Medical Staff Credentialing Policy

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CREDENTIALING POLICY
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CREDENTIALING POLICY

ARTICLE I.
APPOINTMENT TO THE MEDICAL STAFF

1.1 QUALIFICATIONS FOR APPOINTMENT

1.1.1 General

A. Appointment to the Medical Staff is a privilege that shall be extended only to professionally competent individuals who continuously meet the qualifications, standards, and requirements set forth in this Policy and in such policies as are adopted from time to time by the Medical Staff and the Board of Directors of Saint Francis Healthcare. All individuals practicing medicine, dentistry, podiatry, or psychology at Saint Francis Healthcare, unless accepted by specific provisions of this Policy, must have been appointed to the Medical Staff.

B. All procedures described in this Policy shall be subject to the confidentiality provisions described in Section 4.4 of this Policy.

1.1.2 Specific Qualifications

Only physicians, dentists, podiatrists, and psychologists who continuously satisfy the following conditions shall be qualified for membership on the Medical Staff:

1. Have a current unrestricted license to practice in the State of Delaware (except members of the Emeritus Staff);

2. Are located (office and residence) close enough to the Hospital to fulfill their Medical Staff responsibilities and to provide timely and continuous care for their patients in the Hospital, in accordance with those specific requirements that are recommended by the MEC and approved by the Board of Directors (except members of the Emeritus and Community Staff);

3. Possess current, valid professional liability insurance coverage in such form and in amounts satisfactory to the Board of Directors, in compliance with the laws of the State of Delaware, and adequate to provide coverage of the privileges requested or granted. (Physicians admitting or attending patients at Saint Francis Healthcare shall be required to carry professional liability coverage of $1 million per person/$3 million per occurrence);

4. If a physician attending patients at Saint Francis Healthcare, be currently registered at both the state and federal levels to prescribe all medications typically used by practitioners in the same field, which in appropriate circumstances, includes controlled substance classes II-IV.

5. Be able to perform the essential functions of his/her profession for which he/she is seeking privileges, with or without reasonable accommodation.

6. Can demonstrate to the satisfaction of the Board :

    a. Background, experience, training and documented competence;

b. Adherence to the ethics of their profession;

c. Good reputation and character, including the applicant's physical health and mental and emotional stability; and

d. Ability to work harmoniously with others sufficiently that all patients treated by them at the Hospital will receive quality care and the Hospital and Medical Staff will be able to operate in an orderly manner;

7. Physicians, Podiatrists, Psychologists and Oral Surgeons must be board certified in their primary area of practice at Saint Francis Healthcare by the appropriate specialty board of the American Board of Medical Specialties, The American Osteopathic Association, The Council on Podiatric Medical Education, The American Board of Professional Psychology or The American Board of Oral and Maxillofacial surgery, and they must maintain said certification.

Those applicants who are not board certified at the time of application but who by virtue of completing their residency or fellowship training within the last five years are board eligible in their primary specialty, shall be eligible for Medical Staff appointment. However in order to remain eligible, those applicants must achieve board certification in their primary area of practice within five (5) years from the completion of their residency or fellowship training.

Practitioners who have been members of the Medical Staff continuously since January 1, 1999 shall be excluded from the board certification requirement, with the exception that if as of June 28, 2011 they are board certified in their primary area of practice at St. Francis, or ever become certified in their primary area of practice, they must maintain said certification.

Once board certified, individuals whose boards require it must participate in a maintenance of certification program. Individuals who lose certification as a result of failure of a recertification exam must remain eligible for recertification according to the requirements of their board, continue the recertification process and must recertify within three (3) years to remain eligible for medical staff membership.

Waiver of Criteria

Only under extreme and rare circumstances may an individual who does not satisfy the eligibility criteria outlined above request that it be waived. The individual requesting the waiver bears the burden of demonstrating the circumstances, and/or that their qualifications are equivalent to, or exceed, the requirement in question.

A request for waiver shall be submitted to the Credentials Committee for consideration. In reviewing the request for a waiver, the Credentials Committee may, at its discretion, consider the specific qualifications of the individual, input from the Department Chair, the application form and other information supplied by the applicant, and the best interests of the communities served by Saint Francis Healthcare. The waiver may take the form of an extension of a specific amount of time to complete board certification, a complete waiver of the requirement for certification for practitioners whose breadth of experience or other qualifications warrant it, or other form of waiver depending on the circumstances. The Credentials Committee’s recommendation and the basis for it shall be forwarded to the Medical Executive Committee. The Medical Executive Committee shall review the

Credentials Committee action and submit a recommendation and the basis for it to the Board regarding whether to grant or deny the request for a waiver.

An application for appointment that does not satisfy an eligibility criterion will not be considered complete for processing until the Board has determined that a waiver should be granted. No individual is entitled to a waiver or to a hearing if the Board determines not to grant a waiver. The Board may not act to grant an individual a waiver absent a recommendation from the Medical Executive Committee. A determination that an individual is not entitled to a waiver is not deemed a denial of appointment or clinical privileges. The granting of a waiver in a particular case is not intended to set a precedent of eligibility criteria for any other individual or group.

8. Electronic Medical Records

All physicians, dentist, oral surgeons, podiatrists, psychologists and all other independent practitioners on the Medical Staff must participate in the training for Saint Francis Hospital's electronic medical records system (EMR) at such time as the EMR training becomes available. Additionally, all listed providers must agree to use the EMR system. Failure to complete such training will result in temporary suspension of all clinical privileges until the training is complete. Only Emeritus and Community Staff categories are exempt from participation but are permitted to apply for appropriate EMR training and access.

All new physicians, dentists, oral surgeons, podiatrists and psychologists and all other independent practitioners joining the Medical Staff will be required to successfully complete the EMR training at such time as EMR training becomes available before being allowed to treat patients. Only those practitioners applying for Emeritus and Community staff categories are exempt from participation but they are permitted to complete appropriate EMR training if requested.

9. No applicant who is currently excluded from any health care program funded in whole or in part by the federal government, including Medicare or Medicaid, is eligible or qualified for Medical Staff membership;

10. Each member must abide by the Corporate Responsibility program, and the CHE standards of Conduct. Failure to do so shall be grounds for corrective action;

11. Practitioners who diagnose or treat patients via telemedicine link are subject to the usual credentialing and privileging processes of the Medical Staff.

1.1.3. No Entitlement to Appointment

No individual shall be entitled to appointment to the Medical Staff or to the exercise of particular clinical privileges at Saint Francis Healthcare merely by virtue of the fact that such individual:

1. Is licensed to practice a profession in this or any other state;

2. Is a member of any particular professional organization;

3. In the past had or currently has Medical Staff appointment or privileges at any hospital;

4. Resides in the geographic service area of the Hospital;

5. Is affiliated with a particular Medical Staff member or a practice; or

6. For any other reason.

1.1.4. Nondiscrimination Policy

No individual shall be denied appointment on the basis of sex, race, creed, religion, color or national origin, or on the basis of any criterion unrelated to the delivery of quality patient care at the Hospital, to professional qualifications, or to the Hospital's purposes, needs and capabilities.

1.1.5 Ethical and Religious Directives

All Medical Staff appointees exercising clinical privileges at the Hospital shall abide by the terms of the Ethical and Religious Directives for Catholic Health Care Services promulgated from time to time by the National Conference of Catholic Bishops with respect to their practice at the Hospital.

1.2 RESPONSIBILITIES AND REQUIREMENTS FOR APPLICANTS AND APPOINTEES

1.2.1 Basic Responsibilities and Requirements for Applicants and Appointees

As a condition for consideration of an application for Medical Staff appointment or reappointment, and as a condition for continued Medical Staff appointment, if granted, every applicant and appointee specifically agrees to the following:

1. To provide appropriate continuous care and supervision to all patients within the Hospital for whom the individual practitioner has responsibility;

2. To abide by this Policy and all Bylaws, other policies, and rules and regulations of the Medical Staff and Hospital as shall be in force during the time the individual is an applicant or appointed to the Medical Staff;

3. To accept committee assignments and such other reasonable Medical Staff duties and responsibilities as assigned;

4. To provide, with or without request, new or updated information to the Credentials Committee, as it occurs, that is pertinent to any question on the application forms for appointment or reappointment. This information will be provided with or without request, at the time the change occurs, and will include, but not be limited to, changes in licensure status or professional liability insurance coverage, the filing of a professional liability lawsuit against the practitioner, changes in the practitioner's Medical Staff status at any other hospital, exclusion or preclusion from participation in Medicare or any sanctions imposed, and any changes in the individual's ability to safely and competently exercise clinical privileges or perform the duties and responsibilities of appointment because of health status issues, including impairment due to addiction, and any charge of, or arrest for, driving under the influence ("DUI");

5. To attest that the applicant has had an opportunity to read a copy of this Policy and the Bylaws and rules and regulations of the Medical Staff that are in force at the time of application and to agree to be bound by the terms thereof in all matters relating to

consideration of the application, without regard to whether or not appointment to the Medical Staff and/or clinical privileges are granted;

6. To appear, if requested, for personal interviews with regard to the application;

7. To agree that any misrepresentation or misstatement in, or omission from, the application, whether intentional or not, shall constitute grounds for the Hospital to stop processing the application. In the event that an appointment has been granted prior to the discovery of such misrepresentation, misstatement or omission, such discovery may be deemed to result in automatic relinquishment of Medical Staff appointment and privileges. In either situation, the individual shall not be entitled to a hearing. (The individual will be informed in writing of the nature of the misstatement or omission and permitted to provide a written response. The Credentials Committee will review the individual's response and provide a recommendation to the MEC. The MEC will recommend to the Board whether the application should be processed further.);

8. To use the Hospital and its facilities sufficiently to enable appropriate Medical Staff committees and Department Chairpersons and the Hospital to evaluate in a continuing manner the current competence of the appointee;

9. To refrain from illegal fee splitting or other illegal inducements relating to patient referral;

10. To comply with any and all Hospital Compliance Plans relating to billing and reimbursement matters;

11. To refrain from delegating responsibility for diagnoses or care of hospitalized patients to any individual who is not qualified to undertake this responsibility or who is not adequately supervised;

12. To refrain from deceiving patients as to the identity of an operating surgeon or any other individual providing treatment or services;

