PSESH MEDICAL STAFF CREDENTIALS MANUAL

PSESH Medical Executive Committee, approval: 10/02/2025

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All approvals are documented in the official meeting minutes.

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ARTICLE 1: GENERAL

1.A. DEFINITIONS

Unless otherwise specified, the following definitions apply to terms used in this Manual and the other Medical Staff governance documents:

(1) "ADMINISTRATOR" means the individual, irrespective of organizational title, appointed by the Board to act on its behalf in the overall management of the relevant Hospital.

(2) "ADVANCED PRACTICE PROVIDERS" ("APPs") means a practitioner who provides a medical level of care or performs surgical tasks consistent with granted clinical privileges. In accordance with state law and policies of the applicable Providence Alaska Hospital, APPs may be permitted to practice independently or may be required to exercise some or all of those clinical privileges under the direction of, or in collaboration with, a supervising physician. Any applicable supervision or collaboration requirements will be outlined in the policies, procedures, and/or clinical privilege delineations at the participating Providence Alaska Hospital.

(3) "AFFILIATED ENTITY" means any entity which, directly or indirectly, through one or more intermediaries, is controlled by Providence Health & Services System.

(4) "APPLICANT" means an individual who has submitted an application for initial appointment or reappointment to the Medical Staff, the Advanced Practice and Other Licensed Provider Staff, and/or for clinical privileges.

(5) "BOARD" means the Board of the applicable Hospital corporation, which has the overall responsibility for the Hospital, or its designated committee.

(6) "BOARD CERTIFICATION" is the designation conferred by one of the affiliated specialties of the American Board of Medical Specialties, the American Osteopathic Association, the American Board of Oral and Maxillofacial Surgery, the American Board of Podiatric Medicine, or the American Board of Foot and Ankle Surgery, as applicable. For Advanced Practice Providers, the certifying body approved by the Hospital will be included in the delineation of clinical privileges.

(7) "CLINICAL PRIVILEGES" or "PRIVILEGES" means the authorization granted by the Board to render specific clinical procedures and patient care services, subject to the provisions of this Manual.

(8) "CREDENTIALS MANUAL" means this Manual, which shall supersede all prior Credentials policies, procedures and manuals, and which shall be amended in accordance with Article 10.

(9) "DAYS" means calendar days unless the time frame listed is less than ten days in which case "days" will mean business days and will not include Saturdays, Sundays, or federal holidays.

(10) "DENTIST" means a doctor of dental surgery or doctor of dental medicine.

(11) "EX OFFICIO" means service as a member of a body by virtue of an office or position held and, unless otherwise expressly provided, means without voting rights.

(12) "HOSPITAL" means the following Providence Alaska Hospitals that have adopted this Manual through their Medical Staffs and Boards: Providence Kodiak Island Hospital, Providence Seward Hospital, and Providence Valdez Hospital. For purposes of this Manual, the specific participating Providence Alaska Hospital where this Manual is being applied (e.g., the hospital that is credentialing a practitioner) will be referred to as "the Hospital."

(13) "INVESTIGATION" means the process initiated by a resolution of the Medical Executive Committee, or the Board, to evaluate the validity of questions or concerns pertaining to the clinical competence or professional conduct about a member. An investigation is concluded after final action has been taken in accordance with the process as set forth in this Manual. A routine or general review of cases or any evaluation prior to the commencement of an investigation by the Medical Executive Committee, or the Board, is not considered an investigation.

(14) "MEDICAL EXECUTIVE COMMITTEE" ("MEC") means the Medical Staff Executive Committee at a participating Providence Alaska Hospital. The composition and duties of each MEC are described in the Medical Staff Bylaws of each participating Providence Alaska Hospital.

(15) "MEDICAL STAFF" means all physicians and other types of practitioners who are credentialed through the Medical Staff and designated as a member of the Medical Staff by the relevant participating Providence Alaska Hospital. Each participating Providence Alaska Hospital will have a separate Medical Staff.

(16) "MEDICAL STAFF LEADER" means any Medical Staff Officer or committee chair at a participating Providence Alaska Hospital.

(17) "MEMBER" means any physicians or other types of practitioners who have been designated as members of the Medical Staff by the Board at a participating Providence Alaska Hospital.

(18) "NOTICE" means written or electronic communication by regular hand delivery, U.S. mail, e-mail, facsimile, or Hospital mail.

(19) "PHYSICIAN" includes both doctors of medicine and doctors of osteopathy.

(20) "PRACTITIONER" means any individual who has been granted clinical privileges and/or appointment by the Board, including members of the Medical Staff and the Advanced Practice and Other Licensed Provider Staff.

(21) "PROFESSIONAL CLINICAL STAFF" means all physicians, dentists, podiatrists, advanced practice, and other licensed providers who have been granted appointment and/or clinical privileges to practice at a participating Providence Alaska Hospital. Professional Clinical Staff members are subject to the same terms and conditions of appointment and reappointment as specified for members of the Medical Staff. For ease of use, any reference in the Medical Staff Bylaws and other Medical Staff documents to "Medical Staff" shall be interpreted to include all of the members of the Professional Clinical Staff, unless otherwise indicated. See **Appendix A** for a list of Professional Clinical Staff designations for each participating Providence Alaska Hospital.

(22) "PROFESSIONAL PRACTICE EVALUATION" refers to the Hospital's routine and ongoing peer review process as well as the peer review process to evaluate an individual's professional performance when any questions or concerns arise and includes all activities and documentation related to reviewing issues of clinical competence, professional conduct, care management, and health status performance improvement.

(23) "PROFESSIONAL REVIEW ACTION" and "PROFESSIONAL REVIEW ACTIVITY" have the meanings defined in the Health Care Quality Improvement Act of 1986 ("HCQIA").

(24) "REGIONAL CHIEF MEDICAL OFFICER" or "REGIONAL CMO" means the individual appointed to act as the Chief Medical Officer of the Providence Alaska Hospitals.

(25) "RESTRICTION" means a mandatory concurring consultation, where the consultant must approve the proposed procedure or treatment before privileges may be exercised. It does not include performance improvement steps placed upon the exercise of privileges, such as general consultation, second opinions, proctoring, monitoring, education, training, mentoring or specification of a maximum number of patients, nor does it include a limitation on the exercise of clinical privileges resulting from an exclusive arrangement with another physician or group of physicians or other action by the Board.

(26) "SPECIAL NOTICE" means hand delivery, certified mail (return receipt requested), or overnight delivery service providing receipt.

(27) "SUPERVISING PHYSICIAN" means a Medical Staff member with clinical privileges, who supervises or collaborates with an Advanced Practice Provider as

described in policies and procedures at the participating Providence Alaska Hospital.

(28) "SUPERVISION" means the supervision of (or collaboration with) an Advanced Practice Provider by a supervising physician, as described in policies and procedures at the participating Providence Alaska Hospital.

(29) "UNASSIGNED PATIENT" means any individual who comes to the Hospital for care and treatment who does not have an attending physician, or whose attending physician or designated alternate is unavailable to attend the patient, or who does not want the prior attending physician to provide him/her care while a patient at the Hospital.

1.B. TIME LIMITS

Time limits referred to in this Manual and related bylaws, policies and manuals are advisory only and are not mandatory, unless it is expressly stated.

1.C. DELEGATION OF FUNCTIONS

(1) When a function is to be carried out by a Medical Staff Leader, a Medical Staff committee, or a member of administration, the individual, or the committee through its chair, may delegate performance of the function to one or more designees. Any such designee must treat and maintain all credentialing, privileging, and peer review information in a strictly confidential manner and is bound by all other terms, conditions, and requirements of the Medical Staff Bylaws and related policies.

(2) When a member of the Medical Staff is unavailable or unable to perform an assigned function, one or more of the Medical Staff Leaders may perform the function personally or delegate it to another appropriate individual.

1.D. CONFIDENTIALITY AND PEER REVIEW PROTECTION

1.D.1. Confidentiality:

Actions taken and recommendations made pursuant to this Manual will be strictly confidential. There should be no disclosure of any of this information (discussions or documentation) outside of committee meetings, except:

(a) to another authorized individual or body and for the purpose of conducting professional review activity;

(b) as authorized by a Medical Staff or Hospital policy; or

(c) as authorized by the Administrator, Regional CMO, or legal counsel to the Hospital.

Any breach of confidentiality may result in appropriate sanctions, including but not limited to a professional review action or appropriate legal action. Breaches of confidentiality will not constitute a waiver of any privilege. Any practitioner who becomes aware of a breach of confidentiality is encouraged to inform the Regional CMO, Administrator, or Chief of Staff.

1.D.2. Peer Review Protection:

Credentialing, professional practice evaluation, and peer review activities pursuant to this and related policies will be performed by peer review committees in accordance with state law. These committees include, but are not limited to:

(a) all standing and ad hoc Medical Staff and Hospital committees;

(b) hearing and appellate review panels;

(c) the Board and its committees; and

(d) any individual or body acting for or on behalf of a peer review committee, Medical Staff Leaders, and experts or consultants retained to assist in credentialing, professional practice evaluation, and peer review activities.

All oral and written communications, reports, recommendations, actions, and minutes made or taken by peer review committees are confidential and covered by the provisions of applicable law and are deemed to be "professional review bodies" as that term is defined in the Health Care Quality Improvement Act of 1986 ("HCQIA"), 42 U.S.C. §11101 et seq.

1.E. SUBSTANTIAL COMPLIANCE

While efforts will be made to comply with the provisions of this Manual, substantial compliance is all that is required. Technical or minor deviations from the procedures in this Manual do not invalidate any recommendation that is made or any review or action that is taken. The procedures in this Manual may be expanded to provide greater process or protections for an individual member.

1.F. LOCAL HOSPITAL POLICY VARIATIONS

Any variations in this Policy that are specific to an individual Providence Alaska Hospital may be set forth in a separate hospital-specific appendix to the Policy.

ARTICLE 2: QUALIFICATIONS, CONDITIONS, AND RESPONSIBILITIES

2.A. QUALIFICATIONS

2.A.1. Threshold Eligibility Criteria:

To be eligible to apply for initial appointment, reappointment, or clinical privileges, and to eligible for continued appointment, reappointment, or clinical privileges, individual must demonstrate satisfaction of all of the following threshold eligibility criteria (or be granted a waiver in accordance with Section 2.A.2), as applicable:

(a) have a current, unrestricted license to practice in this state that is not subject to any restrictions, probationary terms, or conditions not generally applicable to all licensees, and have never had a license to practice revoked, restricted or suspended by any state licensing agency;

(b) have a current, unrestricted DEA registration and state controlled substance license (if applicable);

(c) be able to provide timely and continuous care for his or her patients when providing care at the Hospital;

(d) have (or be in the process of obtaining) current, valid professional liability insurance coverage in a form and in amounts satisfactory to the Hospital. The MEC shall have an opportunity for input into changes in coverage requests;

(e) have never been, and not currently be, excluded or precluded from participation in Medicare, Medicaid, or other federal or state governmental health care program;

(f) have never had Medical Staff or Advanced Practice and Other Licensed Provider Staff appointment, or clinical privileges denied, revoked, or terminated by any health care facility, including this Hospital, for reasons related to clinical competence or professional conduct;

(g) have never resigned Medical Staff or Advanced Practice and Other Licensed Provider Staff appointment or relinquished privileges during an investigation or in exchange for not conducting such an investigation at any health care facility, including this Hospital;

(h) have not been convicted of, or entered a plea of guilty or no contest to, any felony or misdemeanor related to Medicare, Medicaid, or other federal or state governmental or private third-party payer fraud or program abuse or have been required to pay a civil money penalty for the same since the beginning of medical education (e.g., medical school);

(i) have not been convicted of, or entered a plea of guilty or no contest to, any felony or misdemeanor relating to controlled substances, illegal drugs, violent acts, sexual misconduct, moral turpitude, or child or elder abuse within the last seven years (this criterion will be interpreted in accordance with applicable law);

(j) have an appropriate coverage arrangement, as determined by the Chief of Staff, with other members of the Medical Staff for those times when the individual will be unavailable;

(k) document compliance with all applicable training and educational protocols that may be adopted by the MEC and required by the Board, including, but not limited to, those involving electronic medical records or patient safety;

(l) meet any current or future eligibility requirements that are applicable to the clinical privileges being sought;

(m) if applying for privileges in an area that is covered by an exclusive contract or arrangement, meet the specific requirements set forth in that contract;

(n) demonstrate recent clinical activity in their primary area of practice, in an acute care hospital (or, if applying for outpatient practice only, in a similar outpatient setting) during the last two years;

(o) have successfully completed:

(1) a residency and, if applicable, fellowship training program approved by the Accreditation Council for Graduate Medical Education, the American Osteopathic Association or the approved Canadian or United Kingdom equivalent in the specialty in which the applicant seeks clinical privileges;

(2) a dental or an oral and maxillofacial surgery training program accredited by the Commission on Dental Accreditation of the American Dental Association;

(3) a podiatric surgical residency program accredited by the Council on Podiatric Medical Education of the American Podiatric Medical Association; or

(4) for professionals other than physicians, dentists or podiatrists, have satisfied the applicable training requirements as established by the Hospital;

(p) be certified in their primary area of practice at the Hospital by the appropriate specialty/subspecialty board of the American Board of Medical Specialties, the American Osteopathic Association, or the approved Canadian or United Kingdom equivalent; the American Board of Oral and Maxillofacial Surgery, the American Dental Association, or the American Board of Podiatric Surgery, as applicable, or,

if not certified, be within five years from the date of completion of their residency or fellowship training, in order to be eligible for Medical Staff appointment;

(q) maintain board certification as set forth in Hospital policy and/or the relevant delineation of clinical privileges; and

(r) if seeking to practice as an Advanced Practice Provider, have an agreement to practice under the direction of, or in collaboration with, a supervising physician as, and only if, required under Hospital policy and/or the clinical privileges being sought.

