CREDENTIALS POLICY MANUAL

Medical Staff
Indu and Raj Soin Medical Center
Beavercreek, Ohio

Effective: 8/05/2010
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TABLE OF CONTENTS

ARTICLE I: INTRODUCTION AND POLICY

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.

1.2 Application Policy.

As a general policy, this Hospital permits application to the Medical Staff from qualified Practitioners as described in Articles II and III of 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 APPs are described in Article VI of this Manual; no other provisions of this Manual, except those in Article I and Article VI, applies to APPs unless expressly stated. The KHN Centralized Credentialing Office (CCO), as agent of the Credentials Committee of participating hospitals within the Kettering Health Network, conducts credentialing for Soin Medical Center as referenced in the Bylaws, including the collection of required information, data and processing fee; and seeking to verify and develop evidence related to the personal and professional background of practitioners seeking initial and renewed Medical Staff appointment and/or Privileges.

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 (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.

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 II: PROCEDURES FOR APPOINTMENT, REAPPOINTMENT & PRIVILEGING

2.1 **Application Process.**

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

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

(b) Licensure History. Documentation of satisfaction of the licensure qualifications set forth in the Bylaws, including 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 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 (if volume is low, this may require review of procedure logs and/or competency reviews from other institutions to verify competency), (b) information regarding reviews under the Hospital's peer review activities, (c) information regarding reviews by the Hospital's Credentials Committee, Department Chair, and/or the MEC.

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

(f) Continuing Education. A listing or provision of documentation of continuing education as delineated by the privilege profile or at a minimum of ten (10) hours within the respective specialty. 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:

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

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

(c) Specialty or sub-specialty board certification.

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

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

(f) Participation in any Federal Healthcare Program.

(g) Faculty appointment at any professional school.

(h) Professional Liability Insurance.

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

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

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

(h) Professional Liability Insurance and History. Documentation verifying Professional Liability Insurance coverage meeting the qualifications set forth in the Bylaws and any relevant Hospital policies, including the

name(s) of present insurance carrier(s), proof of continuous Professional Liability Insurance coverage (*e.g.* tail) and detailed information regarding the Applicant's malpractice/negligence claims' history and experience during the past five (5) years from the insurance carrier.

(i) Ability to Carry Out Privileges Requested. Statement of the Applicant's ability to fully and competently carry out the Privileges requested, with or without reasonable accommodation, with documentation confirming this statement. Each Applicant is expected to meet the criteria related to the privileges they are requesting on the privilege form. For initial applications, the confirmation must be from 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.

(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, and authorization for the Hospital to conduct a criminal background check when necessary.

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

(o) 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.

(p) Request for Hospital Affiliation. Denote primary hospital affiliation.

(q) 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.

(r) 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.

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

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

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

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

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

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

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

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

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

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

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

(d) Understands and agrees that if Medical Staff appointment and/or requested Privileges are denied based upon the Applicant's competence or conduct, the Applicant may be subject to reporting to the National Practitioner Data Bank and/or state authorities.

(e) Agrees to notify the Chief of Staff and/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 it Bylaws, Rules and Regulations, and to the degree that any

incongruence is perceived, the Bylaws, Rules and Regulations are shall govern.

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

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

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

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

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

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

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

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

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

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

2.3 **Processing the Application.**

2.3-1 Submission of Application. The application shall be submitted to the CCO, which shall review the application for completeness. The CCO shall be responsible for collecting all applicable materials, for verifying all qualification information received, and for promptly notifying the Applicant of any problems with obtaining required information. Upon notification of such problems, the Applicant must obtain and furnish the required information. If the Applicant fails to furnish the requested information within 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.

2.3-2 Primary Source Verification/Data Repository Queries. The CCO shall perform primary source verification. The credentials of all Applicants shall be checked through the National Practitioner Data Bank and other data repositories as necessary prior to granting membership and/or Privileges. Each query to the NPDB is facility specific. The CCO shall also check the OIG Cumulative Sanction report, the General Services Administration List of Parties Excluded from Federal Procurement and Non-Procurement Programs and any other appropriate sources to determine whether the Applicant has been convicted of a healthcare related offense, or debarred, excluded or otherwise made ineligible for participation in a federal healthcare program.

