Advanced Practice Provider Policy

SUMMA HEALTH SYSTEM

A Medical Staff Document

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ARTICLE I

DEFINITIONS

The following definitions shall apply to this Advanced Practice Provider (APP) Policy:

ADVANCED PRACTICE PROVIDER or **APP**: Those physician assistants, advanced practice registered nurses, and other qualified, eligible healthcare professionals, as reflected in Exhibit A of this Policy, who have applied for, or who have applied for and been granted, Privileges to practice at the Hospital either independently or in collaboration with or under the supervision of a Physician, Dentist, or Podiatrist, as applicable, with Medical Staff appointment and Privileges at the Hospital.

ADVERSE: A recommendation or action of the Medical Executive Committee or Board that denies, limits (*i.e.* suspension, restriction, *etc.*) for a period in excess of fourteen (14) days, or terminates Privileges on the basis of professional conduct or clinical competence.

APPOINTEE: A Practitioner who has been granted appointment to the Medical Staff.

BOARD or **GOVERNING BODY:** The Board of the Hospital. Reference to the Board or Governing Body shall include any Board committee or individual authorized by the Board to act on its behalf in certain matters**.**

CLINICAL DEPARTMENT or **DEPARTMENT:** The Medical Staff Departments as designated in the Medical Staff Bylaws. The head of each Department shall be designated as the Department Chair.

CLINICAL PRIVILEGES or **PRIVILEGES:** The permission granted by the Board to a Practitioner or APP to provide designated patient care, treatment, and/or services at/for the Hospital within defined limits based upon the Practitioner's or APP's professional license, education, training, experience, competence, ability, character, and judgment.

DENTIST: An individual with a D.D.S. or D.M.D. degree who is fully licensed to practice dentistry in the State of Ohio, unless otherwise provided in the Medical Staff Bylaws or Policies, and whose practice is in the area of oral and maxillofacial surgery or the area of general dentistry or a specialty thereof.

EXECUTIVE SESSION: Voting members of the Medical Executive Committee and Hospital Legal Counsel

FEDERAL HEALTHCARE PROGRAM: Medicare, Medicaid, TRICARE, or any other federal or state program providing health care benefits that is funded directly or indirectly by the United States government.

HOSPITAL: Summa Health System.

HOSPITAL PRESIDENT: the President of the Hospital.

JOINT CONFERENCE COMMITTEE: An *ad hoc* special-purpose Board committee consisting of an equal number of Board members (selected by the Board) and Medical Staff Appointees (selected by the MEC). Should the Board revise the Hospital's governing documents to provide for a standing Joint Conference Committee then this definition will be deemed likewise automatically amended as well.

MAIL: Unless otherwise specified, includes either electronic (e-mail or electronic posting) or regular mail.

MEDICAL EXECUTIVE COMMITTEE (MEC): The executive committee of the Medical Staff as defined in the Medical Staff Bylaws.

MEDICAL STAFF: Those Medical Staff Appointees with such Prerogatives and responsibilities as set forth in the Medical Staff category to which each has been appointed.

MEDICAL STAFF BYLAWS or **BYLAWS**: The Medical Staff Bylaws, and amendments thereto, that constitute the basic governing document of the Medical Staff**.**

MEDICAL STAFF PRESIDENT: The Practitioner elected by the Medical Staff to be its chief officer. The Medical Staff President shall also be the chair of the Medical Executive Committee.

MEDICAL STAFF POLICY or POLICIES: Those additional Medical Staff governing documents, recommended by the Medical Executive Committee and approved by the Board, that serve to implement the Medical Staff Bylaws including, but not limited to, the Credentials Policy, Organization Policy, Medical Staff Patient Care Policies, and this Advanced Practice Provider Policy.

ORAL AND MAXILLOFACIAL SURGEON: A Dentist who engages in that part of dental practice dealing with the diagnosis, surgery, and adjunctive treatment of diseases, injuries, and defects of the oral and maxillofacial regions.

PHYSICIAN: An individual with an M.D. or D.O. degree who is fully licensed to practice medicine in the State of Ohio unless otherwise provided in the Medical Staff Bylaws or Policies.

PODIATRIST: An individual with a D.P.M. degree who is fully licensed to practice podiatry in the State of Ohio unless otherwise provided in the Medical Staff Bylaws or Policies.

PRACTITIONER: Unless otherwise expressly provided, any Physician, Dentist, Psychologist, or Podiatrist.

PREROGATIVE: A participatory right granted, by virtue of Medical Staff category, to an Appointee that is exercisable subject to the ultimate authority of the Board and to the conditions and limitations imposed in the Medical Staff Bylaws and Policies.

PROFESSIONAL LIABILITY INSURANCE: Professional liability insurance coverage of such kind and in such amount acceptable to the Board, as the Board may determine from time to time, by an insurance company licensed in the United States or having coverage by a company who has an underwriting agreement with a licensed U.S. insurance company to assure adequate reserves for payment of claims.

PSYCHOLOGIST: An individual with a doctoral degree in psychology, school psychology, or a doctoral degree deemed equivalent by the Ohio State Board of Psychology who is fully licensed to practice psychology in the State of Ohio unless otherwise provided in the Medical Staff Bylaws or Policies.

SPECIAL NOTICE: Written notification sent by certified mail, return receipt requested, or by personal delivery service with signed acknowledgement of receipt.

SYSTEM: Summa Health.

TELEMEDICINE: The use of electronic equipment or other communication technologies to provide or support clinical care at a distance.

Words used in this Advanced Practice Provider Policy shall be read as the singular or plural, as the context requires. The captions or headings are for convenience only and are not intended to limit or define the scope or effect of any provision of this Policy.

ARTICLE II
POLICY OVERVIEW

2.1 APPLICABILITY OF POLICY

2.1.1 This Policy is only applicable to APPs who have requested and/or been granted Privileges through the Medical Staff process.

2.1.2 All APPs who request Privileges at the Hospital must be credentialed through the Medical Staff consistent with this Policy and granted Privileges prior to providing care, treatment, and/or services to patients at the Hospital.

2.1.3 Attached hereto, and incorporated by reference herein, is Exhibit A which sets forth the APP occupations/professions that are credentialed, eligible for Privileges, and managed through the Medical Staff pursuant to this Policy.

2.1.4 The Medical Staff shall make recommendations to the Board, upon request, with respect to: (1) the APP occupations or professions that are eligible to request Privileges at the Hospital; (2) for each eligible APP occupation/profession, the mode of practice (*e.g.* independent, supervised, or collaborative), the scope of practice, and applicable Privilege set for each; (3) whether any changes should be made to existing APP requirements (*e.g.*, qualifications, duties, privilege sets, *etc.*).

2.2 LIMITATIONS

2.2.1 APPs are not granted appointment to the Medical Staff, may not hold Medical Staff office or serve as a Medical Staff officer, Department Chair, or Division Chief, and are not entitled to the fair hearing and appeal rights afforded to Medical Staff Appointees.

2.2.2 APPs may:

(a) Attend Medical Staff meetings but may not vote on Medical Staff matters.

(b) Attend meetings of the Medical Staff Department/Division to which they are assigned but may not vote on Department/Division matters.

(c) Serve on (and be removed from) Medical Staff committees by the Medical Staff President with the right to vote on committee matters if so designated at the time of selection.

2.2.3 APPs granted Privileges shall have such procedural rights, to the extent applicable, as set forth in Article VIII of this Policy.

2.2.4 APPs must comply with all limitations and restrictions imposed by their respective licenses, certificates/certifications, or other credentials required by Ohio law to practice, the terms of their standard care arrangement or supervision agreement, as applicable, and may only provide care, treatment, and services in

accordance with this Policy, other applicable Hospital/Medical Staff policies, the Privileges granted to them, and applicable laws, rules, and regulations.

2.2.5 APPs may not admit patients to the Hospital.

2.3 DUTIES OF APPOINTEES WHO SUPERVISE OR COLLABORATE WITH AN APP

2.3.1 Those Medical Staff Appointees with Privileges at the Hospital who supervise or collaborate with an APP shall agree to:

(a) Adhere to the requirements of any supervision agreement or standard care arrangement and otherwise provide appropriate supervision/collaboration consistent with this Policy, the APP's Privilege set, and applicable laws, rules, and regulations.

(1) It shall be the responsibility of the supervising Physician or Podiatrist and his/her Physician Assistant to have and maintain a current, valid supervision agreement(s) in accordance with applicable Ohio laws and State Medical Board of Ohio rules.

(2) It shall be the responsibility of the Advanced Practice Registered Nurse and his/her collaborating Physician or Podiatrist to have and maintain, if required, a current, valid, standard care arrangement(s) in accordance with applicable Ohio laws and Ohio Board of Nursing rules.

(b) Provide immediate notice to the Credentialing Office when the collaborating/supervising Practitioner receives notice of (i) any grounds for summary suspension or automatic suspension/automatic termination of the APP’s Privileges; or (ii) the occurrence of any action that establishes grounds for corrective action against the APP.

(c) Provide immediate notice to the Credentialing Office when the standard care arrangement or supervision agreement expires or is terminated.

(d) Provide immediate notice to the Credentialing Office when the Practitioner ceases to serve as the APP’s collaborating or supervising Practitioner.

(e) Acknowledge and convey to the APP that the APP’s Privileges at the Hospital shall be automatically suspended or automatically terminated pursuant to the grounds set forth in Section 7.3 or Section 7.4 of this Policy.

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

2.4 NOT A CONTRACT

This Advanced Practice Provider Policy is not intended to and shall not create any contractual rights between the Hospital and any APP or collaborating/supervising Practitioner. Any and all contracts of association or employment shall control contractual and financial relationships between the Hospital and APPs or collaborating/supervising Practitioners.

2.5 TIME COMPUTATION

2.5.1 "Day(s)" shall mean calendar days including Saturdays, Sundays, and Legal Holidays.

2.5.2 "Working Day(s)" shall mean Monday through Friday excluding Legal Holidays.

2.5.3 "Legal Holiday" shall mean New Year's Day, Labor Day, Memorial Day, Fourth of July, Thanksgiving Day, and Christmas Day.

2.6 USE OF DESIGNEES

Whenever an individual is authorized to perform a duty by virtue of his/her position (*e.g.*, Medical Staff President, VPMA/VPSA, Hospital President, *etc*.), then the term shall also include the individual's designee.

ARTICLE III

QUALIFICATIONS FOR CLINICAL PRIVILEGES AND APP RESPONSIBILITIES

3.1 NATURE OF CLINICAL PRIVILEGES

3.1.1 Clinical Privileges shall be extended only to professionally competent APPs who continuously meet the qualifications, standards, and requirements set forth in this Policy.

3.1.2 No APP, including those employed by or in a position by virtue of a contract with the Hospital, shall provide care, treatment, and/or services to patients in the Hospital unless he or she is has been granted Clinical Privileges in accordance with the procedures set forth in this Policy.

3.1.3 An APP who is granted Clinical Privileges is entitled to exercise such Privileges and is responsible for fulfilling such obligations as set forth in this Policy and the applicable Privilege set, and as otherwise required by the Department to which he/she is assigned.

