postanesthesia 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. CRNAs shall be appointed to the Department of Anesthesia.

B. **Certified Physician Assistants (PA)**

(Source: Chapter 4730 of the Ohio Revised Code; Chapter 4731-4 of the Ohio Administrative Code)

(1) A physician assistant 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 the Medical Staff Services Department 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 two PAs at any one time.

(2) A PA is authorized to provide (i) assistance in surgery in surgery in the Hospital, (ii) any 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. Each time a PA 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.

(3) In the case of a PA's practice within the Emergency Room, if the supervising physician routinely practices in the emergency room, the

supervising physician shall provide on-site supervision of the PA when the PA practices in the emergency room. If the supervising physician does not routinely practice in the emergency room, the supervising physician may, on occasion, send the physician assistant to the emergency room 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 room to personally evaluate the patient and, at the request of an emergency room physician, the supervising physician shall go to the emergency department to personally evaluate the patient. A physician assistant shall be appointed to the Professional Staff Department to which his/her Supervising physician is appointed.

C. **Speech Pathologists And Audiologists**

(Source: Chapter 4753 of the Ohio Revised Code and Chapter 4753 of the Ohio Administrative Code)

(1) Speech pathologist is defined as a person who practices speech-language pathology, applying the principles, methods, or procedures related to the development and disorders of human communication. The practice of speech-language pathology at the Hospital includes planning, directing, supervising and conducting diagnostic or habilitative or rehabilitative interventional programs for individuals with disorders of communication including disorders and related disorders of speech, articulation, fluency, voice, oral and written language, oral pharyngeal or laryngeal sensorimotor competencies, mastication or deglutition, auditory or visual processing memory or cognition and assisted augmentative communication treatment and devices.

(2) An audiologist is defined as a person who practices audiology in applying the principles, methods, or procedures related to hearing and the disorders of hearing. The practice of audiology at the Hospital includes assessment of those with hearing, balance or related disorders; planning, directing, supervising and conducting habilitative or rehabilitative programs for those with disorders of hearing or balance; planning and directing hearing conservation programs; hearing instrument selection, fitting and after care; administering and interpreting tests of hearing, balance and tinnitus, including neurophysiologic studies relating to hearing, balance and intraoperative monitoring.

(3) A speech pathologist or audiologist providing services at the Hospital is required to have a current Ohio speech-language pathology or audiology license.

(4) A speech pathologist or audiologist providing services at the Hospital is prohibited from engaging in procedures or activities that are the practice of medicine or surgery, or in any task in the normal practice of medicine or surgery, even if delegated by a licensed physician.

(5) Speech pathologists and audiologists may care for inpatients in the Hospital only under the order of a member of the Professional Staff. Supervision by a physician is not required; provided, however:

(a) For inpatients, the members of the Professional Staff admitting such patients maintain the ultimate authority for supervision and management of the patients' care in the Hospital; or

(b) For outpatients, the members of the Professional Staff attending such patients maintain the ultimate authority for supervision and management of the patients' care in the Hospital.

(6) Speech pathologists and audiologists shall be appointed to the Department of Otolaryngology or any other department wherein their services are being utilized.

D. **Certified Nurse Midwives**

(Source: Chapter 4723 of the Ohio Revised Code; Chapter 4723 of the Ohio Administrative Code)

(1) 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 registered 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. ACNM may perform episiotomies, normal vaginal deliveries, and/or repair vaginal tears. ACNM 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.

(2) Certified nurse midwives shall be appointed to the Department of Obstetrics/Gynecology.

E. **Certified Nurse Practitioner**

(Source: Chapter 4723 of the Ohio Revised Code and Chapter 4723 of the Ohio Administrative Code)

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 registered 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. Certified nurse practitioners shall be appointed to the Professional Staff Department or Section to which his/her collaborating practitioner is appointed.

F. **Clinical Nurse Specialist**

(Source: Chapter 4723 of Ohio Revised Code and Chapter 4723 of the Ohio Administrative Code)

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 registered 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. Clinical nurse specialists shall be appointed to the Professional Staff Department to which his/her collaborating practitioner is appointed.

G. REGISTERED NURSE FIRST ASSISTANTS IN SURGERY (RNFA)

(Source: Ohio's Nurse Practice Act and Board of Nursing regulations regarding RNFA scope of practice have been rescinded and are silent on RNFA practice. Advance practice nurses follow the standards of practice relative to registered nurses found at Chapter 4723 of the Ohio Revised Code and Chapter 4725-4-03 of the Ohio Administrative Code. Ohio's Board of Nursing uses a Decision Making Model to assist Ohio RNs with scope of practice questions. RNs practicing at this Hospital as a first assist in surgery must at all times adhere to Ohio law.)