2.3-3 Complete Application. Upon completion of the collection and verification process, the CCO shall transmit the application and all supporting documents to the medical staff services department. The medical staff services department will then be responsible for performing a comprehensive review, competency evaluation for the privileges requested and query the NPDB. The application is considered complete only when deemed so by the medical staff services personnel.

2.3-4 Incomplete Application. An application that is incomplete, deficient, or for which the CCO is unable to develop the evidence initially required to support the qualifications and other informational elements contained therein shall not be processed. The CCO shall notify the Applicant of the deficiencies. The Applicant's failure to respond or to furnish the information requested in connection with an application within thirty (30) 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. At any time during the review process, the application may be deemed incomplete by the Department Chair, Chair – Credentials Committee, Chair – Medical Executive Committee or the Board.

2.4 **Appointment and Privileging Process.**

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

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

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

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

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

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

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

(c) Adverse MEC Recommendation. When the recommendation of the MEC is deemed Adverse to the Applicant, the corrective action provisions of the Bylaws, if applicable, shall apply. The President/CEO shall notify the Applicant of the recommendation, by Special Notice, and the Applicant's right, if any, to the procedural rights provided for in the Bylaws. No such Adverse recommendation shall be required to be forwarded to the Board until after the Applicant has exercised, or has been deemed to have waived, his/her right, if any, to a hearing as provided for in the Bylaws.

2.4-5 Action by the Board of Directors.

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

(b) Without Benefit of MEC Recommendation. If the Board does not receive a MEC recommendation within thirty (30) days after the MEC's receipt of the completed application (or an additional thirty (30) days thereafter if the MEC defers the application as permitted in Section 2.4-4(a) above), the Board may, after notifying the MEC of the Board's intent and allowing a reasonable period of time for response by the MEC, take action on the Board's own initiative using the same type of criteria considered by the MEC. If the Board's action is favorable, it shall become effective as the final decision of the Board. If such action is Adverse, the President/CEO shall promptly notify the Applicant of such Adverse decision, by Special Notice, and hold its decision in abeyance until the Applicant has exercised, or has been deemed to have waived, his or her rights, if any, as

referenced in the Bylaws. The fact that the Adverse decision is held in abeyance shall not be deemed to confer Privileges when none existed before.

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

2.4-6 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 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.

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

2.5 **Application for Appointment Only**.

Due to the limited nature of an appointment to the Associate Medical Staff - Membership Only Professional, and 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 the Associate Medical Staff - Membership Only Professional, and without Privileges, may be acted upon by the Board upon recommendation of the MEC chair. Denial of an application for appointment without Privileges shall not trigger procedural due process rights nor shall it create a reportable event for purposes of federal or state law.

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

2.6-1 Criteria for Review. A Practitioner shall be notified no later than 180 days prior to the date of expiration of his/her appointment and/or Privileges. No later than one hundred twenty (120) days before the expiration date, the Practitioner must furnish to the CCO the required documentation. Each assessment concerning the biennial reappointment of a Medical Staff Appointee and/or the regranting of Privileges shall be based upon:

(a) Updates to the information provided in the Practitioner's application, from the time of the Practitioner's initial appointment/privileging or last

reappointment/privileging, that are necessary to bring the Practitioner's file current.

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

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

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

(e) Morbidity and mortality data, when available.

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

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

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

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

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

2.6-2 Review and Recommendation. The CCO shall verify the information provided on the application for reappointment and/or re-grant of Privileges, query the same data banks and programs as with an initial application for appointment and/or Privileges, and notify the Practitioner of any deficiencies or verification problems. The Practitioner has the burden of producing adequate information and resolving any doubts about the data. After the application for reappointment and/or re-grant of Privileges has been declared complete by the CCO, the same process as set forth above with respect to initial applications for appointment and/or Privileges shall be followed.

2.6-3 Failure to Submit an Application for Reappointment/Privileges. Failure, without good cause, to submit a timely application for reappointment and/or a re-grant 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.