2.A.2. Process for Waiver of Threshold Eligibility Criteria:

(a) Any applicant who does not satisfy one or more of the threshold eligibility criteria may request that it be waived. Waivers of threshold eligibility criteria will not be granted routinely. The applicant requesting the waiver bears the burden of demonstrating exceptional circumstances, and that his or her qualifications are equivalent to, or exceed, the criterion in question.

(b) A request for a waiver will be submitted to the Chief of Staff for consideration. In reviewing the request for a waiver, the Chief of Staff may consult with the Administrator and Regional CMO.

(c) The Chief of Staff may consider the specific qualifications of the applicant in question, the application form and other information supplied by the applicant, and the best interests of the Hospital and the communities it serves. The Chief of Staff will forward their recommendation, including their reasons, to the MEC. Any recommendation to grant a waiver must include the specific reasons for the recommendation.

(d) The MEC will review the recommendation of the Chief of Staff and make a recommendation to the Board regarding whether to grant or deny the request for a waiver. Any recommendation to grant a waiver must include the specific reasons for the recommendation.

(e) The Board's determination regarding whether to grant a waiver is final.

(f) If a waiver is granted that does not specifically include a time limitation, the waiver is considered to be permanent and the individual does not have to request a waiver at subsequent reappointment cycles.

(g) A determination to grant a waiver does not mean that appointment will be granted, only that processing of the application can begin.

(h) No applicant is entitled to a waiver or to a hearing if the Board determines not to grant a waiver. A determination not to grant a waiver is not a "denial" of

appointment or clinical privileges and the individual who requested the waiver is not entitled to a hearing. Rather, that individual is ineligible to request appointment or clinical privileges. A determination of ineligibility is not a matter that is reportable to either the state licensure board or the National Practitioner Data Bank. A determination to grant a waiver in a particular case is not intended to set a precedent for any other applicant or group of applicants.

2.A.3. Factors for Evaluation:

The following factors will be evaluated as part of the appointment and reappointment processes:

(a) relevant training, experience, and demonstrated current competence, including medical/clinical knowledge, technical and clinical skills, clinical judgment and an understanding of the contexts and systems within which care is provided;

(b) adherence to the ethics of the profession, continuous professional development, an understanding of and sensitivity to diversity, and responsible attitude toward patients and the profession;

(c) good reputation and character;

(d) ability to safely and competently perform the clinical privileges requested;

(e) ability to work harmoniously with others, including, but not limited to, interpersonal and communication skills sufficient to enable them to maintain professional relationships with patients, families, and other members of health care teams; and

(f) recognition of the importance of, and willingness to support, a commitment to quality care and recognition that interpersonal skills and collegiality are essential to the provision of quality patient care.

2.A.4. No Entitlement to Appointment:

No one is entitled to receive an application, be appointed or reappointed to the Medical Staff or Advanced Practice and Other Licensed Provider Staff or be granted or exercise particular clinical privileges merely because he or she:

(a) is employed by this Hospital or its affiliates or has a contract with this Hospital;

(b) is or is not a member or employee of any particular physician group;

(c) is licensed to practice a profession in this or any other state;

(d) is a member of any particular professional organization;

(e) has had in the past, or currently has, Medical Staff or Advanced Practice and Other Licensed Provider Staff appointment or privileges at any hospital or health care facility;

(f) resides in the geographic service area of the Hospital; or

(g) is affiliated with, or under contract to, any managed care plan, insurance plan, HMO, PPO, or other entity.

2.A.5. Nondiscrimination:

No one will be denied appointment or clinical privileges on the basis of gender, race, creed, sexual orientation, national origin, or faith.

2.A.6. Ethical and Religious Directives:

All members will abide by the terms of the Ethical and Religious Directives for Catholic Health Care Services promulgated by the National Conference of Catholic Bishops with respect to their practice at the Hospital. No member will engage in activity prohibited by the Directives at the Hospital unless an exemption has been granted. A copy of the Directives and any exemptions shall be made available to every applicant.

2.B. GENERAL CONDITIONS OF APPOINTMENT, REAPPOINTMENT, AND CLINICAL PRIVILEGES

2.B.1. Basic Responsibilities and Requirements:

As a condition of being granted appointment, reappointment or clinical privileges and as a condition of ongoing appointment and clinical privileges, every individual specifically agrees to the following:

(a) to provide timely and continuous care for his or her patients when scheduled to provide care at the Hospital;

(b) to abide by the bylaws, policies, and procedures of the Hospital and Medical Staff and any revisions or amendments thereto;

(c) to participate in Medical Staff affairs through committee service and participation in performance improvement and peer review activities, and to perform such other reasonable duties and responsibilities as may be assigned;

(d) to provide emergency call coverage, consultations, and care for unassigned patients, as determined by the MEC;

(e) to comply with clinical practice or evidence-based protocols pertinent to his or her medical specialty, as may be adopted by the MEC or document the clinical reasons for variance;

(f) to obtain, when requested, an appropriate fitness for practice evaluation, which may include diagnostic testing (such as blood and/or urine test) or a complete physical, mental, and/or behavioral evaluation, as set forth in Article VI of this Manual;

(g) to participate in personal or phone interviews in regard to an application for initial appointment or reappointment, if requested;

(h) to use the Hospital sufficiently to allow continuing assessment of current competence;

(i) to seek consultation whenever necessary;

(j) to complete in a timely manner all medical and other required records;

(k) to perform all services and to act in a cooperative and professional manner;

(1) to promptly pay any applicable dues, assessments, or fines;

(m) to utilize the Hospital's electronic medical record system;

(n) to satisfy continuing medical education requirements;

(o) to attend and participate in any applicable orientation programs at the Hospital within the time period established by policy;

(p) to comply with all applicable training and educational protocols that may be adopted by the MEC, including, but not limited to, those involving electronic medical records, patient safety, and infection control;

(q) to maintain a current e-mail address with Medical Staff Services, which will be the primary mechanism used to communicate all Medical Staff or Advanced Practice and Other Licensed Provider Staff information to the member;

(r) to disclose conflicts of interest regarding relationships with pharmaceutical companies, device manufacturers, other vendors or other persons or entities as may be required by Hospital or Medical Staff policies, including, but not limited to, disclosure of financial interests in any product, service, or medical device not already in use at the Hospital that a Medical Staff member may request the Hospital to purchase;

(s) that, if the individual is a member of the Medical Staff who serves or plans to serve as a supervising physician to an Advanced Practice Provider, the member of the

Medical Staff will abide by any supervision requirements and conditions of practice set forth in Hospital policy; and

(t) that, if the individual is an Advanced Practice Provider, he or she will abide by any supervision requirements and conditions of practice set forth in Hospital policy, if applicable to their practice.

2.B.2. Burden of Providing Information:

(a) All applicants and members have the burden of producing information deemed adequate by the Hospital for a proper evaluation of current competence, character, ethics, and other qualifications and for resolving any doubts.

(b) Applicants have the burden of providing evidence that all the statements made and all information provided by the applicant in support of the application are accurate and complete.

(c) An application will be complete when all questions on the application form have been answered, all supporting documentation has been supplied, and all information has been verified from primary sources. An application will become incomplete if the need arises for new, additional, or clarifying information. Any application that continues to be incomplete 30 days after the applicant has been notified of the additional information required will be deemed to be withdrawn.

(d) Applicants are responsible for providing a complete application, including adequate responses from references. An incomplete application will not be processed. Applications that are considered incomplete will deem the applicant ineligible to reapply for a period of two years or greater. Applicants may submit a request for waiver of the requirement, which will be processed in the same manner as a waiver of threshold eligibility criteria.

(e) Applicants and members are responsible for notifying the Chief of Staff or Medical Staff Services of any change in status or any change in the information provided on the application form. This information is required to be provided with or without request, at the time the change occurs, and includes, but will not be limited to:

(1) any information on the application form;

(2) any threshold eligibility criteria for appointment or clinical privileges;

(3) any and all complaints, documents or other information known to the practitioner regarding, or changes in, licensure status or DEA controlled substance authorization;

(4) changes in professional liability insurance coverage;

(5) the filing of a professional liability lawsuit against the practitioner;

(6) arrest, charge, indictment, conviction, or a plea of guilty or no contest in any criminal matter;

(7) exclusion or preclusion from participation in Medicare, Medicaid or any other federal or state healthcare program or any sanctions imposed with respect to the same;

(8) any changes in the practitioner's ability to safely and competently exercise clinical privileges or perform the duties and responsibilities of appointment because of health status issues, including, but not limited to, impairment due to addiction (all of which will be referred for review under the policy on practitioner health); and

(9) any investigations, complaints, disciplinary actions, counseling, or other Human Resources actions if employed by the Hospital or its affiliates.

2.C. APPLICATION

2.C.1. Information:

(a) Application forms (which may be electronic) for appointment, reappointment, and clinical privileges will be designated by the Hospital.

(b) The application will contain a request for specific clinical privileges and will require detailed information concerning the applicant's professional qualifications. The applicant will sign the application (by electronic signature) and certify that he or she is able to perform the privileges requested and the responsibilities of appointment.

2.C.2. Misstatements and Omissions:

(a) Any misstatement in, or omission from, the application is grounds to stop processing the application. The applicant will be informed in writing of the nature of the misstatement or omission and permitted to provide a written response. The Chief of Staff will review the response and determine whether the application should be processed further.

(b) If appointment has been granted prior to the discovery of a misstatement or omission, appointment and privileges may be deemed to be automatically relinquished pursuant to this Manual.

(c) No action taken pursuant to this section will entitle the applicant or member to a hearing or appeal.

2.C.3. Grant of Immunity and Authorization to Obtain/Release Information:

(a) Conditions Prerequisite to Application and Consideration:

As a condition of having a request for application considered or applying for appointment, reappointment, clinical privileges, or a scope of practice, every individual accepts the terms set forth in this Section.

(b) Scope of Conditions:
The terms set forth in this Section:

(1) commence with the individual's initial contact with the Hospital, whether an application is furnished or appointment, clinical privileges, or scope of practice are granted;

(2) apply throughout the credentialing process and the term of any appointment, reappointment, clinical privileges, or scope of practice; and

(3) survive for all time, even if appointment, reappointment, clinical privileges, or scope of practice is denied, revoked, reduced, restricted, suspended, or otherwise affected as part of the Hospital's professional review activities and even if the individual no longer maintains appointment, clinical privileges or a scope of practice at the Hospital.

(c) Use and Disclosure of Information about Individuals:

(1) Information Defined.

For purposes of this Section, "information" means information about the individual, regardless of the form (which shall include verbal, electronic, and paper), which pertains to the individual's appointment, reappointment, clinical privileges, or scope of practice, or the individual's qualifications for the same, including, but not limited to:

(i) information pertaining to the individual's clinical competence, professional conduct, reputation, ethics, and ability to practice safely with or without accommodation;

(ii) any matter addressed on the application form or in the Medical Staff Bylaws, this Manual, and other Hospital or Medical Staff policies and procedures;

(iii) any reports about the individual which are made by the Hospital, its Medical Staff Leaders, or their representatives to the National Practitioner Data Bank or relevant state licensing boards/agencies; and

(iv) any references received or given about the individual.

(2) Authorization for Criminal Background Check.

The individual agrees to sign consent forms to permit a consumer reporting agency to conduct a criminal background check and report the results to the Hospital.

(3) Authorization to Share Information within the System.

The individual authorizes the Hospital and its affiliates within the Providence Health & Services System to share information with one another.

(4) Authorization to Obtain Information from Third Parties.

The individual authorizes the Hospital, Medical Staff Leaders, and their representatives to request or obtain information from third parties and specifically authorizes third parties to release information to the Hospital.

(5) Authorization to Disclose Information to Third Parties.

The individual authorizes the Hospital, Medical Staff Leaders, and their representatives to disclose information to other hospitals, health care facilities, managed care organizations, government regulatory and licensure boards or agencies, and their representatives to assist them in evaluating the individual's qualifications.

(d) Hearing and Appeal Procedures:

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

(e) Immunity:

To the fullest extent permitted by law, the individual releases from any and all liability, extends immunity to, and agrees not to sue the Hospital, the Board, and the Medical Staff, their authorized representatives, any members of the Medical Staff, Advanced Practice and Other Licensed Provider Staff, or Board, and any third party who provides information.

This immunity covers any actions, recommendations, reports, statements, communications, or disclosures that are made, taken, or received by the Hospital, its representatives, or third parties in the course of credentialing and peer review

activities or when using or disclosing information as described in this Section. Nothing herein shall be deemed to waive any other immunity or privilege provided by federal or state law.