(1) To practice as an RNFA at the Hospital, the Hospital requires RNFAs to have the following qualifications:

(a) Minimum of twenty-four (24) months of perioperative nursing experience.

(b) Certification as a certified nurse operating room (CNOR).

(c) Current Ohio RN license.

(d) Current cardiopulmonary certification.

(2) The RNFA at the Hospital will function as a member of the surgical team by first assisting in operating room on minor/major procedures with direct supervision by the employing physician. S/he will be responsible preoperatively for:

(a) Interviewing the surgical patient for a comprehensive health history; and

(b) Performing nursing physical assessments

and is responsible during surgery for:

(a) Handling of tissue;

(b) Providing exposure;

(c) Using instruments;

(d) Suturing;

(e) Providing hemostasis; and

(f) Closing tissue and skin.

and is responsible postoperatively for:

(a) Assisting in the safe delivery of the patients to the recovery room (PACU);

(b) Communicating to the appropriate health care personnel and family members;

(c) Performing follow-up care to evaluate patient condition;

(d) Performing postoperative activities, which may include removing sutures, chest tubes, drains or pacing wires; and

(e) Participating in discharge planning and providing discharge instructions.

The Hospital permits the RN to function in the capacity of an RNFA only when under the direct supervision of the surgeon who is present in the operating room during the surgery.

The RN functioning at the Hospital as an RNFA is prohibited from performing surgery, acting as a surgeon, holding one's self out as a surgeon, practicing medicine or holding one's self out as a physician; transplanting organs; or performing a surgical task or procedure which is the primary purpose for the surgery.

An RN functioning at the Hospital as an RNFA shall be appointed to the Department of Surgery.

H. **Hospital Administrative Assistants**

(1) Qualifications

(a) A Hospital Administrative Assistant is an unlicensed employee who performs a set of specific clerical services and works only under the direct supervision of the responsible physician.

(b) The Hospital Administrative Assistant shall have a high school diploma or the equivalent and a minimum of two years' work experience in the healthcare field in order to have a basic understanding of medical terminology and the functioning of the physician's and Hospital's environment.

(c) If formal courses have been taken, the Hospital Administrative Assistant shall provide documentation of satisfactory completion.

Any certification or higher education shall be reported to the Credentials Committee and shall be maintained as part of the credentialing process for the Hospital Administrative Assistant.

(2) Procedures Permitted in Hospital

(a) Clerical functions only.

(b) Obtaining signature of patient on informed consent form. Providing the risks, benefits and alternatives to any procedure remains the sole personal obligation of the physician performing the procedure.

(c) Delivering written patient education materials to patients.

(d) Collecting, reviewing and organizing patient records in preparation of physician rounds.

(e) Responding to pages on physician's behalf: triaging need for response from physician.

(f) Communicating requests from patients and staff to physician.

(3) Procedures prohibited in Hospital

(a) Any direct patient care.

(b) Entering an Appointee's orders or test interpretations into the medical record or other clinical logs.

(c) Performing History and Physicals or performing any type of diagnosing.

(d) Diagnosing, prescribing, ordering or administering any medication.

(e) Documenting or entering clinical information, notes or orders in the medical record.

(f) Conveying Appointee orders to Hospital staff.

(4) Supervision by Physician

(a) As the Hospital Administrative Assistant is not performing any clinical functions, the physical presence of the physician in the Hospital is not necessary. However, the physician must be available for immediate consult with respect to any questions that

arise by patients or staff as to the appropriateness of the Hospital Administrative Assistant's activities.

(b) Professional staff department appointment

(c) Hospital Administrative Assistant shall be appointed to the Professional Staff Department to which his/her supervising physician is appointed.

I. **Neonatal Nurse Practitioners**

(1) Qualifications

(a) Current Ohio RN License (Renewed Biannually).

(b) Current Ohio certificate of authority to practice as a neonatal nurse practitioner.

(c) Current Ohio certificate to prescribe drugs and therapeutic devices, either a CTP or a CTP-E, if applicable.

(d) Current Drug Enforcement Administration Number, if applicable.

(e) Current National Certification by the American Nurse Credentialing Center or another national certifying organization approved by the Ohio board of nursing.

(f) Graduate degree in related nursing specialty from an educational institution accredited by a National or Regional accrediting organization.