3.2 DURATION OF CLINICAL PRIVILEGES

3.2.1 A grant/regrant of Clinical Privileges shall be for a period of not more than two (2) years.

3.2.2 A grant/regrant of Clinical Privileges for less than two (2) years shall not be deemed Adverse for purposes of this Policy.

3.3 EFFECT OF OTHER AFFILIATIONS

3.3.1 No APP shall be entitled to be granted/exercise particular Clinical Privileges at the Hospital merely by virtue of the fact that he or she holds a certain degree or is duly licensed to practice in this or in any other state; is certified by any clinical board; is a member of any professional organization; had in the past, or presently has, privileges at this Hospital or at another hospital or healthcare facility; or, contracts with or is employed by the Hospital.

3.4 ADDITIONAL CONSIDERATIONS

3.4.1 In the case of initial applications for Clinical Privileges or applications for new Clinical Privileges during the course of a Privilege period, the requested Privileges must be compatible with any policies, plans, or objectives formulated by the Board concerning:

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

(b) The Hospital's ability to provide the facilities, equipment, personnel, and financial resources that will be necessary if the application is approved.

(c) The Hospital's decision to contract exclusively for the provision of certain medical/professional services with a Practitioner/APP or group of Practitioners/APPs other than the affected APP.

3.5 QUALIFICATIONS FOR CLINICAL PRIVILEGES

Unless otherwise provided in this Policy, only APPs who meet the following general qualifications so as to demonstrate to the satisfaction of the Hospital that they are ethical, professionally competent, and that patients treated by them can reasonably expect to receive quality care shall be considered for Privileges:

3.5.1 Baseline Qualifications

(a) Successful completion of the education and training required by Ohio law to practice his/her profession.

(b) Have and maintain a current, valid, and unsuspended license (to include, as applicable, prescriptive authority or a prescriber number) or other credentials required by Ohio law to practice his/her profession. APPs shall meet the continuing education requirements necessary to maintain his/her license (or other credentials required by Ohio law to practice his/her profession) as determined by the applicable state licensing entity and shall provide Hospital with an attestation confirming his/her satisfaction of such requirements upon request.

(c) Have in force and provide evidence of continuous Professional Liability Insurance coverage.

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

(e) Be eligible to participate in Federal Healthcare Programs.

(f) Be able to read and understand the English language, to communicate effectively and intelligibly in English (written and verbal), and be able to prepare medical record entries and other required documentation in a legible and professional manner.

(g) Provide, if applicable, documentation of certification (*e.g.,* national nursing specialty certification, *etc.*) and maintain certification in his/her area(s) of practice at the Hospital by the appropriate specialty/subspecialty board(s).

(h) Designate, if necessary for the Privileges requested, an appropriate Practitioner with Medical Staff appointment and Privileges at the Hospital to supervise or collaborate with the APP.

(i) Have and maintain, if necessary for the Privileges requested, a current, valid supervision agreement or standard care arrangement with his/her

supervising or collaborating Physician or Podiatrist, as required by Ohio law, and provide a current copy of such agreement/arrangement (and any amendments thereto) to the Hospital.

(j) Satisfaction of the additional qualifications (*e.g.*, further education, training, experience, *etc.*), if any, as detailed in the applicable APP privilege set.

3.5.2 Additional Qualifications

(a) Evidence of good judgment.

(b) Documentation and demonstration of current professional competence (*i.e.*, ability to exercise the Privileges requested with or without a reasonable accommodation).

(c) Adherence to the ethics of their respective professions.

(d) Ability to work cooperatively with others so as not to adversely affect patient care or disrupt Hospital operations.

(e) Willingness to participate in and properly discharge those responsibilities defined by the Medical Staff.

(f) Agreement to abide by this APP Policy.

3.6 NONDISCRIMINATION

No APP shall be denied Privileges on the basis of: race; color; sex (including pregnancy); sexual orientation; gender identity; gender expression; transgender status; age (40 and older); religion; marital, familial, or health status; national origin; ancestry; disability; genetic information; veteran or military status; or any other characteristic(s) or class protected by applicable law.

3.7 BASIC RESPONSIBILITIES OF APPS GRANTED PRIVILEGES

3.7.1 Unless otherwise provided in this Policy, the ongoing responsibilities of each APP shall include the following responsibilities consistent with the Privileges granted to each such APP:

(a) Providing patients with quality care meeting the applicable professional standard(s).

(b) Managing and coordinating, (either independently (*e.g.*, LISW) or in cooperation with the APP's supervising/collaborating Practitioner as required by law), the patient's care, treatment, and services.

(c) Abiding by this Policy and other applicable Hospital/Medical Staff policies and procedures.

(d) Discharging, in a cooperative manner, such reasonable responsibilities and assignments as requested by the Medical Staff, including committee assignments, if applicable.

(e) Preparing and completing, in a timely, legible, and complete fashion, medical records for all patients for whom the APP provides care, treatment, and/or services in the Hospital and preparing any other records as required by the Medical Staff and/or the Hospital.

(f) Abiding by the principles of professional ethics adopted by the applicable professional association(s) pertaining to the APP.

(g) Aiding, as requested and/or required by the Department Chairs, in any Medical Staff approved educational programs for student APPs.

(h) Working cooperatively with Practitioners, other APPs, nurses, Hospital administration, and others so as not to adversely affect patient care or Hospital operations.

(i) Retaining responsibility within his/her area(s) of professional competence for the continuous care and supervision of each patient in the Hospital for whom he/she is providing care, treatment, and/or services, or arrange for a qualified substitute having the same or greater level of Privileges to provide such care and supervision.

(j) Participating in continuing education programs as determined by the Medical Staff or Medical Executive Committee and as otherwise required to maintain current licensure.

(k) Caring for patients in the Hospital within the scope of his/her Privileges.

(l) Keeping the Medical Staff informed by notifying the Credentialing Office if/when any information set forth in the APP's current application changes including, but not limited to, any action, proposed action, or investigation regarding the APP's license, DEA registration, privileges at other facilities, changes in Professional Liability Insurance coverage, or any other action, proposed action, or investigation that could affect his/her Clinical Privileges at this Hospital.

(m) Completing orientation requirements upon initial grant of Privileges.

(n) Meeting the general qualifications for Privileges as set forth in §3.5.

(o) Discharging such other APP obligations as may be established from time to time by the Medical Staff or the Medical Executive Committee.

(p) Cooperating in any relevant or required review of an APP's (including his/her own) credentials, qualifications, or compliance with this Policy or other applicable Hospital/Medical Staff policies; and refraining from directly or indirectly interfering, obstructing, or hindering any such

review, whether by threat of harm or liability, by withholding information, or by refusing to perform or participate in assigned responsibilities or otherwise.

(q) Cooperating and participating, as requested by the Medical Staff, in quality assurance activities and utilization review activities whether related to oneself or others.

(r) Abiding by the terms of the Hospital's Corporate Responsibility Program and HIPAA Notice of Privacy Practices prepared and distributed to patients as required by the federal patient privacy regulations.

3.7.2 Failure to satisfy any of the aforementioned responsibilities may be grounds for denial of regrant of Privileges or corrective action pursuant to this Policy.

ARTICLE IV
PROCESSING APPLICATIONS FOR INITIAL GRANT OF CLINICAL PRIVILEGES

4.1 BURDEN OF PRODUCING INFORMATION

4.1.1 In connection with all applications for Clinical Privileges, the APP shall have the burden of producing information for an adequate evaluation of his/her qualifications and suitability for the Clinical Privileges requested, of resolving any reasonable doubts about these matters, and of satisfying requests for information.

4.2 CONTENT OF APPLICATION

4.2.1 Unless otherwise provided in this Policy:

(a) A written, signed application for Privileges must be submitted to the the Credentials Verification Organization (CVO) on the application approved by the Board. If the initial application is not returned by the requesting applicant within sixty (60) days after the date that the applicant is provided an application, the application will be deemed to have been voluntarily withdrawn. For any future consideration for Clinical Privileges, the applicant will need to submit a new, full application including application fee.

(b) For initial grant of Clinical Privileges, the applicant is required to provide the following when submitting an application:

(1) Current Ohio License

(2) Current DEA Registration Certificate (if necessary for the Privileges requested)

(3) Evidence of Board Certification (if necessary for the Privileges requested) (*e.g.,* national nursing certification, *etc.*).

(4) Current Certificate of Professional Liability Insurance

(5) Proof of Continuous Professional Liability Insurance for the prior five (5) years; or, for new graduates, for such shorter period of time as the APP has practiced outside of a training program.

(6) Completed Delineation of Clinical Privileges Form

(7) Signed Security Agreement

(8) Signed Code of Conduct Form

(9) Signed I’m 4 Safety Form

(10) Signed Parking Permit

(11) Signed Attestation Form

(12) Tuberculosis/Health Status Evaluation Form

(13) Non-Refundable Application Processing Fee

(14) A copy of the APP's current, valid supervision agreement(s) or standard care arrangement(s), including amendments thereto, if necessary for the Privileges requested.

4.2.2 The application shall require detailed information regarding the APP's qualifications for Clinical Privileges which shall include, but not be limited to, information concerning:

(a) The applicant's satisfaction of the required education and training.

(b) The APP's current ability to safely and competently exercise the Privileges requested with or without a reasonable accommodation.

(c) A chronology and account of all professional practice since completion of education/training and information concerning any period of more than two (2) months during which the applicant was not in practice.

(d) All present and past clinical privileges at the Hospital or any other hospital/healthcare organization.

(e) Any action taken by any hospital or health care organization concerning limiting of privileges or any action taken toward that end regardless of whether privileges were actually limited.

(f) Any corrective action taken by any hospital or health care organization against the APP.

(g) Voluntary (while under investigation or to avoid investigation for conduct or clinical competency concerns) or involuntary relinquishment of professional license or DEA registration; termination, limitation, reduction, or loss of Clinical Privileges at Hospital or another hospital or health care organization.

(h) Names and addresses of at least three (3) professionals/peers in the APP's same professional discipline (*e.g.*, similarly trained and licensed APPs) or Practitioners who have recently worked with the applicant, and directly observed his/her professional performance over a reasonable period of time, and who can and will provide reliable information regarding the applicant's: current professional competence; the applicant's documented experience, the results of care, treatment, and/or services provided, and the conclusions drawn from quality assessment and improvement activities when available; his/her ethics; and, ability to work with others.

(1) At least one (1) reference shall be from the institution where the applicant has just finished training or the most recent institution where the applicant was/is practicing; and, if possible, another shall be from an active member of the Hospital Medical Staff.

(2) Three (3) references are requested but two (2) are acceptable for processing the application.

(3) References should not be associates or partners of the applicant and may not be provided by the applicant's relatives.

(4) Peer recommendations shall include information regarding the applicant's medical/clinical knowledge, technical/clinical skills, clinical judgment, interpersonal skills, communication skills, and professionalism.

(5) 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 APP-specific data collected from various sources for the purpose of validating current competence.

(i) Number and expiration date of current license to practice in Ohio and number and expiration date of current license to practice in any other jurisdiction, if any.

(j) Copy of current DEA registration (if necessary for the Privileges requested) verifying continued registration, certificate number, and expiration date as applicable.

