Las Palmas Del Sol Healthcare

CREDENTIALS POLICY

July 28, 2020

CREDENTIALS POLICY
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APPENDIX A ..... ADVANCED PRACTICE PROFESSIONALS

APPENDIX B ..... CONFLICT OF INTEREST GUIDELINES

ARTICLE 1
GENERAL

1.A. DEFINITIONS

The following definitions apply to terms used in this Policy, the Medical Staff Bylaws and the Organization Manual:

(1) "ADVANCED PRACTICE PROFESSIONALS" ("APPs") means individuals other than Physicians, Dentists, Oral Maxillofacial Surgeons, and Podiatrists who are authorized by law and by the Hospital to provide a medical level of care or perform surgical tasks consistent with the Clinical Privileges granted to the APP, but who are required by law and/or the Hospital to exercise some or all of those Clinical Privileges pursuant to delegation, direction and/or supervision by or in collaboration with a Supervising/Collaborating Practitioner. The categories of Advanced Practice Professionals practicing at the Hospital are set forth in Appendix A.

(2) "AFFILIATED ENTITY" means any entity which directly or indirectly, through one or more intermediaries, controls, is controlled by, or is under common control with the Hospital.

(3) "APPLICANT" means an individual who has submitted a Request for Consideration ("RFC"), Recredentialing Request for Consideration ("RRFC"), Request for Increased, New Clinical Privileges, or Change in Prescriptive Authority ("RFINCP"), or request for any other Clinical Privileges (for example, a request for temporary Privileges) to the CPC and, after evaluation, has had his or her RFC/RRFC/RFINCP or other request for Privileges forwarded to the Medical Staff Office to be processed by the Hospital and Medical Staff Leaders as an Application.

(4) "APPLICATION" means a Request for Consideration ("RFC"), Recredentialing Request for Consideration ("RRFC"), Request for Additional Privileges ("RFINCP"), or other request for Clinical Privileges that has been forwarded by the CPC, after evaluation, to the Medical Staff Office for review in accordance with this Policy.

(5) "BOARD" or "BOARD OF TRUSTEES" means the local governing body of the Hospital, appointed by the Board of Directors which delegates specific authority and responsibility to the Board of Trustees. It is the governing body for purposes of compliance with The Joint Commission standards for the Accreditation of Hospitals and the Centers for Medicare & Medicaid Services ("CMS") Conditions of Participation for Hospitals. All references herein to "Board" are to the Board of Trustees unless specifically indicated otherwise and, specifically, are not references to the "Board of Directors."

(6) "BOARD OF DIRECTORS" means the body of individuals elected by the shareholders of the Corporation (or selected or appointed by the Partnership) to hold ultimate responsibility for the Hospital and to serve as the ultimate governing body of the Corporation (or Partnership).

(7) "BOARD CERTIFICATION" or "BOARD CERTIFIED" 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, upon a Physician, Dentist, Oral Maxillofacial Surgeon, or Podiatrist, as applicable, or, for an Advanced Practice Professional, the designation conferred by a certifying body approved by the Hospital, as set forth in Hospital policy and/or the relevant delineation of Clinical Privileges.

(8) "CAMPUS" means the Las Palmas campus at 1801 North Oregon St., El Paso, TX 79902 or the Del Sol campus at 10301 Gateway West, El Paso, Texas 79925.

(9) "CAMPUS CHIEF OF STAFF" means the officer elected in accordance with the Bylaws to serve as Chief of Staff - Las Palmas or Chief of Staff - Del Sol.

(10) "CHIEF EXECUTIVE OFFICER" ("CEO") means the individual appointed by the Board of Directors to act on its behalf and on the behalf of the Board of Trustees in the overall management of the Hospital, or his or her designee. Any reference to the Chief Executive Officer shall also include the Chief Executive Officer – Las Palmas and the Chief Executive Officer – Del Sol unless the context clearly indicates otherwise or the reference is to the Chief Executive Officer of the Hospital. Any reference to the "Chief Executive Officers" means all three.

(11) "CHIEF MEDICAL OFFICER" means the individual appointed by the Hospital to act as the Chief Medical Officer of the Hospital, at the direction of the CEO and in cooperation with the President of the Medical Staff. Any reference to the Chief Medical Officer shall also include the Chief Medical Officer – Las Palmas and the Chief Medical Officer – Del Sol unless the context clearly indicates otherwise or the reference is to the Chief Medical Officer of the Hospital. Any reference to the "Chief Medical Officers" means all three.

(12) "CHIEF NURSING EXECUTIVE" means the registered nurse appointed by the Board who has administrative authority for nursing services in the Hospital. The Chief Nursing Executive appoints a Chief Nursing Officer for each campus. The Chief Nursing Executive also may serve as the Chief Nursing Officer.