(g) Must submit a log documenting the successful completion of fifty (50) diagnostic/therapeutic procedures representative of the privileges being requested. This number may be reduced if approved by the Department of Pediatrics and supported by the Credentials Committee. This log shall be submitted with the initial application for privileges under Article VII of the Bylaws of the Professional Staff of Grandview/Southview Hospital.

(2) Collaboration

(a) The nurse practitioner shall collaborate with physicians who are members of the Professional Staff. The nurse practitioner and collaborating physician must enter into a Standard Care Arrangement. A nurse practitioner and physician are considered to be in collaboration when the physician is continuously available to

communicate with the certified nurse practitioner either in person or by telephone, radio, or other form of telecommunication.

(b) The nurse practitioner's collaborating physician must be actively engaged in direct clinical practice in Ohio and practicing in a specialty that is the same as or similar to the nurse practitioner's specialty.

(c) No nurse practitioner who holds a certificate to prescribe may collaborate with a physician who has entered into standard care arrangements with more than three nurses who hold certificates to prescribe.

(d) Each time a nurse practitioner writes a medical order, the nurse practitioner 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 nurse practitioner shall use forms that clearly identify the collaborating physician under whom the nurse practitioner is authorized to write the order.

(e) The neonatal nurse practitioner is to function at all times in collaboration with a physician.

(3) Scope of Practice

(a) A neonatal nurse practitioner may only provide nursing care that calls upon knowledge and skill obtained from advanced formal education and clinical experience. A nurse practitioner authorized to practice as a neonatal nurse practitioner, in collaboration with one or more physicians, may provide preventative and primary care services and evaluate and promote wellness within the nurse's specialty, consistent with the nurse's education and certification, and in accordance with the rules adopted by the Ohio Board of Nursing. A neonatal nurse practitioner who holds a valid certificate to prescribe issued under the relevant section of the Ohio Revised Code (currently, Section 4723.48) may, in collaboration with one or more physicians, prescribe drugs and therapeutic devices in accordance with the relevant section of the Ohio Revised Code (currently, Section 4723.481).

(b) If the nurse practitioner ceases to be employed by a physician or the Hospital, the nurse practitioner may not perform any procedures in the Hospital until such time as the nurse practitioner is employed by the Hospital or a physician who is a member in good standing of the Professional Staff.

(c) No nurse practitioner shall fail to wear at all times when on duty a placard, plate, or other device identifying himself or herself as a "neonatal nurse practitioner."

(4) Standard Care Arrangement

(a) A neonatal nurse practitioner may practice only in accordance with a standard care arrangement entered into with each physician with whom the nurse collaborates. A copy of the standard care arrangement shall be retained on file at each site where the nurse practices. Prior approval of the standard care arrangement by the Board of Nursing is not required, but the Board may periodically review it for compliance.

(b) A standard care arrangement shall be in writing and shall contain the following:

(i) Criteria for referral of a patient by the nurse practitioner to a collaborating physician.

(ii) A process for the nurse practitioner to obtain a consultation with a collaborating physician.

(iii) A plan for coverage in instances of emergency or unplanned absences of either the nurse practitioner or a collaborating physician that provides the means whereby a physician is available for emergency collaboration.

(iv) A clear outline of the services and procedures offered by the nurse practitioner.

(v) A procedure for regular review of the referrals by the nurse practitioner to other health care professionals and the care outcomes for a random sample of all patients seen by the nurse practitioner.

(vi) A process for resolution of disagreements.

(vii) Signatures of the nurse practitioner and all of the collaborating physicians.

(viii) Plan for incorporation of new technology.

(ix) Proposed schedule for review of the certificate of authority.

(x) Arrangement regarding reimbursement.

(xi) Ohio Board of Nursing must be notified in writing within 30 days when there is a change in a collaborating physician.

(c) For nurse practitioners with a CTP or CTP-E, in addition to the requirements of IXD2 above:

(i) Time frame for personal review of a patient by a collaborating physician in case of emergency.

(ii) Provision for use of drugs with non-FDA approval.

(iii) Provision for use of drugs with off-label indications.

(iv) At least semi-annual review of prescriptions written by the nurse practitioner.

(d) Nothing in Ohio law prohibits a hospital from hiring a nurse practitioner as an employee and negotiating the standard care arrangement on behalf of the employee as necessary to meet the requirements of this section. A standard care arrangement between the hospital's employee and the employee's collaborating physician is subject to approval by the medical staff and governing body of the hospital prior to implementation of the arrangement at the hospital.

(e) Copies of the standard care arrangement must be provided to the Medical Staff Office after each annual review.