13. To seek consultation whenever necessary;

14. To promptly notify the VPMA/CMO, and the President of the Medical Staff or designee, of any change in eligibility for payments by third-party payors or for participation in Medicare, including any sanctions imposed or recommended by the federal Department of Health and Human Services, and/or the receipt of a PRO citation and/or quality denial letter concerning alleged quality problems in patient care;

15. To abide by generally recognized ethical principles applicable to the applicant's or appointee's profession;

16. To participate in the quality improvement and assessment activities of clinical departments;

17. To complete in a timely manner the medical and other required records for all patients as required by the Medical Staff bylaws, rules and regulations, this Policy and other applicable policies of the Medical Staff and Hospital;

18. To work cooperatively and professionally with Medical Staff appointees, Medical Staff leadership, Hospital management, other practitioners and Hospital personnel;

19. To promptly pay any applicable Medical Staff dues and assessments annually by March 31st. Medical Staff members, other than Emeritus, who fail to pay their dues by September 30th, will be considered to have voluntarily resigned from the Medical Staff;

20. To participate in education programs at the Hospital (both for the appointee's own benefit and for the benefit of other professionals and Hospital personnel);

21. To appropriately satisfy the medical education requirements for Medical Staff appointees;

22. To authorize the release of all information necessary for an evaluation of the individual's qualifications for initial or continued appointment, reappointment, and/or clinical privileges;

23. To abide by the terms of the Ethical and Religious Directives for Catholic Health Care Services as provided in Section 1.1-5 above; and

24. To promptly notify the VPMA/CMO immediately upon notice of any proposed or actual exclusion from any federally funded health care program and disclose to the hospital President, by telephone call and in writing, any notice to the member or his or her representative of proposed or actual exclusion and/or any pending investigation of the member from any health care program funded in whole or in part by the federal government, including Medicare or Medicaid.

1.2.2 Burden of Providing Information

A. The applicant shall have the burden of producing information deemed adequate by the Hospital for a proper evaluation of competence, character, ethics, and other qualifications and for resolving any doubts about such qualifications.

B. The applicant shall have the burden of providing evidence to the satisfaction of the Credentials Committee that all the statements made and information given on the pre-application, application and other hospital documents are true and correct.

C. Until the applicant has provided all information requested by the Hospital, the application for appointment or reappointment shall be deemed incomplete and will not be further processed. Should information provided in the initial application for appointment change during the course of an appointment year, the appointee has the burden to provide information about such change to the Credentials Committee sufficient for the Credential's Committee's review and assessment.

1.2.3 Effect of Application

By requesting an application and/or applying for appointment, reappointment, or clinical privileges, the individual expressly accepts the following conditions:

1. Whether or not appointment or clinical privileges are granted;

2. Throughout the term of any appointment or reappointment period and thereafter and as applicable, to any third-party inquiries received after the individual leaves the Medical Staff about his/her tenure at the Hospital.

A. Immunity:

To the fullest extent permitted by law, the individual releases from any and all liability, extends absolute immunity to, and agrees not to sue the Hospital, any member of the Medical Staff, their authorized representatives, and third parties who provide information for any matter relating to appointment, reappointment, clinical privileges, or the individual's qualifications for the same. This immunity covers any actions, recommendations, reports, statements, communications, and/or disclosures involving the individual that are made, taken, or received by the Hospital, its authorized agents, or third parties in the course of credentialing and peer review activities.

B. Authorization to Obtain Information from Third Parties:

The individual specifically authorizes the Hospital, Medical Staff leaders, and their authorized representatives (1) to consult with any third party who may have information bearing on the individual's professional qualifications, credentials, clinical competence, character, ability to perform safely and competently, ethics, behavior, or any other matter reasonably having a bearing on his or her qualifications for initial and continued appointment to the Medical Staff, and (2) to obtain any and all communications, reports, records, statements, documents, recommendations or disclosures of third parties that may be relevant to such questions. The individual also specifically authorizes third parties to release this information to the Hospital and its authorized representatives upon request.

C. Authorization to Release Information to Third Parties:

The individual also authorizes Hospital representatives to release information to other hospitals, health care facilities, managed care organizations, government regulatory and licensure boards or agencies, and their agents when information is requested in order to evaluate his or her professional qualifications for appointment, privileges, and/or participation at the requesting organization/facility, and any licensure or regulatory matter.

D. Hearing and Appeal Procedures:

The individual agrees that the hearing and appeal procedures set forth in this Policy will be the sole and exclusive remedy with respect to any professional review action taken by the Hospital.

E. Legal Actions:

If, notwithstanding the provisions in this Section, an individual institutes legal action and does not prevail, he or she will reimburse the Hospital and any member of the Medical Staff named in the action for all costs incurred in defending such legal action, including reasonable attorney's fees.

For purposes of this Section, the term "Hospital Representative" includes the Board, its Directors and committees; the Hospital Chief Executive Officer, and his or her designee, the VPMA/CMO, the Medical Staff organization and all Medical Staff members, Departments, Sections, Committees,

and their Chairpersons who have responsibility for collecting or evaluating the applicant's credentials and acting upon his/her application, and any authorized representative of any of the foregoing individuals or bodies.

1.3 PROCEDURE FOR INITIAL APPOINTMENT

1.3.1 Submission of Application

A. The application for Medical Staff appointment shall be submitted to the VPMA/CMO. It must be accompanied by payment of such processing fees as may be required by the Hospital. After reviewing the application to determine that all information has been provided, and that any questions have been answered, and after reviewing all references and other information or materials deemed pertinent, and after verifying the information provided in the application with primary sources, the VPMA/CMO shall transmit the complete application and all supporting materials to the appropriate department chairperson.

B. An application shall be deemed to be complete when all questions on the application form have been answered, all supporting documentation has been supplied, and all information verified. An application shall become incomplete if the need arises for new, additional or clarifying information at any time during the evaluation process. An incomplete application will not be further processed. Any application that continues to be incomplete ninety (90) days after the applicant has been notified of the additional information required shall be deemed to be withdrawn. It is the responsibility of the applicant to provide a complete application, including adequate responses from references.

C. Any current Medical Staff member shall have the right to appear in person before the Credentials Committee to discuss in private and confidence any concerns the Medical Staff member may have about the applicant.

D. New applicants to the Medical Staff who are currently excluded from any health care program funded, in whole or in part, by the federal government shall be notified that their applications will not be processed because they do not meet the basic qualifications for membership. They shall further be notified that they have no right to a hearing pursuant to this Article regarding the matter.

1.3.2 Factors to be Considered

Each recommendation concerning appointment of a practitioner shall be based upon the following factors:

1. Ethical behavior, clinical competence, and clinical judgment in the treatment of patients, including medical/clinical knowledge, technical and clinical skills, interpersonal and communication skills, and professionalism with patients, families, and other members of the health care team and peer evaluations relating to the same;

2. Participation in Staff duties;

3. Compliance with the Bylaws, policies, and rules and regulations of the Hospital and Medical Staff;

4. Behavior at the Hospital, including cooperation with Medical Staff and Hospital personnel relating to patient care, the orderly operation of the Hospital, and the general attitude toward patients, the Hospital and its personnel;

5. Utilization of Hospital resources;

6. Utilization patterns (e.g., length of patient stays);

7. Current physical and mental health status and ability to perform the privileges requested competently and safely;

8. Capacity to satisfactorily treat patients as indicated by the results of the Hospital's quality improvement activities or other reasonable indicators of continuing qualifications, such as ongoing professional practice evaluation (OPPE) and/or focused professional practice evaluation (FPPE);

9. Satisfactory completion of such continuing education requirements as may be imposed by law, the Hospital, or applicable accreditation organizations;

10. Current professional liability insurance status and pending malpractice challenges, including claims, lawsuits, judgments, and settlements;

11. Current status of professional licenses, including currently pending challenges to any license or registration;

12. Voluntary or involuntary termination of Medical Staff appointment or voluntary or involuntary limitation, reduction, or loss of clinical privileges at another hospital;

13. Voluntary or involuntary relinquishment of federal or state Controlled Substance licensure or certification; and

14. Other reasonable indicators of continuing qualifications.

1.3.3 Review by the Department Chairperson and/or Section Director

A. The appropriate department chairperson(s) or section director(s) shall review the application and all supporting materials and shall provide the Credentials Committee with a written report concerning the applicant's qualifications for appointment and requested clinical privileges.

B. As part of his/her evaluation, the department chairperson and/or any section director has the right to meet with the applicant to discuss any aspect of the application, qualifications, and requested clinical privileges. The department chairperson and/or any section director shall evaluate the applicant's education, training, experience and make inquiries with respect to the same to the applicant's past or current department chiefs, residency training director and any other individuals who may have knowledge about the applicant's education, training, experience and ability to work with others.

C. The department chair and/or section director shall be available to the Credentials Committee to answer any questions that may be raised with respect to his/her report and findings.

1.3.4 Credentials Committee Review

A. The Credentials Committee shall examine evidence of the applicant's character, professional competence, qualifications, prior behavior, and ethical standing and shall determine, through information contained in the references given by the applicant, and from other sources available to the Committee, including the report and findings from the chairperson of each clinical department and/or section in which privileges are sought, whether the applicant has satisfied all of the necessary qualifications for appointment and for the clinical privileges requested.

B. As part of the process of making its recommendation, the Credentials Committee shall have the right to meet with the applicant to discuss the applicant's application, qualifications, and clinical privileges requested.

C. The Credentials Committee may use the expertise of the Department Chairperson, the Section Director, the VPMA/CMO, any member of the Department or Committee, or an outside consultant, if additional information is required regarding the applicant's qualifications.

D. If, after considering the report of the Department Chairperson or Section Director concerned, the Credentials Committee's recommendation is favorable, the Credentials Committee shall recommend provisional department appointment. All recommendations to appoint, including provisional department appointment, must specifically recommend the clinical privileges to be granted, which may be qualified by any probationary or other conditions or restrictions as deemed appropriate by the Credentials Committee.

E. If the recommendation of the Credentials Committee is delayed longer than ninety (90) days after receipt of the Department Chairperson's or Section Director's report, the Chairperson shall send a letter to the applicant, with a copy to the MEC, the VPMA/CMO and the Chief Executive Officer, explaining the delay.