(13) "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 Policy.

(14) "COMPLETE" means, in the context of an Application for Membership or Clinical Privileges, that all questions presented to the individual have been answered, all supporting documentation (including adequate responses from references and all information in the possession of third parties that has been deemed necessary for full and appropriate evaluation of the applicant's qualifications) has been supplied, and all information has been verified from primary sources.[1] A Complete Application for

[1] All information obtained through primary source verification and/or obtained through attestation of the Practitioner may be relied upon for 150 Days for credentialing purposes, at which point that information must be re-verified.

Membership or Clinical Privileges will become incomplete if the need arises for new, additional, or clarifying information at any time.

(15) "CORE PRIVILEGES" or "CORE" means a defined grouping of Clinical Privileges for a specialty or subspecialty that includes the fundamental patient care services that are routinely taught in residency or fellowship training for that specialty or subspecialty and that have been determined by the Medical Staff Leaders and Board to require closely related skills and experience.

(16) "CORPORATION" means El Paso Healthcare System, Ltd. d/b/a/ Las Palmas Del Sol Healthcare.

(17) "CREDENTIALING PROCESSING CENTER" ("CPC") means the regional credentialing center that provides intake, follow-up, data/image management, and verification of Requests for Consideration ("RFC"), Recredentialing Requests for Consideration ("RRFC"), Requests for Additional Privileges ("RFINCP"), and all other requests for Clinical Privileges (for example, temporary Privileges), pursuant to a Service Level Agreement with the Hospital.

(18) "DAYS" means calendar Days, unless otherwise noted.

(19) "DENTIST" means a doctor of dental surgery ("D.D.S.") or doctor of dental medicine ("D.M.D.").

(20) "GOOD STANDING" means a Practitioner who continues to meet all eligibility criteria and other qualifications for initial and renewed Medical Staff Membership and Clinical Privileges, as applicable, has continually satisfied the basic responsibilities of Medical Staff Membership and Clinical Privileges, is not delinquent with respect to his or her completion of medical records, and is not currently subject to a performance improvement plan, under Investigation, nor subject to a recommendation for professional review action.

(21) "HOSPITAL" means El Paso Healthcare System, Ltd. d/b/a Las Palmas Del Sol Healthcare, which includes the main campus of Las Palmas campus located at 1801 North Oregon St., El Paso, TX 79902 and the Del Sol campus located at 10301 Gateway West, El Paso, Texas 79925. As the term is used in the Bylaws and any ancillary governance documents, it shall mean all of the facilities, services, and locations licensed or accredited as part of the Hospital, which is an organization inclusive of the Medical Staff.

(22) "HOSPITAL ADMINISTRATION" means the executive members of the Hospital staff, including the Chief Executive Officer, the Chief Executive Officer - Las Palmas, the Chief Executive Officer - Del Sol, the Chief Operating Officer (COO), the Chief Financial Officer (CFO), the Chief Nursing Executive (CNE), the Chief Medical Officer, the Chief Medical Officer – Las Palmas, Chief Medical Officer – Del Sol, and any other Medico-Administrative Officers.

(23) "INELIGIBLE PERSON" means any individual who is (1) currently excluded, suspended, debarred, or otherwise ineligible to participate in federal health care programs; (2) has been convicted of a criminal offense related to the provision of health care items or

services but has not yet been excluded, debarred, or otherwise declared ineligible; or (3) is currently excluded on a state exclusion list.

(24) "INVESTIGATION" means the process of gathering and reviewing information related to a concern involving a Practitioner, which begins after a formal resolution by the Medical Executive Committee or Board to commence an Investigation and is concluded after final action has been taken on the matter that was subject to Investigation, as set forth in this Policy. An investigation is deemed automatically commenced on imposition of a summary action or if the Medical Executive Committee recommends a denial or restriction of clinical privileges or Medical Staff membership based on clinical competence or professional conduct on initial appointment or reappointment.

(25) "MEDICAL EXECUTIVE COMMITTEE" or "MEC" means the Medical Executive Committee of the Medical Staff, as set forth in the Medical Staff Bylaws document.

(26) "MEDICAL PEER REVIEW" means "medical peer review" as defined under Texas Law, which is "the evaluation of medical and health care services, including evaluation of the qualifications and professional conduct of professional health care practitioners and of patient care provided by those practitioners. The term includes evaluation of the: (A) merits of a complaint relating to a health care practitioner and a determination or recommendation regarding the complaint; (B) accuracy of a diagnosis; (C) quality of the care provided by a health care practitioner; (D) report made to a medical peer review committee concerning activities under the committee's review authority; (E) report made by a medical peer review committee to another committee or to the board as permitted or required by law; and (F) implementation of the duties of a medical peer review committee by a member, agent, or employee of the committee." 2 Medical Peer Review includes a "Professional Review Action" and "Professional Review Activity" as defined below.