(5) Procedures permitted in Hospital

Providing all patient care authorized to be performed by a certificated and licensed neonatal nurse practitioner by virtue of the applicant's training, education and Standard Care Arrangement (a current copy of which must be on file with the application).

(6) Procedures Prohibited in Hospital

(a) Providing any functions beyond those specifically set forth in the neonatal nurse practitioner's standard care arrangement or not in accordance with the rules of the Board of Nursing.

(b) Performing procedures for a practitioner who is not a member in good standing of the Professional Staff.

(c) Acting as being authorized to practice any nursing specialty other than the specialty designated on the nurse's current, valid certificate of authority.

(d) Engaging for a fee, salary, or other consideration, or as a volunteer, in the practice of a nursing specialty other than the specialty designated on the nurse's current, valid certificate of authority.

(e) Prescribing any drug or device to perform or induce an abortion, or to otherwise perform or induce an abortion.

(7) Prescriptive Authority

(a) A neonatal nurse practitioner with prescriptive authority (CTP or CTP-E) is subject to all of the following:

(i) Hold a valid CTP after having met the requirements as specified in the relevant sections of the Ohio Revised Code (currently, ORC 4723.82 or 4723.484). The initial certificate to prescribe that the Ohio Board of Nursing issues is an externship certificate (CTP-E). Under the externship certificate, the nurse may obtain experience in prescribing drugs and therapeutic devices by participating in an externship that evaluates the nurse's competence, knowledge, and skill in pharmacokinetic principles and their clinical application to the specialty being practiced. During the externship, the nurse may prescribe drugs and therapeutic devices only when one or more physicians are providing supervision in accordance with the rules adopted under Section 4723.50 of the ORC. After completion of the externship (1500 clinical hours of which 500 are direct under direct supervision by a collaborating physician), the neonatal nurse practitioner may apply for a new certificate to prescribe. On receipt of the new certificate (CTP), the nurse practitioner may prescribe drugs and therapeutic devices in collaboration with one or more physicians. There must be 12 pharmacology CEU's in a two year period to maintain the CTP.

(ii) The nurse's prescriptive authority shall not exceed the prescriptive authority of the collaborating physician.

(iii) The nurse's prescriptive authority shall not exceed the scope of practice in the nurse's specialty area.

(iv) The nurse may personally furnish to a patient a sample of any drug or therapeutic device, subject to all of the following:

a. The amount of the sample furnished shall not exceed a seventy-two (72) hour supply, except when the minimum available quantity of the sample is packaged in an amount that is greater than a seventy-two (72) hour supply, in which case the nurse may furnish the sample in the packaged amount.

b. No charge may be imposed for the sample or for furnishing it.

c. Samples of controlled substances may not be personally furnished.

(v) The nurse may personally furnish to a patient a complete or partial supply of antibiotics, antifungals, scabicides, contraceptives and prenatal vitamins.

(8) Professional Staff Department Appointment

Neonatal nurse practitioners shall be appointed to the Professional Staff Department to which his/her collaborating physician is appointed.

J. **Perfusionists**

(1) Qualifications

(a) Board certification or eligibility by the American Board of Cardiovascular Perfusion (ABCP). If the perfusionist is board eligible, at the time of the original appointment as an Allied Health Practitioner, he or she must become board certified within three (3) years of his or her original appointment as an Allied Health Practitioner.

(b) When the perfusionist is recertified, he or she shall submit a copy of such recertification to the medical staff office.

(c) Must submit a log documenting the successful completion of fifty (50) perfusion cases. This log shall be submitted with the initial application for privileges under Article VII of the Bylaws of the Professional Staff of Grandview/Southview Hospital.

(2) Procedures Permitted in Hospital

(a) Maintaining extracorporeal circulation/cardiopulmonary support (including bypass, cardiopulmonary support and extra-corporeal membrane oxygenation);

(b) Operating counterpulsation devices (including intra-aortic balloon pumps);

(c) Operating ventricular assistance devices (including left ventricular assistance devices and right ventricular assistance devices);

(d) Performing blood conversion techniques (autotransfusion utilizing the cell saver);

(e) Administering cardioplegic solution;

(f) Performing anticoagulation and hematologic monitoring and analysis;

(g) Performing physiologic monitoring;

(h) Performing blood gas and chemistry monitoring;

(i) Inducing hypothermia or hyperthermia, with reversal, including circulatory arrest;

(j) Performing hemodilution;

(k) Performing hemofiltration (ultrafiltration); and

(l) Administering medications, blood components and anesthetic agents via extracorporeal circuit.