ARTICLE 3: PROCEDURE FOR INITIAL APPOINTMENT AND PRIVILEGES

3.A. APPLICATIONS FOR INITIAL APPOINTMENT AND PRIVILEGES

(1) Prospective applicants will be sent the application form for appointment and the applicable criteria for clinical privileges.

(2) Applications may be provided to residents who are in the final six months of their training. Final action will not be taken until all applicable threshold eligibility criteria are satisfied.

3.B. PROCEDURE FOR INITIAL APPOINTMENT AND PRIVILEGES

3.B.1. Initial Review of Application:

(a) A completed application form with copies of all required documents must be returned to Medical Staff Services within 45 days after receipt. Membership and/or clinical privileges will not be granted until the application fee is received.

(b) As a preliminary step, the application will be reviewed by Medical Staff Services to determine that all questions have been answered and that the applicant satisfies all threshold eligibility criteria. Applicants who fail to return completed applications or fail to meet the threshold eligibility criteria will be notified that their applications will not be processed. A determination of ineligibility does not entitle the individual to a hearing and appeal.

(c) Medical Staff Services will oversee the process of gathering and verifying relevant information, and confirming that all references and other information deemed pertinent have been received.

(d) Evidence of the applicant's character, professional competence, qualifications, behavior, and ethical standing will be examined. This information may be contained in the application, and obtained from references and other available sources, including the applicant's past or current department chair at other health care entities (if any), residency training director, and others who may have knowledge about the applicant's education, training, experience, and ability to work with others. The National Practitioner Data Bank will be queried as required.

(e) An interview(s) with the applicant will be conducted, if requested. The purpose of the interview is to discuss and review any aspect of the applicant's application, qualifications, and requested clinical privileges. This interview will be conducted by one or any combination of any of the following: the MEC or its representative(s), the Chief of Staff, the Regional CMO, or the Administrator.

3.B.2. MEC Member Review:

(a) A designated member of the MEC shall evaluate the applicant's education, relevant training, and experience. Such evaluation shall include inquiries directed to the applicant's past and current department chairperson(s) (if any), residency training director, and others who may have knowledge about the applicant.

(b) As part of the evaluation process, the designated MEC member may meet with the applicant to discuss any aspect of the application, the individual's qualifications, and the requested clinical privileges or scope of practice.

(c) The designated MEC member shall prepare a written report and recommendation concerning the applicant's qualifications. This report and recommendation shall address whether the applicant satisfies the current criteria for the clinical privileges or the scope of practice requested.

(d) A complete application may be considered for temporary clinical privileges in accordance with Section 4.D of this Manual.

3.B.3. Administrator Review:

The Administrator will review the designated MEC member's report, the application, and any supporting materials and make a recommendation to the MEC.

3.B.4. MEC Review:

(a) The MEC shall review and consider the report prepared by the designated MEC member and the recommendation of the Administrator before making its own recommendation.

(b) The MEC may use the expertise of any Medical Staff member, Advanced Practice and Other Licensed Provider Staff member, or an outside consultant, if additional information is required regarding the applicant's qualifications.

(c) After determining that an applicant is otherwise qualified for appointment and privileges, if there is any question about the applicant's ability to perform the privileges requested and the responsibilities of appointment, the MEC may require a fitness for practice evaluation within a reasonable time as determined by the MEC by a physician(s) satisfactory to the MEC. The results of this evaluation will be made available to the MEC. Failure to undergo a fitness for practice evaluation within a reasonable time after a written request from the MEC will be considered a voluntary withdrawal of the application.

(d) The MEC may recommend the imposition of specific conditions. These conditions may relate to behavior (e.g., personal code of conduct) or to clinical issues (e.g., general consultation requirements, appropriate documentation requirements, proctoring, completion of CME requirements). The MEC may also recommend

that appointment or permission to practice be granted for a period of less than two years in order to permit closer monitoring of an individual's compliance with any conditions.

(e) If the recommendation of the MEC is to appoint or grant permission to practice, the recommendation shall be forwarded to the Board.

(f) Any recommendation by the MEC that would entitle the affected individual to a hearing and appeal shall be forwarded to the Administrator who shall promptly notify the affected individual by special notice. If the individual is seeking Medical Staff membership and clinical privileges, the Administrator shall hold the recommendation until after the individual has exercised or has waived the hearing and appeals rights set forth in this Manual.

3.B.5. Board Action:

(a) The Board may delegate to a committee, consisting of at least two Board members, action on appointment, reappointment, and clinical privileges if there has been a favorable recommendation from the MEC and there is no evidence of any of the following:

(1) a current or previously successful challenge to any license or registration;

(2) an involuntary termination, limitation, reduction, denial, or loss of appointment or privileges at any other hospital or other entity; or

(3) an unusual pattern of, or an excessive number of, professional liability actions resulting in a final judgment against the applicant.

Any decision reached by the Board Committee to appoint will be effective immediately and will be forwarded to the Board for consideration at its next meeting.

(b) When there has been no delegation to the Board Committee, upon receipt of a recommendation that the applicant be granted appointment and clinical privileges, the Board may:

(1) grant appointment and clinical privileges as recommended; or

(2) refer the matter back to the MEC or to another source for additional research or information; or

(3) modify the recommendation.

(c) If the Board disagrees with a favorable recommendation, it should first discuss the matter with the Chief of Staff. If the Board's determination remains unfavorable,

the Administrator will promptly send special notice that the applicant is entitled to request a hearing.

(d) Any final decision by the Board to grant, deny, modify, or revoke appointment or clinical privileges will be disseminated to appropriate individuals and, as required, reported to appropriate entities.

3.B.6. Time Periods for Processing:

Once an application is deemed complete, it is expected to be processed within 120 days, unless it becomes incomplete. 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.

3.C. EXTERNAL PROCTOR AUTHORIZATION PROCESS

(1) External Proctor authorization may be granted by the Medical Staff leaders referenced below to visit the Hospital for the purpose of proctoring a member performing a new privilege, or a procedure with the use of new technology, when no Medical Staff member has the necessary expertise. The decision as to whether to grant external proctor authorization shall be in the sole discretion of the Medical Staff leaders referenced below in subsection (5).

(2) External Proctors may include: (a) a device manufacturer trainer who has been thoroughly trained as required by the manufacturer, (b) a physician or physician team as sponsored by said device manufacturer, and (c) a qualified physician, outside of the Hospital, who has recognized expertise in said procedure.

(3) External Proctors are not granted clinical privileges and may not admit, treat, examine, consult, write or give verbal orders, perform or assist (except verbally) with procedures, write in the medical record, or otherwise participate directly in the care of any patient. They shall not be members of the Medical Staff and shall not have access to any of the rights or prerogatives of membership, but shall abide by all applicable Hospital and Medical Staff Bylaws, policies, procedures, and other governance documents.

(4) The External Proctor application form and all required documentation will be forwarded to Medical Staff Services at least 10 business days prior to the procedure to be proctored. Documentation and verifications required prior to authorization include:

- request from current Medical Staff member for the External Proctor;
- Consent and Release of Information;
- Proctor Application;

- Confidentiality Form;
- current CV;
- letter submitted directly to the Hospital from the proposed proctor's primary practice facility indicating he/she is currently in good standing, possesses the clinical privileges to perform the procedures for which he/she wishes to proctor the member of the Medical Staff, and that he/she has successfully performed a minimum number (as determined by the MEC) of the procedures that he/she will be proctoring at the Hospital;
- evidence that demonstrates current clinical competence and overall qualifications to perform the privileges in question;
- if sponsored by a vendor, documentation from the vendor indicating they are an approved proctor;
- copy of government issued ID;
- NPDB report (Medical Staff Services will obtain); and
- verification of licensure (Medical Staff Services will obtain).

No External Proctor authorization may be granted in cases in which the Proctor Guidelines of the Medical Staff and the credentialing criteria are not met.

(5) External Proctor authorization may be granted for up to one year upon the concurrence of the Chief of Staff, in consultation with the Regional CMO, each of whom must be satisfied as to the qualifications of the member's applicant for such privileges and as to the need for proctoring. External Proctor authorization shall be granted through the issuance of a written delineation form which shall describe in reasonable detail the scope and duration of the authorization being granted.

(6) External Proctors must report to Medical Staff Services upon arrival to the Hospital for identity verification and issuance of a proctor badge. Fees charged by the External Proctor will be the responsibility of the Physician requesting External Proctor authorization.

ARTICLE 4: CLINICAL PRIVILEGES

4.A. CLINICAL PRIVILEGES

4.A.1. General:

(a) Appointment or reappointment will not confer any clinical privileges or right to practice at the Hospital. Individuals may only exercise those clinical privileges that have been granted by the Board, subject to the terms of this Manual.

(b) A request for privileges will be processed only if an applicant satisfies threshold eligibility criteria for the delineated privileges. An individual who does not satisfy the eligibility criteria for clinical privileges may request that the criteria be waived and the waiver process outlined in Article 2 will be followed.

(c) Requests for clinical privileges that are subject to an exclusive contract or arrangement will not be processed except as consistent with the applicable contract or arrangement. Similarly, requests for clinical privileges will not be processed if the Hospital has determined not to accept an application in the specialty.

(d) The granting of clinical privileges includes responsibility to participate in emergency service call obligations sufficient to enable the Hospital to satisfy its obligations under the Emergency Medical Treatment and Active Labor Act.

(e) Recommendations for clinical privileges will be based on consideration of the following:

(1) education, relevant training, experience, and demonstrated current competence, including medical/clinical knowledge, technical and clinical skills, judgment, interpersonal and communication skills, and professionalism with patients, families, and other members of the health care team and peer evaluations relating to these criteria;

(2) appropriateness of utilization patterns;

(3) ability to perform the privileges requested competently and safely;

(4) information resulting from ongoing and focused professional practice evaluation and other performance improvement activities, as applicable;

(5) availability of coverage in case of the applicant's illness or unavailability;

(6) adequate professional liability insurance coverage for 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 or voluntary or involuntary termination, limitation, reduction, or loss of appointment or clinical privileges at another hospital;

(10) Practitioner-specific data as compared to aggregate data, when available;

(11) morbidity and mortality data, when available; and

(12) professional liability actions, especially any such actions that reflect an unusual pattern or number of actions.

(f) An applicant has the burden of establishing qualifications and current competence for clinical privileges requested.

(g) The report of the designated MEC member will be processed as a part of the application for privileges. Clinical privileges will be granted for a period not to exceed two years.

(h) Requests for additional clinical privileges must state the additional clinical privileges requested and provide information sufficient to establish eligibility. If the member is eligible and the request is complete, it will be processed in the same manner as an application for initial clinical privileges.

4.B. TELEMEDICINE PRIVILEGES

4.B.1. Processing Requests for Telemedicine Privileges:

(a) Telemedicine is the provision of clinical services to patients by practitioners from a distance via electronic communications.

(b) A qualified individual may be granted telemedicine privileges regardless of whether the individual is appointed to the Medical Staff or Advanced Practice or Other Licensed Provider Staff. All individuals considered for telemedicine privileges must provide evidence of adequate insurance coverage, which may be through a separate rider.

(c) Requests for initial or renewed telemedicine privileges will be processed through one of the following options, as determined by the Administrator in consultation with the Chief of Staff:

(1) A request for telemedicine privileges may be processed through the same process for Medical Staff or Advanced Practice or Other Licensed Provider Staff applications, as set forth in this Manual. In such case, the individual must satisfy all qualifications and requirements set forth in this Manual, except those relating to geographic location, coverage arrangements, and emergency call responsibilities.

(2) If the individual requesting telemedicine privileges is practicing at a distant hospital that participates in Medicare or a telemedicine entity (as that term is defined by Medicare) that participates in Medicare, a request for telemedicine privileges may be processed using an alternative process that relies on the credentialing and privileging decisions made by the distant hospital or telemedicine entity. In such cases, the Hospital must ensure, through a written agreement, that the distant hospital or telemedicine entity complies with all applicable Medicare regulations and accreditation standards. The distant hospital or telemedicine entity must provide:

(i) confirmation that the practitioner is licensed in Alaska;

(ii) a current list of privileges granted to the practitioner;

(iii) information indicating that the applicant has actively exercised the relevant privileges during the previous 12 months and has done so in a competent manner;

(iv) confirmation that the applicant satisfies all of the distant hospital or telemedicine entity's qualifications for the clinical privileges granted;

(v) confirmation that all information provided by the distant hospital or telemedicine entity is complete, accurate, and up-to-date; and

(vi) any other information required by the agreement or requested by the Hospital.

(3) Prior to granting telemedicine privileges, the National Practitioner Data Bank will be queried and the Office of Inspector General's List of Excluded Individuals/Entities will be checked.

(4) The information received about the individual requesting telemedicine privileges will be provided to the MEC for review and recommendation and to the Board for final action.

(d) Notwithstanding the process set forth in this section, the Hospital may determine that an applicant for telemedicine privileges is ineligible for appointment or clinical

privileges if the applicant fails to satisfy the threshold eligibility criteria set forth in this Manual.

(e) Telemedicine privileges, if granted, will be for a period of not more than two years.