1.3.5 Credentials Committee Report

A. Not later than ninety (90) days from its receipt of the application and all required and requested information, the Credentials Committee shall send its recommendation and written findings in support thereof, to the MEC, unless such recommendation is delayed and notice of the same is provided as required under Section 1.3-5(E) above. The completed application and all supporting documentation shall accompany the Credentials Committee recommendation and findings. The Credentials Committee report shall contain one of the following recommendations:

1. That the applicant be appointed to the Medical Staff;
2. That the applicant be deferred for further consideration; or
3. That the application be rejected for Medical Staff.

B. When the Credentials Committee recommends appointment to the Medical Staff, it shall also make a specific recommendation regarding the clinical privileges to be granted, and any limitations or conditions on the appointment of the privileges.

C. The Chairperson of the Credentials Committee shall be available to the MEC to answer any questions that may be raised with respect to the Credentials Committee's recommendation.

1.3.6 Medical Executive Committee Review

A. At its next regular meeting after receipt of the written findings and recommendation of the Credentials Committee, the MEC shall prepare a report. The report shall:

1. Adopt the findings and recommendation of the Credentials Committee;

2. Refer the matter back to the Credentials Committee for further consideration and preparation of responses to specific questions raised by the MEC prior to its final recommendation;

3. Set forth the reasons and any supporting documentation, for its disagreement with the Credentials Committee's recommendation; or

4. May request evaluations of the practitioner where there is doubt about an applicant's ability to perform the privileges requested.

This report shall be forwarded, along with the Credentials Committee's report, through the Chief Executive Officer to the Board of Directors.

B. If the recommendation of the MEC is favorable to the applicant, it shall transmit its recommendation through the Chief Executive Officer to the Board of Directors, including the findings and recommendation of the Credentials Committee. All recommendations to appoint must also specifically recommend the clinical privileges to be granted, which may be qualified by any probationary or other conditions or restrictions related to such clinical privileges.

C. If the recommendation of the MEC would entitle the applicant to request a hearing pursuant to the Fair Hearing Plan, it shall be forwarded to the Chief Executive Officer or his/her designee, who shall promptly notify the applicant in writing, certified mail, return receipt requested. The Chief Executive Officer or his/her designee shall then hold the application until after the applicant has exercised or waived the right to a hearing as provided in the Fair Hearing Plan, after which the Chief Executive Officer or his/her designee shall forward the recommendation of the MEC, together with the complete application and all supporting documentation, for further consideration to the Board of Directors.

D. Upon receipt of a favorable recommendation from the MEC that an applicant be granted appointment and the requested clinical privileges, the Board of Directors may:

1. Appoint the applicant and grant clinical privileges as recommended;

2. Refer the matter back to the MEC or to another source inside or outside the Hospital for additional research or information; or

3. Reject the recommendation. If the Board of Directors decides to reject a favorable recommendation, it shall send its decision and the reasons therefore to the Chief

Executive Officer and/or designee who shall promptly notify the applicant in writing, certified mail, return receipt requested. If the applicant is entitled to a hearing or appeal, as outlined in the Fair Hearing Plan, the Board of Directors shall not make a final decision until the applicant has exercised or waived his/her rights under the Fair Hearing Plan.

E. The time frame for processing a complete application for initial appointment will be no later than 120 days from the date the application is deemed complete until final approval by the Board of Directors. This time period is intended to be a guideline only and will not create any right for the applicant to have the application processed within this precise time period.

1.4 CLINICAL PRIVILEGES

1.4.1 General

A. Medical Staff appointment or reappointment as such shall not confer any clinical privileges or right to practice at the Hospital.

B. Each individual who has been appointed to the Medical Staff shall be entitled to exercise only those clinical privileges specifically granted by the Board of Directors.

C. The grant of clinical privileges shall carry with it acceptance of the obligations of such privileges, including emergency service and other rotation obligations established to fulfill the Hospital's responsibilities under the Emergency Medical Treatment and Active Labor Act (EMTALA) and/or other applicable requirements or standards.

D. Clinical privileges shall be voluntarily relinquished only in the manner that provides for the orderly transfer of patient care obligations.

E. The clinical privileges recommended to the Board of Directors shall be based upon consideration of the following:

The applicant's education, training, experience, demonstrated current competence and judgment, including medical/clinical knowledge, technical and clinical skills, interpersonal and communication skills, and professionalism with patients, families, and other members of the health care team and peer evaluations relating to the same;

1. Appropriateness of utilization patterns;

2. Ability to perform the privileges requested competently and safely;

3. Information resulting from ongoing and focused professional practice evaluation, performance improvement and other peer review activities, if applicable;

4. The applicant's ability to meet all current criteria for the requested clinical privileges;

5. Availability of qualified physicians or other appropriate appointees to provide medical coverage for the applicant in case of the applicant's illness or unavailability;

6. Adequate levels of professional liability insurance coverage with respect to the clinical privileges requested;

7. The Hospital's available resources and personnel;

8. Any previously successful or currently pending challenges to any licensure or registration, or the voluntary or involuntary relinquishment of such licensure or registration;

9. Any information concerning professional review actions, voluntary or involuntary termination of Medical Staff appointment or voluntary or involuntary limitation, reduction, or loss of clinical privileges at another hospital or health care facility; and

10. Other relevant information, including a written report and findings by the chairperson of each of the clinical departments in which such privileges are sought.

F. The applicant shall have the burden of establishing qualifications for and competence to exercise the clinical privileges requested.

G. The report(s) of the appropriate department chairperson(s) shall be forwarded to the Credentials Committee and processed as part of the initial application for staff appointment.

1.4.2. Clinical Privileges for Dentists, Oral Surgeons, and Podiatrists

A. The scope and extent of surgical procedures that a dentist, oral surgeon or podiatrist may perform in the Hospital shall be delineated and recommended in the same manner as other clinical privileges.

B. Surgical procedures performed by dentists, oral surgeons and podiatrists shall be under the overall supervision of the Chairperson of the Department of Surgery. A medical history and physical examination of the patient shall be made and recorded by an allopathic or osteopathic physician or oral surgeon who holds an appointment to the Medical Staff before dental or podiatric surgery shall be scheduled for performance, and a designated allopathic or osteopathic physician shall be responsible for the medical care of the patient throughout the period of hospitalization.

C. The dentist, oral surgeon or podiatrist shall be responsible for the dental or foot care of the patient, including the dental or podiatric history and physical examination as well as all appropriate elements of the patient's record. Dentists, oral surgeons and podiatrists may write orders within the scope of their license and consistent with the Medical Staff rules and regulations, and in compliance with the Medical Staff Bylaws and this Policy.

1.4.3 Clinical Privileges for New Procedures

Whenever a Medical Staff member requests clinical privileges to perform a new procedure or service not currently being performed at the Hospital (or a significant new technique to perform an existing procedure), the following process shall be followed:

A. The matter shall first be referred to the Department Chairperson who shall investigate the service or procedure and make a recommendation including the following issues (1) whether the new procedure or service is desirable in view of the resources and facilities of Saint Francis Healthcare; (2) the minimum education, training and experience necessary to perform the procedure or provide the service in question in accordance with generally accepted standards of quality; and (3) the extent of monitoring and supervision that should be required.

B. The Department Chairperson shall submit his/her report and recommendation to the Credentials Committee, which shall review the matter and shall forward its recommendation along with the Department Chairperson's report to the MEC.

C. The MEC shall review the matter, prepare its own recommendation and shall forward all reports to the Board of Directors for final action.

D. The Board, after reviewing the Medical Staff's recommendations on the matter, shall make a final decision regarding whether the new procedure or service is one that may be offered to patients. The Board may consider numerous factors, including, without limitation, the Hospital's capability to perform the procedure in question, the Hospital's needs and mission, and community's need for the procedure or service.

E. Should the Hospital decide to offer the new procedure or service, the Credentials Committee shall investigate the procedure or service and develop criteria to determine the qualifications required for the grant of clinical privileges to perform the new procedure or service.

1.4.4 Clinical Privileges that Cross Specialty Lines

A. Requests for clinical privileges that traditionally at the Hospital have been exercised only by individuals from another specialty will not be processed until the steps outlined in this Section have been completed and a determination has been made regarding the individual's eligibility to request the clinical privileges in question.

B. The Credentials Committee will conduct research and consult with experts, including those on the Medical Staff (e.g., Department Chairpersons, individuals on the Medical Staff with special interest and/or expertise) and those outside the Hospital (e.g., other hospitals, residency training programs, specialty societies).

C. The Credentials Committee may or may not recommend that individuals from different specialties be permitted to request the privileges at issue. If it does, the Committee may develop recommendations regarding:

1. the minimum education, training, and experience necessary to perform the clinical privileges in question;

2. the clinical indications for when the procedure is appropriate;

3. the extent of monitoring and supervision that should occur if privileges would be granted;

4. the manner in which the procedure would be reviewed as part of the Hospital's ongoing performance improvement activities (including an assessment of outcomes data for all relevant specialties); and

5. the impact, if any, on emergency call responsibilities.

The Credentials Committee will forward its recommendations to the MEC, which will review the matter and forward its recommendations to the Board for final action.

1.5 TEMPORARY CLINICAL PRIVILEGES

1.5.1 Circumstances

Upon the written concurrence of the Chairperson of the department where the privileges will be exercised and of the President of the Medical Staff or designee the Chief Executive Officer may grant temporary clinical privileges in the following circumstances:

A. Pendency of Application: After receipt of a completed application for Staff appointment, including a request for specific temporary clinical privileges, and after an interview with the Chairperson of each Department in which privileges have been requested, and after Credentials Committee approval, an appropriately licensed applicant may be granted temporary privileges for a period of up to 120 days. In exercising such privileges, the applicant shall act under the supervision of the Chairperson of the Department to which he/she is assigned and in accordance with the conditions specified in Section 1.5-2 below.

B. To fulfill an important patient care need upon receipt of a written request for specific temporary privileges, an appropriately licensed practitioner of documented competence who is not an applicant for membership may be granted temporary privileges on a case by case basis when there is an important patient care need that mandates an immediate authorization to practice. Such privileges shall be exercised in accordance with the conditions specified in Section 1.5-2 below and shall be restricted to a period of 120 days, after which such practitioner shall be required to apply for membership on the Medical Staff before being allowed to attend additional patients.

