

# Medical Staff Credentials Policy Manual

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Kettering Medical Center System

A Medical Staff Document

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## ARTICLE I: CREDENTIALING, APPOINTMENT, AND PRIVILEGING PROCESS

### 1.1 **Incorporation of Definitions**

- 1.1-1 This Credentials Policy Manual adopts and incorporates by reference the definitions contained in the Medical Staff Bylaws, unless otherwise specified herein.
- (a) For purposes of this Manual, the term “Hospital” means Kettering Medical Center System (KMCS) including Kettering Medical Center, Sycamore Medical Center, and Troy Hospital. Kettering Medical Center, Sycamore Medical Center and Troy Hospital have elected to have a unified Medical Staff.
  - (b) For purposes of this Manual, the term “Medical Staff” means the KMCS Medical Staff.
- 1.1-2 Whenever an individual is authorized to perform a duty by virtue of the individual’s position (*e.g.*, the Hospital President/CEO, Chief Medical Officer (CMO), Chief of Staff, Clinical Department Chair, *etc.*) then the term shall also include the individual’s authorized designee.

### 1.2 **Applicability of Policy**

- 1.2-1 As a general policy, the Hospital permits application to the Medical Staff from qualified Practitioners as described in Articles 3 and 4 of the Medical Staff Bylaws and in this Manual. Qualified Practitioners may apply for Medical Staff appointment and Clinical Privileges, Medical Staff appointment without Clinical Privileges, or Clinical Privileges without Medical Staff appointment as described in the Medical Staff Bylaws and this Manual.
- 1.2-2 Eligible APPs may apply for Clinical Privileges at the Hospital in accordance with the procedures set forth in the APP Policy, as such policy may be amended from time to time.
- 1.2-3 The KHN Centralized Credentialing Office (CCO) conducts credentialing for Kettering Health Network facilities as provided in Section 3.1 of the Bylaws.

### 1.3 **Burden**

- 1.3-1 It is the burden of the applicant requesting Medical Staff appointment and/or Privileges to provide all information necessary for the Hospital to:
- (a) Make a proper evaluation of the applicant’s qualifications.
  - (b) Resolve any doubts about the applicant’s qualifications or any other concerns that the Hospital may have.

(c) Make a reasonable and informed decision on the application.

1.3-2 An application is incomplete until deemed complete by the CCO and Medical Staff Services (in accordance with the procedures set forth in this Manual), and accepted as complete by the Credentials Committee and Medical Executive Committee, which may remand an application to the CCO to be considered incomplete until identified information is received or questions resolved.

#### 1.4 **Non-Discrimination**

Neither the Hospital nor its Medical Staff will discriminate in granting Medical Staff appointment and/or Privileges on the basis of race; color; sex (including pregnancy); sexual orientation; gender identity; gender expression; transgender status; age (40 and older); religion; marital, familial, or health status; national origin; ancestry; disability (provided that the applicant can competently exercise the Privileges requested with or without a reasonable accommodation); genetic information; veteran or military status; or any other characteristic(s) or class protected by applicable laws, rules, and/or regulations.

#### 1.5 **Application for Initial Appointment/Granting of Privileges**

1.5-1 **Application Content.** All applications for Medical Staff appointment and/or Privileges shall be in writing (or electronic format as available), shall be signed (or otherwise authenticated) and dated by the applicant, and shall be submitted on a form approved by the MEC. The application shall include all of the following, as applicable to the type of Medical Staff appointment and/or Clinical Privileges requested:

- (a) **Professional Education and Post-Graduate Training.** Documentation of satisfaction of the education and training qualifications set forth in the Bylaws including: the name of the institution(s) and the dates attended; any degrees attained; course of study or program(s) completed; and, for all post-graduate training, the names of individuals responsible for reviewing the applicant's performance.
- (b) **Licensure History.** Documentation of satisfaction of the licensure qualifications set forth in the Bylaws including: a copy of all current, valid professional licenses or certificates (as well as all previous licenses held); a copy of a current, valid Drug Enforcement Administration registration (if necessary for the Privileges requested); the date of issuance; and the license, certificate, or registration number(s).
- (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. References from at least two (2) Practitioners in the applicant's same professional discipline (preferably with the same professional credentials) with personal knowledge of the applicant's current clinical activity (from residency, if the applicant is a new graduate, or from facilities where the applicant is practicing), competence, and ability to perform the Privileges requested. 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.
- (e) Requests. Written request stating the Medical Staff category and/or Privileges for which the applicant wishes to be considered.
- (f) Continuing Education. Certification by the applicant that he or she has completed the continuing education required for licensure as determined by the applicable state licensing board and such other continuing education as may be required by the Hospital and set forth in the applicable Delineation of Privileges or other appropriate document. 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 or voluntarily (while under investigation or to avoid investigation for conduct or clinical competency concerns) or involuntarily denied, suspended, reduced, modified, limited, not renewed, relinquished or terminated/revoked:
  - (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 Health 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 a contractual relationship based on issues of clinical competency, impairment, professional or personal judgment, disruptive behavior, and/or moral turpitude.

If any of such actions has occurred or is pending, the applicant shall provide a summary of the facts, any requested documents, 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 Competence. Each applicant is expected to meet the criteria set forth in the applicable Delineation of Privileges.
  - (i) Clinical Experience/Activity. Documentation regarding the applicant's clinical experience/activity.
  - (ii) Ability to Carry Out Privileges Requested. Statement of the applicant's ability to fully and competently exercise the Privileges requested, with or without a reasonable accommodation, with documentation confirming this statement.
    - 1) For initial applications, confirmation of an applicant's current competence may be obtained through peer references attesting to the applicant's clinical experience/activity and current competence and supplemental professional practice evaluation data from the organization at which the applicant currently exercises the Privileges requested at the Hospital (*e.g.*, procedure logs with outcomes to support the requested Privileges, *etc.*). Privileges are subject to a period of focused professional practice evaluation at the Hospital when initially granted.
    - 2) For applications requesting regrant of Privileges, confirmation of an applicant's current competence is based upon the Hospital's focused and ongoing professional practice evaluation data in addition to any supplemental data requested, as needed.

- (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.
- (k) Affiliations. The applicant's chronological work history to include:
  - (i) The location of the applicant's office(s);
  - (ii) The name and address of any health care organization, facility, or practice setting at which the applicant has previously provided or is presently providing clinical care, treatment, and/or services to patients or otherwise had or has medical staff appointment, clinical privileges, an employment relationship, or any other association to include the dates of each such affiliation, status, and general scope of clinical privileges or duties;
  - (iii) Names and addresses of other Practitioners with whom the applicant is or has been associated and the dates of the associations.
- (l) Regulatory Actions. Information as to whether the applicant has been the subject of investigation by a Federal Health Program and, if so, the outcome of such investigation.
- (m) Conflict of Interest. Documentation of compliance with any Board approved conflict of interest policy as such policy may change from time to time.
- (n) Criminal History/Criminal Background Check Investigation
  - (i) Information regarding any criminal history (other than minor traffic offenses) for the past seven (7) years to include the status and, if applicable, resolution of 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.
  - (ii) Documentation of compliance with the Hospital's criminal background investigation requirements and authorization for the Hospital to conduct a criminal background check.
- (o) Proof of Identity. Applicants must provide a form of government-issued photo identification to verify that they are, in fact, the individual requesting Privileges.
- (p) Ethics and Relations. Information bearing upon the applicant's professional ethics, character, interpersonal skills, and conduct.
- (q) Request for Hospital Affiliation. Request for primary hospital affiliation.

- (f) Other. Such other information as the MEC may recommend and the Board may determine is required from time to time.