4.B.2. Review of Telemedicine Privileges:

(a) Individuals granted telemedicine privileges will be subject to the Hospital's peer review activities. The results of the peer review activities, including any adverse events and complaints filed about the practitioner providing telemedicine services from patients, other practitioners or staff, will be shared with the hospital or entity providing telemedicine services.

(b) Telemedicine privileges granted in conjunction with a contractual agreement will automatically expire with the expiration or termination of the agreement.

4.C. FOCUSED PROFESSIONAL PRACTICE EVALUATION FOR INITIAL PRIVILEGES

(1) All initial grants of clinical privileges, whether at the time of appointment, reappointment, or during the term of an appointment, will be subject to focused professional practice evaluation by a physician(s) designated by the MEC.

(2) This focused professional practice evaluation may include chart review, monitoring, proctoring, external review, and other information. The clinical activity requirements, including numbers and types of cases to be reviewed, will be determined by the MEC.

(3) Unless an extension or waiver is granted, a newly appointed member's appointment and privileges will expire if he or she fails to fulfill the clinical activity requirements within the time frame recommended by the MEC. In such case, the individual may not reapply for initial appointment or privileges for two years.

(4) If a member who has been granted additional clinical privileges fails to fulfill the clinical activity requirements within the time frame recommended by the MEC, the additional clinical privileges will expire and the member may not reapply for the privileges in question for two years unless an exception or waiver is granted.

(5) When, based upon information obtained through the focused professional practice evaluation process, a recommendation is made to terminate, revoke, or restrict clinical privileges for reasons related to clinical competence or professional conduct, the individual will be entitled to a hearing and appeal.

4.D. TEMPORARY CLINICAL PRIVILEGES

4.D.1. Eligibility to Request Temporary Clinical Privileges:

(a) Applicants. Temporary privileges for an applicant for initial appointment may be granted by the Administrator under the following conditions:

(1) the applicant has submitted a complete application, along with any application fee;

(2) the verification process is complete, including verification of current licensure, relevant training or experience, current competence, ability to exercise the privileges requested, and current professional liability coverage; compliance with privileges criteria; and consideration of information from the National Practitioner Data Bank, from a criminal background check, and from OIG queries;

(3) the applicant demonstrates that (i) there are no current or previously successful challenges to his or her licensure or registration, and (ii) he or she has not been subject to involuntary termination of appointment or involuntary limitation, reduction, denial, or loss of clinical privileges, at another health care facility;

(4) the application is pending review by the full MEC and the Board, following a favorable recommendation by the designated MEC member; and

(5) temporary privileges for a new applicant will be granted for a maximum period of 120 consecutive days.

(b) Urgent Patient Care Need. The Administrator, upon recommendation of the Chief of Staff, may also grant temporary privileges in other limited situations when there is an important patient care, treatment, or service need, under the following circumstances:

(1) the temporary privileges are needed (i) for the care of a specific patient; (ii) when a proctoring or consulting practitioner is needed, but is otherwise unavailable; or (iii) when necessary to prevent a lack or lapse of services in a needed specialty area (e.g., locums);

(2) the following factors are considered and/or verified prior to the granting of temporary privileges: current licensure, relevant training or experience, current competence (verification of good standing in the individual's most recent hospital affiliation), current professional liability coverage acceptable to the Hospital, and results of a query to the National Practitioner Data Bank, and from OIG queries; and

(3) the grant of clinical privileges in these situations will not exceed 120 days; however, in exceptional situations, this period of time may be extended in the discretion of the Administrator and the Chief of Staff.

Any individual seeking temporary privileges for an urgent patient care need who is currently appointed in good standing to another Providence Hospital with a grant of clinical privileges relevant to the request for temporary privileges shall be immediately authorized to exercise temporary privileges upon verification of good standing by Medical Staff Services and the completion of a query to the National Practitioner Data Bank; verification of the additional factors referenced above is not required. For all other individuals, the verifications for such grants of privileges shall generally be accomplished in advance; however, in an emergency situation, where life-threatening circumstances exist, the verifications listed above may be completed immediately after the grant of privileges.

(c) Automatic Expiration. All grants of temporary privileges shall automatically expire upon the date specified at the time of initial granting unless further affirmative action is taken to renew such temporary privileges by the Chief of Staff and the Administrator.

(d) Compliance with Bylaws and Policies. Prior to any temporary privileges being granted, the individual must agree in writing to be bound by the Bylaws, policies, procedures, and protocols of the Medical Staff and the Hospital.

(e) FPPE. Individuals who are granted temporary privileges will be subject to the Hospital policy regarding focused professional practice evaluation.

4.D.2. Supervision Requirements:

Special requirements of supervision and reporting may be imposed on any individual granted temporary clinical privileges.

4.D.3. Withdrawal of Temporary Clinical Privileges:

(a) The Administrator may withdraw temporary admitting privileges at any time, after consulting with the Chief of Staff. Clinical privileges shall then expire as soon as patients have been discharged or alternate care has been arranged.

(b) If the care or safety of patients might be endangered by continued treatment by the individual granted temporary privileges, the Administrator, or the Chief of Staff may immediately withdraw all temporary privileges. The Chief of Staff shall assign to another practitioner responsibility for the care of such individual's patients until they are discharged or an appropriate transfer arranged. Whenever possible, consideration shall be given to the wishes of the patient in the selection of a substitute physician.

4.E. EMERGENCY PRIVILEGES

(1) For the purpose of this Section, an "emergency" is defined as a condition which could result in serious or permanent harm to patient(s) and in which any delay in administering treatment would add to that harm.

(2) In an emergency situation, a member may administer treatment to the extent permitted by their license, regardless of specific grant of clinical privileges.

(3) When the emergency situation no longer exists, the patient will be assigned by the Chief of Staff to a member with appropriate clinical privileges, considering the wishes of the patient.

4.F. DISASTER PRIVILEGES

(1) When the disaster plan has been implemented and the immediate needs of patients in the facility cannot be met, the Administrator and Chief of Staff may use a modified credentialing process to grant disaster privileges to eligible volunteer licensed practitioners ("volunteers").

(2) Disaster privileges are granted on a case-by-case basis after verification of identity and licensure.

(a) A volunteer's identity may be verified through a valid government-issued photo identification (i.e., driver's license or passport).

(b) A volunteer's license may be verified in any of the following ways: (i) current license to practice; (ii) primary source verification of the license; or (iii) identification indicating that the individual has been granted authority to render patient care in disaster circumstances or is a member of a Disaster Medical Assistance Team, the Medical Resource Corps, the Emergency System for Advance Registration of Volunteer Health Professionals, or other recognized state or federal organizations or groups.

(3) Primary source verification of a volunteer's license will begin as soon as the immediate situation is under control and must be completed within 72 hours from the time the volunteer begins to provide service at the Hospital.

(4) In extraordinary circumstances when primary source verification cannot be completed within 72 hours, it should be completed as soon as possible. In these situations, there must be documentation of the following: (a) the reason primary source verification could not be performed in the required time frame; (b) evidence of the volunteer's demonstrated ability to continue to provide adequate care; and (c) an attempt to obtain primary source verification as soon as possible. If a volunteer has not provided care, then primary source verification is not required.

(5) The Medical Staff will oversee the care provided by volunteer licensed independent practitioners. This oversight will be conducted through direct observation,

mentoring, clinical record review, or other appropriate mechanism developed by the Medical Staff and Hospital.

4.G. CONTRACTS FOR SERVICES

(1) From time to time, the Hospital may enter into contracts or arrangements with practitioners and/or groups of practitioners for the performance of clinical and administrative services at the Hospital. All individuals providing clinical services pursuant to such contracts will obtain and maintain clinical privileges at the Hospital, in accordance with the terms of this Manual.

(2) To the extent that:

(a) any such contract or arrangement confers the exclusive right to perform specified services to one or more practitioners or groups of practitioners, or

(b) the Board by resolution or other arrangement limits the practitioners who may exercise clinical privileges in any clinical specialty to employees of the Hospital or its affiliates,

no other practitioner except those authorized by or pursuant to the contract or arrangement may exercise clinical privileges to perform the specified services while the contract or resolution is in effect. This means that only practitioners so authorized are eligible to apply for appointment or reappointment to the Medical Staff and for the clinical privileges in question. No other applications will be processed.

4.H. CLINICAL PRIVILEGES FOR NEW PROCEDURES

(1) Requests for clinical privileges to perform either a procedure not currently being performed at the Hospital or a new technique to perform an existing procedure ("new procedure") will not be processed until a determination has been made that the procedure will be offered by the Hospital and criteria for the clinical privilege(s) have been adopted.

(2) As an initial step in the process, the individual seeking to perform the new procedure will prepare and submit a report to the Administrator and Chief of Staff addressing the following:

(a) minimum education, training, and experience necessary to perform the new procedure safely and competently;

(b) clinical indications for when the new procedure is appropriate;

(c) whether there is empirical evidence of improved patient outcomes with the new procedure or other clinical benefits to patients;

(d) whether proficiency for the new procedure is volume-sensitive and if the requisite volume would be available;

(e) whether the new procedure is being performed at other similar hospitals and the experiences of those institutions; and

(f) whether the Hospital currently has the resources, including space, equipment, personnel, and other support services, to safely and effectively perform the new procedure.

The Administrator and Chief of Staff will review this report, conduct additional research as necessary, and make a preliminary recommendation as to whether the new procedure should be offered at the Hospital.

(3) If the preliminary recommendation is favorable, the Administrator and Chief of Staff will forward their recommendation to the MEC. The MEC will then develop threshold credentialing criteria to determine those individuals who are eligible to request the clinical privileges. In developing the criteria, the MEC may conduct additional research and consult with experts, as necessary, and develop recommendations regarding:

(a) the minimum education, training, and experience necessary to perform the procedure or service;

(b) the clinical indications for when the procedure or service is appropriate;

(c) the extent (time frame and mechanism) of focused monitoring and supervision that should occur if the privileges are granted; and

(d) the manner in which the procedure would be reviewed as part of the Hospital's ongoing and focused professional practice evaluation activities.

(4) The MEC will then forward its recommendations to the Board for final action.

ARTICLE 5: PROCEDURE FOR REAPPOINTMENT

5.A. PROCEDURE FOR REAPPOINTMENT

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

5.B. REAPPOINTMENT CRITERIA

5.B.1. Eligibility for Reappointment:

To be eligible to apply for reappointment and renewal of clinical privileges, an individual must have, during the previous term of appointment or privileges:

(a) completed all medical records and be current at the time of reappointment;

(b) completed all continuing medical education requirements;

(c) satisfied all Medical Staff or Advanced Practice and Other Licensed Provider Staff responsibilities, including payment of any dues, fines, and assessments;

(d) continued to meet all qualifications and criteria for appointment and the clinical privileges requested;

(e) paid any applicable reappointment processing fee; and

(f) had sufficient patient contacts to enable the assessment of current clinical judgment and competence for the privileges requested. Any member seeking reappointment who has minimal activity at the Hospital must submit such information as may be requested (such as a copy of their confidential quality profile from their primary hospital, clinical information from their private office practice, or a quality profile from a managed care organization or insurer) before the application will be considered complete and processed further.

5.B.2. Factors for Evaluation:

In considering an application for reappointment, the factors listed in Section 2.A.3 of this Manual will be considered. Additionally, the following factors will be evaluated as part of the reappointment process:

(a) compliance with the bylaws, policies, and procedures of the Medical Staff and Hospital;

(b) participation in membership duties, including committee assignments, emergency call, consultation requests, quality of medical record documentation, cooperation

with case management, participation in quality improvement, utilization activities, and professional practice evaluation activities, and such other reasonable duties and responsibilities as assigned;

(c) the results of the Hospital's performance improvement activities, including ongoing and focused professional practice evaluation, 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);

(d) verified complaints received from patients and their families, visitors, or staff; and

(e) other reasonable indicators of continuing qualifications.

5.C. REAPPOINTMENT PROCESS

5.C.1. Reappointment Application:

(a) An application for reappointment will be furnished to members at least three months prior to the expiration of their current appointment term. A completed reappointment application must be returned to Medical Staff Services within 45 days.

(b) Failure to return a completed application within 45 days will result in the assessment of a reappointment processing fee. Failure to return a complete application within 60 days of receipt may result in the automatic expiration of appointment and clinical privileges at the end of the then current term of appointment unless the application can still be processed in the normal course, without extraordinary effort. If an automatic expiration occurs, reinstatement may be requested if the reappointment application is complete, verified and submitted for approval within 180 days of expiration of membership. Otherwise, the initial application process and fees will apply.

(c) The application will be reviewed by Medical Staff Services to determine that all questions have been answered and that the member satisfies all threshold eligibility criteria for reappointment and for the clinical privileges requested.

(d) Medical Staff Services will oversee the process of gathering and verifying relevant information. Medical Staff Services will also be responsible for confirming that all relevant information has been received.

(e) Appointment terms will not extend beyond two years.

5.C.2. Processing Applications for Reappointment:

(a) Medical Staff Services will forward the application to the designated MEC member and the application for reappointment will be processed in a manner consistent with applications for initial appointment.

(b) Additional information may be requested from the applicant if any questions or concerns are raised with the application or if new privileges are requested.