1.5.2 Conditions

Temporary privileges shall be granted only when the information available reasonably supports a favorable determination regarding the requesting practitioner's qualifications, ability, and judgment to exercise the privileges requested and only after the practitioner has satisfied the requirements regarding professional liability insurance. Special requirements of consultation and reporting may be imposed by the Director of the Department responsible for supervision of a practitioner granted temporary privileges. Before temporary privileges are granted, the practitioner must acknowledge in writing that he/she has received (or has been given access to) and read the Medical Staff Bylaws, rules and regulations and policies and that he/she agrees to be bound by the terms thereof in all matters relating to his/her temporary privileges.

1.5.3 Termination

A. The granting of any temporary admitting and clinical privileges is a courtesy on the part of the Hospital and any or all may be terminated if a question or concern arises regarding the individual's clinical performance or professional conduct.

B. Under such circumstances, the President of the Medical Staff or designee, or the Chief Executive Officer may, after consultation with the pertinent Department Chairperson, terminate any or all of such practitioner's temporary privileges. If the life or well-being of a patient or other person may be endangered by continued treatment by the practitioner, the termination may be effected by any person entitled to impose a summary suspension.

C. In the event of such termination, the practitioner's patients then in the Hospital shall be assigned to another practitioner by the pertinent Department Chairperson. The wishes of the patient shall be considered, where feasible, in choosing a substitute practitioner.

1.5.4 Rights of the Practitioner

A practitioner shall not be entitled to the procedural rights (hearing or appellate review) because his/her request for temporary privileges is refused or because all or any portion of his/her temporary privileges are terminated, suspended or otherwise restricted.

1.6 EMERGENCY CLINICAL PRIVILEGES

A. In an emergency, any practitioner who is not currently appointed to the Medical Staff may be permitted by the Chief Executive Officer and/or his/her designee to exercise clinical privileges to the extent permitted by his/her license. Similarly, in an emergency, a physician currently appointed to the Medical Staff may be permitted by the Hospital to exercise clinical privileges to the extent permitted by his/her license, regardless of that individual's Department status or specific grant of clinical privileges.

B. When the emergency situation no longer exists, the patient shall be assigned by the President of the Medical Staff or designee, to an appropriate Medical Staff member with appropriate clinical privileges. The wishes of the patient shall be considered in the selection of a substitute physician.

1.7 DISASTER CREDENTIALING

A. Purpose: When the Emergency Management Plan has been activated for Saint Francis Healthcare, the Hospital may be unable to handle the immediate and emergent patient care needs. At that time, it may become necessary to grant disaster privileges, temporarily, to external physicians to help care for an unusually high number of critically ill patients.

B. Policy: During the disaster in which the Emergency Management Plan has been activated, the Chief Executive Officer, VPMA/CMO shall grant disaster privileges to individuals deemed qualified and competent, for the duration of the disaster situation. Granting of these privileges will be handled on a case-by-case basis and is not a "right" of the requesting provider.

C. Procedure:

1. Hospital Administration will inform Medical Staff Office that the Emergency Management Plan has been activated and that disaster privileging will be required.

2. A Disaster Privileging Form will be given to any licensed independent practitioner wishing to request these privileges. The form must be completed to the extent

possible and signed by the requesting licensed independent practitioner prior to approval of disaster privileges. The form must be accompanied by his or her valid government-issued photo identification (a driver's license or passport), and at least one of the following:

- Current hospital photo ID card.
- Current medical license with valid photo ID issued by a State, Federal, or regulatory agency.
- Identification that certifies the physician is a member of a State or Federal disaster medical assistance team.
- Identification that certifies the physician has been granted authority by a federal, state, or municipal entity to administer patient care in emergencies.
- Presentation by a current Hospital or Medical Staff member who can vouch for the physician's identity.

3. As soon as the immediate situation is under control, the Medical Staff Office personnel will complete within 72 hours the primary source verification of the medical license of the physician. In addition, the DEA certification and the malpractice insurance carrier will be verified to the extent possible.

4. A signed Disaster Privileges Request Form, which binds the practitioner to follow the Bylaws of the Medical Staff and related hospital policies, and any supporting documents will be forwarded to the Chief Executive Officer, VPMA/CMO for final approval.

5. Once approved, the physician will be notified that he/she may begin working. A photo ID will be provided to the physician.

6. The practitioner shall be paired with a currently credentialed Medical Staff member and should act under the direct supervision of a Medical Staff member. Any observed concerns should be reported to the VPMA/CMO or Department Chair, as soon as possible.

7. As soon as possible after the initial implementation of the Emergency Management Plan, Medical Staff Office personnel will verify additional information on all physicians who have requested disaster privileges such as:

   a. Current competence

   b. NPDB query

   c. Medicare sanction information.

8. If any adverse information is uncovered during this verification process, this information will be brought to the attention of the Chief Executive Officer, VPMA/CMO, who granted the privileges. A determination will be made at that time whether or not to immediately terminate the disaster privileges for that physician.

9. The CEO or VPMA/CMO must approve the continuation of disaster privileges within 72 hours.

10. When the Hospital has deemed that the Emergency Management Plan is no longer needed, all disaster privileges will immediately terminate.

1.8 CONTRACT PRACTITIONERS

The Medical Staff appointment and clinical privileges of any staff member who has an exclusive contractual relationship with the Hospital or who is either an employee of, principal of, or partner in an entity that has an exclusive contractual relationship with the Hospital shall be governed by the provisions of the pertinent contract. Unless otherwise provided in the contract, the contract practitioner shall not be entitled to procedural rights (including a fair hearing and appellate review) based upon the termination of Medical Staff membership or clinical privileges occurring as a result of the expiration or termination of the contract.

1.9 TELEMEDICINE

A. Definition: Telemedicine is the electronic transmission of images and other health information from the one facility to another facility for the purposes of clinical interpretation and/or consultation.

B. Credentialing: Physicians performing clinical services via telemedicine will follow the same procedure for appointment and clinical privileges as all other physician applicants.

C. Active Status: Will not be eligible to hold office or vote at medical staff meetings.

1.10 VOLUNTARY RELINQUISHMENT OF PRIVILEGES

A. A Medical Staff member may request voluntary relinquishment of clinical privileges by submitting a written request to the Department Chairperson specifying the clinical privilege(s) to be relinquished and the reasons for the request. The Department Chairperson will make a recommendation to the MEC.

B. The Department Chairperson will report to the MEC as to whether the relinquishment of the privilege(s) would create an unreasonable burden on the on-call rotation. The MEC may request a meeting with the member involved. The MEC will make a recommendation to the Board.

C. The Board will make a final decision on the request, based upon, among other factors, how the request will affect the Hospital's ability to comply with applicable regulatory requirements, including EMTALA. The Board's decision will be reported in writing by the CEO to the member, the Executive Committee, and the applicable department chairperson. If the Board permits the relinquishment of privileges, it will specify the effective date of the relinquishment.

D. Failure of a member to request relinquishment of clinical privileges as set forth above will result in the member being maintained on the call schedule without any change to his or her call responsibilities.

E. Members must maintain competency for the core privileges in their specialty. Members who have voluntarily limited their practice to include less than core privileges typically associated with their specialty may be required either to arrange for appropriate coverage OR to participate in a general on-call schedule and to maintain sufficient competence to fulfill this responsibility.

1.11 CORE PRIVILEGES

A. Application Process Requirements

Individuals requesting clinical privileges at the Hospital are required to apply for core privileges in their specialties as may be defined by each clinical department. The scope of core privileges for each clinical department shall be recommended by the department chairperson and must be approved by the Credentials Committee, MEC, and Board. Core privileges (and the eligibility criteria related to them) may be revised if recommended by the department chairperson and approved by the Credentials Committee, MEC and Board.

B. Rules Governing Exercise of Core Privileges

Individuals who have been granted core privileges shall be required to do the following:

1. provide emergency call coverage for patients requiring emergency care within the scope of their core privileges; and

2. provide consultations for patients requiring consults within the scope of their core privileges.

C. Exemption from Core Privileges

1. Any individual who wishes to be exempt from a particular privilege(s) within the core for a specialty must apply for an exemption in writing, documenting the good cause basis for the request.

2. After considering the recommendations from the relevant department chairperson and the Credentials Committee, the MEC shall make a recommendation in support of or against such exemption. The following factors may be considered by the Medical Staff leadership in their review of the request:

    a. the Hospital's mission and its obligation to serve the health care needs of the community by providing timely, quality health care on a local basis;

    b. fairness to the individual requesting the exemption, including past service and the other demands placed upon the individual;

    c. fairness to the other Medical Staff members who serve on the call roster in that specialty, including the effect that the removal would have upon them;

    d. any gaps in call coverage that might/would result from a Medical Staff member's removal from the call roster for the specific privilege and the

feasibility and safety of transferring patients to other facilities in that situation;

e. the expectations of other members of the Medical Staff who are in different specialties but who routinely rely on the specialty in question in the care of the patients who present to the emergency department;

f. the perceived inequities in exemptions being available to some; and

g. how the request may affect the Hospital's ability to comply with applicable regulatory requirements, including EMTALA.

3. If the MEC recommends against granting an exemption, the individual shall be entitled to appear before the Executive Committee before the Executive Committee makes a final recommendation to the Board.

4. If the MEC recommends in favor of granting the exemption, the recommendation shall be forwarded to the Board for its review and action.

5. The Board shall make a final decision on the exemption request based upon consideration of the factors set forth in (a) above. The Board's decision shall be reported in writing by the President of the Medical Staff to the member, the MEC, and the applicable department chairperson, and shall specify the effective date of the exemption.

6. No individual is entitled to an exemption or to a hearing if the Board determines not to grant an exemption. A denial of a request for exemption does not entitle an individual to request a hearing.

D. Special Privileges Beyond the Core

Individuals who have requested and been granted special privileges in addition to the core privileges for their specialty shall be required to provide such services on an emergency and consultative basis, as may be requested.

ARTICLE II
REAPPOINTMENT

2.1 PROCEDURE FOR REAPPOINTMENT

All terms, conditions, requirements, and procedures relating to initial appointment shall apply to continued appointment and clinical privileges and to reappointment.

2.2 APPLICATION

A. Each current Medical Staff member who is eligible to be reappointed to the Medical Staff shall be responsible for completing a reappointment application form.