(27) "MEDICAL STAFF" or "STAFF" means the body comprised of all Physicians, Dentists, Oral Maxillofacial Surgeons, and Podiatrists who have been granted Membership in the Medical Staff by the Board.

(28) "MEDICAL STAFF LEADER" means any Medical Staff officer, department chairperson, section director, or committee chairperson.

(29) "MEDICAL STAFF YEAR" means the period from January 1 to December 31 each year.

(30) "MEMBER" means any Physician, Dentist, Oral Maxillofacial Surgeon, or Podiatrist who has been granted initial or renewed Membership in the Medical Staff by the Board.

(31) "MEMBERSHIP" means the designation of being a Member of the Medical Staff, following a grant of Membership in the Medical Staff by the Board.

2 Tex. Occ. Code Sec. 151.002(a)(7).

(32) "NON-PRIVILEGED HEALTHCARE PRACTITIONER" means an individual who by HCA Policy is allowed to order specific diagnostic tests and services, but who is not a Member of the Medical Staff and has not been granted Clinical Privileges to practice at the Hospital.

(33) "NOTICE" means written communication by regular U.S. mail, e-mail, facsimile, Hospital mail or hand delivery. Notice by U.S. mail or Hospital mail shall be deemed delivered on the third day following deposit with the U.S. mail or Hospital mail.

(34) "ORAL MAXILLOFACIAL SURGEON" means an individual who has successfully completed a postgraduate program in oral and maxillofacial surgery accredited by the Commission on Dental Accreditation (CODA).

(35) "PATIENT CONTACT" includes any admission, consultation, procedure, response to emergency call, evaluation, treatment, or service performed in any facility operated by the Hospital, including outpatient facilities.

(36) "PHYSICIAN" means a doctor of medicine ("M.D.") or a doctor of osteopathy ("D.O.").

(37) "PODIATRIST" means a doctor of podiatric medicine ("D.P.M.").

(38) "PRACTITIONER" means any individual who has been granted Clinical Privileges and/or Membership by the Board, including, but not limited to, Members of the Medical Staff and Advanced Practice Professionals.

(39) "PRESENT" and "PRESENCE" means in-person attendance or active participation by telephone or other electronic means in a meeting, unless otherwise provided.

(40) "PROFESSIONAL PRACTICE EVALUATION" ("PPE") refers to the Hospital's initial and ongoing medical peer review and professional practice evaluation processes. These processes include, but are not limited to, the review and assessment of Practitioners' clinical performance, professionalism, and health status/ability to exercise Clinical Privileges safely and competently.[3]

(41) "PROFESSIONAL REVIEW ACTION" and "PROFESSIONAL REVIEW ACTIVITY" have the meanings defined in the Health Care Quality Improvement Act of 1986 ("HCQIA"), specifically an action or recommendation of a professional review body (Board or Medical Staff committee): (a) which is taken or made in the conduct of professional review activity, (b) which is based on the competence or professional conduct of a Practitioner, (c) which conduct affects or could affect adversely the health or welfare of a patient or patients, and (d) which affects (or may affect) adversely the clinical privilege of the Practitioner.[4]

(42) "QUORUM" means the number of Medical Staff Members or others with the prerogative to vote and who are required to be Present for the Medical Staff, committee, department, division or section (or other entity) to conduct business.

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[3] MS.08.01.01; MS.08.01.03

[4] 42 U.S.C. §11101 *et seq.*

(43) "RECREDENTIALING REQUEST FOR CONSIDERATION" ("RRFC") means the form that a Practitioner submits to the CPC for evaluation in order to request consideration for renewed Medical Staff Membership and Clinical Privileges.

(44) "REQUEST FOR INCREASED, NEW CLINICAL PRIVILEGES, OR CHANGE IN PRESCRIPTIVE AUTHORITY" ("RFINCP") means the form that a Practitioner completes and submits to the CPC for evaluation in order to request consideration for Clinical Privileges that are in addition to those Clinical Privileges that have already been granted to the Practitioner at the Hospital.

(45) "REQUEST FOR CONSIDERATION" ("RFC") means the form that a Practitioner completes and submits to the CPC for evaluation in order to request consideration for initial Membership in the Medical Staff and Clinical Privileges.