(3) Procedures Prohibited in Hospital

Performing any functions other than those delineated in Article VIII, Section B above.

(4) Supervision by Physician

The perfusionist shall be under the direct supervision of a member of the Professional Staff with privileges to perform the underlying procedure.

(5) Professional Staff Department Appointment

A perfusionist shall be appointed to the Thoracic-Cardiovascular Surgery Department.

K. **Apheresis Category**

(1) Qualifications

A health professional has obtained a certificate of satisfactorily having completed a training course in the monitoring and operation of monitoring devices related to apheresis procedures. In lieu of a certificate, demonstration of adequate training must be provided. A license is not necessarily required.

(2) Procedures Permitted in Hospital

(a) Monitoring and operation of monitoring devices to assist physicians or other licensed independent practitioners ("LIP") in the performance of apheresis procedures.

(b) May document in the medical record only that data which is related to equipment and/or patient monitoring during apheresis procedures.

(3) Procedures Prohibited in the Hospital

The apheresis Allied Health Practitioner will not have admission or Clinical Privileges.

(4) Supervision by Physician

(a) The apheresis Allied Health Practitioner will function under the direction and supervision of their employing physician/LIP who currently has privileges at the Hospital and who will be responsible for all their Hospital activities.

(b) All chart entries allowed under this section must be cosigned by the supervising physician/LIP by the end of the procedure.

(c) The supervising LIP physician must be no more than 30 minutes away from the apheresis Allied Health Practitioner and be able at all times to respond on site to the Hospital when his/her presence is needed by the apheresis Allied Health Practitioner.

L. **Surgical Assistants**

(1) Qualifications

(a) Certification as Surgical Technologist.

(b) Qualification to sit for certification as a first assistant.

(c) Successful completion of examination for first assistant.

M. **Procedures Permitted in Hospital**

The CST-CFA may perform, under the direct supervision of the physician, the following:

(a) Handling of tissue;

(b) Providing exposure;

(c) Using instruments;

(d) Suturing;

(e) Providing hemostasis; and

(f) Closing of tissue and skin.

N. **Limited Specialty Surgical Scrub/Assistant**

(1) Qualifications

(a) Will have documented proof of three (3) months experience in an operating room or an office/clinic setting for a particular surgical procedure, such as, ophthalmology, dental/oral, etc.

(b) Will have documented evidence of specialized training and appropriate certification in the requested specialty.

(2) Procedures Permitted in Hospital

(a) Handling of tissue;

(b) Using instruments;

(c) Provide visual access for the surgeon by retracting tissue, keeping the surgical site dry, and holding or passing the instruments as needed by the surgeon; and

(d) Other duties as approved by the supervising surgeon and the Chair of the Clinical Department or Section.

(3) Supervision by Physician

(a) Work under the direct supervision of the surgeon who is a member of the Professional Staff with privileges to perform the underlying procedure; and

(b) Can only function in the approved specialty.

O. **Radiologist Assistant**

(1) Definitions

(a) "Radiologist assistant" means an individual who assists a radiologist in the care of radiology patients by engaging in any of the activities authorized under section 4774.08 of the Ohio Revised Code ("ORC").

(b) The definition of Radiology Assistant does not apply to either of the following:

(i) A student participating in an advanced academic program that must be completed to receive a certificate to practice as a radiologist assistant, as those programs are described in division (B)(3) of section 4774.03 of the ORC;

(ii) A person who is otherwise authorized to perform any of the activities that a radiologist assistant is authorized to perform, either pursuant to another provision of the ORC or pursuant to the rules adopted by the State medical board regarding physician delegation of medical tasks.

(2) Qualifications

Current, valid certificate to practice as a radiologist assistant.

(3) Supervision by Radiologist

(a) A radiologist assistant shall practice only under the supervision of a radiologist acting in accordance with State laws and Hospital policy.

(b) The supervising radiologist shall provide on-site supervision of the radiologist assistant. The supervision shall be provided by being physically present in the same location as the radiologist assistant. The provision of on-site supervision does not necessarily require that the supervising radiologist be in the same room as the radiologist assistant. On-site supervision shall be provided when the radiologist assistant performs a radiologic procedure on a patient who is under minimal sedation.

(c) When the radiologist assistant performs a radiologic procedure on a patient who is under general anesthesia, deep sedation, or moderate sedation, the supervising radiologist shall provide direct supervision. The supervision shall be provided by being physically present in the same room as the radiologist assistant, with the radiologist assistant in the actual sight of the supervising radiologist when the radiologist assistant is performing the radiologic procedure.