5.C.3. Conditional Reappointments:

(a) Recommendations for reappointment may be subject to an applicant's compliance with specific conditions. These conditions may relate to behavior (e.g., professional code of conduct) or to clinical issues (e.g., general consultation requirements, proctoring, completion of CME requirements, documentation). Reappointments may be recommended for periods of less than two years to permit closer monitoring of a member's clinical performance, professional conduct, and ongoing qualifications for appointment and privileges.

(b) A recommendation of a conditional reappointment or for reappointment for a period of less than two years does not, in and of itself, entitle a member to request a hearing or appeal.

(c) Additionally, if questions or concerns are being addressed at reappointment or in the event the applicant for reappointment is the subject of an investigation or a 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.

5.C.4. Potential Adverse Recommendation:

(a) If the MEC is considering a recommendation to deny reappointment or to reduce clinical privileges, the Chief of Staff will notify the member of the possible recommendation and invite the member to meet prior to any final recommendation being made.

(b) Prior to this meeting, the member will be notified of the general nature of the information supporting the recommendation contemplated.

(c) At the meeting, the member will be invited to discuss, explain, or refute this information. A summary of the interview will be made and included with the committee's recommendation.

(d) This meeting is not a hearing, and none of the procedural rules for hearings will apply. The member will not have the right to be represented by legal counsel at this meeting and no recording (audio or video) of the meeting will be permitted or made.

ARTICLE 6: MANAGING PERFORMANCE ISSUES

6.A. INITIAL MENTORING EFFORTS AND OTHER PROGRESSIVE STEPS

(1) This Manual encourages the use of initial mentoring efforts and progressive steps by Medical Staff Leaders and Hospital administration to address questions relating to a practitioner's clinical practice, professional conduct, and/or health. The goal of these efforts is to arrive at voluntary, responsive actions by the practitioner to resolve questions that have been raised. Medical Staff Leaders and members of Hospital administration have been authorized by the MEC to engage in initial mentoring efforts and progressive steps and all of these activities are undertaken on behalf of these committees as part of their professional practice evaluation functions.

(2) Initial mentoring efforts include activities such as:

(a) informal discussions or coaching by a Medical Staff Leader (e.g., advising an individual of policies regarding appropriate behavior, communication issues, emergency call obligations, or the timely and adequate completion of medical records); and

(b) sharing comparative data, including any variations from clinical practice or evidence-based protocols or guidelines, in order to assist the individual with conforming his or her practice to appropriate norms.

These efforts may be documented in the discretion of the Medical Staff Leader and maintained in the practitioner's confidential file.

(3) Progressive steps are defined as follows:

(a) addressing minor performance issues through informational letters;

(b) sending an educational letter that describes opportunities for improvement and provides specific guidance and suggestions;

(c) facilitating formal collegial counseling (i.e., a planned, face-to-face meeting between an individual and one or more Medical Staff Leaders) in order to directly discuss a matter and the steps needed to be taken to resolve it; and

(d) developing a Performance Improvement Plan, which may include a wide variety of tools and techniques that can result in a constructive and successful resolution of the concern.

All progressive steps shall be documented in a constructive manner and included in an individual's confidential file. Any written responses to any of these

progressive steps by the individual shall also be included in the individual's confidential file.

(4) All of these efforts are fundamental and integral components of the Hospital's professional practice evaluation activities and are confidential and protected in accordance with state law.

(5) Initial mentoring efforts and progressive steps are encouraged, but are not mandatory, and shall be within the discretion of the appropriate Medical Staff Leaders and Hospital administration. When a question arises, the Medical Staff Leaders and/or Hospital administration may:

(a) address it pursuant to the initial mentoring efforts and progressive steps provisions of this Section;

(b) refer the matter for review in accordance with another relevant policy; or

(c) refer it to the MEC for its review and consideration in accordance with this Article.

(6) Should any recommendation be made or an action taken that entitles an individual to a hearing in accordance with this Manual, the individual is entitled to be accompanied by legal counsel at that hearing. However, practitioners do not have the right to be accompanied by counsel when the Medical Staff Leaders and members of administration are engaged in initial mentoring efforts or other progressive steps. These efforts are intended to resolve issues in a constructive manner and do not involve the formal hearing process. In addition, there shall be no recording (audio or video) or transcript made of any meetings that involve initial mentoring efforts or progressive steps activities.

6.B. GUIDELINES FOR COLLEGIAL INTERVENTION

6.B.1. No Recording:

There will be no recording (audio or video) or transcript made of any meetings that involve initial mentoring efforts or other progressive steps activities.

6.B.2. No Right to the Presence of Others:

(a) Credentialing and peer review activities, including all activities set forth in this Article, are confidential and privileged to the fullest extent permitted by law. Accordingly, individuals who are not a part of the Hospital's credentialing and peer review process will not be permitted to attend a meeting that takes place pursuant to this Article unless permitted by the Chief of Staff.

(b) If the individual refuses to meet, the meeting will be canceled and it will be reported to the MEC that the individual declined to attend the meeting.

6.B.3. No Right to Counsel or Representation:

(a) Members do not have the right to be accompanied by legal counsel or other representation when the Medical Staff Leaders and Hospital administration engage in initial mentoring efforts or other progressive steps. These efforts are intended to resolve issues in a constructive manner. The Chief of Staff may make an exception to this general rule.

(b) If the individual refuses to meet without their lawyer or other representative present, the meeting will be canceled and it will be reported to the MEC that the individual declined to attend the meeting.

6.B.4. Involvement of Supervising Physician in Matters Pertaining to Advanced Practice Providers:

If any peer review activity pertains to the clinical competence or professional conduct of an Advanced Practice Provider who is required to practice under the direction of, or in collaboration with, a supervising physician under Hospital policy, the supervising physician will be notified and may be invited to participate.

6.C. ADDITIONAL METHODS FOR PROGRESSIVE STEPS

6.C.1. Mandatory Meeting:

(a) Whenever there is a concern regarding an individual's clinical practice or professional conduct, Medical Staff Leaders may require the individual to attend a mandatory meeting.

(b) Special notice will be given at least three days prior to the meeting and will inform the individual that attendance at the meeting is mandatory and reasonable efforts will be made to accommodate the individual's schedule and availability.

(c) Failure of an individual to attend a mandatory meeting may result in an automatic relinquishment of appointment and privileges as set forth in Article VII.

6.C.2. Fitness for Practice Evaluation:

(a) Emergent Need. A practitioner may be requested to immediately submit to a fitness for practice evaluation to determine his or her ability to safely practice. Such a request for an immediate evaluation may be made when two Medical Staff Leaders (or one Medical Staff Leader and one member of the Hospital administration) have a reasonable belief that the individual poses an immediate threat to patients, the

individual themselves, or others. Such belief may be based on the review of a reported concern and/or after a personal assessment of the practitioner.

(b) Other Requests. A request for a fitness for practice evaluation may also be made as follows:

(1) of an applicant during the initial appointment or reappointment processes when requested by the MEC;

(2) of a member during an investigation; and

(3) of a member seeking reinstatement from a leave of absence.

(c) The Medical Staff Leaders, Hospital administration, or committee that requests the evaluation will: (i) identify the health care professional(s) to perform the evaluation; (ii) inform the individual of the time period within which the evaluation must occur; and (iii) provide the individual with all appropriate releases and/or authorizations to allow the Medical Staff Leaders, or relevant committee, to discuss with the health care professional(s) the reasons for the evaluation and to allow the health care professional to discuss and report the results to the Medical Staff Leaders or relevant committee.

(d) The cost of such fitness for practice evaluation will be borne by the Hospital. However, the individual will be solely responsible for the costs of any follow-up care recommended as a result of the assessment.

(e) Failure to obtain the requested evaluation may result in an application being withdrawn or an automatic relinquishment of appointment and privileges as set forth in Article VII.

6.C.3. Clinical Competency Assessment:

(a) An individual may be requested to participate in a clinical competency assessment to determine their ability to safely and competently practice.

(b) A request for a clinical competency assessment may be made of a member during the reappointment process, as part of the collegial intervention process, or during an investigation. The request may be made by Medical Staff Leaders, the MEC, an investigating committee or another peer review committee.

(c) The Medical Staff Leaders or committee that requests the assessment will: (i) identify the organization to perform the assessment; (ii) inform the individual of the time period within which the assessment must occur; and (iii) provide the individual with all appropriate releases and/or authorizations to allow the Medical Staff Leaders, or relevant committee, to discuss with the organization the reasons

for the assessment and to allow the organization to discuss and report the results of the assessment to the Medical Staff Leaders or relevant committee.

(d) Failure to obtain the requested assessment may result in an automatic relinquishment of appointment and privileges as set forth in Article VII.

6.D. LEAVES OF ABSENCE

6.D.1. Initiation:

(a) A leave of absence for more than 90 days (to include a sabbatical) should be requested in writing and submitted to the Chief of Staff or Medical Staff Services by practitioners who are scheduled to provide services at the Hospital during that time. The request should, when possible, state the beginning and ending dates and the reasons for the leave. Except in extraordinary circumstances, the request will be submitted at least 30 days prior to the anticipated start of the leave; active duty military service or National Guard Reserves members who are deployed for service are not required to provide 30 days' prior notice.

(b) The Chief of Staff will determine whether a request for a leave of absence will be granted, after consulting with the Administrator. The granting of a leave of absence or reinstatement may be conditioned upon the individual's completion of all medical records.

(c) Members of the Medical Staff or Advanced Practice and Other Licensed Provider Staff must report to the Chief of Staff or Medical Staff Services any time they are away from the Hospital or patient care responsibilities for longer than 90 days and the reason for such absence is related to their physical or mental health or otherwise to their ability to care for patients safely and competently. Upon becoming aware of such circumstances (whether through a report of the practitioner or otherwise), the Chief of Staff, in consultation with the Administrator, may trigger an automatic medical leave of absence at any point after becoming aware of the Medical Staff member's absence from patient care.

(d) Leaves of absence are matters of courtesy, not of right. In the event that it is determined that an individual has not demonstrated good cause for a leave, or where a request for extension is not granted, the determination will be final, with no recourse to a hearing and appeal.

6.D.2. Duties of Member on Leave:

During a leave of absence, the member may not exercise any clinical privileges and will be excused from staff responsibilities (e.g., meeting attendance, committee service, emergency service call obligations) and may not exercise the prerogatives of membership. The obligation to pay dues will continue during a leave of absence except that a member granted a leave of absence for U.S. military service will be exempt from this obligation.

An individual must submit proof of professional liability insurance or a claims made tail policy covering the duration of the leave of absence.

6.D.3. Reinstatement:

(a) Individuals requesting reinstatement (other than those whose leave was due to military service) will submit a written summary of their professional activities during the leave and any other information that may be requested by the Hospital. Requests for reinstatement will be reviewed by the Chief of Staff and Administrator.

(b) If the Chief of Staff and Administrator make a favorable recommendation on reinstatement, the individual may immediately resume clinical practice. However, if they have any questions, those questions will be noted, and the reinstatement request will be forwarded to the full MEC and Board. The recommendation for reinstatement from the leave of absence may be subject to specific conditions such as proctoring or monitoring to allow for a closer assessment of the individual's competence.

(c) If the leave of absence was for health reasons (except for a maternity leave), the request for reinstatement must be accompanied by a report from the individual's physician indicating that the individual can resume a hospital practice and safely exercise the clinical privileges requested. The individual may also be required to submit a comprehensive fitness for practice evaluation by a physician(s) satisfactory to the Chief of Staff.

(d) Except for leaves granted for military service, failure to request reinstatement from a leave of absence within one year will be deemed a voluntary resignation of appointment and clinical privileges unless an extension is granted by the Chief of Staff, in consultation with the Administrator. Extensions will be considered only in extraordinary cases where the extension of a leave is in the best interest of the Hospital.

(e) If an individual's current appointment expires during a leave of absence, the individual will be permitted to request reappointment at the same time reinstatement is sought. However, the request for reappointment will not be evaluated until it is determined that the individual is eligible for reinstatement.

6.E. PRECAUTIONARY SUSPENSION OR RESTRICTION OF CLINICAL PRIVILEGES

6.E.1. Grounds for Precautionary Suspension or Restriction:

(a) Whenever failure to take action may result in imminent danger to the health and/or safety of any individual, the Administrator, Chief of Staff, or MEC, in conjunction with the Regional CMO, is authorized to (1) suspend or restrict all or any portion of an individual's clinical privileges or (2) afford the individual an opportunity to

voluntarily refrain from exercising clinical privileges while the matter is being reviewed. The process defined below will apply regardless of the option used in this paragraph.

(b) A precautionary suspension can be imposed at any time, including after a specific event, a pattern of events, or a recommendation by the MEC that would entitle the individual to request a hearing. When possible, prior to the imposition of a precautionary suspension or restriction, reasonable efforts will be made to meet with the individual in question and review the concerns and afford the individual an opportunity to respond.

(c) Precautionary suspension is a temporary step in the professional review activity and does not imply any final finding regarding the concerns supporting the suspension.

(d) A precautionary suspension is effective immediately and will be promptly reported to the Administrator and the Chief of Staff. A precautionary suspension will remain in effect unless it is modified by the Administrator or the Board.