1.5-2 Effect of Application. By applying for Medical Staff appointment and/or Privileges, the applicant:

- (a) Acknowledges and attests that the application is correct and complete, and that any material misstatement or omission is grounds for denial or termination of appointment and/or Privileges.
- (b) Agrees to appear for personal interviews, if required, in support of the application.
- (c) Acknowledges the scope and extent of, and agrees to be bound by, the authorization, immunity, confidentiality, and release provisions of the Medical Staff Bylaws.
- (d) Confirms that if an Adverse ruling is made with respect to his or her Medical Staff appointment and/or Privileges, the applicant will exhaust the administrative remedies afforded by the Medical Staff Bylaws, if applicable, before resorting to formal legal action.
- (e) Understands and agrees that if Medical Staff appointment and/or requested Privileges are denied based upon clinical competence or conduct, the applicant may be subject to reporting to the National Practitioner Data Bank and/or state authorities.
- (f) Agrees to notify Medical Staff Services immediately if any information contained in the application changes. The foregoing obligation shall be a continuing obligation as long as the applicant is an Appointee to the Medical Staff and/or has Privileges at the Hospital.
- (g) Confirms receipt of or access to the Medical Staff Bylaws and Manuals/Policies and has had an opportunity to review the Medical Staff Bylaws and Manuals/Policies.
- (h) Agrees to be bound by the terms of and to comply in all respects with the Medical Staff Bylaws and Manuals/Policies, 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 if the applicant is granted Medical Staff appointment and/or Privileges and in all matters relating to consideration of the applicant's application without regard to whether or not appointment and/or Privileges are granted.
- (i) Agrees to fulfill the Medical Staff responsibilities set forth in the Medical Staff Bylaws.

1.5-3 Review of Qualifications. The applicant will be given the opportunity to go through the qualification requirements with a Hospital or Medical Staff representative either in person, by telephone, electronically, or in writing. Upon receipt of the completed application and required application fee, if any, a credentials file will be created and maintained for the applicant by the Hospital.

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

1.6-1 In making recommendations to the Board regarding Medical Staff appointments and/or Privileges, the Medical Staff may consider any policies, plans, and objectives formulated by the Board concerning:

- (a) The Hospital's current and projected patient care needs.
- (b) The Hospital's ability to provide the physical (*e.g.* facilities and equipment), personnel, and financial resources that will be required if the application is acted upon favorably.
- (c) The Hospital's strategic plan of development.
- (d) The Hospital's decision to contract exclusively for the provision of certain medical services with a Practitioner or group of Practitioners other than the applicant.

1.6-2 When an application is denied solely on the basis of this provision, to the extent the applicant seeks and is entitled to have a hearing pursuant to 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.

1.6-3 The following Practitioners are not eligible to request an application for Medical Staff appointment and/or Privileges at the Hospital: (i) Practitioners who provide services currently provided under an exclusive Hospital contract and who are not employed by or otherwise associated with the contracted group, and (ii) Practitioners who provide services not currently available at the Hospital.

1.7 **Application & Credentialing Verification Process**

1.7-1 Submission of Application. The application shall be submitted to the CCO, which shall review the application for completeness.

1.7-2 Collection & Verification Process

- (a) 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.

- (b) Upon notification of such problems, the applicant must obtain and furnish the required information. If the applicant fails to furnish the requested information within ninety (90) days after 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.

1.7-3 Primary Source Verification/Data Repository Queries.

- (a) The CCO shall perform primary source verification and query data repositories as necessary.
- (b) 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 Health Program.
- (c) Upon completion of the collection and verification process, the CCO shall transmit the completed application and all accompanying documents to Medical Staff Services
- (d) Medical Staff Services will collate the application and verify case logs (as applicable), continuing education, and any other criteria required by the applicable Delineation of Privileges.
- (e) Medical Staff Services shall conduct a National Practitioner Data Bank (NPDB) query on applicants at the time of initial request for Medical Staff appointment and/or Privileges, upon reappointment/regrant of Privileges, and when a Practitioner requests additional Privileges during a current appointment/Privilege period. Medical Staff Services shall also conduct an NPDB query each time a Practitioner applies for temporary Privileges. Each query to the NPDB is facility specific.
- (f) Medical Staff Services shall monitor, on an ongoing basis, any new NPDB reports received as a result of participation in the NPDB's continuous query process.

1.7-4 When the application is complete, Medical Staff Services shall notify the chair of the Clinical Department in which the applicant seeks Privileges that the application and accompanying materials are available for review.

1.8 Appointment and Privileging Process

1.8-1 Credentials Records. A separate credentials file shall be maintained for each Practitioner requesting initial appointment, reappointment and/or Privileges.

- 1.8-2 Clinical Department Chair Review and Recommendation. Upon notification from Medical Staff Services that a completed application is available for review, the chair of the applicable Clinical Department shall review the application and accompanying materials. The Clinical Department Chair may meet with the applicant to discuss any aspect of the application, his or her qualifications, and/or the requested Privileges (if any). Upon completion of this review, the Clinical Department Chair shall make a recommendation to the Credentials Committee regarding whether the applicant should be (1) appointed to the Medical Staff and/or granted Privileges with or without limitation, (2) denied Medical Staff appointment and/or Privileges (in whole or in part), or (3) deferred for further consideration.
- 1.8-3 Credentials Committee Review and Recommendation
- (a) Upon receipt of a recommendation from the Clinical Department Chair the application shall be reviewed by the Credentials Committee. The Credentials Committee may meet with the applicant to discuss any aspect of the application, his or her qualifications, and/or the requested Privileges (if any). Upon completion of this review, the Credentials Committee shall make recommendations to the MEC regarding whether the applicant should be (1) appointed to the Medical Staff and/or granted Privileges with or without limitation, (2) denied Medical Staff appointment and/or Privileges (in whole or in part), or (3) deferred for further consideration.
- (b) If the Credentials Committee does not receive a Clinical Department Chair's recommendation within thirty (30) days after the Clinical Department Chair's receipt of, or access to, the completed application, the Credentials Committee may (after notifying the Clinical Department Chair of the Credential Committee's intent and allowing one week, or other less amount of time in order to ensure that the Credentials Committee's recommendation is received by the MEC within 60 days after Medical Staff Services deeming the application to be complete) make a recommendation to the MEC on the Credentials Committee's own initiative.
- 1.8-4 Medical Executive Committee Review and Recommendation. Upon receipt of a recommendation from the Credentials Committee, the MEC shall consider such recommendation (along with the recommendation of the Clinical Department Chair) and review the application/accompanying materials as necessary. The MEC may meet with the Practitioner to discuss any aspect of the application, his or her qualifications, and/or the requested Privileges (if any). The MEC may take any of the following actions (which may be set forth in the MEC's meeting minutes).
- (a) Defer Recommendation. When the recommendation of the MEC is to defer the application for further consideration, that recommendation must be followed within thirty (30) days, except for good cause, by a subsequent recommendation as to approval or denial of, and any conditions related to, appointment and/or Privileges.

- (b) Favorable MEC Recommendation. When the recommendation of the MEC is favorable to the applicant, the Chief of Staff shall promptly forward the MEC's written recommendation, together with all supporting documentation, to the Board.
- (c) Adverse MEC Recommendation. When the recommendation of the MEC is deemed Adverse to the applicant, the procedural due process rights set forth in the Bylaws, if applicable, shall apply. The Hospital President/CEO shall notify the applicant of the recommendation, by Special Notice, and the applicant's right, if any, to the procedural due process rights provided for in the Bylaws. No such Adverse recommendation shall be required to be forwarded to the Board until after the applicant has exercised, or has been deemed to have waived, the right, if any, to a hearing as provided for in the Bylaws.