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

2.7-1 Request. A Practitioner may, either in connection with reappointment and/or a regrant of Privileges, or at any other time during an appointment/Privilege period, request modification of his/her Medical Staff category and/or Privileges by submitting a written request to the CCO on the prescribed form. Such request shall be processed in substantially the same manner as provided in Section 1.6 for reappointment/regrant of Privileges. A Practitioner whose request for modification has been denied may not submit a similar request for a period of not less than one (1) year from the date of the prior denial.

2.8 **Timeframe**.

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

INDIVIDUAL/GROUP	TIME
CCO Verification	Generally within thirty (30) days of submission of the application. However, if additional information is required from the Applicant, the Applicant will have 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 an application is deemed complete, it is then forwarded to the medical staff services department.
Medical Staff Services	Generally should be completed within fourteen (14) days of receipt of the application from the CCO.
Department/ Chair Evaluation	Generally should be completed within fourteen (14) days of receipt of

	completed application from the medical staff services personnel.
Credentials Committee Evaluation	At the next scheduled meeting after receipt of recommendations from the Department Chair, but a recommendation shall be made to the MEC within 60 days of receipt of a completed application.
MEC Evaluation	At the next scheduled meeting after receipt of recommendations from the Credentials Committee. May be deferred beyond such meeting but will generally be completed within thirty (30) days of such meeting.
Board Evaluation	At the next scheduled meeting after receipt of recommendations from the MEC. May be deferred beyond such meeting, but will generally be completed within thirty (30) days of such meeting.

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

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

2.9 **Resignations and Terminations.**

2.9-1 Resignation of Medical Staff Appointment and/or Privileges. Resignation of Medical Staff appointment and/or Privileges, and the reason for such resignation, shall be submitted in writing to the Chief of Staff through the Medical Staff Services Department. Notification of the resignation shall be forwarded to the President/CEO and all appropriate Hospital personnel. The President/CEO will notify the Practitioner of the Board's receipt of his/her resignation.

2.9-2 Termination of Medical Staff Appointment and/or Privileges. In those cases when a Practitioner moves away from the area without submitting a forwarding address or the Practitioner's written intentions with regard to his/her Medical Staff appointment and/or Privileges, the Practitioner's Medical Staff appointment

and/or Privileges shall be terminated after approval by the MEC and the Board. If a forwarding address is known, the Practitioner will be asked his/her intentions with regard to Medical Staff appointment and/or Privileges and, if the Practitioner does not respond within thirty (30) days, the Practitioner's name will be submitted to the MEC and Board for approval of termination. Consideration may also be given to contacting the applicable state licensing board regarding the Practitioner's actions. The President/CEO will inform the Practitioner of the approved termination by Special Notice.

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

2.10 Impact of Final Adverse Decision or Automatic Termination

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

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

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

2.11 Copying of Practitioner/APP Peer Review Files

All Medical Staff and APP peer review files are confidential including, but not limited to, the credentialing files and anything used in the credentialing process, committees, services, and Medical Staff meeting minutes, reports, and discussions and deliberations concerning this information. Such information shall be disclosed only to those persons and only for the purposes listed in the policy concerning Confidentiality of Practitioner/APP Records. Confidentiality must be maintained for subsequent use of the information, and it is the responsibility of the person requesting the information and anyone receiving the information to maintain such confidentiality.

ARTICLE III: CLINICAL PRIVILEGES

3.1 **Exercise of Privileges.**

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

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

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

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

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

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

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

3.2 **Advanced Practice Provider Services**. Requests for APPs to perform specified patient care services are processed in the manner specified in this Credentials Policy Manual. An APP may, subject to any State licensure or certificate requirements or other limitations, exercise independent judgment within their areas of individual professional competence and participate directly in the management of patients under supervision, as appropriate, in accordance with federal and State regulations and Hospital policy.

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

3.3-1 The Board shall determine the Hospital's scope of patient care services based upon recommendation from the MEC. Overall considerations for establishing new services and procedures include, but are not limited to:

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

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

(c) The availability of another qualified Practitioner(s) with Privileges at the Hospital to provide coverage for the procedure/service when needed.