(e) Within three days of the imposition of a suspension, the individual will be provided with a brief written description of the reason(s) for the action, including the names and medical record numbers of the patient(s) involved (if any). The relevant supervising physician will be notified when the affected individual is an Advanced Practice Provider who is required to practice under the direction of, or in collaboration with, a supervising physician under Hospital policy.

(f) Upon the imposition of a precautionary suspension, the Chief of Staff will assign responsibility for the care of any hospitalized patients to another individual with appropriate clinical privileges. Whenever possible, consideration will be given to the wishes of the patient in the selection of a covering physician.

6.E.2. MEC Procedure:

(a) Within a reasonable time, not to exceed 14 days of the imposition of the suspension or restriction, the MEC will review the reasons for the action.

(b) As part of this review, the individual will be invited to meet with the MEC. In advance of the meeting, the individual may submit a written statement and other information to the MEC.

(c) At the meeting, the individual may provide information to the MEC and must respond to questions raised by committee members. The individual may also propose ways, other than precautionary suspension or restriction, to protect patients, employees or others while the matter is being reviewed.

(d) After considering the matter resulting in the suspension or restriction and the individual's response, if any, the MEC shall determine the appropriate next steps,

which may include, but not be limited to, commencing a focused review or a formal investigation, referring the matter for review pursuant to another policy, or recommending some other action that is deemed appropriate under the circumstances. The MEC shall also determine whether the precautionary suspension or restriction should be continued, modified, or terminated throughout any further review process.

(e) There is no right to a hearing based on the imposition or continuation of a precautionary suspension. The procedures outlined above are deemed to be fair under the circumstances.

6.F. INVESTIGATIONS

6.F.1. Initial Review:

(a) Whenever a serious question has been raised, or where collegial efforts have not resolved an issue, the matter may be referred to the Chief of Staff, Administrator, or the chair of the Board.

(b) Issues or questions that may be subject to further review include those related to the following:

(1) clinical competence or clinical practice, including patient care, treatment or management;

(2) the safety or proper care being provided to patients;

(3) the known or suspected violation of ethical standards, the Medical Staff governance documents or any policy of the Hospital; or

(4) conduct that is considered lower than the standards of the Hospital, undermines the Hospital's culture of safety, or is disruptive to the orderly operation of the Hospital or its Medical Staff, including the inability of the member to work harmoniously with others.

(c) The person to whom the question is referred will make a sufficient inquiry to determine whether the question is credible and, if so, will forward it to the MEC. If the question pertains to an Advanced Practice Provider who is required to practice under the direction of, or in collaboration with, a supervising physician under Hospital policy, the supervising physician may also be notified.

(d) No action taken pursuant to this section will constitute an investigation.

6.F.2. Initiation of Investigation:

(a) The MEC will review the matter in question, may discuss the matter with the individual, and will determine whether to conduct an investigation or direct that the matter be handled pursuant to another policy.

(b) An investigation will commence only after a determination by the MEC.

(c) The MEC will inform the individual that an investigation has begun. The notification shall include:

(1) the date the investigation was commenced;

(2) the composition of the committee that will be conducting the investigation, if already identified;

(3) a statement that the individual will be given an opportunity to meet with the committee conducting the investigation before the investigation concludes; and

(4) a copy of this Section of this Manual, which outlines the process for investigations.

(d) Notification may be delayed if, in the judgment of the MEC, informing the individual immediately might compromise the investigation or disrupt the operation of the Hospital or Medical Staff.

(e) The Board may also determine to commence an investigation and may delegate the investigation to the MEC, a subcommittee of the Board, or an ad hoc committee.

6.F.3. Appointment of Investigating Committee:

(a) Once a determination has been made to begin an investigation, the MEC will decide whether to investigate the matter itself or appoint an individual or committee ("investigating committee") to do so.

(b) When an investigating committee is appointed, reasonable efforts should be made to include individuals with a local perspective. However, the investigating committee will not include any individual who:

(1) is in direct economic competition with the individual being investigated;

(2) is a relative of the individual being investigated;

(3) has an actual bias, prejudice, or conflict of interest that would prevent the individual from fairly and impartially considering the matter; or

(4) actively participated in the matter at any previous level.

The investigating committee may also include individuals not on the Medical Staff or Advanced Practice and Other Licensed Provider Staff.

6.F.4. Investigative Procedures:

(a) The investigating committee has the authority to:

(1) review relevant documents, which may include patient records, incident reports and relevant literature or guidelines;

(2) conduct interviews and prepare a summary of each interview, which each interviewee will be asked to review, revise, and sign;

(3) use external review; or

(4) require an examination or assessment by a health care professional(s) acceptable to it. The individual being investigated will execute a release allowing the investigating committee to discuss with the health care professional(s) the reasons for the examination or assessment and allowing the health care professional to discuss and report the results to the investigating committee. The cost of such health examination will be borne by the Hospital. However, the individual will be solely responsible for the costs of any follow-up care recommended as a result of the assessment.

(b) If a decision is made to obtain an external review, the individual under investigation will be notified of that decision and the nature of the external review. Upon completion of the external review, the individual will be provided a copy of the reviewer's report.

(c) The individual will have an opportunity to meet with the investigating committee before it prepares its report. Prior to this meeting, the individual will be informed of the questions being investigated. The investigating committee may also ask the individual to provide written responses to specific questions related to the investigation.

(d) At the meeting, the individual will be invited to discuss, explain, or refute the questions that gave rise to the investigation or that have been identified by the investigating committee during its review. A summary of the interview with the individual will be made and will be included with the investigating committee's report. The interview summary will be shared with the individual prior to the investigating committee finalizing its report. The individual may review the interview summary and recommend suggested changes.

(e) This meeting is not a hearing, and none of the procedural rules for hearings will apply. Lawyers will not be present at this meeting.

(f) The investigating committee will make a reasonable effort to complete the investigation and issue its report within 45 days, provided that an external review is not necessary. When an external review is used, the investigating committee will make a reasonable effort to complete the investigation and issue its report within 30 days of receiving the results of the external review. These time frames are intended to serve as guidelines and, as such, will not be deemed to create any right for an individual to have an investigation completed within such time periods.

6.F.5. Report of Investigating Committee:

(a) At the conclusion of the investigation, the investigating committee will prepare a report. The report will include a summary of the investigation process, including a list of documents that were reviewed and individuals who were interviewed, along with witness summaries that were prepared. The report will also include specific findings and conclusions regarding the concerns that were under review and the recommendations of the investigating committee.

(b) The report of the investigating committee will be forwarded to the MEC.

6.F.6. Recommendation:

(a) The MEC may accept, modify, or reject any recommendation it receives from an investigating committee. Specifically, the MEC may:

(1) determine that no action is justified;

(2) issue a letter of guidance, counsel, warning, or reprimand;

(3) impose conditions for continued appointment;

(4) require monitoring, proctoring or consultation;

(5) require additional training or education;

(6) recommend reduction or restriction of clinical privileges;

(7) recommend suspension of clinical privileges for a specific period of time or until specified conditions have been met;

(8) recommend revocation of appointment or clinical privileges; or

(9) make any other recommendation that it deems necessary or appropriate.

(b) A recommendation by the MEC that does not entitle the individual to request a hearing, will take effect immediately and will remain in effect unless modified by the Board.

(c) A recommendation by the MEC that would entitle the individual to request a hearing, as set forth in this Manual, will be forwarded to the Administrator, who will promptly inform the individual by special notice. The recommendation will not be forwarded to the Board until after the individual has completed or waived a hearing and appeal.

(d) If the Board makes a modification to the recommendation of the MEC that would entitle the individual to request a hearing, the Administrator will inform the individual by special notice. No final action will occur until the individual has completed or waived a hearing and appeal.

ARTICLE 7: AUTOMATIC RELINQUISHMENT

7.A. AUTOMATIC RELINQUISHMENT

(1) Any of the occurrences described in this Section will constitute grounds for the automatic relinquishment of an individual's appointment and clinical privileges. An administrative relinquishment is considered an administrative action, not an adverse professional review action, and, as such, it generally does not trigger an obligation on the part of the Hospital to file a report with the National Practitioner Data Bank.

(2) Except as otherwise provided below, an administrative relinquishment of appointment and privileges will be effective immediately upon actual or special notice to the individual.

7.A.1. Failure to Complete Medical Records:

Failure of an individual to complete medical records, after notification by the medical records department of the delinquency in accordance with applicable policies and procedures, will result in automatic relinquishment of all clinical privileges.

7.A.2. Failure to Satisfy Threshold Eligibility Criteria:

Failure of an individual to continuously evidence satisfaction of any of the threshold eligibility criteria set forth in this Manual will result in automatic relinquishment of appointment and clinical privileges unless a waiver is granted pursuant to Section 2.A.2 of this Manual.

7.A.3. Criminal Activity:

The occurrence of specific criminal actions will result in the automatic relinquishment of appointment and clinical privileges. Specifically, an arrest, charge, indictment, conviction, plea of guilty or plea of no contest pertaining to any felony or to any misdemeanor involving the following will result in an automatic relinquishment: (a) Medicare, Medicaid, or other federal or state governmental or private third-party payer fraud or program abuse; (b) controlled substances; (c) illegal drugs; (d) violent act; (e) sexual misconduct; (f) moral turpitude; or (g) child or elder abuse.

7.A.4. Failure to Provide Information:

(a) Failure of an individual to notify Medical Staff Services of any change in any information provided on an application for initial appointment or reappointment may result in the automatic relinquishment of appointment and clinical privileges.

(b) Failure of an individual to provide information pertaining to an individual's qualifications for appointment or clinical privileges in response to a written request from an authorized Medical Staff committee, the Chief of Staff or Administrator after given a reasonable time to do so, will result in the automatic relinquishment of appointment and clinical privileges until the information is provided to the satisfaction of the requesting party.

7.A.5. Failure to Attend a Mandatory Meeting:

Failure to attend a mandatory meeting requested by any other authorized Medical Staff committee, Medical Staff leader, or Administrator after appropriate notice has been given and reasonable efforts have been made to accommodate the individual's schedule will result in the automatic relinquishment of appointment and clinical privileges. The relinquishment will remain in effect until the individual attends the mandatory meeting and reinstatement is granted as set forth below.

7.A.6. Failure to Complete or Comply with Training or Educational Requirements:

Failure of an individual to complete or comply with training and educational requirements that are adopted by the MEC and/or required by the Board, including, but not limited to, those pertinent to electronic medical records or patient safety will result in the automatic relinquishment of appointment and clinical privileges.

7.A.7. Failure to Comply with Request for Fitness for Practice Evaluation:

(a) Failure of an applicant to undergo a requested fitness for practice evaluation or to execute any of the required releases (i.e., to allow the Medical Staff Leaders, or the relevant committee, to discuss with the health care professional(s) the reasons for the evaluation and to allow the health care professional to report the results to the Medical Staff Leaders or relevant committee) will be considered a voluntary withdrawal of the application.

(b) Failure of a member to undergo a requested fitness for practice evaluation or to execute any of the required releases (i.e., to allow the Medical Staff Leaders, or the relevant committee, to discuss with the health care professional(s) the reasons for the evaluation and to allow the health care professional to report the results to the Medical Staff Leaders or relevant committee) will result in the automatic relinquishment of appointment and privileges.

7.A.8. Failure to Comply with Request for Clinical Competency Assessment:

Failure of a member to undergo a requested clinical competency assessment or to execute any of the required releases (i.e., to allow the Medical Staff Leaders, or the relevant committee, to discuss with the assessing organization the reasons for the assessment and to allow the organization to report the results of the assessment to the Medical Staff Leaders

or relevant committee) will result in the automatic relinquishment of appointment and privileges.

7.A.9. Reinstatement from Automatic Relinquishment and Resignation:

(a) If an individual believes that the matter leading to the administrative relinquishment of appointment and privileges has been resolved within 90 days of the relinquishment, the individual may request to be reinstated.

(b) Requests for reinstatement will be processed as follows:

(1) For requests related to delinquent records, reinstatements will be processed in accordance with applicable policies and procedures. Failure to complete the medical records that caused relinquishment within the time required will result in automatic resignation from the Medical Staff.

(2) For requests related to the expiration or lapse of a license, controlled substance authorization, or insurance coverage, reinstatements will be processed by Medical Staff Services. If any questions or concerns are noted, Medical Staff Services will refer the matter for further review in accordance with (3) below.

(3) For requests related to a failure to provide information, attend a meeting, or complete/comply with training or educational requirements, reinstatements will be processed by the Chief of Staff and Administrator.

(4) For requests related to criminal activity or a failure to comply with a request for a fitness to practice evaluation or clinical competency assessment, reinstatement will be processed by the MEC. If an individual seeks reinstatement prior to the resolution of the matter that triggered the automatic relinquishment, the individual bears the burden of demonstrating that the underlying matter does not raise concerns about the individual's professional qualifications or ability to competently and safely exercise clinical privileges. The MEC, in its sole discretion, will make a determination regarding whether the individual has met this burden.

If these individuals/committees make a favorable recommendation on reinstatement, the individual may immediately resume clinical practice at the Hospital. If, however, any of the individuals/committees reviewing the request above have any questions or concerns, those questions will be noted and the reinstatement request may be forwarded to the full MEC and/or the Board, as applicable, for review and recommendation.