#### 1.8-5 Action by the Board of Directors

- (a) Favorable MEC Recommendation. The Board may adopt or reject any portion of the MEC's recommendation that was favorable to an applicant or refer the recommendation back to the MEC for additional consideration, but must state the reason(s) for the requested reconsideration and set a time limit within which a subsequent recommendation must be made. If the Board's decision is favorable, the action shall be effective as its final decision. If the Board's decision is Adverse to the applicant, the Hospital President/CEO shall so notify the applicant, by Special Notice, and the applicant shall be entitled to the procedural due process rights, if any, provided for in the Bylaws.
- (b) Without Benefit of MEC Recommendation. If the Board does not receive a MEC recommendation within thirty (30) days after the MEC's receipt of, or access to, the completed application (or an additional thirty (30) days thereafter if the MEC defers the application as permitted in Section 1.8-4 (a) above), the Board may, after notifying the MEC of the Board's intent and allowing a reasonable period of time for response by the MEC, take action on the Board's own initiative using the same type of criteria considered by the MEC. If the Board's action is favorable, the action shall become effective as the final decision of the Board. If the Board's action is Adverse, the Hospital President/CEO shall promptly notify the applicant of such Adverse decision, by Special Notice, and hold its decision in abeyance until the applicant has exercised, or has been deemed to have waived, his or her procedural due process rights, if any, under the Bylaws. The fact that the Adverse decision is held in abeyance shall not be deemed to confer Medical Staff appointment and/or Privileges when none existed before.
- (c) Adverse MEC Recommendation. If the Board is to receive an Adverse MEC recommendation, the Hospital President/CEO shall withhold the recommendation and not forward the application to the Board for action

until after the Hospital President/CEO notifies the applicant, by Special Notice, of the MEC's recommendation and the applicant's right, if any, to the procedural due process rights provided for in the Bylaws and the applicant either exercises or waives such rights.

1.8-6 Joint Conference Committee. Whenever the Board's proposed decision is contrary to the recommendation of the MEC, there shall be a further review of the recommendation by the Board Professional Practice Committee serving in the capacity of an advisory *ad hoc* Joint Conference Committee. This committee shall, after due consideration and within thirty (30) days after receipt of the MEC's recommendation and the Board's proposed decision, make its report to the Board. The Board may then render a final decision.

1.8-7 Final Board Decision. When the Board's decision is final, the Board shall send notice of such decision, through the Hospital President/CEO, to the MEC and, by Special Notice, to the applicant. All decisions to appoint shall include, as applicable, the Medical Staff category to which the applicant is appointed, the Privileges that may be exercised (if any), and any special conditions related thereto.

## 1.9 Application for Appointment Only

1.9-1 Due to the limited nature of an appointment to the Associate Medical Staff - Membership Only, and without Privileges, such applicants shall only be required to satisfy the qualifications and provide such information as set forth in the applicable Medical Staff category and as the MEC and Board may otherwise deem necessary. If time constraints so require, an application for appointment to the Associate Medical Staff - Membership Only, and without Privileges, may be acted upon by the Board upon recommendation of the MEC chair. Provided such denial is not based upon an applicant's conduct or clinical competence, denial of an application for appointment without Privileges shall not trigger procedural due process rights nor create a reportable event for purposes of federal or state law.

1.9-2 Practitioners shall be recommended for appointment to the Membership Only – Honorary Medical Staff category by the MEC subject to Board approval.

1.9-3 Written requests for transfer to the Membership Only – Retired Medical Staff category shall be directed to Medical Staff Services for processing pursuant to the procedure set forth in Section 1.11.

## 1.10 Reappointment/Regrant of Privileges Process

1.10-1 Criteria for Review. A Practitioner shall be notified of the need for reappointment/regrant of Privileges prior to the date of expiration of the Practitioner's current appointment and/or Privileges. The Practitioner is responsible for providing the CCO with the following materials in writing and on a form approved by the MEC. Each assessment concerning reappointment and/or the regranting of Privileges shall be based upon:

- (a) Updates to the information provided in the Practitioner’s application, since the time of the Practitioner’s initial grant of Medical Staff appointment and/or Privileges or last reappointment/regrant of Privileges, as necessary to bring the Practitioner’s file current.
- (b) At least one (1) professional reference from peers familiar with the Practitioner’s practice in the Medical Staff Department and clinical service area where Privileges are sought
- (c) Data regarding the Practitioner from Medical Staff peer review activities and professional practice evaluation (*e.g.*, FPPE/OPPE). If volume is low, this may require review of supplemental data such as procedure logs and/or additional peer references/quality information from other healthcare facilities where the Practitioner is actively practicing to verify the Practitioner’s current clinical competency.
- (d) When regranting Privileges, review of the Practitioner’s clinical performance within the Hospital.
- (e) Relevant Practitioner specific data as compared to aggregate data, when available.
- (f) Morbidity and mortality data, when available.
- (g) Fulfillment/satisfaction of Medical Staff responsibilities.
- (h) Attestation of continuing medical and/or professional training and education completed outside the Hospital during the current appointment/Privilege period with supporting documentation as requested.
- (i) Any requests for additional or reduced Privileges or for a change in Medical Staff category including the basis therefore.
- (j) Such other information as the MEC and Board may deem necessary.

#### 1.10-2 Processing Applications for Reappointment/Regrant of Privileges

- (a) Applications for Medical Staff reappointment and/or regrant of Privileges shall be processed in accordance with the procedure set forth in Sections 1.7 and 1.8 for initial applications for appointment and/or Privileges. For purposes of reappointment/regrant of Privileges, the references to “applicant” and “appointment” and “Privileges” in Sections 1.7 and 1.8 shall be read as “Practitioner” and “reappointment” and “regrant of Privileges” respectively.
- (b) A Practitioner requesting regrant of Privileges must have provided sufficient care, treatment, and/or services at the Hospital during the prior appointment/Privilege period to enable the Clinical Department Chair, the

Credentials Committee, and the MEC to assess the Practitioner's current clinical competence for the Privileges requested. Any Practitioner seeking regrant of Privileges who has had minimal activity at the Hospital must submit, as requested, such additional peer references and supplemental information (e.g., professional practice evaluation/quality assessment information, etc.) from the hospital at which the Practitioner primarily practices before the Practitioner's application for regrant of Privileges shall be considered complete and further processed.

1.10-3 Failure to Submit or Process an Application for Reappointment/Regrant of Privileges by the End of an Appointment/Privilege Period

- (a) Under no circumstances shall Medical Staff appointment and/or Privileges extend beyond the expiration date of the Practitioner's current appointment/Privilege period.
- (b) Failure, without good cause, to submit an 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 due process rights provided in the Bylaws. A Practitioner seeking to reapply after a voluntary resignation shall be required to submit an application for initial appointment and/or Privileges; provided, however, that the Practitioner may submit an application for reappointment and/or regrant of Privileges for up to six (6) months after a voluntary resignation.
- (c) If an application for Medical Staff reappointment and/or regrant of Privileges has not been fully processed by the expiration date of the Practitioner's current appointment/Privilege period, the Practitioner's Medical Staff appointment and Privileges shall terminate as of the last day of the Practitioner's current appointment/Privilege period. A Practitioner whose Medical Staff appointment and Privileges are so terminated shall not be entitled to the procedural due process rights set forth in the Medical Staff Bylaws. If the Practitioner qualifies, temporary Privileges to meet an important patient care, treatment, or service need pursuant to Section 2.3-2 of this Manual may be granted.

1.11 Requests for Modification of Appointment Status and/or Privileges

1.11-1 Request. A Practitioner may, either in connection with reappointment and/or a regrant of Privileges, or at any other time during an appointment/Privilege period, request modification of the Practitioner's Medical Staff category (i.e., a transfer from one Medical Staff category to another) and/or Privileges by submitting a written request to Medical Staff Services on the prescribed form.

1.11-2 Procedure. Such request shall be processed in substantially the same manner as provided in Section 1.10 for reappointment/regrant of Privileges. A Practitioner whose request for modification has been denied may not submit a similar request for a period of not less than one (1) year from the date of the prior denial.

1.11-3 Request for Additional Privileges. If additional Privileges are requested, sufficient information shall be provided to establish the Practitioner's eligibility, as specified in the privileging criteria set forth in the applicable Delineation of Privileges, for such Privileges. Requests for new Privileges during a current appointment/Privilege period will require evidence of appropriate education, training, and experience supportive of the request and will be subject to a period of focused professional practice evaluation, if such Privileges are granted.