B. The reappointment application shall be furnished to the Medical Staff member at least four (4) months prior to the expiration of the member's current appointment period. The completed reappointment application shall be submitted to the VPMA/CMO at least three

(3) months prior to the expiration of the member's current appointment period. Failure to submit an application by that time will result in automatic expiration of the member's appointment and clinical privileges at the end of the then current term of appointment unless good cause is shown for the delay.

C. Reappointment, if granted, shall be for a period of not more than two (2) years.

D. Except as provided below, if an application for reappointment is submitted timely, but the Board has not acted on it prior to the end of the current term, the individual's appointment and clinical privileges will expire at the end of the then current term of appointment. Subsequent Board action may be needed to grant reappointment and renewal of clinical privileges.

E. In those situations where the Board has not acted on a pending application for reappointment, and there is an important patient care need that mandates an immediate authorization to practice, including but not limited to an inability to meet on-call coverage requirements, or denying the community access to needed medical services, the CEO will have the authority to grant the individual temporary clinical privileges until such time as the Board can act on the application. Prior to granting temporary privileges, the CEO will consult with the chairperson of the applicable department, the Chair of the Credentials Committee, or the President of the Medical Staff or designee. The temporary clinical privileges will be only for a period not to exceed 120 days.

F. In the event the application for reappointment is the subject of an investigation or hearing at the time reappointment is being considered, a conditional reappointment for a period of less than two years may be granted pending the completion of that process.

2.3 FACTORS TO BE CONSIDERED

A. Each recommendation concerning reappointment of a practitioner currently appointed to the Medical Staff shall be based upon the following factors:

1. Ethical behavior, clinical competence, and clinical judgment in the treatment of patients, including medical/clinical knowledge, technical and clinical skills, interpersonal and communication skills, and professionalism with patients, families, and other members of the health care team and peer evaluations relating to the same;

2. Participation in Staff duties;

3. Compliance with the Bylaws, policies, and rules and regulations of the Hospital and Medical Staff;

4. Behavior at the Hospital, including cooperation with Medical Staff and Hospital personnel relating to patient care, the orderly operation of the Hospital, and the general attitude toward patients, the Hospital and its personnel;

5. Utilization of Hospital resources;

6. Utilization patterns (e.g., length of patient stays);

7. Current physical and mental health status, including ability to perform the privileges requested competently and safely;

8. Capacity to satisfactorily treat patients as indicated by the results of the Hospital's quality improvement activities or other reasonable indicators of continuing qualifications, including ongoing professional practice evaluations, and other peer review activities, taking into consideration practitioner-specific information compared to aggregate information concerning other individuals in the same or similar specialty (provided that, other practitioners will not be identified);

9. Any focused professional practice evaluations;

10. Satisfactory completion of such continuing education requirements as may be imposed by law, the Hospital, or applicable accreditation organizations;

11. Current professional liability insurance status and pending malpractice challenges, including claims, lawsuits, judgments, and settlements;

12. Current status of professional licenses, including currently pending challenges to any license or registration;

13. Voluntary or involuntary termination of Medical Staff appointment or voluntary or involuntary limitation, reduction, or loss of clinical privileges at another hospital;

14. Voluntary or involuntary relinquishment of federal or state Controlled Substance licensure or certification; and

15. Other reasonable indicators of continuing qualifications.

B. To be eligible to apply for renewal of clinical privileges, an individual must have performed sufficient procedures, treatments or therapies in the previous appointment term to enable the appropriate department chairperson and the Credentials Committee to assess the applicant's current clinical competence for the privileges requested.

2.4 PROCEDURE FOR REAPPOINTMENT

2.4.1 Review by the Department Chairperson

A. No later than three (3) months prior to the end of the current appointment period, the VPMA/CMO, shall send to the Chairperson of each Department a current list of all practitioners who have clinical privileges in that Department, together with a description of the clinical privileges that each holds, accompanied by copies of their applications for reappointment.

B. Each Department Chairperson shall provide the Credentials Committee with a written report concerning each practitioner seeking reappointment. The Chairperson shall include in each written report, when applicable, the reasons for any recommended changes in staff category or clinical privileges or the reasons for a recommendation of non-reappointment. The Department Chairpersons shall be available to the Credentials Committee to answer any questions that may be raised with respect to any practitioner.

2.4.2 Credentials Committee Review

A. The Credentials Committee, after receiving the reports from each department chairperson, shall review all pertinent information available, including all information provided from other committees of the Medical Staff and Hospital, for the purpose of determining its recommendations regarding staff reappointment, clinical privileges and staff category for the ensuing appointment period.

B. As part of the process of making its recommendation, the Credentials Committee may require an individual currently seeking reappointment to undergo a physical and/or mental examination by a physician or physicians satisfactory to the Credentials Committee, either as part of the reappointment process or at any time during the appointment period to aid the Committee in determining whether it should recommend that clinical privileges be granted or continued. The results of such examination shall be made available for the Credentials Committee's consideration. Failure of a practitioner to undergo such examination within a reasonable time of being requested to do so in writing by the Credentials Committee shall constitute a voluntarily relinquishment of all clinical privileges until such time as the Credentials Committee has received the examination results and has had a reasonable opportunity to evaluate them and make a recommendation thereon.

C. The Credentials Committee shall have the right to require the practitioner seeking reappointment to meet with the Committee to discuss any aspect of the individual's reappointment application, qualifications, or clinical privileges requested.

D. The Credentials Committee may use the expertise of the Department Chairperson, any member of the Medical Staff, or an outside consultant, if it decides additional information is needed regarding a practitioner's qualifications for reappointment.

E. After considering all the available information regarding a practitioner, the Credentials Committee shall prepare a report recommending reappointment or non-reappointment, specific clinical privileges, and any restrictions or other conditions regarding reappointment or clinical privileges. When non-reappointment, non-promotion, or a change in clinical privileges is recommended, the reason for such recommendation shall be stated. The Credentials Committee shall forward its written findings and recommendations, as well as the completed application for reappointment and supporting documentation, to the MEC in time for that Committee to consider the practitioner's reappointment at its regularly scheduled meeting before the expiration of the applicant's appointment period.

F. The Chairperson of the Credentials Committee shall be available to the MEC (or to the Board of Directors) to answer any questions that may be raised with respect to its report or recommendations.

2.4.3 Medical Executive Committee Review

A. The MEC shall review the written findings and recommendations of the Credentials Committee and shall:

1. Adopt the findings and recommendations of the Credentials Committee;

2. Refer the matter back to the Credentials Committee for further consideration and preparation of responses to specific questions raised by the MEC prior to its final recommendation; or

3. Set forth in its report and recommendation the reasons, along with supporting documentation, for its disagreement with the Credentials Committee's recommendation.

B. If the recommendation of the MEC is favorable, it shall transmit its recommendation, as well as the report of the Credentials Committee, through the Chief Executive Officer, or his/her designee, to the Board of Directors. All recommendations to reappoint must also specifically recommend the clinical privileges to be granted.

C. Any recommendation by the MEC that would entitle the affected individual to the procedural rights (hearing and appellate review) in the Fair Hearing Plan, shall be forwarded to the Chief Executive Officer, or his/her designee, who shall promptly notify the affected individual by certified mail, return receipt requested. The Chief Executive Officer, or his/her designee, shall then hold the recommendation until after the individual practitioner has exercised or waived the right to a hearing as provided in the Fair Hearing Plan. After such time, the Chief Executive Officer, or his/her designee, shall forward the recommendation of the MEC, together with all supporting documentation, to the Board of Directors. The Chairperson of the MEC shall be available to the Board of Directors to answer any questions that may be raised regarding the practitioner.

D. In the event the Board of Directors decides to consider modification of the action of the MEC and such modification would entitle the practitioner to a hearing in accordance with the Fair Hearing Plan, it shall notify the affected practitioner through the Chief Executive Officer and shall take no final action until the practitioner has exercised or waived the procedural rights provided in the Fair Hearing Plan.

E. The time frame for processing a complete application for reappointment will be no later than 120 days from the date the application is deemed complete until final approval by the Board of Directors. This time period is intended to be a guideline only and will not create any right for the applicant to have the application processed within this precise time period.

2.4.4 Conditional Reappointments

A. Recommendations for reappointment and renewed privileges may be contingent upon an individual's compliance with certain specific conditions. These conditions may relate to behavior (e.g., code of conduct) or to clinical issues (e.g., general consultation requirements, proctoring, completion of CME requirements). The imposition of such conditions does not entitle an individual to request a hearing.

B. In addition, reappointments may be recommended for periods of less than two years in order to permit closer monitoring of an individual's compliance with any conditions that may be imposed. A recommendation for reappointment for a period of less than two years does not, in and of itself, entitle an individual to request a hearing.

2.5 PROCEDURES FOR REQUESTING AN INCREASE IN CLINICAL PRIVILEGES

2.5.1 Application for Additional Clinical Privileges

Whenever, during the term of appointment, additional clinical privileges are desired, a practitioner may submit a written request for increased clinical privileges to the VPMA/CMO. The request shall state in detail the specific clinical privileges desired and the practitioner's relevant recent training and experience that justify the additional privileges. This request shall be transmitted to the appropriate Department Chairperson. Thereafter, it shall be processed in the same manner as an application for initial clinical privileges.

2.5.2 Factors to Be Considered

A. Recommendations for additional clinical privileges shall be based upon the following factors:

1. Relevant recent training;

2. Observation of patient care provided;

3. Review of the records of patients treated in this or other hospitals;

4. Results of the Hospital's quality improvement activities;

5. The applicant's ability to meet the qualifications and criteria for the clinical privileges requested; and

6. Other reasonable indicators of the practitioner's continuing qualifications for the privileges in question.

B. The granting of such increased privileges may be accompanied by requirements for supervision, consultation or other conditions or restrictions.

ARTICLE III
LEAVE OF ABSENCE

3.1 PROCEDURE FOR LEAVE OF ABSENCE

A. Medical Staff members may, for good cause, be granted leave of absence by the Board of Directors for a definite period of time, not to exceed one (1) year. Absence for longer than one (1) year shall constitute voluntary resignation from Medical Staff membership and clinical privileges unless an exception is made by the Board of Directors upon the recommendation of the MEC.

B. A practitioner must submit his/her request for a leave of absence to the President of the Medical Staff or designee and shall state the beginning and ending dates of the requested leave. The President of the Medical Staff or designee shall transmit the request, together with a recommendation, to the Chief Executive Officer for action by the Board of Directors.