(d) In the case of any radiologic procedure not specifically permitted under this Section but that a radiologist assistant is authorized to perform pursuant to authority of the State medical board, the supervising radiologist shall provide the level of supervision specified by the State medical board.

(e) The supervising radiologist of a radiologist assistant assumes legal liability for the services provided by the radiologist assistant.

(f) No radiologist assistant shall fail to wear at all times when on duty a placard, plate, or other device identifying himself or herself as a "radiologist assistant."

(4) <u>Procedures Permitted in the Hospital under Supervision and in Accordance with Privileges Granted by the Hospital.</u>

(a) Perform fluoroscopic procedures;

(b) Assess and evaluate the physiologic and psychological responsiveness of patients undergoing radiologic procedures;

(c) Evaluate image quality, make initial image observations, and communicate observations to the supervising radiologist;

(d) Administer contrast media, radio-isotopes, and other drugs prescribed by the supervising radiologist that are directly related to the radiologic procedures being performed;

(e) Perform any other radiologic procedures specified by the state medical board in rules adopted under section 4774.11 of the Revised Code.

(5) Procedures Prohibited in Hospital

(a) Interpret radiologic images;

(b) Make diagnoses;

(c) Prescribe therapies;

(d) Administer or participate in the administration of general anesthesia, deep sedation, moderate sedation, as such are defined by the State medical board.

P. **Medical Assistants**

(1) Each medical assistant must be an employee of and/or under the supervision of physician(s) who are presently appointed to the Professional Staff in accordance with the Allied Health Practitioner requirements of Article VII of the Bylaws. When a physician(s) employs a Medical Assistant, the privileges relating to the Medical Assistant can be granted only to the medical staff member(s). Any designated alternate must also agree to assume such responsibility for the Medical Assistant.

(2) When state, county, or city licensure has been established, each Medical Assistant must have such licensure as it applies to the area of activity.

(3) Each Medical Assistant must document satisfactory completion of education and/or training, inclusive of having been certified by the Certifying Board of the American Association of Medical Assistants, as applicable. Experience may be substituted for a formal course in rare instances, but must be documented and acceptable to the clinical service, Credentials Committee, Allied Health Practitioner Credentials Subcommittee, the Medical Executive Committee, and the Hospital Board.

(4) Each supervising physician must develop and submit duties applicable to the Medical Assistant which shall be well-defined in a written scope of practice that is reviewed and approved by the applicable clinical service subject to final approval by the Credentials Committee, the Allied Health Practitioner Credentials Subcommittee, the Medical Executive Committee and the Board, in accordance with Article VII of the Bylaws and reviewed bi-annually at the time of the supervising physician's reappointment.

(5) Specialized Categories

(a) Certified Medical Assistants

(1) Qualifications

a. Certified by the Certifying Board of the American Association of Medical Assistants.

b. Fill the requirements and qualifications applicable to an Allied Health Practitioner under Article VII of the Bylaws.

(2) Duties

a. The supervising physician shall submit a written scope of practice and Supervising Medical Staff Member Agreement to the Medical Staff for approval in accordance with Article VII of the Bylaws.

Q. **Physician Liaison RN/LPN Medical Assistants**

(1) Qualifications

(a) Possess a current and valid license under the State of Ohio to practice nursing as a RN or LPN.

(b) Fulfill the requirements and qualifications applicable to an Allied Health Practitioner under Article VII of the Bylaws.

(2) Duties

The supervising physician shall submit a written scope of practice and Supervising Medical Staff Member Agreement to the Medical Staff for approval in accordance with Article VII of the Bylaws.

R. **Pathologist Assistant**

(1) Qualifications

(a) Graduation from a masters level American Association Pathologists Assistants ("AAPA") approved program; or

(b) Graduation from a bachelors-level training in an appropriate major (biology, premedical, medical technology), AND 2 years' experience performing tasks as a pathologist assistant; or

(c) Associates level training in an appropriate field (medical technology, history, cytology), AND 4 years' experience performing tasks as a pathologist assistant; or

(d) Certification as a Pathologist Assistant by the AAPA; and

(e) Continuous compliance with annual continuing education requirements as promulgated by AAPA (currently, no less than 25 hours per year in an appropriate field).

(2) Procedures/Functions Permitted in Hospital

(i) General Procedural Duties include organizing, specimens for gross review (specimen transportation, computer accessioning, cassette labeling, specimen lineup, processor loading, clean-up), cutting frozen sections, embedding/cutting/staining permanent sections, cytology specimen preparation/staining, transcription, handing specimens for send-out procedures/consultations and preparation of pathology quality assurance reports.