## 1.12 Timeframe

1.12-1 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 and good faith manner. Unless the application is incomplete, requires additional information, or for other good cause, the following timeframe guidelines will be used as a goal in which to process the application:

### INDIVIDUAL/GROUP

### TIME

CCO Verification

Generally within thirty (30) days of submission of the application. However, if additional information is required from the applicant, the applicant will have ninety (90) days to respond to requests for such information. The time spent awaiting a response from the applicant shall not count towards the CCO verification time.

Clinical Department Chair  
Evaluation

Generally within thirty (30) days after notification that the completed application is available for review.

Credentials Committee  
Evaluation

At the next scheduled meeting after receipt of a recommendation from the Clinical Department Chair subject to Section 1.8-3 (b).

MEC Recommendation

At the next scheduled meeting after receipt of a recommendation from the

Credentials Committee subject to Section 1.8-4.

Board Decision

At the next scheduled meeting after receipt of a recommendation from the MEC subject to Section 1.8-5.

These time periods are only guidelines and are not directives. The timeframe guidelines in this section do not create any rights for a Practitioner to have an application processed within these precise periods. The burden of providing all necessary information and providing such information in a timely manner remains at all times with the Practitioner.

If, for any reason, the procedural due process provisions 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.

### 1.13 **Resignations and Terminations**

1.13-1 **Resignation of Medical Staff Appointment and/or Privileges.** Resignation of Medical Staff appointment and/or Privileges shall be submitted, in writing, to Medical Staff Services. Notification of the resignation shall be forwarded to the Board, through the Hospital President/CEO, the Chief of Staff, and all appropriate Hospital personnel.

1.13-2 **Termination of Medical Staff Appointment and/or Privileges.** In those cases when a Practitioner moves away from the area (without submitting a forwarding address) or otherwise ceases to practice at the Hospital without indicating the Practitioner's written intentions with regard to Medical Staff appointment and/or Privileges, the Practitioner's Medical Staff appointment and/or Privileges shall be terminated after approval by the MEC and the Board. If a forwarding address is known, the Practitioner will be asked about the Practitioner's intentions with regard to Medical Staff appointment and/or Privileges. If the Practitioner does not respond within thirty (30) days, the Practitioner's name will be submitted to the MEC and Board for approval of termination. Consideration may also be given to contacting the applicable state licensing board regarding the Practitioner's actions. The President/CEO will inform the Practitioner of the approved termination by Special Notice.

1.13-3 **Completion of Medical Records.** A Practitioner who resigns Medical Staff appointment and/or Privileges is obligated to complete all medical records for which the Practitioner is responsible prior to the effective date of the resignation. In the event a Practitioner fails to do so, consideration may be given by the Hospital to contacting the applicable state licensing board regarding the Practitioner's actions.

### 1.14 **Reapplication Waiting Periods**

1.14-1 Except as otherwise provided in this Manual, or as otherwise determined by the Board upon recommendation of the Medical Executive Committee in light of exceptional circumstances:

- (a) A Practitioner whose Medical Staff appointment and Privileges are automatically terminated pursuant to Sections 10.6-1, 10.6-3, 10.6-4, 10.6-6, or 10.6-7 of the Medical Staff Bylaws shall not be eligible to reapply for Medical Staff appointment and/or Privileges for a period of at least two (2) years from the effective date of the automatic termination.
- (b) A Practitioner who has received a final Adverse decision regarding Medical Staff appointment/reappointment and/or grant/regrant of Privileges shall not be eligible to reapply for Medical Staff appointment and/or Privileges for a period of at least two (2) years from the latter of the date of the notice of the final Adverse decision or final court decision.
- (c) A Practitioner who has resigned Medical Staff appointment and/or Privileges or who fails to seek Medical Staff reappointment and/or regrant of Privileges while under investigation or to avoid an investigation for conduct or clinical competency concerns shall not be eligible to reapply for Medical Staff appointment and/or Privileges for a period of at least two (2) years from the effective date of the resignation.
- (d) A Practitioner who has withdrawn an initial application for Medical Staff appointment and/or Privileges for conduct or clinical competency concerns shall not be eligible to reapply for Medical Staff appointment and/or Privileges for a period of at least two (2) years from the effective date of the application withdrawal.

1.14-2 Applications submitted after the required two (2) year waiting period will be processed as an initial application, and the Practitioner must submit such additional information as required by the Medical Executive Committee or Board to show that any basis for the earlier automatic termination, Adverse decision, resignation, or withdrawal has been resolved or no longer exists. If such information is not provided, the new application will be considered incomplete and voluntarily withdrawn and will not be further processed.

## ARTICLE II: CLINICAL PRIVILEGES

### 2.1 Exercise of Privileges

2.1-1 Limitation on Privileges. Each Practitioner practicing at the Hospital shall, in connection with such practice, be entitled to exercise only those Privileges that have been determined to be within the individual's scope of demonstrated competency, consistent with Hospital capabilities, and specifically granted to the Practitioner.

2.1-2 Request for Privileges. Each application must contain a request for the specific delineated Privileges desired by the Practitioner, if any. The evaluation of such request shall be based upon the qualifications set forth in the Medical Staff Bylaws, this Manual, and the applicable Delineation of Clinical Privileges in addition to consideration of the Practitioner's competency in the following areas: patient care, medical/clinical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice. The Practitioner shall have the burden of establishing his or her current qualifications for the Privileges requested. A request for Privileges or regrant of Privileges shall be processed in accordance with the applicable procedure set forth in Article I of this Manual with the exception that:

- (a) Temporary privileges will be processed in accordance with the procedure set forth in Section 2.3.
- (b) Disaster privileges will be processed in accordance with the procedure set forth in Section 2.5.
- (c) Telemedicine privileges will be processed in accordance with the procedure set forth in Section 2.6.

2.1-3 Adoption/Amendment of Delineations of Clinical Privileges.

- (a) Privileges must be defined and delineated as clearly as possible, avoiding broad and general terms. Qualifications for obtaining/maintaining a grant/regrant of delineated Clinical Privileges are developed by the applicable Medical Staff Department and may include a core Privilege delineation and/or special request Privileges as defined by education, training, experience, demonstrated current clinical competency, specialty, patient types or diseases, major treatment areas, degree of complexity, and other components as recommended by applicable national associations or specialty accrediting bodies.
- (b) Adoption, or amendment, of Delineation of Clinical Privileges requires: preparation of the Delineation of Privileges (or amendment thereto) by the applicable Medical Staff Department; review of the Delineation of Privileges (or amendment thereto) by the Credentials Committee; recommendation for adoption or amendment of the Delineation of

Privileges by the MEC; and, approval of the Delineation of Privileges (or amendment thereto) by the Board.

#### 2.1-4 Dentists, Oral Surgeons, Podiatrists, and Psychologists

##### (a) Dentists and Oral Surgeons

- (i) Dentists and Oral Surgeons may admit patients to the Hospital if granted Privileges to do so.
- (ii) Privileges exercised by Dentists and Oral Surgeons shall be under the overall supervision of the Clinical Department Chair of Surgery. The Department Chair (or Chief of Staff if the Department Chair is not available) shall decide any disputed issue.
- (iii) An Oral Surgeon, if granted the Privilege to do so, may perform the admitting history and physical for the Oral Surgeon's patients.
- (iv) With the exception of admission of a patient by an Oral Surgeon granted Privileges to perform an H&P, upon admission of a dental patient a Physician Medical Staff Appointee with appropriate Privileges shall be responsible for completing the admission history and physical examination, and caring for any medical problem that may be present at the time of admission or that may arise during hospitalization that is outside the scope of practice of the Dentist (or Oral Surgeon, as applicable). If a medical problem exists, the consulting Physician shall determine the risk and effect of the proposed surgical procedure on the health of the patient. The Dentist (or Oral Surgeon, as applicable) is responsible for obtaining medical consultation in accordance with the above provisions.
- (v) The Dentist or Oral Surgeon, as applicable, is solely responsible for completion of the components of the medical record related to the care of the patient that are within the Dentist's/Oral Surgeon's scope of licensure and granted Privileges. If there is a medical problem, the consulting Physician shall participate in the discharge of the patient and completion of the medical record.