(d) The quality and availability of training programs.

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

(f) Whether there is a community need for the service or procedure.

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

(a) The Practitioner must submit a written request for Privileges to the MEC via the Chief of Staff. The request shall include a description of the Privileges being requested, the reason why the Practitioner believes the Hospital should recognize such Privileges, and any additional information that the Practitioner believes may be of assistance to the MEC in evaluating the request.

(b) The MEC will request that the Credentials Committee establish an *ad hoc* committee to develop criteria and to submit such criteria to the MEC within a required timeframe not to exceed a period of sixty (60) days. For good cause shown, the *ad hoc* committee may be granted additional time in which to complete its task. The criteria should be based upon a determination as to what specialties are likely to request the Privilege; the positions of specialty societies, certifying boards, etc.; the available training programs; and criteria required by other hospitals with similar resources and staffing. If the *ad hoc* committee decides to recommend that the Privilege be recognized at the Hospital, the *ad hoc* committee must provide in its report the recommended standards to be met with respect to the following: education, training, fellowship/board status; experience; whether proctoring/monitoring should be required and, if so, the number of cases/procedures to be included; and, if possible, the number of cases/procedures that should be performed during an appointment/Privilege period to establish current competency. If the *ad hoc* committee determines that the service or procedure can or should be included in an existing Privilege set, the *ad hoc* committee will provide the basis for its determination.

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

3.4 **Types of Temporary Privileges.**

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

1. New applicant with complete application awaiting review and approval by the medical staff and board of directors. Temporary Privileges for new Applicants may be granted upon the application being deemed complete by the Medical Staff Services department and upon favorable recommendation by the Department Chair. The Applicant must have a complete and verified application and awaiting review and approval by the medical staff and board of directors.

   - There is verification of current medical licensure, relevant training or experience, current competence, ability to perform the privileges requested, National Practitioner Data Bank report, and current malpractice insurance; and

   - The applicant has no current or previously successful challenges to licensure or registration and that the applicant has not been subject to involuntary limitation, reduction, denial, or loss of clinical privileges.

   Temporary Privileges may be granted in this circumstance only when sufficient evidence exists that the granting of such Privileges is prudent and for a period not to exceed the pendency of the application or one hundred twenty (120) days, whichever is less.

   (a) Important Patient Care Need. Temporary Privileges may be granted to a Practitioner to meet an important patient care need as documented in a letter of request (*e.g.*, for the immediate care of a specific patient), but only after verification of the Practitioner's current licensure**,** DEA certificate, insurance, and current competence relative to the Privileges being requested as evidenced by at least one recent reference from a previous hospital, chief or department (service) chair. Temporary Privileges may be granted in this circumstance for an initial period of thirty (30) days and may be renewed for additional thirty (30) day periods as necessary for the care of a particular patient. Temporary Privileges granted under this circumstance may be granted no more than three (3) times in any 12 month period.

(b) Provisional**.** Appointment to the active and courtesy Medical Staff categories is provisional for at least one (1) year in accordance with ~~of~~ the Bylaws pending satisfactory clinical performance and fulfillment of other Medical Staff requirements as determined by the Credentials Committee and Medical Executive Committee, and as approved by the Board. During this time the Appointee's performance is monitored by the Department Chair in which such individual is assigned to determine eligibility for appointment to the active or courtesy Staff, as relevant. The nature and scope of the required observation shall be determined on a Service by Service basis, and shall be consistently applied. The duration of provisional status may not exceed two full years, at which time the failure of the Hospital to remove such provisional status and advance the Appointee to active or courtesy Staff categories shall be deemed a termination of his or her Staff appointment. An Appointee whose membership is so terminated shall have the right accorded by the Medical Staff Bylaws to an active or courtesy member (as applicable to the Appointee) who has failed to be reappointed to such category of the Medical Staff. The Appointee who is subject to provisional status is eligible to serve on Service and Staff committees, but are ineligible to hold office on the Medical Staff and have no voting rights on Medical Staff matters.