(k) Board certification, if necessary for the Privileges requested (*e.g.*, national nursing certification)

(l) Information as to whether any of the following have ever been or are in the process of being denied, revoked/terminated, suspended, reduced, involuntarily relinquished, or relinquished while under investigation or to avoid investigation for conduct or clinical competency concerns:

(1) Privileges at any hospital or health care institution.

(2) Membership in, or association with, any local, State, or national professional organizations.

(3) Board certification(s).

(4) License to practice any health profession in any jurisdiction.

(5) Prescriptive authority/DEA number or any other controlled substances registrations.

(6) Faculty appointment at any professional school.

(7) Professional Liability Insurance.

(8) Participation in any Federal Healthcare Program.

(m) Documentation of continuing education activities or attestation that the applicant meets all continuing education activities/requirements necessary to maintain Ohio licensure.

(n) Documentation of required immunizations and/or health screenings.

(o) Conviction(s), arrest(s), or charge(s) of a felony or misdemeanor (other than minor traffic offenses) including crimes related to children, adolescents, and/or adults.

(p) Names and addresses of the applicant's present and past Professional Liability Insurance carriers and a current certification from the present carriers. The insurance carrier must be approved by the Board and have a current rating of A- or better by an A.M. Best insurance rated company carrying at least the minimum limits of coverage as mandated by the Board ($1 million/$3 million set by the Board 8/1998).

(q) Completion of the Professional Liability Claim Form which will include information on any and all claims, judgments, and settlements against the applicant during the past five (5) years and information regarding any denial, limitation, or cancellation of liability insurance during the past five (5) years; or, for new graduates, for such shorter period of time as the APP has practiced outside of a training program.

(r) Names and addresses of affiliated Practitioners/APPs, if any, the nature of the affiliation, and the date on which the affiliation commenced.

(s) Information concerning any and all legal action the applicant has commenced against any other health care facility and/or organization with respect to denial or loss of privileges, termination of privileges, termination of any contracted services, or any other legal action so commenced.

(t) Information necessary to complete required background checks. Background checks/inquiries (to include criminal and civil reports) will be a part of all credentialing verifications.

(u) Information required pursuant to the Hospital's conflict of interest policy, if any, as applicable.

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

(w) To the extent applicable to the Privileges requested, the name of the APP's collaborating or supervising Practitioner(s) (who must hold Medical Staff appointment and Privileges at the Hospital) and receipt, as applicable, of a current, valid supervision agreement(s) or standard care arrangement(s) including any amendments thereto.

(x) Government-issued photo identification to verify that the applicant is, in fact, the individual requesting Privileges.

(y) Such other information as the MEC may recommend and the Board may require from time to time.

(z) The applicant's signature.

4.2.3 Each application for Privileges shall be in writing, submitted on the prescribed form with all provisions completed (or accompanied by an explanation of why answers are unavailable), and signed and dated by the applicant.

4.2.4 When an applicant requests an application form, he/she shall be given a copy of, or access to, this Policy, other applicable Medical Staff policies, Department specific rules and regulations, and information regarding delineated Clinical Privileges.

4.3 EFFECT OF APPLICATION

4.3.1 By applying for Clinical Privileges at the Hospital each applicant:

(a) Signifies his/her willingness to appear for interviews in support of his/her application.

(b) Agrees to the provisions set forth in Article X of this Policy regarding confidentiality of information, immunity for reviews and actions taken, and release of liability for obtaining and sharing information including, but not limited to:

(1) Authorizing Hospital/Medical Staff Representatives to consult with others who have been associated with the applicant regarding the applicant's clinical competency, professional qualifications, and performance. Applicant authorizes such individuals and organizations to candidly provide all such information to the Hospital/Medical Staff.

(2) Consenting to the inspection and copying of records and documents that may be material to an evaluation of the applicant's qualifications and ability to carry out the delineated Clinical Privileges requested, and authorizing all individuals and organizations who have custody of such records and documents to permit such inspection, copying, and transmittal.

(3) Releasing from any liability, to the fullest extent permitted by law, all Hospital/Medical Staff Representatives for their acts performed in connection with investigating and evaluating the applicant's qualifications for Clinical Privileges.

(4) Releasing from any liability, to the fullest extent permitted by law, all Third Parties who provide information regarding the applicant, including otherwise privileged and confidential information.

(5) Consenting to the disclosure to other hospitals, licensing boards, the National Practitioner Data Bank, background check entities, and other similar organizations of any information regarding the APP's professional conduct or clinical competence that the Hospital may have and releasing Medical Staff, Hospital and all authorized agents and/or Representatives of the Medical Staff and Hospital from liability for doing so to the fullest extent permitted by law.

(c) Acknowledges that he/she has received access to, and has a responsibility to review, this APP Policy and other applicable Hospital/Medical Staff policies. The applicant agrees that during all times that he/she holds Clinical Privileges at the Hospital he/she will comply with this Policy and applicable Hospital/Medical Staff policies as they exist and as they may be modified from time to time.

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

(e) Acknowledges his/her obligation to satisfy the applicable responsibilities set forth in this Policy including, but not limited to, practicing in an ethical manner and providing continuous care to patients.

(f) Agrees to notify the Credentialing Office 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 has Privileges at the Hospital.

(g) Agrees that when an Adverse action or recommendation is made with respect to his/her Privileges, the applicant will exhaust the administrative remedies afforded by this Policy before resorting to formal legal action.

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

4.4 ACTION UPON RECEIPT OF AN APPLICATION FOR PRIVILEGES

Unless otherwise provided in this Policy, the procedure for acting upon applications for Privileges shall be as set forth below.

4.4.1 Collection & Verification of Credentialing Information

(a) The applicant shall deliver a completed application to the Credentialing Office along with a non-refundable application fee. For purposes of this Policy, a completed application is defined as containing all information requested on the application, any and all letters of recommendation as requested, and timely providing of any and all other information requested by the Medical Staff to evaluate the APP's professional qualifications including, but not limited to, current clinical competence. Upon receipt of a completed application and required application fee, a credentials file will be created and maintained by the Hospital.

(b) The Credentialing Office shall expeditiously seek to collect and verify the applicant's references, licensure status (or status of other credentials required by Ohio law to practice his/her profession), and other evidence submitted in support of the application. The Credentialing Office shall query the National Practitioner Data Bank and 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 health care related offence or debarred, excluded, or otherwise made ineligible for participation in a Federal Healthcare Program.

(c) The applicant shall be notified of any problems in obtaining the information required and it shall be the applicant's obligation to obtain the required information in accordance with the specified time period. Failure to provide the requested documentation with the application or within thirty (30) days after a request therefore will result in the application being incomplete and may be deemed a voluntary withdrawal of the application.

(d) Upon completion of the collection and verification process, the credentials file will be presented to the Division Chief, where applicable, and then to the appropriate Department Chair for review.

4.4.2 Department Action

(a) Upon receipt of the credentials file, the Department Chair shall review the application and accompanying documentation and may, when deemed appropriate, conduct a personal interview with the applicant.

(b) The Department Chair shall review all matters deemed relevant to an evaluation regarding a request for Clinical Privileges including, but not limited to, information concerning the applicant's current clinical

competence within the scope of Privileges requested. The Department Chair shall transmit to the MEC Credentials Committee a written evaluation as to approval or denial of Clinical Privileges and any special conditions to be attached.

4.4.3 APP/AHP Credentials Committee Action

(a) The APP/AHP Credentials Committee is responsible for reviewing the Department Chair's evaluation, the application, and accompanying documentation upon receipt.

(b) The APP/AHP Credentials Committee is then responsible for preparing and submitting a written report to the Medical Executive Committee with its evaluation as to approval or denial of Clinical Privileges and any special conditions to be attached.

4.4.4 Medical Executive Committee Action

(a) The Medical Executive Committee shall review the application and accompanying documentation in addition to the evaluations from the Department Chair and MEC Credentials Committee at the Medical Executive Committee's next regularly scheduled meeting following receipt thereof.

(b) The Medical Executive Committee shall vote on the pending application and, on the basis thereof, may take any of the following actions:

(1) Defer Action: A decision by the MEC to defer action on the application must be revisited, except for good cause, within thirty (30) days with a subsequent recommendation as to approval or denial of, and any special conditions on, Privileges, and Department affiliation.

(2) Favorable Action: If the MEC makes a favorable recommendation regarding the application, the MEC shall promptly forward its recommendation, together with all accompanying documentation, to the Board.

(3) Adverse Recommendation: If the MEC's recommendation is Adverse to the applicant, the Medical Staff President shall inform the applicant of the recommendation, by Special Notice, and the applicant shall then be entitled, if applicable, to the procedural due process rights set forth in Article VIII of this Policy. 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 the procedural due process rights as provided for in this Policy.

4.4.5 Board Action

(a) The Board may take any of the following actions with regard to an application for Privileges:

(1) 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.

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

(ii) If the Board's decision is Adverse to the applicant, the Hospital President shall notify the applicant, by Special Notice, and the applicant shall be entitled, if applicable, to the procedural due process rights provided for in Article VIII of this Policy.

(2) Without Benefit of MEC Recommendation: If the MEC fails to make a recommendation within the time required, the Board may, after informing the MEC of the Board's intent and allowing a reasonable period of time for response by the MEC, make its own determination using the same type of criteria considered by the MEC.

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

(ii) If the Board's decision is Adverse to the applicant, the Hospital President shall notify the applicant, by Special Notice, and the applicant shall be entitled, if applicable, to the procedural due process rights provided for in the Article VIII of this Policy.

(3) Adverse MEC Recommendation: If the Board is to receive an Adverse Medical Executive Committee recommendation, the Medical Staff President shall withhold the recommendation and not forward it to the Board until after the applicant is notified, by Special Notice, of the Adverse recommendation and the applicant's right, if any, to the procedural due process rights provided for in Article VIII of this Policy, and the applicant either exercises or waives such rights.

4.4.6 Joint Conference Committee Review

(a) Whenever the Board's proposed decision is contrary to the recommendation of the MEC, there shall be further review of the recommendation by an *ad hoc* Joint Conference Committee to the extent

such a referral has not previously been made (*e.g.*, pursuant to the hearing/appeal process). This committee shall, after due consideration, make its written recommendation to the Board within ten (10) days after referral to the committee.

(b) Thereafter, the Board may act. Such action by the Board may include accepting, rejecting, or modifying, in whole or part, the recommendation of the Joint Conference Committee.

4.4.7 Time Guidelines

(a) The following time periods are considered guidelines and do not create any rights for an applicant to have his/her application processed within these precise periods; provided, however, that this provision shall not apply to the time periods contained in Article VIII of this Policy.

(b) When Article VIII this Policy is activated by an Adverse recommendation or action as provided herein, the time requirements set forth in Article VIII shall govern the continued processing of the application.

Individual/Group	Time
Credentialing Office	30 Days
Department Chair	30 Days
APP/AHP Credentials Committee	Next regular meeting
Medical Executive Committee	Next regular meeting
Board of Directors	Next regular meeting

4.4.8 Notice of Final Decision

(a) The Board, through the Hospital President, shall give notice of its final decision to the applicant, by Special Notice, and to the Medical Staff President. The Medical Staff President shall, in turn, communicate the decision to the appropriate Medical Staff leaders and committees.