##### (b) Podiatrists

- (i) Podiatrists may admit patients to the Hospital if granted Privileges to do so.
- (ii) Privileges exercised by Podiatrists shall be under the overall supervision of the Clinical Department Chair of Orthopedics. The Department Chair (or Chief of Staff if the Department Chair is not available) shall decide any disputed issue.

- (iii) A Podiatrist, if granted the Privilege to do so, may perform the admitting history and physical for the Podiatrist's patients.
  - (iv) At the time of admission of a podiatric patient, a Physician Medical Staff Appointee with appropriate Privileges shall be responsible for completing the admission history and physical examination (provided the Podiatrist is not otherwise granted Privileges to do so), and caring for any medical problem that may be present at the time of admission or that may arise during hospitalization that is outside of the scope of practice of the Podiatrist. If a medical problem exists, the consulting Physician shall determine the risk and effect of the proposed surgical procedure on the health of the patient. The Podiatrist is responsible for obtaining medical consultation in accordance with the above provisions.
  - (v) The Podiatrist is solely responsible for completion of the components of the medical record related to care of the patient that are within the Podiatrist's scope of licensure and granted Privileges. If there is a medical problem, the consulting Physician shall participate in the discharge of the patient and completion of the medical record.
- (c) Psychologists. Psychologists may neither admit nor co-admit patients to the Hospital but may treat patients who have been admitted by a Practitioner with admitting Privileges provided the Psychologist maintains a consultative relationship with the attending Practitioner during the course of treatment of the patient. Privileges exercised by Psychologists shall be under the overall supervision of the Clinical Department Chair of Internal Medicine. The Psychologist is solely responsible for completion of the components of the medical record related to care of the patient that are within the Psychologist's scope of licensure and granted Privileges.

2.2 **Recognition of New Service or Procedure.** A new Delineation of Privileges must be approved by the Board for all new services and procedures except for those that are clinically or procedurally similar to an existing modality in which case amendment of an existing Delineation of Privileges may be appropriate.

2.2-1 The Board shall determine the Hospital's scope of patient care services based upon recommendations from the MEC. Overall considerations for establishing new services and procedures at the Hospital include, but are not limited to:

- (a) The Hospital's available resources and staff.
- (b) The Hospital's ability to appropriately monitor and review the competence of the performing Practitioner(s).

- (c) The availability of other qualified Practitioners with Privileges at the Hospital to provide coverage for the procedure/service when needed.
- (d) The quality and availability of applicable training programs.
- (e) Whether such service or procedure currently, or in the future, would be more appropriately provided through a contractual arrangement with the Hospital.
- (f) Whether there is a community need for the service or procedure.

2.2-2 Requests for Privileges for a new service or procedure at the Hospital that has not yet been recognized by the Board shall be processed as follows:

- (a) The Practitioner must submit a written request for the new service or procedure to Medical Staff Services. The request should include a description of the new service or procedure for which Privileges are being requested, the reason why the Practitioner believes the Hospital should recognize such Privileges, and any additional information that the Practitioner believes may be of assistance to the MEC in evaluating the request for the new service or procedure.
- (b) Medical Staff Services will notify the applicable Clinical Department Chair of such request.
  - (i) If the Department Chair determines that the new service or procedure should not be recognized at the Hospital, the Department Chair will provide the basis for such recommendation to the Credentials Committee.
  - (ii) If the Department Chair determines that the service or procedure can or should be included in an existing Delineation of Privileges, the Department Chair will provide the basis for such recommendation to the Credentials Committee.
  - (iii) If the Department Chair recommends that the new service or procedure be recognized at the Hospital and determines that a new Delineation of Privileges is required, the applicable Department shall develop and submit to the Credentials Committee a new Delineation of Privileges based upon:
    - 1) A determination as to what specialties are likely to request the Privileges.
    - 2) The positions of specialty societies, certifying boards, *etc.*
    - 3) The available training programs.

- 4) Recommended standards to be met with respect to the following: education; training; board certification; experience; current competency; focused professional practice evaluation requirements to assess current competency, *etc.*
  - 5) Criteria required by other hospitals with similar resources and staffing.
- (c) Upon receipt of a recommendation from the Department Chair, the Credentials Committee shall review the matter and forward its recommendation to the MEC.
  - (d) Upon receipt of a recommendation from the Credentials Committee, the MEC shall review the matter and forward its recommendation to the Board.
  - (e) Upon receipt of a recommendation from the MEC, the Board will review the matter and make a final decision.
    - (i) If the Board approves the new service/procedure and corresponding new Delineation of Privileges (or amendment of an existing Delineation of Privileges set), the requesting Practitioner(s) may apply for such Privileges consistent with the procedure set forth in Article I of this Manual.
    - (ii) If the Board does not approve the new service/procedure, the requesting Practitioner(s) will be so notified. A decision by the Board not to recognize a new service or procedure does not constitute an appealable event for purposes of the Bylaws.

2.3 **Temporary Privileges.** Temporary Clinical Privileges may be granted only in the circumstances and under the conditions set forth in this section. Special requirements of consultation and reporting may be imposed by the Chief of Staff. In all cases, the Practitioner requesting temporary Privileges must agree in writing to abide by the Medical Staff Bylaws, Manuals/Policies, and applicable policies and procedures of the Hospital. The President/CEO (acting on behalf of the Board) may, upon recommendation of the applicable Clinical Department Chair and the Chief of Staff, grant temporary Privileges on a case by case basis in the following circumstances:

- 2.3-1 **Pending Application.** Temporary Privileges may be granted to an applicant for new Privileges with a complete application that raises no concerns who is awaiting review and approval by the MEC and the Board upon receipt of a written request therefore and:
- (a) Verification of the qualifications set forth in the Medical Staff Bylaws and the information set forth in Section 1.5-1 of this Manual (*e.g.*, licensure,

DEA registration if necessary for the Privileges requested, professional liability insurance, *etc.*)

- (b) Completion of a query and evaluation of the National Practitioner Data Bank information and such other queries as required by Section 1.7-3 of this Manual.
- (c) Verification that the applicant has no current or previously successful challenges to licensure.
- (d) Verification that the applicant has not been subject to the involuntary termination of medical staff appointment at another organization.
- (e) Verification that the applicant has not been subject to the involuntary limitation, reduction, denial or loss of clinical privileges.
- (f) One recent reference from a current or previous department chair at a hospital where the Practitioner currently practices or practiced.
- (g) Recommendation of the Credentials Committee chair.

Temporary Privileges may be granted in this circumstance only when sufficient evidence exists that the granting of such Privileges is prudent and for a period not to exceed the processing of the application (*i.e.*, completion of review and action on the application by the MEC and Board) or one hundred twenty (120) days, whichever is less. Under no circumstances may temporary Clinical Privileges be granted if the application is still pending because the applicant has not responded in a satisfactory manner to a request for clarification of a matter or for additional information.

Applicants for “new Privileges” include a Practitioner applying for Privileges at the Hospital for the first time, a Practitioner with current Privileges who is requesting one or more additional Privileges during the current Privilege period, and a Practitioner who is in the reappointment/regrant process and is requesting one or more additional Privileges.

### 2.3-2 Important Patient Care Need

- (a) Temporary Privileges may be granted to a Practitioner to meet an important patient care need but only after:
  - (i) The applicant submits an application requesting temporary privileges to fulfill an important patient care need.
  - (ii) Verification of the Practitioner’s: current licensure; DEA registration (if necessary for the Privileges requested); Professional Liability Insurance; and current competence relative to the Privileges being requested as evidenced by at least one recent

reference from a current or previous department chair at a hospital where the Practitioner currently practices or practiced.