(c) Failure to resolve a matter leading to an automatic relinquishment and to be reinstated as set forth above within 90 days of the relinquishment will result in an automatic resignation from the Medical Staff.

7.B. ACTIONS OCCURRING AT AFFILIATED ENTITIES

(1) Each system hospital, and affiliated entity, will share information regarding the implementation or occurrence of any of the actions listed below with other affiliated entities at which an individual is employed, appointed, or granted clinical privileges:

(a) grant of conditional initial appointment, reappointment, or continued appointment;

(b) grant or imposition of a leave of absence;

(c) triggering of automatic relinquishment of appointment or clinical privileges;

(d) any voluntary or involuntary modification of appointment or clinical privileges for reasons related to the individual's clinical competence, conduct, or health;

(e) resignation based on determination that there was a misstatement or omission on the application for appointment or reappointment or supporting information;

(f) adoption of a performance improvement plan;

(g) imposition of a precautionary suspension or agreement to modify clinical privileges or to refrain from exercising some or all clinical privileges; and

(h) implementation of a professional review action, including denial, suspension, revocation or termination of appointment or clinical privileges for reasons related to the individual's clinical competence, conduct or health.

(2) Upon notice that any of the actions set forth above have occurred at, or been implemented by, any affiliated entity, that action will be administratively implemented at the Hospital. Alternatively, a determination may be made that the member no longer satisfies threshold eligibility criteria.

(3) The administrative implementation of an action at the Hospital may be waived by the Board after consideration of a recommendation from the MEC. The administrative implementation of the action will continue unless an exception is granted and the member has been notified in writing. The granting of an exception is within the discretion of the Board and is final. An exception may be granted only as follows:

(a) based on a finding that the granting of an exception will not affect patient safety, quality of care, or hospital operations; and

(b) after review of the specific circumstances and any relevant documents (including peer review documents) from the affiliated entity where the action first occurred. The burden is on the member to provide evidence showing that an exception is appropriate.

(4) Neither the administrative implementation of any action set forth above at the Hospital, nor the denial of an exception, will entitle any individual to any procedural rights, formal investigation, hearing, or appeal.

ARTICLE 8: HEARING AND APPEAL PROCEDURES

8.A. INITIATION OF HEARING

8.A.1. Grounds for Hearing:

(a) An individual is entitled to request a hearing whenever the MEC makes one of the following recommendations:

(1) denial of initial appointment to the Medical Staff;

(2) denial of reappointment to the Medical Staff;

(3) revocation of appointment to the Medical Staff;

(4) denial of requested clinical privileges to a Medical Staff member or an individual seeking Medical Staff appointment;

(5) revocation of clinical privileges of a Medical Staff member;

(6) suspension of a Medical Staff member's clinical privileges for more than 30 days (other than precautionary suspension);

(7) restriction of a Medical Staff member's clinical privileges for more than 30 days, including a mandatory concurring consultation requirement, in which the consultant must approve the course of treatment in advance; or

(8) denial of a Medical Staff member's reinstatement from a leave of absence if the reasons relate to professional competence or conduct.

(b) No other recommendation or action will entitle the individual to a hearing.

(c) If the Board makes any of these determinations, without an adverse recommendation by the MEC, an individual would be entitled to request a hearing. For ease of use, this Article refers to adverse recommendations of the MEC. When a hearing is triggered by an adverse recommendation of the Board, any reference in this Article to the "MEC" will be interpreted as a reference to the "Board."

8.A.2. Actions Not Grounds for Hearing:

None of the following actions constitute grounds for a hearing. These actions take effect without hearing or appeal. The individual is entitled to submit a written explanation regarding these actions which will be included in their file:

(a) determination that an individual is ineligible for appointment or clinical privileges and that the individual's application will not be processed because they fail to meet threshold eligibility criteria;

(b) determination that an individual is ineligible to request appointment or privileges, or to continue appointment or the exercise of privileges because a specialty is closed under a staff development plan or is covered by an exclusive contract;

(c) determination that an application will not be processed because it is incomplete or untimely;

(d) determination that an application will not be processed due to a misstatement or omission;

(e) expiration of appointment and clinical privileges due to a failure to timely submit an application for reappointment;

(f) change in assigned staff category or a determination that an individual is not eligible for appointment to a specific staff category;

(g) issuance of a letter of guidance, counsel, warning, or reprimand;

(h) adoption or imposition of conditions, monitoring, supervision, proctoring, or a general consultation requirement (i.e., the individual must obtain a consult, but need not get prior approval for the treatment);

(i) adoption of condition or imposition of a requirement for additional training or continuing education;

(j) adoption of a performance improvement plan;

(k) a requirement that an individual complete a fitness for practice evaluation;

(l) the grant of conditional appointment or reappointment or the grant of appointment or reappointment for a period of less than two years;

(m) imposition of a precautionary suspension;

(n) automatic relinquishment of appointment or privileges;

(o) denial of a request for a leave of absence or for an extension of a leave;

(p) activation of administrative medical leave of absence;

(q) removal from the on-call roster or any other reading or rotational panel;

(r) decision not to grant, or the withdrawal of, temporary privileges;

(s) termination of any contract with or employment by the Hospital; and

(t) removal from the Telemedicine, Community, or Honorary Staffs.

8.A.3. Notice of Recommendation:

The Administrator will promptly give special notice of a recommendation which entitles an individual to request a hearing. This notice will contain:

(a) a statement of, and the general reasons for, the recommendation;

(b) a statement that the individual has the right to request a hearing on the recommendation within 30 days of receipt of this notice; and

(c) a copy of this Article.

8.A.4. Request for Hearing:

An individual has 30 days following receipt of the notice to request a hearing. The request must be in writing, to the Administrator, and must include the name, address, and telephone number of the individual's counsel, if any. Failure to request a hearing will constitute waiver of the right to a hearing, and the recommendation will be transmitted to the Board for final action.

8.A.5. Notice of Hearing and Statement of Reasons:

(a) The Administrator (or his or her designee) will schedule the hearing and provide, by special notice to the individual requesting the hearing, the following:

(1) the time, place, and date of the hearing;

(2) a proposed list of witnesses who will give testimony at the hearing and a brief summary of the anticipated testimony;

(3) the names of the hearing panel members and presiding officer, if known; and

(4) a statement of the specific reasons for the recommendation, including a list of patient records (if applicable), and a general description of the information supporting the recommendation. This statement may be revised or amended at any time, even during the hearing, so long as the additional material is relevant to the recommendation or the individual's qualifications and the individual has had a sufficient opportunity, up to 30 days, to review and respond with additional information.

(b) The hearing will begin as soon as practicable, but no sooner than 30 days after the notice of the hearing, unless an earlier hearing date has been specifically agreed to in writing by the parties.

8.A.6. Hearing Panel, Presiding Officer, and Hearing Officer:

(a) Hearing Panel:

The Administrator, after consulting with the Chief of Staff, will appoint a hearing panel in accordance with the following guidelines:

(1) The hearing panel will consist of at least three health care professionals, one of whom will be designated as chair.

(2) The hearing panel may include any combination of:

(i) member(s) of the Medical Staff;

(ii) physicians and other practitioners not connected with the Hospital (e.g., practitioners not on the Medical Staff); or

(iii) layperson(s) who may, or may not, be connected with the Hospital.

If individuals who are not connected with the Hospital are appointed to the hearing panel, reasonable efforts should be made to assure local perspectives are obtained by the panel.

(3) Knowledge of the underlying peer review matter, in and of itself, will not preclude the individual from serving on the hearing panel.

(4) Employment by, or other contractual arrangement with, the Hospital or an affiliated entity will not preclude an individual from serving on the Panel.

(5) The hearing panel will not include any individual who:

(i) is in direct economic competition with the individual requesting the hearing;

(ii) is a relative of the individual requesting the hearing;

(iii) has an actual bias, prejudice, or conflict of interest that would prevent the individual from fairly and impartially considering the matter; or

(iv) actively participated in the matter at any previous level.

(b) Presiding Officer:

(1) The Administrator, after consulting with the Chief of Staff, will appoint an attorney to serve as the presiding officer. The presiding officer may not be, or represent clients who are, in direct economic competition with the individual requesting the hearing. The presiding officer will not act as an advocate for either side at the hearing.

(2) The presiding officer will:

(i) schedule and conduct a pre-hearing conference;

(ii) allow the participants in the hearing to have a reasonable opportunity to be heard and to present evidence, subject to reasonable limits on the number of witnesses and duration of direct and cross-examination;

(iii) prohibit conduct or presentation of evidence that is cumulative, excessive, irrelevant or abusive or that causes undue delay;

(iv) maintain decorum throughout the hearing;

(v) determine the order of procedure;

(vi) rule on matters of procedure and the admissibility of evidence; and

(vii) conduct argument by counsel on procedural points outside the presence of the hearing panel unless the Panel wishes to be present.

(3) The presiding officer may be advised by legal counsel to the Hospital with regard to the hearing procedure.

(4) The presiding officer may participate in the private deliberations of the hearing panel, be a legal advisor to it, and may draft the report of the hearing panel's decision based upon the findings and discussions of the Panel, but will not vote on its recommendations.

(c) Hearing Officer:

(1) As an alternative to a hearing panel, in matters in which the underlying recommendation is based upon concerns involving behavior, sexual harassment, or failure to comply with policies or procedures, the Administrator, after consulting with the Chief of Staff, may appoint a hearing officer.

(2) The hearing officer, who should be an attorney, will perform the functions of a hearing panel. The hearing officer may not be, or represent clients, in direct economic competition with the individual requesting the hearing.

(3) If a hearing officer is appointed instead of a hearing panel, all references in this Article to the "hearing panel" or "presiding officer" will refer to the hearing officer.

(d) Objections:

An objection to any member of the hearing panel, the presiding officer, or the hearing officer will be made in writing, within ten days of receipt of notice, to the Administrator. The objection, which must include reasons to support it, must also be provided to the Chief of Staff. The Chief of Staff will be given a reasonable opportunity to comment on the objections. The Administrator will rule on the objection and give notice to the parties. The Administrator may request that the presiding officer make a recommendation as to the validity of the objection.

(e) Compensation:

Members of the hearing panel and the presiding officer may be compensated for their service by the Hospital. The individual requesting the hearing will be offered the opportunity to contribute to the compensation paid.

8.A.7. Counsel:

The presiding officer, hearing officer, and counsel for either party may be an attorney at law who is licensed to practice in any state.

8.B. PRE-HEARING PROCEDURES

8.B.1. General Procedures:

(a) The pre-hearing and hearing processes will be conducted in an informal manner. Formal rules of evidence or procedure will not apply.

(b) Neither party has the right to issue subpoenas or interrogatories or to depose witnesses or other individuals prior to the hearing or to otherwise compel any individual to participate in the hearing or pre-hearing process.

(c) Neither the individual who requested the hearing, nor any other person acting on behalf of the individual, may contact Hospital employees or Medical Staff members whose names appear on the MEC's witness list or in documents provided pursuant to this Article concerning the subject matter of the hearing, until the Hospital has been notified and has contacted the individuals about their willingness to be interviewed.

(d) The Hospital will advise the individual who requested the hearing once it has contacted the employees or members and confirmed their willingness to meet. Any employee or member may agree or decline to be interviewed by or on behalf of the individual who requested the hearing. If an employee or member who is on the MEC's witness list agrees to be interviewed pursuant to this provision, counsel for the MEC and/or the Hospital may be present for the interview.

8.B.2. Witness List:

(a) The witness list will include a brief summary of the anticipated testimony.

(b) The witness list of either party may, in the discretion of the presiding officer, be amended at any time during the hearing, provided that notice of the change is given to the other party. If the witness list is amended, the other party may request a postponement if additional time is needed to prepare for the new witness.

8.B.3. Provision of Relevant Information:

(a) Prior to receiving any confidential documents, the individual requesting the hearing must agree, in writing, that all documents and information will be maintained as confidential and will not be disclosed or used for any purpose outside of the hearing. The individual must also provide a written representation that their counsel and any expert(s) have executed Business Associate agreements in connection with any patient Protected Health Information contained in any documents provided.

(b) Upon receipt of the above agreement and representation, the individual requesting the hearing will be provided with a copy of the following:

(1) copies of, or reasonable access to, all patient medical records referred to in the statement of reasons, at the individual's expense;

(2) reports of experts relied upon by the MEC;

(3) copies of relevant minutes (with portions regarding other physicians and unrelated matters deleted); and

(4) copies of any other documents relied upon by the MEC.

The provision of this information shall not waive any privilege.

(c) The individual will have no right to discovery beyond the above information. No information will be provided regarding other practitioners on the Medical Staff.

8.B.4. Pre-Hearing Conference:

(a) The presiding officer will require the individual and the MEC (or a representative of each, who may be counsel) to participate in a pre-hearing conference.

(b) The pre-hearing conference will be scheduled at least 14 days before the hearing.

(c) The parties will exchange witness lists and proposed documentary exhibits at least 10 days prior to the pre-hearing conference.

(d) All objections to exhibits or witnesses will be submitted, in writing, five days in advance of the pre-hearing conference. The presiding officer will not entertain subsequent objections unless the party offering the objection demonstrates good cause.