(b) A decision and notice to grant Clinical Privileges shall include, if applicable:

(1) The Department(s) to which he/she is assigned.

(2) The delineated Clinical Privileges granted.

(3) Any special condition(s) attached to the Clinical Privileges.

4.5 PROCEDURE FOR APP REGRANT OF PRIVILEGES

4.5.1 Every grant of Clinical Privileges shall be reviewed at least every twenty-four (24) months. Regrant of Privileges shall be for a period of not more than twenty-four (24) months.

4.5.2 Regrant of Privileges shall be based on all factors bearing upon the APP's:

(a) Ongoing satisfaction of the qualifications for Privileges set forth in §3.5 of this Policy.

(b) Fulfillment of the responsibilities identified in §3.7 of this Policy.

(c) Compliance with this Policy and other applicable Hospital/Medical Staff policies and procedures.

(d) Compliance with Department policies, procedures, and rules and regulations.

(e) Completion of required continuing education including Hospital mandated education (*e.g.*, I'm 4 Safety, *etc*.) and education required by the applicable State board to maintain current licensure.

(f) Any other criteria as may be recommended by the MEC and approved by the Board that bears upon the ability of the APP to continue, as applicable, to carry out the APP's duties and responsibilities and/or to competently exercise the delineated Clinical Privileges.

(g) Professional practice evaluation data from focused and ongoing professional practice evaluation activities, including morbidity and mortality information if available, shall be reviewed and considered as part of the regrant of Privileges process.

(h) Upon regrant of Privileges, when APP-specific data is unavailable at the Hospital for the APP requesting regrant of Privileges, the Medical Staff shall obtain and evaluate additional peer recommendations.

(i) If, during the preceding Privileges period, an APP has not had enough Patient Encounters at the Hospital from which sufficient professional practice evaluation data has been generated to provide a basis for evaluation of the APP's current clinical competence, supplemental performance data may be requested from the hospital at which the APP has his/her primary affiliation for consideration.

4.5.3 Process for Regrant of Privileges

(a) Prior to the end of the APP's current Privilege term, he/she will be sent an application for regrant of Privileges from the Credentialing Office of the Hospital.

(b) Completed applications for regrant of Privileges, along with the non-refundable regrant application fee, shall be submitted to the Credentialing Office.

(c) Failure to pay the required application fee for regrant of Privileges shall be deemed a voluntary resignation and the Credentialing Office shall not proceed to process the application.

4.5.4 Application for Regrant of Privileges

(a) The application for regrant of Privileges shall be sufficient in scope to update the information required by §4.2 of this Policy necessary to bring the APP's credentials file current since the last submission of such information including:

(1) Present delineated Clinical Privileges granted and any request for a change in Clinical Privileges with the basis therefore. A request for new Privileges shall require documentation of additional education, training, and experience in support of the new Privileges requested and will be subject to focused professional practice evaluation, to assess clinical competency, if granted.

(2) Number and expiration date of any professional state license and current Drug Enforcement Administration registration (if necessary for the Privileges requested).

(3) Name of Professional Liability Insurance carrier, manual number, amount of coverage, and assurance that a continuum of insurance is maintained.

(4) Attestation (and supporting documentation, as requested) of continuing education activities for which the APP has received credit which relate to the scope of the APP's clinical practice and/or as required by the applicable State board to maintain current licensure.

(5) A list of all hospitals at which the APP has privileges at the time of regrant of Privileges including identification of the type of clinical privileges. Designation of primary affiliation must be confirmed or stated.

(6) Any change in affiliations with other Practitioners/APPs. Any suspension, revocation, or denial of a license to practice taken in any jurisdiction, or any action taken toward that end now pending.

(7) Any change in or challenge to delineated clinical privileges taken by any other facility, hospital, or health care organization.

(8) Any change in or challenge to any membership or fellowship in any professional associations, affiliations, or organizations.

(9) Voluntary (while under investigation or to avoid investigation for conduct or clinical competency concerns) or involuntary

relinquishment of license or registration; or denial, termination, suspension, or limitation of delineated clinical privileges at another hospital.

(10) Any change in or challenge to board certification.

(11) Any denial or cancellation of Professional Liability Insurance, any and all professional liability actions in which the APP has been named as a party, and any and all claims, judgments, demands, and settlements against him/her.

(12) Compliance with required immunizations and/or health screenings.

(13) The APP's continuing ability to safely and competently exercise the Privileges requested with or without a reasonable accommodation.

(14) Conviction(s), arrest(s), or charge(s) of a felony or misdemeanor (other than minor traffic offenses) including crimes related to children, adolescents, and/or adults.

(15) Completion of Hospital mandated refresher education (*e.g.,* I'm 4 Safety, *etc.*) as applicable.

(16) Any new or amended supervision agreement(s) or standard care arrangement(s) and any changes to his/her supervising or collaborating Practitioners, as applicable to the Privileges requested.

(17) Any additional information required to be reported to the Credentialing Office pursuant to §4.3.1 (f).

4.5.5 Collection and Verification

(a) Information with respect to applications for regrant of Privileges shall be collected and verified in accordance with the procedure set forth in §4.4.1 of this Policy to the extent applicable.

4.5.6 Review and Action on Applications for Regrant of Clinical Privileges

(a) Applications for regrant of Privileges shall be reviewed and acted upon in accordance with the procedure set forth in §4.4.2 through §4.4.6 of this Policy.

(b) For purposes of regrant of Privileges, the terms "applicant" and "Privileges" as used in §4.4.2 through §4.4.6, shall be read as "APP" and "regrant of Privileges" respectively.

4.5.7 Time Period for Processing Applications for Regrant of Clinical Privileges

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

(b) If an application for regrant of Privileges is not submitted or has not been fully processed by the expiration date of the APP's current Privilege period, the APP's Privileges shall terminate as of the last date of his/her current Privilege period. An APP whose Privileges are so terminated shall not be entitled to the procedural due process rights provided in Article VIII of this Policy.

(c) If the APP qualifies, he/she may be granted temporary Privileges to meet an important patient care need pursuant to §5.5 of this Policy.

4.6 REQUESTS FOR MODIFICATIONS OF CLINICAL PRIVILEGES

4.6.1 An APP who seeks modification of delineated Privileges may submit such a request in connection with regrant of Privileges, or at any other time, by submitting a written request to the Credentialing Office. A request for modification of Privileges shall include the applicable Delineation of Clinical Privileges form. Such request may not be filed within one (1) year of the time a similar request has been denied.

4.6.2 Requests for new Clinical Privileges during a current Privilege period must be accompanied by appropriate documentation of training/education supportive of the request and will be subject to focused professional practice evaluation if granted.

4.6.3 A request for modification of Privileges or new Privileges during a current Privilege period shall be processed in the same manner as an application for regrant of Privileges.

4.7 VOLUNTARY RESIGNATION OF PRIVILEGES

4.7.1 Resignation of Privileges, and the reason for such resignation, shall be submitted in writing to the Credentialing Office. Notification of the resignation shall be forwarded to the Board, the appropriate Medical Staff leaders/committees, and Hospital personnel for information.

4.7.2 An APP who resigns his/her Privileges is obligated to complete all medical records for which he/she is responsible prior to the effective date of the resignation. In the event an APP fails to do so, consideration may be given by the Hospital to contacting the applicable State licensing board regarding the APP's actions.

4.7.3 Provided that resignation of Privileges pursuant to this section is determined by the Board to be voluntary, such resignation shall not give rise to any procedural due process rights set forth in Article VIII of this Policy.

4.7.4 A request for Privileges subsequently received from an APP who resigns his/her Privileges pursuant to this section must be submitted and shall be processed in the manner specified for applications for initial granting of Privileges.

ARTICLE V

DELINEATION OF CLINICAL PRIVILEGES; TEMPORARY PRIVILEGES; EMERGENCY PRIVILEGES; DISASTER PRIVILEGES

5.1 DELINEATED CLINICAL PRIVILEGES

5.1.1 An APP who seeks to provide clinical care, treatment, and/or services at the Hospital shall be entitled to exercise only those delineated Clinical Privileges specifically granted.

5.1.2 APPs granted Clinical Privileges shall exercise such Privileges in accordance with the applicable Delineation of Clinical Privileges, applicable laws, rules, regulations, and accreditation standards; this Policy; Department policies and rules and regulation; other applicable Hospital/Medical Staff policies; and the APP's supervision agreement or standard care arrangement, as applicable.

5.1.3 Delineation of Privileges may be adopted and amended following review by the applicable Department Chair and the APP/AHP Credentials Committee, recommendation of the Medical Executive Committee, and approval by the Board. Privilege sets shall be developed consistent with applicable laws, rules, regulations, and accreditation/professional practice standards.

5.2 RECOGNITION OF NEW SERVICE/PROCEDURE

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

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

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

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

(d) The quality and availability of training programs.

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

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

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

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

(b) The Credentialing Office will notify the APP/AHP Credentials Committee chair of such a request.

(1) If the APP/AHP Credentials Committee determines that the service or procedure should not be recognized at the Hospital, the APP/AHP Credentials Committee will provide the basis for its recommendation to the MEC.

(2) If the APP/AHP Credentials Committee determines that the service or procedure can or should be included in an existing Privilege set, the APP/AHP Credentials Committee shall request that the applicable Department submit to the committee a revised Privilege set for review. The APP/AHP Credentials Committee will provide the basis for its recommendation to the MEC along with proposed revisions to the existing Privilege set.

(3) If the APP/AHP Credentials Committee decides to recommend that the new Privileges be recognized at the Hospital, the APP/AHP Credentials Committee shall request that the applicable Department develop and submit to the APP/AHP Credentials Committee a new Privilege set based upon:

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

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

(iii) The available training programs.

(iv) Recommended standards to be met with respect to the following: education; training; fellowship/board status; experience; and, focused professional practice evaluation requirements to establish current competency (*e.g.*, simulation, proctoring, *etc.*).

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

(c) Upon receipt of a recommendation from the APP/AHP Credentials Committee, the MEC will act. The recommendation of the MEC whether favorable or not favorable, will be forwarded to the Board for review and action.

(d) The Board will act on the recommendation from the MEC by either:

(1) Approving the new service or procedure. The APP(s) request for Privileges for such service/procedure may then be acted upon consistent with the applicable procedure outlined in this Policy.

(2) Denying the request for the new service or procedure in which case the APP(s) will be so notified. A decision by the Board not to recognize a new service or procedure does not constitute an appealable event pursuant to this Policy.

5.3 REQUESTS FOR CLINICAL PRIVILEGES

5.3.1 Each application must contain a request for the specific delineated Clinical Privileges desired by the APP.

5.3.2 Requests for Clinical Privileges and regrant of Clinical Privileges shall be processed in accordance with the applicable procedure set forth in Article IV with the exception that:

(a) Requests for temporary Privileges shall be processed according to the procedure set forth in §5.5.

(b) Requests for disaster Privileges shall be processed according to the procedure set forth in §5.7.