3.2 TERMINATION OF LEAVE OF ABSENCE

A. At the conclusion of the stated time period for the leave of absence, the Medical Staff member shall submit a request for reinstatement to the President of the Medical Staff or

designee. The request shall include a summary of all professional activities undertaken during the period of the leave. If requested by the President of the Medical Staff or designee, the Medical Staff member shall provide further information relating to the practitioner's professional qualifications, current competence, and/or ethical conduct. A Medical Staff member who fails to timely submit a request for reinstatement shall be deemed to have voluntarily resigned from the Staff.

B. If the leave of absence was for medical reasons, then the Medical Staff member must submit a report from his or her attending physician indicating that the member is physically or mentally capable of resuming a hospital practice and exercising the clinical privileges requested. The Medical Staff member shall also provide any other information requested by the President of the Medical Staff or designee, the Credentials Committee, the MEC, or the Board of Directors. At the request of the MEC, the Medical Staff member shall undergo a physical or mental examination by a physician chosen by the Committee.

C. The request and all supporting documentation and information shall be transmitted to the Credentials Committee, which shall forward to the MEC a recommendation regarding the practitioner's reinstatement. The MEC thereafter shall consider all the information and transmit its recommendation and the reasons therefore, to the Board of Directors for final action.

D. If the Board of Directors grants reinstatement, it may modify the practitioner's staff category and/or clinical privileges, or impose conditions (such as supervision, observation, consultation, or probation) on the exercise of clinical privileges.

ARTICLE IV
PEER REVIEW PROCEDURES FOR QUESTIONS INVOLVING
MEDICAL STAFF MEMBERS

4.1 COLLEGIAL INTERVENTION

A. This Policy encourages the use of progressive steps by Medical Staff leaders and Hospital management, beginning with collegial and educational efforts, to address questions relating to an individual's clinical practice and/or professional conduct. The goal of these efforts is to arrive at voluntary, responsive actions by the individual to resolve questions that have been raised.

B. Collegial intervention is a part of ongoing and focused professional practice evaluation, performance improvement, and peer review.

C. Collegial intervention efforts involve reviewing and following up on questions raised about the clinical practice and/or conduct of staff members and pursuing counseling, education, and related steps, such as the following:

1. advising colleagues of all applicable policies, such as policies regarding appropriate behavior, emergency call obligations, and the timely and adequate completion of medical records;

2. proctoring, monitoring, consultation, and letters of guidance; and

3. sharing comparative quality, utilization, and other relevant information, including any variations from clinical protocols or guidelines, in order to assist individuals to conform their practices to appropriate norms.

D. The relevant Medical Staff leader(s) (Officers, applicable Committee and Department Chairpersons and the VPMA/CMO) will determine whether it is appropriate to include documentation of collegial intervention efforts in an individual's confidential file. If documentation of collegial efforts is included in an individual's file, the individual will have an opportunity to review it and respond in writing. The response will be maintained in that individual's file along with the original documentation.

E. Collegial intervention efforts are encouraged, but are not mandatory, and will be within the discretion of the appropriate Medical Staff leaders and Hospital management.

F. The relevant Medical Staff leader(s), in conjunction with the CEO, will determine whether to direct that a matter be handled in accordance with another policy (e.g., code of conduct policy; practitioner health policy; peer review policy). Medical Staff leaders may also direct these matters to the MEC for further action.

4.1.1 Investigation Procedure

A. Whenever a concern or question has been raised regarding the conduct or activities of a Medical Staff member, or where collegial efforts have not resolved an issue,: the President of the Medical Staff or designee, appropriate department chairperson, or Chief Executive Officer (or designee) shall make sufficient inquiry to ascertain that the concern or question is credible, after which a report of such conduct or activity shall be submitted in writing to the MEC. If any of the inquiring individuals set forth in this provision believe it to be in the best interest of the Hospital and the Medical Staff member involved, he/she may, but are not required to, discuss the matter with the affected Medical Staff member.

B. The MEC shall consider all reports submitted to it and determine whether to discuss the matter with the practitioner concerned and/or to begin an investigation.

C. The President of the Medical Staff or designee shall promptly notify the Chief Executive Officer in writing of all requests for corrective action and all investigations and shall keep the Chief Executive Officer fully informed of all actions taken in connection with such matters.

D. If the concern contains sufficient information to warrant a recommendation, the MEC, must provide a personal interview with the individual being investigated before the recommendation is delivered.

E. In any case where a practitioner may lose his/her privileges, the MEC must immediately appoint an ad hoc Investigation Committee consisting of up to three (3) members of the MEC or other Medical Staff members to investigate the matter. This Investigation Committee shall not include any individual who previously participated in the recommendation, had any direct involvement in the matter, or any direct competitors, partners, associates, or relatives of the person being investigated.

F. The Investigation Committee shall have the cooperation of the Hospital and Medical Staff. With the approval of the Chief Executive Officer, the Investigation Committee may obtain

information from outside consultants. The Investigation Committee may also require the involved practitioner to submit to a physical or mental examination by a physician satisfactory to the Committee and may require that the results of such examination be made available for the committee's consideration.

G. The investigated practitioner must have an opportunity to meet with the MEC or the Investigation Committee before it makes its report. At this meeting (but not, as a matter of right, in advance of it), the individual shall informed of the general nature of the evidence supporting the question being investigated and shall be invited to discuss, explain or refute the information. This interview shall not constitute a hearing and none of the procedural rules provided in the Fair Hearing Plan shall apply. A summary of such interview shall be made by the Investigation Committee and included in the MEC report outlining the recommendations for appropriate sanction/action.

H. The MEC may accept, modify, or reject the recommendation it receives from the investigation committee.

4.1.2. Corrective Recommendations and Action

A. In acting after the investigation, the MEC may:

1. Determine that no action is justified;

2. Issue a letter of counsel, education or guidance;

3. Issue a written warning;

4. Issue a letter of reprimand;

5. Impose conditions for continued practice;

6. Impose a requirement for non-binding consultation;

7. Recommend modification of clinical privileges (e.g., reduction, suspension, or restrictions);

8. Recommend permanent revocation of Medical Staff appointment;

9. Make such other recommendations as it deems necessary or appropriate.

B. If the action of the MEC is not of the kind that entitles the individual to a hearing, the action shall take effect immediately without action of the Board of Directors and without the right of appeal to the Board of Directors. A report of the action taken and the reasons therefore shall be made to the Board of Directors through the Chief Executive Officer or designee, and the action shall stand unless modified by the Board of Directors.

C. Any recommendation by the MEC that would entitle the affected practitioner to a hearing under the Fair Hearing Plan shall be forwarded to the Chief Executive Officer or designee who shall promptly notify the affected individual by certified mail, return receipt requested. The Chief Executive Officer or designee shall then hold the recommendation until after the individual has exercised or has waived the right to a hearing as provided in the Fair Hearing

Plan, after which the Chief Executive Officer or designee shall forward the recommendation of the MEC, together with all other information, to the Board of Directors. The Chairperson of the MEC shall be available to the Board of Directors to answer any questions that may be raised with respect to the recommendation.

D. In the event the Board of Directors determines to consider modification of the action or recommendation of the MEC and such modification would entitle the individual to a hearing in accordance with the Fair Hearing Plan, the Chief Executive Officer or designee shall notify the affected practitioner and no final action will be taken until the individual has exercised or waived his or her rights to a hearing.

4.2. **PRECAUTIONARY SUSPENSION** OR RESTRICTION **OF CLINICAL PRIVILEGES**

4.2.1. Criteria for Initiation and Initial Procedure

A. The Chair of the Board of Directors, the Chief Executive Officer or designee, the VPMA/CMO, and the Department Chairpersons shall each have the authority to suspend or restrict all or any portion of the clinical privileges of a Medical Staff member or other individual whenever failure to take such action may result in an **imminent danger** to the health and/or safety of any patient or other individual. Such precautionary suspension or restriction shall be deemed an interim precautionary step in the professional review activity related to the ultimate professional review action that may be taken with respect to the suspended individual but is not a complete professional review action in and of itself. It shall not imply any final finding of responsibility for the matter that precipitated the suspension or restriction. The individual may be afforded an opportunity to voluntarily refrain from exercising privileges pending an investigation.

B. The individual imposing the precautionary suspension shall immediately report the suspension in writing to the Chief Executive Officer and the President of the Medical Staff or designee.

C. The Chief Executive Officer shall provide immediate notice to the affected practitioner and shall promptly thereafter provide written notice to the practitioner.

D. A precautionary suspension shall become effective immediately upon imposition. A precautionary suspension shall remain in effect, unless earlier terminated by the Chief Executive Officer or his/her designee.

E. Immediately upon the imposition of a precautionary suspension or restriction, the appropriate department chairperson or, if that individual is unavailable, the President of the Medical Staff or designee, shall assign to another practitioner with appropriate clinical privileges, the responsibility for care of the suspended practitioner's patients still in the Hospital. The wishes of the patient shall be considered in the selection of the substitute practitioner.

F. A precautionary suspension or restriction can be imposed at any time including, but not limited to, immediately after the occurrence of an event that causes concern, following a pattern of occurrences that raises concern, or following a recommendation of the Executive Committee that would entitle the individual to request a hearing.

4.2.2. Medical Executive Committee Procedure

A. The MEC will review the matter resulting in a precautionary suspension or restriction within a reasonable time under the circumstances, not to exceed 14 days. Prior to, or as part of, this review, the individual may be given an opportunity to meet with the MEC. The individual may propose ways other than precautionary suspension or restriction to protect patients, employees and/or the smooth operation of the Hospital, depending on the circumstances. The practitioner shall have the right to a hearing if the suspension exceeds 14 days.

B. After considering the matters resulting in the suspension or restriction and the individual's response, if any, the Executive Committee will determine whether there is sufficient information to warrant a final recommendation, or whether it is necessary to commence an investigation. The Executive Committee will also determine whether the precautionary suspension or restriction should be continued, modified, or terminated pending the completion of the investigation (and hearing, if applicable) pursuant to the investigation procedures set forth in Section 4.1.1.

C. There is no right to a hearing based on the imposition or continuation of a precautionary suspension or restriction which does not exceed 14 days.