(ii) Preparation, gross description and dissection of human tissue surgical specimens, with procedures and functions that include:

a. Assuring appropriate specimen accessioning

b. Obtaining clinical history, including scans, x-rays, laboratory data, etc.

c. Describing gross anatomic features, dissecting surgical specimens, and preparing tissues for histologic processing

d. Overseeing receipt of biological specimens such as blood, tissue and toxicological material for studies such as flow cytometry, image analysis, immunohistochemistry etc., and performing special procedures including Faxitron imaging and tumor triage

e. Photographing all pertinent gross specimens and microscopic slides

f. Performing duties relating to the administrative maintenance of surgical pathology protocols, reports and data, including the filing of reports, protocols, photographic and microscopic slides; assuring the completion of specimen coding; and billing

g. Assuring proper maintenance of equipment, provision of adequate supplies, and cleanliness of the surgical pathology suite

h. Assisting in the organization and coordination of anatomic pathology conferences

i. Performing such administrative, budgetary, supervisory, teaching and other duties as may be assigned by the supervising physician at the request of the Chair of the relevant Clinical Department

(3) Procedures Prohibited in Hospital

(a) Performing any functions other than those delineated above in this Article XIII, Section A.1.(b).

(b) Responsibilities related to postmortem examinations are currently not applicable.

(c) The pathologist assistant cannot make a diagnosis.

(4) Supervision by Physician

The pathologist assistant is under the direction and supervision of an active member of the Professional Staff who has unrestricted Clinical Privileges in pathology.

(5) Professional Staff Department Appointment

The pathologist assistant shall be appointed to the Department of Pathology and Clinical Laboratories.

R. **Private Dependent Non-Privileged Practitioners**

In general, 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 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 in the Bylaws or other Bylaws governing documents. 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.

S. **Private Dependent Non-Privileged Medical Scribes**

(1) Qualifications

(a) A medical scribe is an unlicensed employee or independent contractor of an Appointee who performs a set of specific scribing services and works only under the direct supervision of the responsible Appointee.

(b) The medical scribe shall have a high school diploma or the equivalent and possess an adequate understanding of medical terminology and the functioning of EHR systems to be able to accurately enter data into the medical record as dictated by the Appointee.

(c) The medical scribe shall be required to adhere to all policies of the Hospital and related regulatory requirements, including all information management, HIPAA, HITECH, confidentiality, and patient rights standards.

(d) If formal courses have been taken, the medical scribe shall provide documentation of satisfactory completion. Any certification or higher education shall be reported to the AHP Subcommittee and shall be maintained as part of the Appointee's or AHP's approval file for such individual.

(2) Procedures permitted in Hospital

(a) Secretarial, non-clinical functions only.

(b) Entering information into the electronic medical record or chart at the direction of an Appointee to document (on behalf of the Appointee) the Appointee's dictation and/or activities.

(c) Gathering laboratory results, faxed radiology reports, medical records and other data for review by the Appointee.

(d) Initiating and answering calls for the Appointee, but may not give or take medical data over the phone.

(e) Acting to collect, review and organize patient records in preparation of physician rounds.

(3) Procedures prohibited in Hospital

(a) Any direct patient care.

(b) Performing History and Physicals or any form of diagnosing.

(c) Diagnosing, prescribing, ordering or administering of any medication.

(d) Conveying Appointee orders to Hospital staff.

(e) Entering an Appointee's orders or test interpretations into the medical record or other clinical logs.

(f) Giving or taking medical data from any third party, including over the phone.

(g) Communicating medical advice, information, or care plans of any kind to the patient or patient's family/friends.

(h) Bringing patients food or water or assisting others with their clinical roles.

(i) Dispositioning patients or having access to narcotic prescription blanks or lock boxes.

(4) Supervision by Physician

The physical presence of the physician in the Hospital is required. The scribe must at all times be supervised by, report to, and be accountable to the Appointee

(5) Professional Staff Department

A Medical Scribe shall be accountable to the Appointee and affiliated with the Professional Staff Department to which his/her supervising physician is appointed.

APPENDIX A-1

(APPLICABLE TO ARTICLE 4 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 registered 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 11-05-2012)
e-copy at: http://codes.ohio.gov/oac/4723-8-04

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 an agreement to abide by the terms of the standard care 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 patient 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 patients 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 patient 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 patients 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 patient 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;

(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; and

(iv) Provisions for the use of schedule II controlled substances.