5.4 FOCUSED & ONGOING PROFESSIONAL PRACTICE EVALUATION

5.4.1 The Hospital's focused professional practice evaluation ("FPPE") process is set forth in detail, in the Medical Staff Professional Practice Evaluation and Peer Review Policy (#1.29) and shall be implemented for all: (i) APPs requesting initial Privileges; (ii) existing APPs requesting new Privileges during the course of a Privilege period; and, (iii) in response to concerns regarding an APP's ability to provide safe, high quality patient care. The FPPE period shall be used to determine the APP's current clinical competence and ability to perform the requested Privileges. If an APP resigns while under an FPPE for quality of care/clinical competency concerns, the APP will, as applicable, be subject to reporting to the National Practitioner Data Bank.

5.4.2 Upon conclusion of the FPPE period, ongoing professional practice evaluation ("OPPE") shall be conducted on all APPs with Privileges. The Hospital's OPPE process is set forth, in detail, in the Medical Staff Professional Practice Evaluation and Peer Review Policy (#1.29) and requires the Hospital to gather, maintain, and review data on the performance of all APPs with Privileges on an ongoing basis.

5.5 TEMPORARY PRIVILEGES

5.5.1 Conditions

(a) Temporary Privileges may be granted only in the circumstances and under the conditions described below.

(b) Special requirements of consultation and reporting may be imposed by the Department Chair responsible for the supervision of the APP exercising temporary Privileges as applicable.

(c) Under all circumstances, the APP requesting temporary Privileges must agree in writing to abide by this Policy and other applicable policies of the Medical Staff and those of the Hospital in all matters relating to his/her activities in the Hospital.

5.5.2 Circumstances

Upon written recommendation of the Department Chair and Medical Staff President, the Hospital President may grant temporary Privileges on a case-by-case basis in the following circumstances:

(a) Pendency of a Completed Application

To an applicant for new Privileges with a complete application that raises no concerns who is awaiting review and approval by the Medical Executive Committee and Board but only after:

(1) Receipt of a completed application including a request for specific temporary Privileges.

(2) Verification of the following:

(i) Current licensure

(ii) Relevant training/experience

(iii) Current competence

(iv) Ability to perform the Clinical Privileges requested

(v) Other criteria required by this Policy for a completed application

(3) A query and evaluation of the OIG and National Practitioner Data Bank Information.

(4) To the extent applicable to the Privileges requested, the name of the APP's collaborating or supervising Practitioner(s) (who must hold Medical Staff appointment and Privileges at the Hospital) and receipt, as applicable, of a current, valid supervision agreement(s) or standard care arrangement(s) (and any amendments thereto).

(5) Along with the completed application, the record must establish that the applicant has no current or previously successful challenges to his/her licensure or registration; has not been subject to any involuntary limitation, reduction, denial or loss of clinical privileges; and has not been suspended or terminated from any Federal Healthcare Program.

(6) For purposes of this section, an "applicant for new Privileges" includes: an APP applying for Clinical Privileges at the Hospital for the first time; an APP currently holding Clinical Privileges who is requesting one or more additional Privileges; and an APP who is in the regrant of Privileges process and is requesting one or more additional Privileges.

(7) Temporary Privileges may be granted in this circumstance for a period not to exceed the pendency of the application (*i.e.*, completion of review and action on the application by the MEC and Board) or one hundred twenty (120) days whichever is less.

(8) Under no circumstances may temporary Privileges be initially granted or renewed if the application is still pending because the applicant has not responded in a satisfactory manner to a request for clarification of a matter or for additional information.

(b) Important Patient Care, Treatment, and/or Service Need

To an APP to meet an important patient care, treatment, and/or service need but only after:

(1) Receipt of a written request for the specific temporary Privileges desired.

(2) Telephonic confirmation (or receipt of a copy) of current, valid licensure, DEA/controlled substances registration (if necessary for the Privileges requested), and adequate Professional Liability Insurance.

(3) A fully positive written or oral reference specific to the APP's current competence relative to the Privileges being requested from a responsible medical staff authority at the APP's current hospital affiliation.

(4) NPDB and OIG database queries must be completed and reviewed before granting temporary Privileges in this instance.

(5) To the extent applicable to the Privileges requested, the name of the APP's collaborating or supervising Practitioner(s) (who must hold Medical Staff appointment and Privileges at the Hospital) and receipt, as applicable, of a current, valid supervision agreement(s)

or standard care arrangement(s), including any amendments thereto.

(6) Temporary Privileges may be granted in this circumstance for an initial period of up to thirty (30) days and may be renewed for additional periods of up to thirty (30) days as necessary for an important patient care, treatment, and or service need. In no event may temporary Privileges exceed one hundred twenty (120) days.

5.5.3 Termination of Temporary Privileges

(a) The Hospital President, Vice President of Medical Affairs, Vice President of Surgical Affairs, or Medical Staff President shall terminate an APP's temporary Privileges:

(1) For failure to abide by this Policy or other applicable policies of the Hospital or Medical Staff.

(2) Upon the discovery of any information or the occurrence of any event that raises a question about an APP's professional qualifications or ability to exercise any or all of the Privileges granted.

(b) The Hospital President, Vice President of Medical Affairs, Vice President of Surgical Affairs, or Medical Staff President may at any time revoke any or all of an APP's temporary Privileges.

(c) Where the life or well-being of a patient is determined to be endangered, the APP's temporary Privileges may be terminated by any person entitled to impose a summary suspension pursuant to §7.2 of this Policy.

(d) An APP who has been granted temporary Privileges is not an Appointee to the Medical Staff and is not entitled to the procedural due process rights afforded to Appointees. An APP shall not be entitled to the procedural due process rights set forth in the Medical Staff Bylaws or in this APP Policy because the APP's request for temporary Privileges is refused, in whole or in part, or because all or any portion of such Privileges are terminated, not renewed, restricted, suspended, or otherwise limited, modified, or monitored in any way. Refusal to grant an APP temporary Privileges or termination of an APP's temporary Privileges is not a reportable event for purposes of federal or state law.

(e) In the event an APP's temporary Privileges are restricted, suspended, or terminated, the APP's patients then in the Hospital shall be assigned to another Practitioner/APP by the appropriate Department Chair. The wishes of the patient will be considered, where feasible, in choosing a substitute Practitioner/APP.

5.6 EMERGENCY PRIVILEGES

5.6.1 In the case of an emergency, any APP with Privileges is permitted to provide any type of patient care, treatment, and/or services necessary as a life-saving measure or to prevent serious harm provided that the care, treatment, and services provided are within the scope of the APP's license. An APP exercising emergency Privileges may use every facility of the Hospital available including calling for any consultation(s) necessary or desirable. When an emergency situation no longer exists, such APP must request the Clinical Privileges necessary to continue to treat the patient if the APP is not already granted such. In the event such Clinical Privileges are denied or the APP does not desire to request such Clinical Privileges, the patient shall be assigned to an Appointee of the Medical Staff with appropriate Privileges.

5.6.2 For the purpose of this section, an "emergency" is defined as a condition in which the life of a patient is in immediate danger and any delay in administering treatment would add to that danger.

5.6.3 Emergency Privileges shall automatically terminate upon alleviation of the emergency situation. An APP who exercises emergency Privileges shall not be entitled to the procedural due process rights set forth in this Policy.

5.7 DISASTER PRIVILEGES

5.7.1 Volunteer Ohio APPs who do not otherwise possess Clinical Privileges at the Hospital may be granted disaster Privileges (subject to applicable Ohio licensure laws, rules, and regulations) when the Hospital's Emergency Operations Plan has been activated in response to an externally officially declared disaster, whether it is local, state or national, and the Hospital is unable to meet immediate patient needs.

5.7.2 The Hospital President, Vice President of Medical Affairs, Vice President of Surgical Affairs, or the Administrator-on-Call may grant disaster Privileges to volunteer Ohio APPs on a case-by-case basis after:

(a) Verification of a current, valid government-issued photo identification issued by a state or federal agency (*e.g.*, driver's license or passport) and at least one of the following:

(1) A current picture identification card from a health care organization that clearly identifies professional designation.

(2) A current license to practice.

(3) Primary source verification of licensure.

(4) Identification indicating that 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 state or federal response organization or group.

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

(6) Confirmation by a Practitioner/APP currently privileged by the Hospital or by a Hospital staff member with personal knowledge of the volunteer APP and his/her professional qualifications.

(b) Completion of a query of appropriate sources (OIG, *etc.*) to determine whether the volunteer has been convicted of a healthcare related offense or debarred, suspended, excluded, or otherwise made ineligible for participation in a Federal Healthcare Program.

(c) To the extent applicable to the Privileges requested, receipt of the name of the volunteer APP's collaborating or supervising Practitioner(s) (who must also apply for and be granted disaster Privileges at the Hospital in order for the volunteer APP to be granted disaster Privileges) and receipt, as applicable, of a current, valid supervision agreement or standard care arrangement, including any amendments thereto.

(d) A record of all information regarding the volunteer APP will be retained in the Credentialing Office.

5.7.3 It is anticipated that these disaster Privileges may be granted to in-state volunteer APPs in response to such a disaster as necessary in accordance with applicable Ohio licensure laws, rules, and regulations.

5.7.4 The volunteer APP must present himself/herself to the Credentialing Office where the above information will be collected by credentials staff. If the above items are available, the Hospital President, Vice President of Medical Affairs, Vice President of Surgical Affairs, or the Administrator-on-Call may grant disaster Privileges.

5.7.5 The volunteer APP will be referred to Protective Services for a temporary ID badge according to Protective Services procedure.

5.7.6 The activities of volunteer APPs who receive disaster Privileges shall be monitored by the applicable Department Chair in cooperation with the volunteer APP's supervising or collaborating Practitioner. The activities of volunteer APPs who are independent APPs (*e.g.,* LISW) shall be monitored by a Hospital employee with comparable Privileges.

5.7.7 Primary source verification of licensure occurs as soon as the disaster is under control or within 72 hours from the time the volunteer APP presents himself/herself to the Hospital, whichever comes first.

(a) If primary source verification of a volunteer APP's licensure cannot be completed within 72 hours of the APP's arrival due to extraordinary circumstances, the Hospital documents all of the following:

(1) Reasons primary source verification of licensure could not be performed within 72 hours of the APP's arrival.

(2) Evidence of the APP's demonstrated ability to continue to provide adequate care, treatment, and services.

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

(b) If, due to extraordinary circumstances, primary source verification of licensure of the volunteer APP cannot be completed within 72 hours of the APP's arrival, it is performed as soon as possible.

5.7.8 Based on its oversight of each volunteer APP, the Hospital determines within 72 hours of the APP's arrival if granted disaster Privileges should continue.

5.7.9 The volunteer APP's disaster Privileges will continue for the duration of the disaster only (unless sooner terminated by the volunteer APP or authorized Hospital representative) and will automatically terminate at the end of the disaster as determined by the Hospital President or Administrator-on-Call.