- (iii) Completion of a query and evaluation of the National Practitioner Data Bank information and such other queries as required by Section 1.7-3 of this Manual.
- (b) Temporary Privileges may be granted in this circumstance for an initial period of up to thirty (30) days and may be renewed for additional periods of up to thirty (30) days as necessary for the care of a particular patient(s)/group of patients. Temporary Privileges for an important patient care need shall be granted no more than three (3) times during a twelve-month period after which the Practitioner must apply for Medical Staff appointment and Privileges at the Hospital through the routine process in order to continue to practice at the Hospital.
- (c) Examples of important patient care needs may include, but are not limited to:
  - (i) The care of a patient who requires specialized skills that no currently privileged Practitioner at the Hospital possesses.
  - (ii) A currently privileged Practitioner will be absent from the Hospital and another Practitioner (who does not currently possess Medical Staff appointment and Privileges at the Hospital) is needed to cover the Practitioner's patients during the absence (*i.e.*, short-term *locum tenens* arrangements).
  - (iii) The patient care volume exceeds the level that can be handled by currently privileged Practitioners at the Hospital and additional Practitioners (*i.e.*, short-term *locum tenens*, *etc.*) are needed to temporarily handle the volume.
  - (iv) Visiting faculty or other Practitioners who have been invited to participate in the care of a specific patient (or who come to the Hospital to perform a select procedure, assist an existing Medical Staff Appointee with Privileges, or to temporarily serve in a clinical role of definitive scope) and who otherwise have no need to obtain Medical Staff appointment and Privileges at the Hospital (*i.e.*, for geographical reasons, *etc.*).

2.4 **Emergency Privileges.** In the case of an emergency, any Practitioner, to the degree permitted by the Practitioner's license, shall be permitted and assisted to do everything possible to save the life of a patient using Hospital resources as necessary including the calling of consultations. When the extraordinary circumstances necessitating this action are no longer present, said Practitioner must relinquish care of the patient to the Practitioner of record or arrange for appropriate post-emergency care. For purposes of this section,

“emergency” is defined as a situation where serious permanent harm is imminent or in which an individual’s life is in immediate danger. Emergency Privileges are not utilized to “cover” a Practitioner who has failed to follow Medical Staff guidelines in applying for Privileges.

## 2.5 **Disaster Privileges**

2.5-1 Disaster Privileges may be granted to licensed volunteer Practitioners (subject to applicable Ohio licensure laws, rules, and regulations) when the Hospital’s emergency operations plan is activated in response to a disaster and the Hospital is unable to meet immediate patient needs. The President/CEO or Chief of Staff may grant such disaster Privileges on a case-by-case basis after verification of a current valid government-issued picture identification (*e.g.*, driver’s license, passport) in addition to at least one (1) of the following:

- (a) primary source verification of licensure.
- (b) a current license to practice.
- (c) a current picture identification card from a health care organization that identifies professional designation.
- (d) 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.
- (e) identification indicating the individual has been granted authority to render patient care, treatment, or services in disaster circumstances by a government entity.
- (f) confirmation of the identity and qualifications of the volunteer Practitioner by a Hospital employee or Practitioner with Privileges at the Hospital.

2.5-2 When possible, primary source verification (a documented phone call is acceptable) of the volunteer Practitioner’s identity/qualifications from the hospital at which the volunteer Practitioner currently exercises Privileges should be obtained.

2.5-3 If not initially verified pursuant to Section 2.5-1, 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 Hospital, 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), verification shall be performed as soon as possible. In such event, the Hospital shall document all of the following: the reasons primary source verification could not be performed within seventy-two (72) hours after the volunteer Practitioner's arrival at the Hospital; evidence of the

volunteer Practitioner's demonstrated ability to continue to provide adequate care, treatment and services; and, evidence of the Hospital's attempt to perform primary source verification as soon as possible.

- 2.5-4 At such time as circumstances allow, the remainder of the verification process shall be done in the same manner as set forth with respect to temporary Privileges to meet an important patient care need.
- 2.5-5 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.
- 2.5-6 It is anticipated that these disaster Privileges may be granted to state-wide and out-of-state volunteer Practitioners as necessary in accordance with, and subject to, applicable Ohio licensure laws, rules, and regulations.
- 2.5-7 All Practitioners who receive disaster Privileges must at all times while at the Hospital wear an identification badge, with photograph, from the facility at which they otherwise hold privileges. If the Practitioner does not have such identification, the Practitioner will be issued a badge identifying and designating the Practitioner as an emergency provider.
- 2.5-8 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 applicable Clinical Department Chair).
- 2.5-9 Disaster Privileges shall cease upon alleviation of the circumstances of disaster as determined by the Hospital President/CEO.

## 2.6 **Telemedicine Privileges**

- 2.6-1 Telemedicine is defined as the provision of clinical services to patients by Practitioners from a distance via electronic communication. The distant-site telemedicine Practitioner provides clinical services to Hospital patients either simultaneously (*e.g.*, teleICU, *etc.*) or non-simultaneously (*e.g.*, teleradiology).
- 2.6-2 Distant-site Practitioners shall be credentialed and privileged to provide telemedicine services by the Hospital in accordance with the Medical Staff Bylaws and this Manual, accreditation standards, and applicable laws, rules, and regulations. If the Hospital has a pressing clinical need and a distant-site Practitioner can supply that service through a telemedicine link, the Practitioner may be evaluated for temporary Privileges as set forth in this Manual.
- 2.6-3 Telemedicine Privileges may be granted by the Hospital to eligible distant-site Practitioners who will not otherwise practice on-site at the Hospital.
- 2.6-4 Clinical privileging decisions encompass consideration of the clinical services that can be appropriately delivered through telemedicine (consistent with commonly

accepted quality standards) and the appropriate use of telemedicine equipment by the distant-site telemedicine Practitioner.

2.6-5 The Hospital must credential and privilege distant-site Practitioners (who will not otherwise practice on-site at the Hospital) providing telemedicine services to the Hospital through one of the following mechanisms:

(a) The Medical Staff shall independently review the credentials and make privileging recommendations to the Board for each distant-site telemedicine Practitioner using the routine credentialing and privileging process set forth in Article I of this Manual; OR,

(b) The Hospital Board may choose to have the Hospital Medical Staff rely upon the credentialing and privileging decisions made by the distant-site hospital or telemedicine entity when making recommendations (pursuant to the process set forth in Article I of this Manual) regarding telemedicine Privileges for each distant-site Practitioner at the Hospital provided that the Board ensures through a written agreement with the distant-site hospital or telemedicine entity that all of the following provisions are met:

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

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

2) When the distant-site is a “distant-site telemedicine entity” the written agreement shall specify that the distant-site telemedicine entity is a contractor of services to the Hospital and, as such, furnishes the contracted services in a manner that permits the Hospital to comply with all applicable conditions of participation for the contracted services including, but not limited to, 42 C.F.R. 482.12 (a)(1)-(a)(7) with regard to the distant-site telemedicine entity Practitioners providing telemedicine services. The written

agreement shall further specify that the distant-site telemedicine entity's medical staff credentialing and privileging process and standards will, at minimum, meet the standards at 42 C.F.R. 482.12 (a)(1)-(a)(7) and at 42 C.F.R. 482.22 (a)(1)-(a)(2), as those provisions may be amended from time to time.

- (ii) Each distant-site Practitioner is privileged at the distant-site for those services to be provided to Hospital patients via telemedicine, and the Hospital is provided with a current list of the distant-site Practitioners and a copy of the current privileges which each such Practitioner can exercise at the distant-site.
- (iii) Each distant-site Practitioner must have a current, valid Ohio license (*e.g.*, in the state in which the patients and Hospital are located) to practice medicine (or other applicable profession) in addition to an appropriate license in the State in which the Practitioner is located (if other than Ohio), as applicable.
- (iv) The Hospital maintains documentation of its internal review of the performance of each distant-site Practitioner who holds Privileges to provide telemedicine services to patients at the Hospital and sends the distant-site such performance information for use in the distant-site's periodic appraisal of the distant-site Practitioner. At a minimum, this information must include:
  - 1) All adverse events that result from the telemedicine services provide by the distant-site Practitioner to Hospital patients, and
  - 2) All complaints the Hospital receives about the distant-site Practitioner.