Before the Credentials Committee makes a recommendation regarding advancement of an Appointee to the active or courtesy Staff, the Credentials Committee shall have as a minimum a written report from the appropriate Service regarding the rendering of proper patient care based on an adequate sampling of records, observation and consultation, an evaluation of both professional and ethical conduct, and cooperation with the Medical Staff and officers and committees of the Medical Staff.

3.4-2 Locum Tenens. A Practitioner seeking Privileges as a *locum tenens* shall submit an application for Privileges and shall have the application processed in accordance with Article II of this Credentials Manual. An approved application for Privileges as a *locum tenens* shall be valid for a period of two (2) years. In the event a Practitioner seeks to act in the capacity of a *locum tenens* more than once during this two (2) year period, the Practitioner will not be required to submit a new application; rather, the Practitioner will only be required to update the information given in the prior approved application and such other information as is deemed necessary by the Chief of Staff similar to the reappointment/Privilege regranting process. In exceptional circumstances, as determined by the President/CEO (acting on behalf of the Board and adhering to State law) and the Chief of Staff in their sole discretion, a *locum tenens* Practitioner may initially qualify for temporary Privileges pursuant to Section 3.3-1. Locum Tenens practitioners will be assigned the medical staff category of Associate – Clinical Privileges Only.

3.4-3 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 any consultation necessary and desirable. When the extraordinary circumstances necessitating this action are no longer present, said Practitioner must relinquish care of the patient to the Practitioner of record or arrange for appropriate post-emergency care. For purposes of this section, "emergency" is defined as a situation where serious permanent harm is imminent or in which an individual's life is in immediate danger and delay in administering treatment could increase the danger or harm. This practice is not utilized to "cover" a practitioner who has failed to follow Medical Staff guidelines in applying for privileges.

3.4-4 Disaster Privileges.

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

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

(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; or

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

(b) The granting of disaster Privileges shall be done in the same manner as temporary Privileges, except that primary source verification of licensure

and competency may be performed after the situation is under control and as circumstances allow.

(a) 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.

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

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

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

(d) All Practitioners who receive disaster Privileges must at all times while at the Hospital wear an identification badge, with photograph, from the facility at which they otherwise hold privileges. If the Practitioner does not have such identification, he/she will be issued a badge identifying him/her and designating the Practitioner as an emergency provider.

(e) The activities of Practitioners who receive disaster Privileges shall be managed by and under the supervision of the Chief of Staff or an appropriate designee (*e.g.*, the Chair of emergency services).

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

3.4-5 Associate Medical Staff-Telemedicine Privileges Only. Telemedicine is defined as the use of medical information exchanged between practitioners at an originating site Hospital, (the site where the patient is physically located at the time of service) and a distant-site (the site where the Practitioner providing the professional service is located) through electronic communications for the

purpose of providing patient care, treatment and services at the originating site, including education services for the Practitioner. For purposes of this manual, telemedicine would not include services that are strictly interpretive in nature, such as reading of images or specimens, or consultations in which a practitioner is simply offering advice to a treating practitioner that typically occur over the phone. Practitioner shall be credentialed and privileged to provide telemedicine by the Hospital in accordance with the Bylaws and this manual, accreditation requirements, and applicable law. If the Hospital has a pressing clinical need and the Practitioner can supply that service through a telemedicine link, the Practitioner may be evaluated for temporary Privileges as set forth in this manual.

Distant-site Practitioners providing telemedicine may be credentialed in accordance with CMS. If telemedicine services are to be furnished through an agreements with a distant-site hospital or telemedicine entity, the Hospital shall be in compliance with the Medicare Conditions of Participation (CoP0 set forth at C.F.R. 482.12(a)(8)&(a)(9), regarding credentialing and privileging based on the Board's approval of its medical staff recommendations in compliance with such CoP. The Hospital Board retains overall responsibility and authority for services furnished under a contract and ensures that the nature and scope of contracted services are defined in writing and meet applicable federal, Ohio State law, accrediting standards, and Hospital Bylaws and policies. The Hospital shall evaluate the contracted care, treatment, and services to determine whether such is being provided according to the contract and level of safety and quality that the Hospital expects.