5.7.10 An APP's disaster Privileges will be immediately terminated in the event any information received through the verification process indicates any adverse information or suggests the volunteer APP is not capable of competently rendering care, treatment, and/or services in a disaster. The Hospital President, Vice President of Medical Affairs, Vice President of Surgical Affairs, or Medical Staff President may, at any time, revoke any or all of a volunteer APP's disaster Privileges. Where the life or well-being of a patient is determined to be endangered, a volunteer APP's disaster Privileges may be terminated by any person entitled to impose a summary suspension pursuant to §7.2 of this Policy.

5.7.11 A volunteer APP who has been granted disaster Privileges is not an Appointee to the Medical Staff and is not entitled to the procedural due process rights afforded to Appointees. A volunteer APP shall not be entitled to the procedural due process rights set forth in the Medical Staff Bylaws or this APP Policy because the volunteer APP's request for disaster Privileges is refused, in whole or in part, or because all or any portion of such disaster Privileges are terminated, not renewed, restricted, suspended, or otherwise limited, modified, or monitored in any way. Refusal to grant a volunteer APP disaster Privileges or termination of a volunteer APP's disaster Privileges is not a reportable event for purposes of federal or state law.

ARTICLE VI

COLLEGIAL INTERVENTION & INFORMAL REMEDIATION

6.1 COLLEGIAL INTERVENTION & INFORMAL REMEDIATION

6.1.1 Any Practitioner/APP may provide information to Medical Staff or Hospital leaders regarding the professional conduct or clinical competence of another Practitioner/APP.

6.1.2 Prior to initiating corrective action against an APP for professional conduct or competency concerns, the Hospital President, the VPMA/VPSA, a Medical Staff officer, or Department Chair may elect, but is not obligated, to attempt to resolve the concern(s) informally. Any such informal, collegial attempts shall be documented and retained in the APP's quality peer review file.

6.1.3 An appropriately designated Medical Staff committee may enter into a voluntary remedial agreement with an APP, consistent with the Medical Staff's professional practice policies, to resolve potential clinical competency or conduct issues. If the affected APP fails to abide by the terms of an agreed-to remedial agreement, the affected APP will be subject to the formal corrective action procedure set forth in §7.1.

6.1.4 Nothing in this Section shall be construed as obligating the Hospital or Medical Staff to engage in collegial intervention or informal remediation prior to implementing formal corrective action on the basis of a single incident.

6.2 IMPAIRED APPS

The collegial intervention/informal remediation procedure for addressing impaired APPs is set forth in the Medical Staff Practitioner/APP Effectiveness Policy as such Policy may be amended from time to time.

6.3 CODE OF CONDUCT

The collegial intervention/informal remediation procedure for addressing code of conduct violations is set forth in the Medical Staff Code of Conduct Policy as such Policy may be amended from time to time.

ARTICLE VII

FORMAL CORRECTIVE ACTION, SUMMARY SUSPENSION, AND AUTOMATIC SUSPENSION/TERMINATION

7.1 FORMAL CORRECTIVE ACTION

7.1.1 Criteria for Initiation

(a) A corrective action investigation may be requested whenever the activities, professional conduct, or clinical competence of an APP is or considered reasonably likely to be:

(1) Inconsistent with his/her responsibilities as set forth in this Policy or other applicable Medical Staff/Hospital policies.

(2) Detrimental to patient safety or to the delivery of quality patient care at the Hospital.

(3) Disruptive to the operation of the Hospital or Medical Staff.

(4) Injurious to the name, welfare, or interest of the Hospital or Medical Staff.

(5) Unethical or below the applicable professional standards of care.

(6) Detrimental to the health or safety of any Practitioner, APP, Hospital employee, or any other person at the Hospital.

(7) Otherwise in violation of this Policy, other applicable Medical Staff or Hospital policies, or Department rules or regulations.

7.1.2 Corrective Action Requests

(a) A request for a corrective action investigation of an APP may be submitted by:

(1) Any Medical Staff committee (which request may be reflected by committee minutes)

(2) A Medical Staff officer

(3) A Department Chair

(4) The Hospital President

(5) The VPMA/VPSA

(6) The Board (or chair thereof)

(b) All requests for corrective action investigations shall be submitted in writing (which request may be reflected in committee minutes) to the Medical Executive Committee, and supported by reference to the specific activities or conduct that constitute the grounds for the request. In the event that the request for corrective action is initiated by the Medical Executive Committee, it shall reflect the basis for its recommendation in its minutes. The Medical Staff President shall promptly notify the Hospital President, in writing, of all requests for corrective action investigations received by the Medical Executive Committee and shall continue to keep him/her fully informed of all action taken in conjunction therewith.

(c) Upon receipt of a request for corrective action, the Medical Executive Committee, in Executive Session, may take one of the following actions:

(1) If, in the opinion of the Medical Executive Committee, there is certainty that no basis exists for the request for a corrective action investigation, the Medical Executive Committee may close the matter and direct the Medical Staff President to notify the individual/group requesting the investigation and the Hospital President of such determination of the Medical Executive Committee and advise them that no further action will be taken at this time.

(2) Defer action on the request for investigation in order to obtain further information.

(3) Determine that no formal corrective action is warranted and remand the matter for informal resolution (*i.e.*, collegial intervention/voluntary remediation) consistent with Article VI and applicable Medical Staff Policies.

(4) Initiate a formal corrective action investigation in accordance with the procedure set forth in this section.

7.1.3 Corrective Action Investigation

(a) A matter shall be deemed to be under formal investigation upon the following event, whichever occurs first:

(1) The start of a Medical Executive Committee meeting at which a request for corrective action is being presented.

(2) The APP is notified by an authorized Hospital or Medical Executive Committee representative (either verbally or by Special Notice) that a request for corrective action has been submitted to the MEC.

(b) For the sole purpose of determining whether there is a potential reportable event, the matter will be deemed to be under formal corrective action until

the end of the Medical Executive Committee meeting at which the issue is presented; provided, however, that if the MEC determines to proceed with a formal corrective action investigation, the matter shall remain under formal investigation until such time as the MEC rejects the request for corrective action, closes the investigation, or a final decision is rendered by the Board. The affected APP shall be provided with written notice, by Special Notice, of a determination by the MEC to go forward with a corrective action investigation.

(c) The MEC may conduct a corrective action investigation itself; assign the task to a Medical Staff officer, a Department Chair, or a standing or *ad hoc committee*; or may refer the matter to the Board for investigation and resolution.

(d) The investigative process shall not entitle the APP to the procedural rights set forth in Article VIII. Appearances by the APP before the investigating individual/group shall be preliminary in nature and none of the procedural rules provided in Article VIII shall apply. The APP shall not be entitled to have legal counsel in attendance at such preliminary appearances unless otherwise permitted at the sole discretion of the investigating individual/group.

(e) The investigating individual/group will proceed with its investigation in a prompt manner. The investigative process may include, without limitation, a meeting with the APP involved who may be given an opportunity to provide information in a manner and upon such terms as the investigating individual/group deems appropriate; with the individual or group who made the request; and/or with other individuals who may have knowledge of, or information relevant to, the events involved.

(f) If the corrective action investigation is conducted by a group or individual other than the MEC or the Board, that group or individual shall submit a written report of the investigation, which may be reflected by committee minutes, to the MEC as soon as practical after its receipt of the assignment to investigate. The report should contain such detail as is necessary for the MEC to rely upon it including recommendations for appropriate corrective action or no action at all (and the basis for such recommendations).

(g) The Medical Executive Committee may, at any time, terminate the investigative process and proceed with action as provided below.

7.1.4 Action Following Completion of Investigation

(a) As soon as practical following completion of its report (which may be reflected by committee minutes); or following receipt of a report from the investigating individual or group, the MEC shall act upon the request for corrective action. The MEC's action may include, without limitation:

(1) A determination that no corrective action be taken.

(2) Issuance of a warning, a letter of admonition, or a letter of reprimand.

(3) Imposition of a focused professional practice evaluation period with retrospective review of cases and/or other review of professional practices or conduct but without requirement of prior or concurrent consultation or direct supervision.

(4) Imposition of prior or concurrent consultation or direct supervision or other form of focused professional practice evaluation that limits the APP's ability to continue to exercise previously exercised Privileges for a period of up to fourteen (14) days.

(5) Imposition of a suspension of all, or any part, of the APP's Privileges for a period up to fourteen (14) days.

(6) Other actions deemed appropriate under the circumstances that will result in a limitation of the APP's Privileges for a period up to fourteen (14) days.

(7) Recommendation of imposition of prior or concurrent consultation or direct supervision or other form of focused professional practice evaluation that limits the APP's ability to continue to exercise previously exercised Privileges for a period in excess of fourteen (14) days.

(8) Recommendation of a suspension of all or any part of an APP's Privileges for a period in excess of fourteen (14) days.

(9) Recommendation of other actions deemed appropriate under the circumstances that will result in a limitation of the APP's Privileges for a period in excess of fourteen (14) days.

(10) Recommendation of revocation of all, or any part, of the APP's Privileges.

(11) Such other recommendation or action as permitted and deemed appropriate under the circumstances.

(b) If the recommendation of the MEC is Adverse to the Appointee (as defined in this Policy), the Medical Staff President shall promptly notify the affected APP, by Special Notice, and the APP shall be entitled, upon timely and proper request, to the procedural due process rights set forth in Article VIII. The Medical Staff President shall hold the Adverse recommendation until the APP has exercised or waived his/her procedural due process rights after which the final MEC recommendation, together with all accompanying information, shall be forwarded to the Board for action.

(c) If the MEC (i) initially referred the corrective action investigation to the Board; or (ii) fails to act on a request for corrective action within a reasonable time as determined by the Board, the Board may proceed with its own investigation or determination, as applicable to the circumstances. In the case of (ii), the Board shall make such determination after informing the MEC of the Board's intent and allowing a reasonable period of time for response by the MEC.

(1) If the Board's decision is not Adverse to the APP, the action shall be effective as its final decision and the Hospital President shall inform the APP of the Board's decision by Special Notice.

(2) If the Board's decision is Adverse to the APP, the Hospital President shall inform the APP, by Special Notice, and the APP shall be entitled, upon timely and proper request, to the procedural rights set forth in Article VIII

(d) The commencement of corrective action procedures against an APP shall not preclude the summary suspension or automatic suspension or automatic termination of all, or any portion, of the APP's Privilege in accordance with the procedures set forth in §7.2, §7.3, or §7.4 of this Article.

7.2 SUMMARY SUSPENSION

7.2.1 Criteria for Initiation

(a) Whenever an APP's conduct appears to require that immediate action be taken to protect or reduce the substantial likelihood of injury or imminent danger to the life, health, or well-being of any patient, employee, or other person present in the Hospital, the following individuals/groups, who may consult with each other for guidance, may summarily suspend or restrict all, or any portion, of the Clinical Privileges of such APP:

(1) Medical Staff President

(2) VPMA/VPSA

(3) Respective Department Chair

(4) Hospital President

(5) MEC

(6) Board (or Board chair)

(b) Such summary suspension shall be deemed an interim action and not a final professional review action. It shall not imply any final findings of responsibility for the situation that caused the summary suspension. Such summary suspension shall be effective immediately upon imposition.

(c) The person or group who imposed the summary suspension shall promptly notify the APP, by Special Notice, of imposition of the summary suspension or restriction.