4.3. **AUTOMATIC** RELINQUISHMENT

4.3.1. Failure to Complete Medical Records

The admitting and clinical privileges of any Medical Staff appointee shall be deemed to be automatically relinquished for failure to complete medical records in accordance with applicable rules and regulations governing the same, after notification of the Medical Records Department of such delinquency. Such relinquishment shall continue until all records of the Medical Staff member are no longer delinquent.

4.3.2. Action by State Licensure Agency

The medical staff membership and clinical privileges of a Medical Staff member shall be automatically relinquished in the event that the appropriate state licensing board terminates or revokes a Medical Staff member's professional license for any reason. If a Staff member's license is suspended, his or her clinical privileges shall also be relinquished until such matter is resolved, and an application for reinstatement of privileges has been approved by the Credentials Committee and the Board of Directors. In the event the Medical Staff member's license is only partially restricted, the clinical privileges affected by the license restriction will be similarly restricted.

4.3.3. Controlled Substance Registration

The Medical Staff membership and clinical privileges of a Medical Staff member shall be automatically relinquished in the event that the appropriate governmental agency revokes, suspends or restricts the member's controlled substance registration.

4.3.4. Failure to be Adequately Insured

The admitting and clinical privileges of any Medical Staff member shall be automatically relinquished if, at any time, such Staff member fails to maintain the required levels and scope of

professional liability insurance coverage. Such relinquishment shall remain in effect until adequate professional liability insurance coverage is obtained.

4.3.5. Failure to Provide Requested Information or Correct Information

A. The Medical Staff membership and clinical privileges of any Medical Staff member shall be automatically relinquished if, at any time, the appointee fails to provide required information pursuant to a formal request by the Credentials Committee, the MEC, or the Chief Executive Officer. Such relinquishment shall remain in effect until the required information is provided to the satisfaction of the requesting party.

B. The Medical Staff membership and clinical privileges of a Medical Staff member shall be automatically relinquished if it is determined that the Medical Staff member knowingly provided erroneous information on any official Medical Staff documents or provided incorrect or inaccurate information to any Hospital or Medical Staff representative.

4.3.6. Medicare and Medicaid Violations

The Medical Staff membership and clinical privileges of a Medical Staff member who is excluded from participation in the Medicare and/or Medicaid program shall be automatically relinquished. The relinquishment shall be effective as of the date of the termination, exclusion or preclusion. A Staff member who is sanctioned, but not excluded from the Medicare and/or Medicaid Program, shall be automatically deemed to be ineligible for reappointment if the sanctions are not resolved, and the Staff member fully reinstated by the expiration of the member's then current reappointment term. It shall be the duty of all Medical Staff members to promptly inform the Hospital of any action taken by either such program.

4.3.7. Criminal Activity

The Medical Staff membership and clinical privileges of any Medical Staff member shall be automatically relinquished if such Medical Staff member is convicted or pleads guilty or *nolo contendere* to any felony crime.

4.3.8. Effect of Automatic Action

Any physician whose Medical Staff membership, admitting or clinical privileges, for any reason, are deemed to be automatically relinquished or who is deemed automatically ineligible for reappointment, shall **not** be entitled to procedural rights (a hearing or appellate review) under the Fair Hearing Plan.

4.4. CONFIDENTIALITY AND REPORTING

A. Actions taken and recommendations made pursuant to this Policy shall be treated as confidential in accordance with applicable legal requirements and such policies regarding confidentiality as may be adopted by the Medical Staff or the Hospital. In addition, reports of actions taken or recommendations made pursuant to this Policy shall be treated as confidential. Nevertheless, the Chief Executive Officer or designee may provide such documents and information to governmental agencies or as otherwise may be required by law.

B. All records and other information generated in connection with and/or as a result of professional review activities shall be confidential and each Medical Staff member or Committee member participating in such review activities shall agree to make no disclosures of any such information except as authorized in writing by the Chief Executive Officer or designee or by legal counsel for the Hospital. Any breach of confidentiality by a Medical Staff member or Committee member may result in professional review action and/or may result in appropriate legal action to ensure that confidentiality is preserved, including application to a court of law for injunctive or other relief.

ARTICLE V.
RESIGNATIONS

5.1. RESIGNATIONS FROM MEDICAL STAFF

Medical Staff members desiring to resign from the Medical Staff must submit a letter of resignation to activate the termination process.

No resignation will be effective until at least 90 days following receipt of a resignation letter unless otherwise determined by the MEC.

ARTICLE VI.
ADOPTION AND AMENDMENT OF CREDENTIALING POLICY

6.1. AMENDMENTS TO CREDENTIALING POLICY

This policy is incorporated by reference in the Medical Staff Bylaws of Saint Francis Healthcare and therefore may only be amended in accordance with the procedure set forth in Section 8.2 of the Medical Staff Bylaws.

6.2. ADOPTION OF CREDENTIALING POLICY

This Policy is adopted and made effective upon approval of the Board of Directors, and supersedes and replaces any and all other previous Medical Staff Bylaws, rules and regulations, or Policies pertaining to the subject matter of this Policy. All activities and actions of the Medical Staff and each individual exercising clinical privileges in the Hospital shall be taken under and pursuant to the requirements and provisions of this Policy.

ARTICLE VII.
ALLIED HEALTH PROFESSIONALS CREDENTIALING POLICY

7.1. POLICY

It is the policy of the Saint Francis Healthcare to grant permission to physicians, podiatrists and dentists who are members of the Medical Staff (Active, Associate to use qualified employed assistants or licensed independent practitioners for certain activities in the hospital care of patients of the employer/physician. In addition, licensed independent practitioners may be granted clinical privileges if they are employees of a physician, podiatrist, dentist, hospital, or contracted vendor of the hospital.

7.2. DEFINITIONS

A. Active/Associate Physician, Podiatrist, Dentist

An Active/Associate physician, podiatrist or dentist is one who maintains staff privileges in accordance with Article III, Section 3.1 and Section 3.2 of the Bylaws of the Medical Staff.

B. Allied Health Professional (AHP)

An employee of an Active/Associate physician, podiatrist, dentist, hospital, or contracted vendor of the hospital, qualified by academic and clinical training and experience to function in a medical support role in the provision of medical care under the direction, supervision, and responsibility of the employer/physician.

C. Board

All references to the "Board" shall be interpreted to refer to The Board of Directors of Saint Francis Healthcare, Inc.

D. Direct Supervision

Supervision, which includes physical presence with the ability to directly observe the assistant in the performance of an approved procedure, evaluation or consultation.

E. Employer/Physician

Physician who employs an AHP and who request permission to use the services of the AHP in providing care to hospital patients.

F. Indirect Supervision

Supervision which includes physical presence on the premises or ready availability by an electronic device with the ability to become physically present within 30 minutes of notification if the situation so warrants.

G. Definition of Licensed Independent Practitioner

Any individual permitted by law and by the organization to provide care, treatment, and services, without direct supervision.

7.3. PROCEDURE

7.3.1. Application Process

A. The applicant must:

1. Complete the application form which provides sufficient information about the education, training and experience of the AHP to permit the hospital to determine the scope of activities the AHP is qualified to perform in the hospital. The form must be signed by the AHP and submitted to the office of the VPMA/CMO.

2. Procure and maintain professional liability insurance for the AHP that covers all activities in the hospital. Insurance coverage must be within minimum limits as established by the Board and CHE. Proof of such insurance shall be furnished to

the Hospital. The AHP may act in the hospital only while such coverage is in effect.

3. All Allied Health Professionals on the Medical Staff must participate in the training for Saint Francis Healthcare's electronic medical records system (EMR) at such time as EMR training becomes available. Additionally, all Allied Health Professionals must agree to use the EMR system.

4. All new Allied Health Professionals joining the Medical Staff will be required to successfully complete the EMR training at such time as EMR training becomes available before being allowed to treat patients.

5. If the applicant is an employee of a physician, podiatrist or dentist, the physician must co-sign the application and agree to indemnify the hospital for any claims, losses or payments resulting from injuries or damage to a patient or property due to an act or omission of the AHP.

6. No applicant who is currently excluded from any health care program funded in whole or in part by the federal government, including Medicare or Medicaid, is eligible or qualified for clinical privileges. In the event that such exclusion occurs following completion of application and/or while AHP is exercising Hospital privileges, the AHP must immediately notify VPMA/CMO office**.**

7. Each applicant must abide by the hospital's Standards of Conduct. Failure to do so shall be grounds for corrective action.

7.3.2. Factors to Be Considered

Each recommendation concerning the granting of clinical privileges for an AHP shall be based upon the following factors:

1. Ethical behavior, clinical competence, and clinical judgment in the care of patients;

2. Participation in Staff duties;

3. Compliance with the Bylaws, policies, and rules and regulations of the Hospital and Medical Staff;

4. Behavior at the Hospital, including cooperation with Medical Staff and Hospital personnel relating to patient care, the orderly operation of the Hospital, and the general attitude toward patients, the Hospital and its personnel;

5. Utilization of Hospital resources;

6. Current physical and mental health status;

7. Capacity to satisfactorily perform his/her duties as indicated by the results of the Hospital's quality improvement activities or other reasonable indicators of continuing qualifications;

8. Satisfactory completion of such continuing education requirements as may be imposed by law, the Hospital, or applicable accreditation organizations;

9. Current professional liability insurance status, claims history, and pending malpractice challenges, including claims, lawsuits, judgments, and settlements;

10. Current status of professional licenses, including currently pending challenges to any license or registration;

11. Voluntary or involuntary termination of Staff appointments or voluntary or involuntary limitation, reduction, or loss of clinical privileges at another hospital;

12. Voluntary or involuntary relinquishment of federal or state Controlled Substance licensure or certification; and

13. Other reasonable indicators of competency.

7.3.3. Review Process

1. Upon receipt of a completed application, the VPMA/CMO will verify the information provided by the physician and the AHP, seek recommendations from previous employers and listed references and obtain other necessary and pertinent information. All information will then be forwarded to the following, in succession, for review and recommendation:

    a. Vice President, Patient Care Services
    b. Medical Staff Departmental Chairman (or designee) of the Department in which the physician holds clinical privileges
    c. Medical Staff Credentials Committee
    d. Medical Executive Committee (MEC)

2. Completed application and recommendations will be forwarded to the Board of Directors for final action.

7.3.4. Delineation of the Scope of Activities

1. In granting permission to a physician, podiatrist or dentist to use an AHP, the Board will delineate the scope of activities each AHP is permitted to undertake in the hospital. The qualifications of the employing physician and his/her ability to provide supervision for the AHP for which he/she is responsible should be considered.