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

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

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

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

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

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

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

    i. All adverse outcomes and events that result from the telemedicine services provided by the distant-site Practitioner to Hospital patients, including adverse outcomes, and

    ii. Complaints about the distant-site Practitioner from patients, other licensed independent practitioners, or staff related to telemedicine services.

e. The Medical Staff at both the Hospital and distant-sites determine and recommend the clinical services that are to be provided by the Practitioner through telemedicine at their respective sites which can be appropriately delivered through this medium, and are consistent with commonly accepted quality standards. Clinical privileging decisions

encompass consideration of the appropriate use of telemedicine equipment by the telemedicine Practitioner. The Medical Executive Committee will make its recommendation to the Board based on

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

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

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

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

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

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

a. Current State license (if other than Ohio, the state of current practice and Ohio telemedicine certificate)

b. Challenges to any licensure or registration

c. Voluntary and involuntary relinquishment of any license or registration

d. Voluntary and involuntary termination of medical staff membership

e. Voluntary and involuntary limitation, reduction or loss of clinical privileges

f. Any evidence of an unusual pattern or an excessive number of professional liability actions resulting in a final judgment against the applicant

g. Documentation as to the applicant's health status as affects performance of the privileges requested

h. Relevant practitioner-specific data as compared to aggregate data, when available

i. Performance measurement data, including morbidity and mortality date, when available

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

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

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

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

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

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

3.5-1 Termination. The President/CEO or the Chief of Staff may, at any time, terminate any or all of a Practitioner's temporary, *locum tenens*, emergency, disaster or

telemedicine Privileges. Where the life or well-being of a patient is determined to be endangered, the Practitioner's Privileges may be terminated by any person entitled to impose a summary suspension pursuant to the Bylaws.

3.5-2 Due Process Rights. A Practitioner who has been granted temporary, *locum tenens*, emergency, disaster or telemedicine Privileges is not an Appointee to the Medical Staff and is not entitled to the procedural due process rights afforded to Appointees. A Practitioner shall not be entitled to the procedural due process rights set forth herein because the Practitioner's request for temporary, *locum tenens*, emergency, disaster or telemedicine Privileges are refused, in whole or in part, or because all or any portion of such Privileges are terminated, not renewed, restricted, suspended or otherwise limited, modified or monitored in any way.

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

3.6 **Assignment.**

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

Anesthesiology:
- Pain Management

Cardiology

Emergency Medicine

Diagnostic Radiology
- Radiation Oncology

Internal Medicine:
- Allergy & Immunology
- Critical Care
- Dermatology
- Endocrinology
- Gastroenterology
- Hematology/Oncology
- Hospitalist
- Infectious Disease
- Nephrology

Neurology
Nuclear Medicine
Palliative Medicine
Pulmonary Medicine
Physical Medicine and Rehabilitation
Psychiatry
Psychology
Rheumatology

Obstetrics/Gynecology

Orthopedics:
Podiatric Medicine

Pathology:
Therapeutic Apheresis

Primary Care
Family Medicine
Pediatrics
Neonatology

Surgery:
Cardiovascular Surgery
Colon & Rectal Surgery
Dentistry
General Surgery
Head and Neck-Otolaryngology
Neurosurgery
Ophthalmology
Plastic and Reconstructive Surgery
Proctology
Urology

3.7 **Periodic Appraisals**.

Ongoing periodic appraisals shall be used to determine the Practitioner's clinical competence and ability to perform the requested Privileges.

ARTICLE IV: LEAVE OF ABSENCE

4.1 Grant of Leave of Absence

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

4.1-2 During a leave of absence, the Appointee is not entitled to exercise Privileges at the Hospital and has no appointment Prerogatives and responsibilities, with the exception that 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 Appointee shall have made arrangements acceptable to the MEC and Board for the care of his/her patients during the leave, and shall have completed all delinquent medical records, except in emergency circumstances.