## 2.7 Termination of Temporary, Disaster, or Telemedicine Privileges

2.7-1 Termination. The President/CEO, CMO, or the Chief of Staff may, at any time, terminate any or all of a Practitioner's temporary, disaster, or telemedicine Privileges. Where the life or well-being of a patient is determined to be endangered, the Practitioner's Privileges may be terminated by any person entitled to impose a summary suspension pursuant to the Bylaws.

2.7-2 Procedural Due Process Rights. A Practitioner who has been granted temporary, disaster, or telemedicine Privileges is not an Appointee to the Medical Staff and is not entitled to the procedural due process rights afforded to Appointees. A Practitioner shall not be entitled to the procedural due process rights set forth herein because the Practitioner's request for temporary, disaster, or telemedicine Privileges are refused, in whole or in part, or because all or any portion of such

Privileges are terminated, not renewed, restricted, suspended, or otherwise limited, modified, or monitored in any way.

2.7-3 Patient Care. In the event a Practitioner’s temporary, disaster, or telemedicine Privileges are terminated, the Practitioner’s patients then in the Hospital shall be assigned to another Practitioner by the Chief of Staff. The wishes of the patient will be considered, where feasible, in choosing a substitute Practitioner.

2.8 Return/Re-Entry to Clinical Practice

2.8-1 To provide a pathway for Practitioners who wish to return to active clinical practice in their respective trained discipline after a period of absence from clinical activity. To ensure that Practitioners have retained current clinical competence and to enhance, broaden, and/or develop clinical/medical skills, the Return to Practice Program delineates guidelines/criteria to be monitored through established focused professional practice evaluation processes. Practitioners granted Medical Staff appointment and Privileges under this program will meet existing standards and requirements delineated within the Medical Staff Bylaws, Manuals/Policies, and specialty-specific Delineation of Privileges criteria.

2.8-2 Clinical Department Chairs (as authorized agents of the appropriate peer review committee) will be responsible for developing the plan with the Practitioner to address specific needs. Program guidelines are outlined on the “Return to Practice” grid below, based on the following components:

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

<b>Years out of Practice</b>	<b>Education</b>	<b>Supervision/ Proctoring</b>	<b>Period of Evaluation</b>	<b>Supervision</b>	<b>Competency Evaluation</b>
<1	Ongoing relevant continuing education	Established focused professional practice evaluation for initial applicants/procedure	3 months	Clinical Department Chair	Retrospective review based on established criteria
1 to 2	Equivalent of 50% of specialty specific continuing education as required for State of Ohio licensure within the	Established focused professional practice evaluation for initial applicants/procedure	6 months	Clinical Department Chair	Retrospective review based on established criteria

	previous 12 months or equivalent education				
>2	Equivalent of 100% of specialty specific continuing education as required for State licensure within the previous 24 months or equivalent education such as board review courses	Established focused professional practice evaluation for applicants/procedure  Concurrent proctoring by active Medical Staff Appointee with appropriate Privileges willing to facilitate RTP in accordance with focused professional practice evaluation plan	6 months	Clinical Department Chair and Medical Staff Proctor	Focused professional practice evaluation forms completed by proctor  Retrospective review based on established criteria

## 2.9 **Professional Practice Evaluation**

### 2.9-1 Focused Professional Practice Evaluation

- (a) The Medical Staff’s focused professional practice evaluation (“FPPE”) process is set forth in detail in the Medical Staff Peer Review/Professional Practice Evaluation Policy. FPPE shall be implemented for all: (a) Practitioners requesting initial Privileges; (b) existing Practitioners requesting new Privileges during the course of a Privilege period; and, (c) in response to concerns regarding a Practitioner’s ability to provide safe, high quality patient care. The FPPE period shall be used to determine each Practitioner’s current clinical competence and ability to perform the requested Privileges.

### 2.9-2 Ongoing Professional Practice Evaluation

- (a) Upon conclusion of the FPPE period, ongoing professional practice evaluation (“OPPE”) shall be conducted on all Practitioners with Privileges at the Hospital. The Medical Staff’s OPPE process is set forth, in detail, in the Medical Staff Peer Review/Professional Practice Evaluation Policy and requires the Hospital/Medical Staff to gather, maintain, and review data on the performance of all Practitioners with Privileges on an ongoing basis

## ARTICLE III: LEAVE OF ABSENCE

### 3.1 **Grant of Leave of Absence**

- 3.1-1 In the event that a Medical Staff Appointee will be absent from practice and unable to exercise Privileges for a period in excess of ninety (90) days, the Appointee shall notify Medical Staff Services in the manner set forth in Section 3.1-2.
- 3.1-2 An Appointee may, for good cause (which may include, but is not limited to, illness, injury, military duty, or educational sabbatical), take a voluntary leave of absence by giving written notice to Medical Staff Services who shall communicate receipt of such notification to others as appropriate. The notice must state the reason for the leave and the approximate period of time of the leave which may not exceed one (1) year except for military service. The MEC may decline a leave of absence in the event that such leave does not satisfy the criteria set forth in Section 3.1-1 and this Section 3.1-2. The decision of the MEC is final without right to appeal.
- 3.1-3 In the event that a leave of absence extends beyond the final date of the Appointee's current appointment and Privilege period, the Appointee may apply for and be granted reappointment to a Medical Staff category without Privileges for the remainder of the leave of absence in which event the Appointee's Clinical Privileges will terminate upon the last day of the Appointee's current appointment/Privilege period. The Appointee may thereafter request a transfer of Medical Staff category and may reapply for such Privileges at such time as the Appointee requests reinstatement from the leave of absence.
- 3.1-4 During a leave of absence, the Appointee is not entitled to exercise Privileges at the Hospital and has no appointment Prerogatives and responsibilities, with the exception that the Appointee must continue to pay Medical Staff dues, if applicable, unless otherwise waived by the MEC.
- 3.1-5 Prior to a leave of absence, the Appointee shall have made arrangements for the care of the Appointee's patients during the leave and shall have completed all medical records for which the Appointee is responsible, except in emergency circumstances.

### 3.2 **Termination of Leave of Absence and Reinstatement/Regrant**

- 3.2-1 In order to qualify for reinstatement of Medical Staff appointment and, as applicable, reinstatement or regrant of Privileges following a leave of absence, the Appointee must maintain Professional Liability Insurance coverage during the leave or purchase tail coverage for all periods during which the Appointee held Privileges at the Hospital. The Appointee shall provide information to demonstrate satisfaction of continuing Professional Liability Insurance coverage or tail coverage as required by this provision upon request for reinstatement of Medical Staff appointment and, as applicable, reinstatement or regrant of Privileges.

- 3.2-2 The Appointee must submit to Medical Staff Services, at least thirty (30) days prior to termination of the leave of absence, a written request for reinstatement of Medical Staff appointment and, as applicable, reinstatement or regrant of Privileges as well as such additional information as is necessary to reflect that the Appointee is qualified for reinstatement/regrant. Such information may include, but is 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) A written summary of relevant clinical activities engaged in during the leave of absence.
- 3.2-3 Reinstatement or regrant of Privileges following a leave of absence may be subject to a focused professional practice evaluation period to assess the Practitioner's current clinical competency.
- 3.2-4 Once the Appointee's request for reinstatement/regrant is deemed complete the procedure set forth in Section 1.10 of this Manual shall be followed.
- 3.2-5 If an Appointee fails to request reinstatement/regrant upon the termination of a leave of absence, the MEC shall make a recommendation to the Board as to how the failure to request reinstatement/regrant should be construed. If the failure is deemed by the Board to be a voluntary resignation, it shall not give rise to the procedural due process rights set forth in the Medical Staff Bylaws. A request for Medical Staff appointment and/or Privileges subsequently received from such Appointee shall be treated and processed as an application for initial appointment and/or Privileges.

**ARTICLE IV: PRACTITIONERS PROVIDING CONTRACTUAL SERVICES;  
INTERNAL CONFLICTS OF INTEREST**

**4.1 Practitioners Providing Contractual Services**

**4.1-1 Qualifications**

- (a) A Practitioner who is or will be providing specified professional services pursuant to a contract with the Hospital is subject to the same qualifications, credentialing, appointment, and privileging processes, and requirements/obligations as any other Practitioner.