(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:

(i) A representative sample of prescriptions written by the nurse;

(ii) A representative sample of schedule II prescriptions written by the nurse; and

(iii) Provisions to ensure that the nurse is meeting all the requirements of rule 4723-9-12 of the Administrative Code related to review of a patient's OARRS report, consultation with the collaborating physician prior to prescribing based on the OARRS report and signs of drug abuse or diversion described in paragraph (B) of rule 4723-9-12 of the Administrative Code, and documentation of receipt and assessment of OARRS report information in the patient's record.

(13) Quality assurance standards consistent with 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.

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Physician Assistants

Physician Assistant Services provided under physician supervisory plan
(Effective 3/22/2013)
e-copy at: http://codes.ohio.gov/orc/4730.09

A. Under a physician supervisory plan approved under section 4730.17 of the Revised Code, a physician assistant may provide any or all of the following services without approval by the state medical board as special services:

(1) Obtaining comprehensive patient histories;

(2) Performing physical examinations, including audiometry screening, routine visual screening, and pelvic, rectal, and genital-urinary examinations, when indicated;

(3) Ordering, performing, or ordering and performing routine diagnostic procedures, as indicated;

(4) Identifying normal and abnormal findings on histories, physical examinations, and commonly performed diagnostic studies;

(5) Assessing patients and developing and implementing treatment plans for patients;

(6) Monitoring the effectiveness of therapeutic interventions;

(7) Exercising physician-delegated prescriptive authority pursuant to a certificate to prescribe issued under this chapter;

(8) Carrying out or relaying the supervising physician's orders for the administration of medication, to the extent permitted by law;

(9) Providing patient education;

(10) Instituting and changing orders on patient charts;

(11) Performing developmental screening examinations on children with regard to neurological, motor, and mental functions;

(12) Performing wound care management, suturing minor lacerations and removing the sutures, and incision and drainage of uncomplicated superficial abscesses;

(13) Removing superficial foreign bodies;

(14) Administering intravenous fluids;

(15) Inserting a foley or cudae catheter into the urinary bladder and removing the catheter;

(16) Performing biopsies of superficial lesions;

(17) Making appropriate referrals as directed by the supervising physician;

(18) Performing penile duplex ultrasound;

(19) Changing of a tracheostomy;

(20) Performing bone marrow aspirations from the posterior iliac crest;

(21) Performing bone marrow biopsies from the posterior iliac crest;

(22) Performing cystograms;

(23) Performing nephrostograms after physician placement of nephrostomy tubes;

(24) Fitting , inserting , or removing birth control devices;

(25) Removing cervical polyps;

(26) Performing nerve conduction testing;

(27) Performing endometrial biopsies;

(28) Inserting filiform and follower catheters;

(29) Performing arthrocentesis of the knee;

(30) Performing knee joint injections;

(31) Performing endotracheal intubation with successful completion of an advanced cardiac life support course;

(32) Performing lumbar punctures;

(33) In accordance with rules adopted by the board, using light-based medical devices for the purpose of hair removal;

(34) Administering, monitoring, or maintaining local anesthesia, as defined in section 4730.091 of the Revised Code;

(35) Applying or removing a cast or splint;

(36) Inserting or removing chest tubes;

(37) Prescribing physical therapy or referring a patient to a physical therapist for the purpose of receiving physical therapy;

(38) Ordering occupational therapy or referring a patient to an occupational therapist for the purpose of receiving occupational therapy;

(39) Taking any action that may be taken by an attending physician under sections 2133.21 to 2133.26 of the Revised Code, as specified in section 2133.211 of the Revised Code;

(40) Determining and pronouncing death in accordance with section 4730.092 of the Revised Code;

(41) Performing other services that are within the supervising physician's normal course of practice and expertise, if the services are included in any model physician supervisory plan approved under section 4730.06 of the Revised Code or the services are designated by the board by rule or other means as services that are not subject to approval as special services.

B. Under the policies of a health care facility, the services a physician assistant may provide are limited to the services the facility has authorized the physician assistant to provide for the facility. The services a health care facility may authorize a physician assistant to provide for the facility include the following:

(1) Any or all of the services specified in division (A) of this section;

(2) Assisting in surgery in the health care facility;

(3) Any other services permitted by the policies of the health care facility, except that the facility may not authorize a physician assistant to perform a service that is prohibited by this chapter.

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Ohio Revised Code § 4730.21. Supervisory duties of physician; number of agreements; quality assurance system.
(Effective 5-17-06)
e-copy at: http://codes.ohio.gov/orc/4730.21

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.

(4) 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.