2. The delineation will permit the AHP to engage in direct patient care activities at the specific level for which permission was granted. Patient care provided by the AHP will be in collaboration with all other health professionals and hospital personnel. All AHP's, regardless of level of function, will assist in the development and implementation of Care Plans of the patients of their respective employer/physician, and assess the results of such care with the employer/physician and appropriate hospital staff members.

3. In the event the Credentials Committee is of the opinion that a requested scope of activities or any part thereof is not supported by the submitted application and materials, the physician requesting use of an AHP in the hospital and the AHP may be given an opportunity to appear before the Credentials Committee and discuss the proposed delineation before any final action is taken by the MEC.

4. The AHP may act in the Hospital pursuant to the approved delineation only so long as he/she maintains any required licensure, remains an employee of the physician who requested permission to use the AHP, and so long as the employer/physician remains an Active/Associate member of the Medical Staff.

5. Under the new direction of the Department Chairperson, each specialty/subspecialty shall prepare a brief Proctoring Plan for practitioners requesting new privileges, which shall be submitted to the Credentials Committee for approval. The Plan will be reviewed and updated as needed and will include the proctoring method(s) to be used, the data sources and collection methods employed, duration of proctoring and the method of evaluating the data, and any circumstances under which monitoring by an external source is required. The Medical Staff office shall maintain copies of all Proctoring Plans.

6. Proctoring may use a combination of the following methods to obtain the best understanding of the care provided, and shall complete the appropriate sections of the proctoring form.

    a. **Prospective proctoring**: Presentation of cases with planned outline of treatment for prospective review of cases documentation and proposed treatment orders.

    b. **Concurrent proctoring**: Real-time observation of a procedure, clinical history and physical examination and/or review of current treatment orders.

    c. **Retrospective evaluation**: Review of case record after care has been completed. May also involve interviews of personnel directly involved in the patient's care.

    Each of the above methods may include observation of:

        a. History and physical

        b. Diagnosis and justification

        c. Proposed treatment of procedure and its indications

        d. Continuity of care provided to the patient

        e. Appropriateness of procedures, tests, and medications prescribed

        f. Appropriateness of length of stay

        g. Adequacy of progress notes

        h. Adequacy of operative notes

        i. Discharge summary

        j. Timely completion of medical records

        k. Technical skills/knowledge (as appropriate)

        l. Punctuality and conduct in OR (as appropriate)

m. Pre and post-operative care

7. Permission to use the AHP may be summarily suspended by the President of the Medical Staff or designee, Departmental Chairperson or the CEO or their designee whenever the activities or professional conduct of the AHP are, or are reasonably likely to be, detrimental to patient safety or the delivery of quality patient care; are disruptive to Hospital operations, or are in contravention of the policies and directives of the Hospital or the Medical Staff. Such suspension will be effective until the next regular meeting of the Credentials Committee, at which time the Credentials Committee will give the physician requesting permission to use the Assistant an opportunity to appear and discuss, explain or refute the concerns leading to the suspension. The Credentials Committee may confirm, modify or reject the summary suspension. A suspension confirmed or modified by the Credentials Committee will remain in effect as specified by the Credentials Committee unless rejected or modified by the MEC at its next regular meeting, at which time the Credentials Committee will give a report of the matter to the MEC. The MEC may confirm, modify or reject the action of the Credentials Committee.

7.4. CATEGORIES OF ALLIED HEALTH PROFESSIONALS

A. Non-Licensed Physician's Employee

B. Registered Nurse or Licensed Practical Nurse

C. Nurse Practitioner or Physician Assistant

D. Certified Registered Nurse Anesthetist

E. Nurse Midwives

7.4.1. Authorized Activities are as follows:

A. Non-Licensed Physician's Employee

1. May visit patients independently;

2. May examine patient limited to area of specialty or expertise;

3. May perform limited non-invasive procedures, as specified on the approved application;

4. May make adjustments to patient care equipment, previously approved;

5. Performance of procedures in the presence of and under the direct supervision of the physician/employer, to include operating room, ambulatory care, emergency room or other location;

6. May perform dressing changes and cultures of wounds after the physician/employer initiates care of each separate wound.

B. Registered Nurse or Licensed Practical Nurse (A professional license issued by the State of Delaware is required)

1. May perform all activities as defined in Category A above;

2. May visit patients independently and record progress notes on charts;

3. May assist in and perform all duties within the scope of practice of his/her employer, which are normally delegated to hospital staff, excluding administration of medications;

4. May dictate, for the employer/physician, the discharge summary, which may only be signed by the employer/physician.

Progress notes documented by the AHP in this category while under direct or indirect supervision must be countersigned by the employer/physician within 24 hours. Orders must be countersigned before they are accepted.

C. Nurse Practitioner or Physician Assistant (A professional license issued by the State of Delaware is required)

1. May perform all activities as defined in Category A&B above without direct supervision;

2. Initial and ongoing assessment of patient's medical, physical and psychosocial status including: dictation H & P, rounding, recording progress notes, and recording admission and discharge summaries;

3. Implement physician directed and initiated treatment plans recorded as verbal orders to be countersigned;

4. Diagnose and determine the appropriate medical management and treatment of patient being seen for initial evaluation;

5. Provide follow-up medical management and treatment of previously diagnosed conditions;

6. Must report to the physician/employer medical regimen~~ts~~ they have ordered while the physician was not physically present. The physician/employer must countersign the recording of medical regimen on the patient's chart within 24 hours;

7. Prescribe and dispense a drug (non-narcotics) for a patient who is under the care of physician/employer (if authorized by the collaborative agreement between the physician and the NP or PA);

8. Interpret and analyze patient data to determine patient status, patient management and treatment;

9. Educate patients and/or families to promote wellness, prevent health problems, maintain current health and intervene appropriate in acute/chronic illness;

10. Institute emergency measures and emergency treatment or appropriate stabilization measures in situations such as cardiac shock, hemorrhage, convulsions, poisoning and allergic reactions;

11. The Nurse Practitioner or Physician Assistant may also be considered for additional privileges based on appropriate training, experience, and demonstration of current competence, and in conjunction with the State of Delaware Board of Nursing and Board of Medical Practice regulations.

Privileges for the following list of specific procedures, which is not all inclusive, may be requested:

a. Placement of Central Venous Catheter;

b. Endotracheal intubation;

c. Arthrocentesis;

d. Lumbar puncture;

e. Chest tube thoracotomy;

f. Debridement, irrigation, suturing, and routine care of superficial wounds;

g. Treatment of minor superficial burns;

h. Removal of superficial foreign bodies;

i. Incision and drainage of abscesses, wound irrigation and packing;

j. Evacuation of hematomas;

k. Nail removal;

l. Control of external hemorrhage;

m. Subcutaneous local and digital anesthesia;

n. Anterior nasal packing for epistaxis;

o. Splitting of sprains and fractures;

p. Cast removal;

q. Initial x-ray interpretation and subsequent physician interpretation;

12. If so certified by the Correspondence Regulatory Council of the Board of Medical Practice, may initiate prescription medications within the scope of the Nurse Practitioner or Physician Assistant practice. (Verification of prescription authority registration is required.)

D. Certified Registered Nurse Anesthetist (CRNA) (A professional license as issued by the State of Delaware is required)

Performs the following duties under the direct and/or indirect supervision of an anesthesiologist:

1. Obtain a health history including psychosocial and biophysical;

2. Conduct physical screening assessment;

3. Prescribe approved medications;

4. Select and administer pre-anesthetic medication;

5. Request and evaluate pertinent laboratory studies;

6. Utilize current techniques in monitoring;

7. Select and administer anesthetic techniques, medications and adjunctive drugs;

8. Perform tracheal intubation and extubation;

9. Identify and manage emergency situations including assessment of adequacy of recovery; antagonism of muscle relaxants; narcotics and other agents; implement appropriate management techniques;

10. Discharge patient from the Recovery Room;

11. Post-anesthesia follow-up and evaluation;

12. Initiate cardiopulmonary resuscitation;

13. Participate in cardiopulmonary resuscitation in absence of a physician;

14. Insert intravenous catheters including central venous pressure catheters by basilic vein and external jugular vein;

15. Internal jugular vein catheterization;

16. The following privileges are required to be under <u>Direct Supervision</u> of an anesthesiologist:

    - Insert Swan-Ganz catheters;
    - Insert arterial lines;
    - Perform regional anesthetics:
        - Spinal
        - Epidural
        - Bier Block

E. Nurse Midwives (A Professional License as issued by the State of Delaware is required)

May perform all activities in accordance with the Protocol for Certified Nurse Midwifery, a supplement to the Allied Health Professional policy.

1. Applicants may seek approval for additional or more specific activities at the time of initial appointment or at any time by letter to the Vice President for Medical Management. Approval of such additional activities will follow the same process as the approval of the initial appointment.

7.5. TERM

The term of appointment and reappointment shall be for a period of not more than two (2) years.

7.6. PROCEDURE FOR REAPPOINTMENT

All terms, conditions, requirements and procedures relating to initial appointment shall apply to continued appointment and clinical privileges and to reappointment. Clinical performance data or one (1) professional reference will be reviewed prior to reappointment.

7.7. IDENTIFICATION

Allied Health Professionals are to dress in a professional manner. A lab coat over street clothes is acceptable. An identification badge noting the assistant's name and professional status is required to be worn at all times.

7.8. ORIENTATION

The Vice President of Patient Care Services will conduct an orientation, which all AHP's must attend prior to engaging in direct patient care activities.

7.9. INTERACTION WITH HOSPITAL STAFF

If a nurse has a question regarding the clinical competence or authority of an AHP, either to act or to issue instructions outside the physical presence of the employer/physician in a particular instance, the nurse has the right and the duty to require the supervising physician to validate the order of the AHP. No order or instruction transmitted by the AHP shall be carried out if the nurse has reason to doubt that the act is within the scope of the appointed AHP's delineation of activities.

7.10. RESPONSIBILITY

The office of the President of Medical Staff or designee is responsible for the implementation and monitoring of this Policy. All questions regarding this Policy should be referred to that office.