**4.1-2 Effect of Termination of Appointment/Privileges**

- (a) A Practitioner's right to provide care, treatment, and/or services at the Hospital is automatically terminated when the Practitioner's Privileges terminate.
- (b) How such actions affect a contract entered into by the Hospital shall be controlled by the contract, but no Practitioner may engage in providing clinical care, treatment, or services to patients at the Hospital without appropriate Clinical Privileges.
- (c) The effect of an Adverse change in a Practitioner's Medical Staff appointment and/or Clinical Privileges on continuation of a contract is governed by the terms of the contract.

**4.1-3 Effect of Contract Expiration or Termination**

- (a) The effect of an exclusive or semi-exclusive contract expiration or termination on a Practitioner's Medical Staff appointment and/or Privileges at the Hospital is addressed in Section 3.9 of the Medical Staff Bylaws.
- (b) The expiration or termination of a non-exclusive contract will not affect a Practitioner's Medical Staff appointment and/or Privileges at the Hospital unless otherwise addressed by the terms of the contract (*e.g.*, resignation, *etc.*).

**4.1-4 Exclusivity Policy**

- (a) If the Hospital adopts a policy involving a closed Department or an exclusive arrangement for a particular service(s), any Practitioner who holds Privileges to provide such service(s), but who is not a party to the exclusive contract/arrangement (or otherwise employed by or contracted with the exclusive contracting entity), may not provide such service(s) as of the effective date of the closure of the Department or start of the exclusive arrangement, irrespective of any remaining time on the Practitioner's appointment, reappointment, and/or Privilege term.

## 4.2 **Internal Conflicts**

- 4.2-1 When performing a function outlined in this Manual, if a Practitioner has or reasonably could be perceived as having a conflict of interest or bias in any matter that comes before the Medical Staff, a Department, or Medical Staff committee, the Practitioner shall declare the conflict to the individual in charge of the meeting.
- 4.2-2 The Practitioner may be asked, and may answer, any questions concerning the matter. The committee (or, in the absence of a committee, the individual in charge of the meeting) is responsible for determining whether a conflict exists and, if so, whether the conflict rises to the level of precluding the Practitioner from participating in the pending matter.
- 4.2-3 The existence of a potential conflict of interest or bias on the part of any Practitioner may be called to the attention of the Chief of Staff, the Department Chair, or applicable committee chair by any other Practitioner or APP with knowledge of it.
- 4.2-4 For purposes of this Section 4.2, the fact that Practitioners are competitors, partners, or employed by the same group does not, in and of itself, automatically disqualify such Practitioner from participating in the review of applications or other Medical Staff matters with respect to their colleagues. The evaluation of whether a conflict of interest exists shall be interpreted reasonably by the persons involved taking into consideration common sense and objective principles of fairness.
- 4.2-5 A Department Chair shall have the duty to delegate review of applications for Medical Staff appointment/reappointment and/or Privileges/regrant of Privileges to another member of the Department if the Department Chair has a conflict of interest with the Practitioner under review that could be reasonably perceived to create bias.

## ARTICLE V: UNIFIED MEDICAL STAFF OPT OUT PROCEDURE

### 5.1 **Name**

The name of the Unified Medical Staff of Kettering Medical Center, Sycamore Medical Center, and Troy Hospital is the Kettering Medical Center System (KMCS) Medical Staff.

### 5.2 **Unified Medical Staff Definitions**

5.2-1 For purposes of this Article, the following additional definitions shall apply:

- (a) ***Electing Hospital or Medical Staff:*** A hospital or a hospital's medical staff that has the ability to elect or has elected, consistent with Board action, to become part of a Unified Medical Staff.
- (b) ***Unified Medical Staff:*** A single medical staff consisting of the medical staffs of two (2) or more Electing Hospitals that is established consistent with the Centers for Medicare & Medicaid Services hospital conditions of participation and consistent with applicable State law.
- (c) ***Eligible Voting Member:*** An Eligible Voting Member is a Practitioner who:
  - (i) Prior to the establishment of a Unified Medical Staff, had an appointment to an Eligible Hospital that included the right to vote on Medical Staff Bylaws.
  - (ii) During the existence of a Unified Medical Staff, has an appointment to the Unified Medical Staff that (a) grants him/her the right to vote on Medical Staff Bylaws; and (b) has Clinical Privileges at one (1) or more Electing Hospital(s) and is physically present at the Electing Hospital(s) when exercising such Clinical Privileges (*e.g.*, Practitioners who only have telemedicine privileges will not have the right to vote).
  - (iii) For purposes of opting out of a Unified Medical Staff, a Practitioner will only be deemed an Eligible Voting Member if the Practitioner has Clinical Privileges at the Electing Hospital that is deciding whether to opt out.

### 5.3 **Procedure to Opt Out of Unified Medical Staff**

5.3-1 The Eligible Voting Members of an Electing Hospital may vote to opt out of the Unified Medical Staff under the following conditions:

- (a) A petition requesting that an opt out vote be called at the annual Medical Staff meeting must be signed by not less than twenty-five percent (25%) of the Eligible Voting Members of the Electing Hospital (not the entire Unified Medical Staff). Such petition must be submitted to the Unified Medical

Staff President not less than 30 days prior to the date of the annual Medical Staff meeting in order for the Unified Medical Staff President to notify the Eligible Voting Members of the Electing Hospital that a vote will be taken by the Electing Hospital (not the entire Unified Medical Staff) to opt out of the Unified Medical Staff at the annual Medical Staff meeting.

- (b) Action to opt out of a Unified Medical Staff requires the affirmative vote of a majority of the Eligible Voting Members of the Electing Hospital, in Good Standing, that are present at the annual Medical Staff meeting provided that the petition set forth in subsection (a) is timely received by the Unified Medical Staff President; and, further provided that the Eligible Voting Members of the Electing Hospital are notified not less than 21 days in advance of the annual Medical Staff meeting that such matter will come to a vote at the meeting. Absentee ballots (submitted to Medical Staff Services prior to the annual meeting) are permitted.

#### 5.4 **Notice of Right to Opt Out of Unified Medical Staff**

- 5.4-1 Each Practitioner will be advised of an Electing Hospital's right to opt out of the Unified Medical Staff annually and at the time of appointment/reappointment and/or grant/regrant of Privileges.

#### 5.5 **Consideration of KMCS Hospital Needs**

- 5.5-1 The KMCS Medical Staff shall consider the unique needs, circumstances, patient population, and services provided at each of the KMCS hospitals in establishing Medical Staff governing documents including the Medical Staff Bylaws, Manuals/Policies, Rules & Regulations, and Delineations of Privileges.
- 5.5-2 Representatives of each KMCS hospital serve on the various Medical Staff committees (*e.g.*, the MEC, Credentials Committee, CQRC, *etc.*) as detailed in the KMCS Medical Staff Organization Manual and provide input with respect to the unique needs, circumstances, patient population, and services provided at each of the KMCS hospitals. Documentation of the outcome of a Medical Staff committee's review of concerns and needs raised is set forth in meeting minutes.
- 5.5-3 Any Practitioner with Medical Staff appointment and/or Privileges at a KMCS hospital(s), may communicate a concern or need regarding a KMCS hospital(s), to any member of the appropriate Medical Staff committee. Alternatively, such Practitioner may communicate a concern or need regarding a KMCS hospital(s) to a Medical Staff officer or to the Practitioner's Department Chair who will refer the matter to the appropriate Medical Staff committee for due consideration or otherwise address the concern in accordance with the Medical Staff governing documents.
- 5.5-4 Each Practitioner who is an Appointee of the KMCS Medical Staff and/or who is granted Privileges to practice at a KMCS hospital(s) is provided access to the

current Medical Staff governing documents (and amendments thereto) which serves to inform each such Practitioner of the process by which local concerns and needs may be raised.

**ADOPTION & APPROVAL**

Adopted by the Medical Executive Committee on November 16, 2021

Adopted by the Board on February 3, 2022