(d) The person or group who imposed the summary suspension shall promptly notify the Medical Staff President, the VPMA/VPSA, the Department Chair, and the Hospital President of the summary suspension.

7.2.2 MEC Action

(a) As soon as possible, but in no event later than three (3) working days after a summary suspension is imposed, the MEC (if the MEC was not involved in the imposition of the summary suspension), shall convene to review and consider the action taken and the need, if any, for corrective action pursuant to §7.1 above. The MEC may invite the APP whose Clinical Privileges have been summarily restricted or suspended to attend the meeting.

(b) Following such a meeting, the Medical Executive Committee may vote to affirm, remove, or modify the summary suspension or restriction provided that the summary restriction/suspension was not imposed by the Board or the Hospital President (on behalf of the Board). In the case of a summary suspension imposed by the Board or Hospital President (on behalf of the Board), the MEC shall provide its recommendation to the Board as to whether such summary suspension should be modified, continued, or terminated. The Board may accept, modify, or reject the MEC's recommendation.

(c) Not later than fourteen (14) days following the original imposition of the summary suspension, the APP shall be notified, by Special Notice, of the Medical Executive Committee's decision; or, in the case of a summary suspension imposed by the Board or the Hospital President (on behalf of the Board), of the MEC's recommendation as to whether such summary suspension should be terminated, modified, or sustained and of the APP's rights, if any, pursuant to Article VIII.

(1) If the summary suspension is not lifted by the conclusion of the fourteenth (14^{th}) day of its imposition, an APP shall have the right to proceed under Article VIII. The terms of the summary suspension shall remain in effect pending the outcome of any procedural due process rights initiated by the APP pursuant to Article VIII.

(2) Lifting the summary suspension within fourteen (14) days of its original imposition on the ground that corrective action was not required shall not be deemed Adverse and a statement to that effect shall be placed in the APP's file.

(d) In the event Board action is required, the Board members will meet sufficiently in advance of the fourteen (14) day deadline to resolve.

7.2.3 Patient Coverage

(a) Immediately upon imposition of a summary suspension or restriction, the Medical Staff President and/or applicable Department Chair(s) shall have authority to designate an Appointee, other than the Department Chair, or another APP with appropriate Privileges to provide for coverage of the hospitalized patients of the suspended APP.

(b) The patients' wishes shall be considered in the selection of an alternate Practitioner/APP. The affected APP shall confer with the alternate Practitioner/APP to the extent necessary to safeguard the patients.

(c) A Practitioner(s) who imposed the summary suspension or restriction, shall not assume direct responsibility for the care of the suspended APP's patients.

7.3 AUTOMATIC SUSPENSION OR LIMITATION

7.3.1 The following events shall result in an automatic suspension or limitation of an APP's Privileges, as applicable, without recourse to the procedural rights set forth in Article VIII:

(a) Licensure. Action by any federal or state authority suspending or limiting an APP's professional license shall result in an automatic comparable suspension/limitation on the APP's Privileges. Whenever an APP's licensure is made subject to probation, the APP's Privileges shall automatically become subject to the same terms of the probation.

(b) Controlled Substance Authorization. Whenever an APP's prescriptive authority, federal Drug Enforcement Administration (DEA) registration, or state controlled substance certificate is suspended, limited or revoked, the APP shall automatically and correspondingly be suspended, limited, or divested of the right to prescribe medications covered by the prescriptive authority or registration/certificate, as of the time such action becomes effective and through its term. Whenever an APP's prescriptive authority, DEA registration, or state controlled substance certificate is made subject to probation, the APP's right to prescribe such medications shall automatically become subject to the same terms of the probation.

(c) Professional Liability Insurance Coverage. If an APP's Professional Liability Insurance coverage lapses, falls below the required minimum, is terminated, or otherwise ceases to be in effect, in whole or in part, the APP's Privileges shall be automatically suspended until such time as the APP presents proof, in writing, that such insurance has been restored or until the APP's Privileges are automatically terminated pursuant to §7.4.1(b) below. The APP shall provide the Hospital with a certified copy

of the insurance certificate from the insurance company and a written statement explaining the circumstances of the APP's non-compliance with the Professional Liability Insurance requirements, any limitations on the new policy, and a summary of relevant activities during the period of no coverage to establish current competency. For purposes of this section, the failure of an APP to provide proof of Professional Liability Insurance shall constitute a failure to meet the requirements of this paragraph.

(d) Federal Healthcare Program. Whenever an APP is suspended from participating in a Federal Healthcare Program, the APP's Privileges shall be immediately and automatically suspended.

(e) Health Screenings/Immunizations. Failure to provide documentation of required immunizations and/or health screenings in accordance with the requirements set forth in the applicable Medical Staff Policy will result in automatic suspension of the APP's Privileges to the extent and in the manner provided for such Medical Staff Policy.

(f) Suspension/Termination of Supervising or Collaborating Practitioner's Appointment/Privileges. For those APPs who are required to have a supervising or collaborating Practitioner, lapse, suspension, or termination of the APP's 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 unless the APP has more than one (1) supervising or collaborating Practitioners with Medical Staff appointment and Privileges at the Hospital.

(g) Termination of Standard Care Arrangement/Supervision Agreement. For those APPs who are required to have a standard care arrangement or supervision agreement, termination or expiration of the APP's standard care arrangement or supervision agreement shall result in an automatic suspension of the APP's Privileges unless the APP has more than one (1) current, valid standard care arrangement or supervision agreement with an appropriate Physician or Podiatrist with Medical Staff appointment and Privileges at the Hospital on file in Medical Staff Services.

(h) Medical Records. Whenever an APP fails to complete medical records as provided for in the Delinquent Medical Records Policy, the APP's Privileges shall be automatically suspended to the extent and in the manner provided for in such Policy.

7.3.2 During such period of time when an APP's Privileges, as applicable, are suspended pursuant to §7.3-1 (a)-(g), he/she may not exercise any Privileges at the Hospital.

7.3.3 During such period of time when an APP's Privileges are limited pursuant to §7.3-1(h) (*i.e.*, delinquent medical records), he/she is subject to the same limitations noted above except that such APP may:

(a) Conclude the management of any patient under his/her care in the Hospital at the time of the effective date of the automatic suspension of Privileges.

(b) Attend an obstetrical patient who has been under his/her active care and management and who comes to term and is admitted to the Hospital in labor.

(c) Attend to the management of any patient under his/her care whose outpatient procedure was scheduled prior to the effective date of the automatic suspension.

(d) Attend to the management of any patient under his/her care requiring emergency care and intervention.

7.3.4 At the next regularly scheduled meeting following the imposition of an automatic suspension, the Medical Executive Committee shall convene to determine if corrective action is necessary in accordance with §7.1.

7.3.5 The lifting of the action or inaction that gave rise to an automatic suspension or limitation on Privileges shall result in the automatic reinstatement of the APP's Privileges provided, however, that the APP shall be obligated to provide such information as the Credentialing Office shall reasonably request to assure that all information in the APP's credentials file is current.

7.4 AUTOMATIC TERMINATION

7.4.1 The following events shall result in an automatic termination of Privileges without recourse to the procedural rights set forth in Article VIII.

(a) Licensure. Action by any federal or state authority terminating an APP's professional license shall result in an automatic termination of the APP's Privileges.

(b) Professional Liability Insurance. In the event that proof of Professional Liability Insurance coverage is not provided to the Hospital within thirty (30) days of an APP's automatic suspension pursuant to §7.3.1(c), the APP's Privileges shall automatically terminate as of the thirty-first (31st) day.

(c) Federal Healthcare Program. Whenever an APP is excluded from participating in a Federal Healthcare Program, the APP's Privileges shall be automatically terminated.

(d) Plea of Guilty to Certain Offenses. If an APP pleads guilty or no contest to or is found guilty of a felony or other serious offense that involves (i) violence or abuse upon a person, conversion, embezzlement, or misappropriation of property; (ii) fraud, bribery, evidence tampering, or perjury; or (iii) a drug offense, the APP's Privileges shall be immediately and automatically terminated.

(e) Immunizations and Health Screenings. In the event that documentation of required immunizations and/or health screenings is not provided in accordance with the requirements set forth in the applicable Medical Staff Policy following an automatic suspension of Privileges pursuant to §7.3.1(e), the APP's Privileges will automatically terminate in the manner provided for in such Medical Staff Policy.

(f) Failure to Complete Hospital Training. Failure to complete Hospital training (*e.g.*, I'm 4 Safety, *etc.*) in accordance with the requirements set forth in the applicable Medical Staff Policy shall result in automatic termination of the APP's Privileges in the manner provided for in such Medical Staff Policy.

(g) Supervising/Collaborating Practitioner. If the APP's Privileges are suspended pursuant to §7.3.1(f) and the APP does not make arrangements for supervision by/collaboration with an appropriate Practitioner with Medical Staff appointment and Privileges at the Hospital within thirty (30) days of the automatic suspension, the APP's Privileges at the Hospital shall automatically terminate as of the one hundred and twenty-first (121st) day.

(h) Failure to Submit New Standard Care Arrangement/Supervision Agreement. If the APP's Privileges are suspended pursuant to §7.3.1(g) and the APP does not submit a new, executed standard care arrangement or supervision agreement with an appropriate Physician or Podiatrist with Medical Staff appointment and Privileges at the Hospital within thirty (30) days of the automatic suspension, the APP's Privileges shall automatically terminate as of the one hundred and twenty-first (121st) day.

ARTICLE VIII

APP PROCEDURAL DUE PROCESS RIGHTS

8.1 APPLICABILITY

8.1.1 The procedural due process rights set forth in this Policy are only applicable to APPs requesting or granted Privileges through the Medical Staff process.

8.1.2 The provisions in the Medical Staff Bylaws setting forth the procedural rights of Medical Staff applicants and Appointees do not apply to APPs.

8.2 PROCEDURAL DUE PROCESS RIGHTS FOLLOWING RECOMMENDATION OF DENIAL OF APPLICATION FOR PRIVILEGES

8.2.1 When the MEC proposes to make a recommendation to deny an APP's application for Privileges based upon professional conduct or clinical competence concerns, the APP shall be provided written notice, by Special Notice, of the MEC's proposed recommendation.

8.2.2 The APP shall then have five (5) working days in which to submit a written response to the MEC as to why such Adverse recommendation should be withdrawn and a favorable recommendation made. The APP may meet with the MEC (or a subcommittee of the MEC) upon request. After reviewing the APP's written response and meeting with the APP (if applicable), the MEC shall make its final recommendation to the Board. The APP will be advised, by Special Notice, of the MEC's final recommendation; and, if applicable, the APP's right to appeal.

8.2.3 If the MEC's recommendation continues to be Adverse to the APP, the APP shall have five (5) working days in which to submit a written appeal to the Board. At the Board's discretion, it may meet (or have a committee of the Board meet) with the APP. During this meeting, the basis of the Adverse recommendation that gave rise to the appeal will be reviewed with the APP and the APP will have the opportunity to present any additional information the APP deems relevant to the review and appeal of the MEC's Adverse recommendation. After reviewing the Adverse recommendation of the MEC, the APP's written response/appeal, and the results of meetings with the APP, if any, the Board shall take action.