(e) At the pre-hearing conference, the presiding officer will resolve all procedural questions, including any objections to exhibits or witnesses.

(f) Evidence unrelated to the reasons for the recommendation or to the individual's qualifications for appointment or the relevant clinical privileges will be excluded.

(g) The presiding officer will establish the time to be allotted to each witness's testimony and cross-examination.

8.B.5. Stipulations:

The parties, and their counsel, will use their best efforts to develop and agree upon stipulations to provide for a more efficient hearing.

8.B.6. Provision of Information to the Hearing Panel:

The following documents will be provided to the hearing panel in advance of the hearing:

(a) a pre-hearing statement that either party may choose to submit;

(b) exhibits offered by the parties following the pre-hearing conference (without the need for authentication); and

(c) stipulations agreed to by the parties.

8.C. HEARING PROCEDURES

8.C.1. Time Allotted for Hearing:

The presiding officer will determine the length of the hearing at the pre-hearing conference. As a general rule, it is expected that the hearing will last no more than 15 hours, with each side being afforded approximately seven and a half hours to present its case, in terms of both direct and cross-examination of witnesses. Both parties are required to prepare their

case so that a hearing will be concluded after a maximum of 15 hours. The presiding officer may, after considering any objections, grant limited extensions upon a demonstration of good cause and to the extent compelled by fundamental fairness.

8.C.2. Rights of Both Sides and the Hearing Panel at the Hearing:

(a) At a hearing, both sides will have the following rights, subject to reasonable limits determined by the presiding officer:

(1) to call and examine witnesses, to the extent they are available and willing to testify;

(2) to introduce exhibits;

(3) to cross-examine any witness;

(4) to have representation by counsel who may call, examine, and cross-examine witnesses and present the case;

(5) to submit a written statement at the close of the hearing; and

(6) to submit proposed findings, conclusions and recommendations to the hearing panel.

(b) If the individual who requested the hearing does not testify, they may be called and questioned.

(c) The hearing panel may question witnesses, request the presence of additional witnesses, or request documentary evidence.

8.C.3. Record of Hearing:

A stenographic reporter will be present to make a record of the hearing. The cost of the reporter will be borne by the Hospital. Copies of the transcript will be available at the individual's expense. Oral testimony will be taken on oath or affirmation administered by any authorized person.

8.C.4. Order of Presentation and Burden:

The MEC will first present its case and bears the initial burden of production of evidence in support of its recommendation. Thereafter, the burden will shift to the individual who requested the hearing to present clear and convincing evidence that the recommendation that prompted the hearing was arbitrary, capricious, or not supported by substantial evidence.

8.C.5. Admissibility of Evidence:

The hearing will not be conducted according to rules of evidence. Evidence will not be excluded merely because it is hearsay. Any relevant evidence will be admitted if it is the sort of evidence on which responsible persons are accustomed to rely on in the conduct of serious affairs. The guiding principle will be that the record contains information sufficient to allow the Board to decide whether the individual is qualified for appointment and clinical privileges.

8.C.6. Persons to Be Present:

The hearing will be restricted to those individuals involved in the proceeding as described in this article. Administrative personnel may be present as requested by the Administrator or Chief of Staff.

8.C.7. Presence of Hearing Panel Members:

A majority of the hearing panel will be present throughout the hearing. In unusual circumstances when a hearing panel member must be absent from any part of the hearing, that hearing panel member must read the portion of the hearing from which they were absent.

8.C.8. Failure to Appear:

Failure to appear and proceed at the hearing, without good cause as determined by the presiding officer, will constitute a waiver of the right to a hearing and the matter will be forwarded to the Board for final action.

8.C.9. Postponements and Extensions:

Postponements and extensions of time may be requested by anyone, but will be permitted only by the presiding officer or the Administrator on a showing of good cause.

8.D. HEARING CONCLUSION, DELIBERATIONS, AND RECOMMENDATIONS

8.D.1. Basis of Hearing Panel Recommendation:

Consistent with the burden on the individual to demonstrate that they satisfy, on a continuing basis, all criteria for initial appointment, reappointment and clinical privileges, the hearing panel will recommend in favor of the MEC unless it finds that the individual who requested the hearing has proved, by clear and convincing evidence, that the recommendation that prompted the hearing was arbitrary, capricious, or not supported by substantial evidence.

8.D.2. Deliberations and Recommendation of the Hearing Panel:

Within 20 days after final adjournment of the hearing (which may be designated as the time the hearing panel receives the hearing transcript or any post-hearing statements, whichever is later), the hearing panel will conduct its deliberations outside the presence of any other person except the presiding officer. The hearing panel will render a recommendation, accompanied by a report, which will contain a statement of the basis for its recommendation.

8.D.3. Disposition of Hearing Panel Report:

The hearing panel will deliver its report to the Administrator. The Administrator will send by special notice a copy of the report to the individual who requested the hearing. The Administrator will also provide a copy of the report to the Chief of Staff.

8.E. APPEAL PROCEDURE

8.E.1. Time for Appeal:

(a) Within 10 days after notice of the hearing panel's recommendation, either party may request an appeal. The request will be in writing, delivered to the Administrator in person or by certified mail, return receipt requested, and will include a statement of the reasons for appeal and the specific facts or circumstances which justify further review.

(b) If an appeal is not requested within 10 days, an appeal is deemed to be waived and the hearing panel's report and recommendation will be forwarded to the Board for final action.

8.E.2. Grounds for Appeal:

The grounds for appeal will be limited to the following:

(a) there was substantial failure by the hearing panel, or the presiding officer, to comply with this Manual or the Medical Staff Bylaws during the hearing, so as to deny a fair hearing; or

(b) the recommendations of the hearing panel were made arbitrarily or capriciously or were not supported by substantial evidence.

8.E.3. Time, Place, and Notice:

Whenever an appeal is requested, the Board chair will schedule and arrange for an appeal. The individual will be given special notice of the time, place, and date of the appeal. The appeal will be held as soon as arrangements can reasonably be made, taking into account the schedules of all the individuals involved.

8.E.4. Nature of Appellate Review:

(a) The Board may serve as the review panel or the Board chair may appoint a review panel, composed of not less than three persons, either members of the Board or others, including but not limited to persons outside the Hospital.

(b) Each party will have the right to present a written statement in support of their position on appeal. The party requesting the appeal will submit a statement first and the other party will then have 10 days to respond.

(c) The review panel may consider the record upon which the recommendation was made, including the hearing transcripts and exhibits, post-hearing statements, the findings and recommendations of the MEC and hearing panel, and any other information that it deems relevant.

(d) In its sole discretion, the review panel may allow each party or their representative to appear personally and make oral argument not to exceed 30 minutes.

(e) When requested by either party, the review panel may, in its discretion, accept additional oral or written evidence subject to the same rights of cross-examination provided at the hearing panel proceedings. Additional evidence will be accepted only if the review panel determines that the party seeking to admit it can demonstrate that it is new and relevant evidence that could not have been presented at the hearing or that any opportunity to admit it at the hearing was improperly denied.

(f) The review panel will prepare a report recommending final action to the Board.

8.F. BOARD ACTION

8.F.1. Final Decision of the Board:

(a) Within 30 days after the Board (i) considers the appeal as a review panel, (ii) receives a recommendation from a separate review panel, or (iii) receives the hearing panel's report and recommendation when no appeal has been requested, the Board will consider the matter and take final action.

(b) The Board may review any information that it deems relevant, including, but not limited to, the findings and recommendations of the MEC, hearing panel, and review panel (if applicable).

(c) The Board may adopt, modify, or reverse any recommendation it receives or refer the matter for further review and recommendation to any individual or committee. Consistent with its ultimate legal authority for the operation of the Hospital and the quality of care provided, the Board may also make its own decision.

(d) The Board will render its final decision in writing, including the basis for its decision. The final decision will be sent by special notice to the individual. A copy will also be provided to the Chief of Staff.

(e) Except where the matter is referred by the Board for further review, the final decision of the Board will be effective immediately and will not be subject to further review.

8.F.2. Right to One Hearing and One Appeal Only:

No individual will be entitled to more than one hearing and one appeal on any matter.

8.G. PROCEDURAL RIGHTS FOR ADVANCED PRACTICE AND OTHER LICENSED PROVIDER STAFF **(ONLY IF APPS ARE NOT MEMBERS OF THE MEDICAL STAFF)**

(1) In the event that a recommendation is made by the MEC that a member of the Advanced Practice and Other Licensed Provider Staff not be granted the clinical privileges requested or that a clinical privilege previously granted be restricted or revoked, the individual shall be notified of the recommendation. The notice shall include a specific statement of the reasons for the recommendation and shall advise the individual that he or she may request a meeting with the MEC before the recommendation is forwarded to the Board for final action.

(2) If the individual desires to request a meeting, he or she must make such request in writing and direct it to the Administrator within 30 days after receipt of the written notice of the adverse recommendation.

(3) If a meeting is requested in a timely manner, it shall be scheduled to take place within a reasonable time frame. The meeting shall be informal and shall not be considered a hearing. The individual (and his or her supervising physician, if applicable) shall be permitted to attend and participate in the meeting. However, no counsel for either the individual or the MEC shall be present.

(4) Following this meeting, the MEC shall make a final recommendation to the Board.

ARTICLE 9: CONFLICTS OF INTEREST

(a) All those involved in credentialing, privileging, and professional practice evaluation activities must be sensitive to potential conflicts of interest to be fair to the individual whose request is being considered or whose qualifications are under review, to protect the individual with the potential conflict, and to protect the integrity of the process.

(b) It is also essential that peers participate in credentialing, privileging, and professional practice evaluation review activities for these activities to be meaningful and effective.

(c) An assessment of whether a conflict of interest exists will be interpreted reasonably by the persons involved, taking into consideration common sense and objective principles of fairness.

(d) When performing a function outlined in this Manual, or any of the other Medical Staff governance documents, if any member has or reasonably could be perceived as having a conflict of interest or a bias, that member will not participate in the final discussion or voting on the matter and will be excused from any meeting during that time. However, the member may provide relevant information and may answer any questions concerning the matter before leaving.

(e) Any member with knowledge of the existence of an actual or potential conflict of interest or bias on the part of any other member may call the conflict of interest to the attention of the Chief of Staff (or another Medical Staff leader if the Chief of Staff is the person with the conflict), or applicable committee chair.

(f) Additionally, members are obligated to notify the Chief of Staff or applicable committee chair of any known or suspected conflicts of interest of those who are involved in reviewing a matter. Any potential conflict of interest that is not timely raised will be deemed to be waived.

(g) The Chief of Staff or applicable committee chair will make a final determination as to whether the provisions in this Article should be triggered or may submit the issue of whether there is a conflict of interest to a vote of the entire committee.

(h) The fact that a member is in the same specialty as a member whose request is being considered or performance is being reviewed does not automatically create a conflict.

(i) No member has a right to compel disqualification of another member based on an allegation of conflict of interest.

(j) The fact that a committee member or Medical Staff Leader chooses to refrain from participation, or is excused from participation, will not be interpreted as a finding of an actual conflict of interest.

ARTICLE 10: AMENDMENTS

(a) The intent is that this Manual be adopted by the participating Providence Alaska Hospitals as a uniform document. Therefore, any proposed amendments to this Manual shall be presented to the MECs of all the participating Providence Alaska Hospitals.

(b) This Manual may then be amended by a majority vote of the members of each MEC present and voting at any meeting of that Committee where a quorum exists. Notice of all proposed amendments shall be provided to each voting staff member of the Medical Staff at least 14 days prior to the MEC meeting, and any voting staff member may submit written comments to the MEC.

(c) If there is any disagreement between the MECs for the participating Providence Alaska Hospitals with respect to an amendment(s), a joint meeting shall be scheduled to discuss and resolve the disagreement. If consensus cannot be achieved at that meeting, then the MECs may consider a site-specific variation. Any such variations that are approved at a participating Providence Alaska Hospital should be set forth in an appendix to the Manual.

(d) No amendment shall be effective unless and until it has been approved by the Board of each Hospital.

ARTICLE 11: ADOPTION

This Manual is adopted and made effective upon approval of the Board, superseding and replacing any and all other Bylaws, policies, and procedures of the Medical Staff or Hospital policies and procedures pertaining to the subject matter thereof.

APPENDIX A: PROFESSIONAL CLINICAL STAFF DESIGNATIONS AT EACH PARTICIPATING PROVIDENCE ALASKA HOSPITAL[1]

Providence Kodiak Island Hospital

Medical Staff
Physicians
Dentists
Podiatrists
Advanced Practice Registered Nurses
Physician Assistants
Optometrists

Providence Seward Hospital

Medical Staff	Advanced Practice and Other Licensed Providers
Physicians	Advanced Practice Registered Nurses
	Physician Assistants
	Psychologists

Providence Valdez Hospital

Medical Staff	Advanced Practice and Other Licensed Providers
Physicians	Advanced Practice Registered Nurses
Dentists	Physician Assistants
Podiatrists	
Psychologists	

Providence St. Elias Specialty Hospital

Medical Staff
Physicians
Dentists
Podiatrists
Psychologists
Advanced Practice Registered Nurses
Physician Assistants
Optometrist

[1] As determined by each participating Providence Alaska Hospital.