4.2 Termination of Leave of Absence and Reinstatement

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

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

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

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

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

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

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

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

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

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

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

ARTICLE V: PRACTITIONER PROVIDING CONTRACTUAL SERVICES

5.1 Exclusivity Policy

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

5.2 Qualifications

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

5.3 Effect of Termination of Appointment/Privileges

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

5.4 Effect of Contract Expiration or Termination

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

ARTICLE VI: ADVANCED PRACTICED PROVIDERS

6.1 General Scope

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

The Allied Health Professionals Committee (APP Committee) is a subcommittee of the Medical Staff Credentials Committee having the responsibility for all credentialing/recredentialing and privileging/reprivileging processes, procedures and matters related to APPs as delegated by the Credentials Committee.

APPs are not eligible for appointment to the Medical Staff. APPs shall not be entitled to any of the rights or prerogatives of appointment to the Medical Staff, including but not limited to the right to vote on Medical Staff matters at any level or to hold any Medical Staff office.

APPs shall not have authority to admit or discharge patients to the Hospital independently, but only under the direction of the attending physician, and 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, codes, and regulations are kept in a central file within Medical Staff Services.

The APP staff is created for the purpose of providing patient care in the Hospital as an adjunct to treatment by Practitioners who are Appointees to the Medical Staff.

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

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

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

All APPs must comply with all limitations and restrictions imposed by their respective licenses, certifications, or legal credentials required by Ohio law, and may only perform services in accordance with provisions relating to their respective professions and contained the applicable provisions of to this Article. Prior to an APP performing services within the Hospital, the APP must complete a Clinical Privilege Profile or scope of practice to be performed at the Hospital, specific to the individual APP. 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 APP 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.

Separate credential and privilege files, which include documentation of continuing education/orientation(s)/reorientation(s), are maintained by Medical Staff Services for each individual functioning as an APP.

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 that particular license or certification, or any other consideration that the Hospital, in its sole discretion, may factor into its decision.

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

6.2 **Categories of Advanced Practice Providers**

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

(a) Certified registered nurse anesthetist (CRNA)

(b) Certified nurse practitioner (CNP)

(c) Clinical nurse specialist (CNS)

(d) Certified nurse midwife (CNM)

(e) Physician assistant (PA)

(f) Genetics Counselor (LCGC)

(g) Registered Dietitian

The Board, in consultation with the Medical Staff, has determined that the following APPs employed by an Appointee, or having an agreement with an Appointee, are recognized and may be permitted to serve in the Hospital as non-privileged APPs at the request of an Appointee and upon review and approval of the APP Committee: Nurse Medical Assistant, Pathology Assistant, Orthopedic Technician, Pump Perfusionist, RNFA, Surgical Assistant, and Surgical Technologists. Such APPs may also be employed by the Hospital or have an agreement with the Hospital.

6.3 Guidelines for Determining the Need for New Categories of APPs

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

6.3-2 Revision of Article VI. Upon recommendation of the MEC and approval by the Board to create a new category of APP, the MEC shall prepare revisions to this Policy Manual and Article VI as necessary to establish the qualifications, requirements, and duties of the APP category, similar to those for other categories contained in this Article VI. These revisions shall be adopted pursuant to Article VII.

6.4 Application, Qualifications, and Privileges

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

6.4-4 Application/Process for Clinical Privileges. Persons seeking Clinical Privileges as an APP shall make application in the same manner as provided in Article II addressing Practitioners; provided, however, that none of the hearing and appeal provisions in Article II apply, but rather, any adverse action against an APP applicant is processed pursuant to Section 6.4-6. The Clinical Privileges of an APP may be granted for any period up to two (2) years. Applications for renewal of Clinical Privileges shall be processed in the same manner as provided for Practitioners as provided in Section 2.6; provided, however, that none of the hearing and appeal provisions in Article II apply, but rather, any adverse action against an APP applicant is processed pursuant to Section 6.4-6 of this Policy Manual.

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

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

Supervision requirements, whether direct or indirect, for APRNs shall be in accordance with this Policy Manual and applicable. Definitions applicable to APRNs are as set forth at ORC 472301.

All orders written by an advance practice nurse or physician assistant (PA) must be signed, timed and dated. PA signatures must include the name of the supervising physician on the order. Co-signatures of orders by the supervising physician are not generally required for APRNs or Physician Assistants by Ohio law or Hospital policy unless specifically restricted by the supervising physician.