8.2.4 Whenever the Board determines that it will decide a matter contrary to the recommendation of the MEC, and the matter has not previously been submitted to the Joint Conference Committee, the matter will be submitted to such committee for review and recommendation before the Board makes its final decision.

8.2.5 The APP will receive written notice, by Special Notice, of the Board's final decision.

8.3 PROCEDURAL DUE PROCESS RIGHTS FOLLOWING CORRECTIVE ACTION OR SUMMARY SUSPENSION

8.3.1 The APP shall have five (5) working days in which to submit a written response to the MEC as to why such limitation, suspension, or termination of the APP's Privileges should, as applicable, be lifted, rescinded, or not take place. The APP may meet with the MEC (or a subcommittee of the MEC) upon request. After reviewing the APP's written response and meeting with the APP (as applicable), the MEC shall make a recommendation regarding the limitation, suspension, or termination of the APP's Privileges to the Governing Body. The APP shall be advised, by Special Notice, of the MEC's recommendation, the basis for such recommendation; and, if applicable, the APP's right to appeal.

8.3.2 If the MEC recommendation is Adverse to the APP, the APP shall have five (5) working days in which to submit a written appeal to the Board. At the Board's discretion, it may meet (or have a committee of the Board meet) with the affected APP. During this meeting, the basis of the Adverse recommendation/action that gave rise to the appeal will be reviewed with the APP and the APP will have the opportunity to present any additional information the APP deems relevant to the review and appeal of the MEC's Adverse recommendation. After reviewing, as applicable, the recommendation of the person/group that imposed a summary suspension, the recommendation of the MEC, the APP's written response/appeal, and the results of meetings with the APP, if any, the Board shall take action.

8.4 EMPLOYER NOTIFICATION

When an APP's Privileges are suspended, terminated, or otherwise curtailed, the APP's employer (if applicable) shall be notified of such action.

ARTICLE IX

LEAVE OF ABSENCE

9.1 REQUEST

9.1.1 At the discretion of the Board, upon recommendation of the Medical Executive Committee and Department Chair, an APP may for good cause (which may include, but not be limited to, medical reasons, military duty, or educational sabbatical) obtain a voluntary leave of absence. A voluntary leave of absence may be requested by submitting a written request to the Credentialing Office stating the reason for the leave and the approximate period of leave desired.

9.1.2 Leaves may not exceed the last date of the APP's current Privilege period.

(a) If an APP is unable to return from a leave prior to the end of his/her current Privilege period, the APP shall be deemed to have resigned as of the last date of his/her current Privilege period and his/her Privileges will automatically terminate as of such date. The APP may thereafter reapply for Privileges at the Hospital at such time as he/she is able to return to practice.

9.1.3 Prior to a leave of absence being granted, the APP shall have made arrangements acceptable to the Medical Executive Committee and Board for the care of his/her patients during the leave.

(a) During the period of the leave, the APP shall not exercise Clinical Privileges at the Hospital and the APP's responsibilities shall be inactive.

(b) In order to qualify for reinstatement of Privileges following a leave of absence, the APP must maintain Professional Liability Insurance coverage during the leave or purchase tail coverage for all periods during which the APP held Privileges at the Hospital. The APP shall provide information to demonstrate satisfaction of continuing Professional Liability Insurance coverage or tail coverage as required by this provision upon request for reinstatement of Privileges.

9.1.4 Termination of Leave

(a) The APP may request reinstatement of his/her Privileges by submitting a written notice to that effect to the Credentialing Office. A request for reinstatement of Privileges shall be submitted not less than thirty (30) days prior to the end of the leave of absence.

(b) A summary shall be submitted by the APP outlining his/her activities during the leave. The APP shall submit such additional information as is necessary to reflect that the APP is qualified for reinstatement of Privileges.

(c) Reinstatement of Privileges following a leave of absence may be subject to a focused professional practice evaluation period to assess the APP's current clinical competency.

(d) When the APP's request for reinstatement of Privileges is deemed complete, the procedure for regrant of Privileges set forth in Article IV of this Policy shall be followed.

9.1.5 Failure to Request Reinstatement

(a) If an APP fails to request reinstatement of Privileges upon the termination of a leave of absence, the Medical Executive Committee shall make a recommendation to the Board as to how the failure to request reinstatement should be construed.

(b) If such failure is determined to be a voluntary resignation, it shall not give rise to any rights pursuant to Article VIII of this Policy.

ARTICLE X

CONFIDENTIALITY, IMMUNITY, AND RELEASES

10.1 SPECIAL DEFINITIONS

10.1.1 For purposes of this Article, the following definitions shall apply:

(a) Information: Any record of proceedings, minutes, records, reports, memoranda, statements, recommendations, data, and other disclosures whether in written or oral form relating to any of the subject matter specified in §10.6

(b) Representative: The Board and any officer, director, or committee or delegated representative thereof; the Hospital President or his/her designee; the Medical Staff organization and any Appointee, officer, Department or committee thereof; and any individual authorized by any of the foregoing (*e.g.,* Hospital Staff, Practitioner, APP, *etc.*) to perform specific information gathering or disseminating functions.

(c) Third Parties: Any and all individuals and organizations providing information to any Representative.

10.2 AUTHORIZATIONS AND CONDITIONS

10.2.1 By applying for or exercising Clinical Privileges within this Hospital, an APP:

(a) Authorizes Representatives to solicit, provide, and act in accordance with this Policy upon Information bearing upon the APP's professional ability and qualifications.

(b) Agrees to be bound by the provisions of this Article and to waive all legal claims against any Representative who acts in accordance with the provisions of this Article.

(c) Acknowledges that the provisions of this Article are express conditions to his/her application for, and acceptance of, grant/regrant of Clinical Privileges at this Hospital.

10.3 CONFIDENTIALITY OF INFORMATION

Information with respect to any APP submitted, collected, or prepared by any Representative of this Hospital or representative of any other health care facility or organization or medical staff for the purpose of: achieving and maintaining quality patient care; evaluating, monitoring, and improving patient care; reducing morbidity and mortality; evaluating the qualifications and clinical competence/performance of an APP or acting upon matters relating to corrective action; contributing to teaching or clinical research activities; or determining that healthcare services were professionally indicated and performed in accordance with the applicable standards of care shall, to the fullest extent permitted by law, be confidential. Such information shall not be disclosed or

disseminated to anyone other than a Representative nor be used in any way except as provided herein or except as otherwise required/permitted by law. Such confidentiality shall also extend to Information of like kind that may be provided by/to any Third Parties engaged in an official, authorized activity for which the Information is needed. The Information so provided shall not become part of any particular patient's medical record or general Hospital records, but will remain in the APP's peer review file.

10.4 BREACH OF CONFIDENTIALITY

It is expressly acknowledged by each APP that violation of the confidentiality provisions provided herein is grounds for corrective action pursuant to the procedure set forth in §7.1 of this Policy.

10.5 IMMUNITY FROM LIABILITY

10.5.1 For Action Taken

Each Representative shall be exempt, to the fullest extent permitted by law, from liability to any APP for damages or other relief for any action taken or statements or recommendations made within the scope of his/her duties as a Representative provided that such Representative does not act on the basis of false information knowing such information to be false.

10.5.2 For Providing Information

Each Representative and any Third Parties shall be exempt, to the fullest extent permitted by law, from liability to an APP for damages or other relief by reasons of providing Information (including otherwise privileged or confidential information) to a Representative concerning an APP who did, or does, exercise Clinical Privileges at this Hospital provided that such Representative or Third Party does not act on the basis of false information knowing such Information to be false.

10.6 ACTIVITIES AND INFORMATION COVERED

10.6.1 Activities

(a) The confidentiality and immunity provided by this Article shall apply to all Information in connection with this Hospital's or any Third Party activities concerning, but not limited to:

(1) Applications for Clinical Privileges

(2) Appraisals for regrant of Clinical Privileges

(3) Any corrective action

(4) Procedural due process rights

(5) Quality assurance/performance improvement activities

(6) Utilization review activities.

(7) Peer review organizations.

(8) Any other Hospital, Department, committee, or Medical Staff activities related to monitoring and maintaining quality patient care.

10.6.2 Information

The Information referred to in this Article may relate to an APP's professional qualifications including, but not limited to, judgment, character, the clinical ability to safely and competently exercise the Privileges requested, professional ethics, or any other matter that might directly or indirectly affect patient care and Medical Staff or Hospital operations.

10.7 AUTHORIZATIONS & RELEASES

Each APP shall, upon request of the Hospital, execute general and specific authorizations and releases in accordance with the expressed provisions and general intent of this Article, subject to applicable laws. Execution of such authorizations and releases shall not be deemed a prerequisite to the effectiveness and/or application of this Article.

10.8 CUMULATIVE EFFECT

Provisions in this Policy and in application forms relating to authorizations, confidentiality of Information, and releases/immunity from liability shall be in addition to any other protections provided by law and not in limitation thereof. In the event of conflict, the superior applicable law shall be controlling.

ARTICLE XI

GENERAL PROVISIONS

11.1 FORMS

Application forms and any other prescribed forms required by this Policy shall be subject to adoption by the Board after considering the recommendation of the Medical Executive Committee.

11.2 INTERNAL CONFLICTS

11.2.1 In any instance where an APP has or reasonably could be perceived to have a conflict of interest in any matter that comes before the Medical Staff, a Department, Division, or Medical Staff committee, the APP is expected to disclose the conflict to the individual in charge of the meeting. The APP may be asked and is expected to answer any questions concerning the conflict. The committee (or, in the absence of a committee, the individual in charge of the meeting) is responsible for determining whether a conflict exists and, if so, whether the conflict rises to the level of precluding the APP from participating in the pending matter.

11.2.2 A Department Chair shall have the duty to delegate review of applications for grant/regrant of Privileges to another member of the Department or to the applicable Division head if the Department Chair could reasonably be perceived as not being able to review such application objectively

11.2.3 For purposes of this §11.2, the fact that APPs are competitors, partners, or employed in the same group shall not, in and of itself, automatically disqualify such APPs from participating in the review of applications or other Medical Staff matters with respect to their colleagues.

11.3 ADOPTION & AMENDMENT OF APP POLICY

11.3.1 This APP Policy may be adopted and amended in accordance with the applicable procedure set forth in the Medical Staff Bylaws for Medical Staff Policies.

ADOPTION & APPROVAL

This Advanced Practice Provider Policy has been adopted by:

Summa Health System Medical Executive Committee on February 13, 2020

This Advanced Practice Provider Policy has been approved by:

The Credentialing Committee of the Summa Health System Board of Directors on February 27, 2020

EXHIBIT A

Advanced Practice Providers credentialed by the Medical Staff and eligible to be granted Clinical Privileges at the Hospital:

Certified Nurse Practitioners (CNP)

Certified Nurse-Midwives (CNM)

Certified Registered Nurse Anesthetists (CRNA)

Clinical Nurse Specialists (CNS)

Licensed Independent Social Worker (LISW)

Licensed Professional Clinical Counselors (LPCC)

Physician Assistants (PA)

Registered Nurse First Assistant (RNFA)

Registered Radiologist Assistant (RRA)