6.4-5 Temporary Clinical Privileges. Licensed APPs may apply for and be granted Temporary Privileges in the same manner as for Practitioners as provided in Section 3.4-1.

6.4-6 Corrective Action and Due Process.

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

(b) Either the APP Committee or the Chief of Staff may limit Clinical Privileges, up to and including suspension or termination, at any time when, in the judgment of the APP Committee or the Chief of Staff, the APP has violated this Article VI, the APP has ceased to be qualified pursuant to this Article VI, or such action is in the best interest of patient care or Hospital operations.

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

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

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

(f) An APP’s Clinical Privileges shall be automatically suspended and reinstated for the same reasons as set forth in the Medical Staff Bylaws for automatic suspensions of Clinical Privileges of Practitioners. In addition, (i) termination or expiration of the standard of care arrangement or supervision agreement; or (ii) lapse, suspension, or termination of the supervising or collaborating Practitioner’s Medical Staff appointment and

/or Privileges for any reason shall result in an automatic suspension of the APP's Privileges. If the APP's Privileges are suspended pursuant to (i) or (ii) above and the APP does not submit a new, executed standard care agreement or supervision agreement with an Appointee with Privileges within thirty (30) days of automatic suspension, the APP's Privileges shall automatically terminate. Such an automatic suspension or termination shall not give an APP any due process rights.

6.5 Confidentiality, Immunity & Release

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

6.6 Federal and State Regulations Regarding APP Privileges

APP privileges, responsibilities and duties shall, at all times, be consistent with federal and State regulations applicable to their specific profession. APPs shall not be granted privileges, responsibilities, or duties that, under State law, require the specific skill, training, or experience of a physician. State regulations regarding the scope of practice and services, supervision requirements prescriptive authority, required certificates, quality assurance standards, practice oversight ratios, and other regulated matters regarding licensed APPs are available from the Hospital Medical Staff Services. Ohio Board of Nursing Rules, including recently adopted rules, can also 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, with implementing administrative rules found at Ohio Administrative Code, Chapter 4723. Ohio State Medical Board Rules governing a Physician Assistant can also be found at http://www.med.ohio.gov/ under "Physician Assistant", and are found at the Ohio Revised Code, Chapter 4730, with implementing administrative rules found at Ohio Administrative Code, Chapter 4730.

6.7 Duties of Practitioners who Employ, Supervise, and/or Collaborate with an APP

Those Practitioners who employ, supervise, and/or collaborate with an APP shall agree to:

6.7-1 Acquaint the APP with the applicable policies of the Medical Staff and/or the Hospital, as well as Practitioners and Hospital personnel with whom the APP shall have contact.

6.7-2 Adhere to the requirements of any supervision agreement or standard care arrangement and otherwise provide appropriate supervision/collaboration consistent with this Article, accrediting agency requirements, and applicable law.

6.7-3 Provide immediate notice to the Medical Staff Services Department when the Practitioner receives notice of (i) any grounds for suspension or termination of the APP as required by the terms of the standard care arrangement or supervision agreement; or (ii) the occurrence of any action that establishes grounds for corrective action against the APP.

6.7-4 Provide immediate notice to the President/CEO when the standard care arrangement or supervision agreement expires or is terminated.

6.7-5 Acknowledge and convey to the APP that the Privileges of the APP at the Hospital shall be automatically suspended tor terminated in the event of the occurrence of an event set forth in Section 6.4.6 (f).

Failure to properly supervise and/or collaborate with the APP shall be grounds for corrective action against an Appointee pursuant to the Medical Staff Bylaws.

ARTICLE VII: ANNUAL REVIEW, ADOPTION AND AMENDMENT

7.1 Annual Review

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

7.2 Adoption and Amendment

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

CERTIFICATION OF ADOPTION AND APPROVAL

Adopted by the Medical Executive Committee on September 13, 2018

Scott Arnold, MD

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Chief of Staff

Approved by the Board of Directors on November 08, 2018
after receipt of a recommendation by the Medical Executive Committee

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Secretary