(46) "RESTRICTION" means a mandatory concurring consultation, where the consultant must approve the proposed procedure or treatment before Clinical Privileges may be exercised. It does not include conditions for performance improvement placed upon the exercise of Clinical 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 Practitioner or group of Practitioners or other action by the Board.

(47) "SPECIAL NOTICE" means hand delivery, certified mail (return receipt requested), or overnight delivery service providing receipt. Special Notice is deemed delivered on the date actually delivered (or refused) by the addressee or a member of the addressee's office staff.

(48) "SPECIAL CLINICAL PRIVILEGES" means Clinical Privileges that fall outside of the Core Privileges for a given specialty, which the Hospital has determined require additional education, training, or experience beyond that required for Core Privileges in order to demonstrate competence.

(49) "SUPERVISING/COLLABORATING PRACTITIONER" means a Practitioner with Clinical Privileges, who has agreed in writing and has been approved by the appropriate licensure board if required to provide delegation, direction and/or supervision to and/or collaborate with an Advanced Practice Professional and to accept full responsibility for the actions of the Advanced Practice Professional while he or she is practicing in the Hospital.

(50) "SUPERVISION" means the delegation, direction and/or supervision of (or collaboration with) an Advanced Practice Professional by a Supervising/Collaborating Practitioner, that may or may not require the actual presence of the Supervising/Collaborating Practitioner, but that does require, at a minimum, that the Supervising/Collaborating Practitioner be readily available for consultation. The requisite level of Supervision (general, direct, or personal) will be determined at the time each Advanced Practice Professional is

credentialed, at a minimum to reflect any applicable written supervision or collaboration agreement required by the state and accreditation or other legal requirements

1.B. DELEGATION OF ADMINISTRATIVE AND MEDICAL STAFF LEADERSHIP FUNCTIONS

(1) Except as follows, when a function is to be carried out by a Member of Hospital Administration, by a Medical Staff Leader or by a Medical Staff committee, the individual, or the committee through its chairperson, may delegate performance of the function to one or more designees. Delegation is not permitted in the following situations:

(a) When the Medical Executive Committee is making a recommendation directly to the Board to grant, deny, restrict, suspend, or revoke the Membership or Clinical Privileges of an individual; and

(b) When the Board is rendering its preliminary or final determination to grant, deny, restrict, suspend, or revoke the Membership or Clinical Privileges of an individual.

(2) When a Medical Staff Member or other Practitioner 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.C. CONFIDENTIALITY AND PEER REVIEW PROTECTION

1.C.1. Medical Peer Review Committee Status:

The Medical Executive Committee, the departments, sections (and service lines if any), and all Medical Staff, department, section (and service line if any) committees (whether standing, special, ad hoc, subcommittee, joint committee, task force, hearing and appellate review panel), as well as the Medical Staff when meeting as a whole, shall be constituted and operate as a "medical peer review committee," "medical committee," and "professional review body," as such terms are defined by Texas and/or federal law, and are authorized by the Board through these Bylaws to engage in Medical Peer Review. This provision shall also apply to any Hospital or other committees engaged in Medical Peer Review at the Hospital, including the Board and its committees.

1.C.2 Confidentiality:

All Medical Peer Review will be strictly confidential. No disclosures of any such information (discussions or documentation) may be made outside of the meetings of the committees charged with such functions, except:

(1) to another authorized individual or body, whether internal or external to the Hospital, for the purpose of conducting Medical Peer Review;

(2) as authorized by Hospital or Medical Staff policy, including any policy governing the sharing of credentialing and peer review information among Affiliated Entities; or

(3) as authorized by the Chief Executive Officer or by legal counsel to the Hospital.

Any breach of confidentiality may result in appropriate sanctions, including but not limited to a corrective action or appropriate legal action. Breaches of confidentiality shall not constitute a waiver of any legal privilege. Any Practitioner who becomes aware of a breach of confidentiality is encouraged to inform the Chief Executive Officers, the Chief Medical Officers, or the President of the Medical Staff (or the Vice-President of the Medical Staff if the President of the Medical Staff is the person committing the claimed breach).

1.C.3. Medical Peer Review Protection:

Medical Peer Review will be performed by medical peer review committees, medical committees, and professional review bodies, which include, but are not limited to:

(1) all standing, special, joint, subcommittee, task force, and ad hoc Medical Staff and Hospital committees;

(2) all departments, sections, and their committees regardless of type;

(3) hearing and appellate review panels;

(4) the Board and its committees regardless of type; and

(5) any individual or body acting for or on behalf of the Professional Practice Evaluation Committee or other peer review committee, Medical Staff Leaders, and experts or consultants retained to assist in Medical Peer Review.

All oral and written communications, reports, recommendations, actions, and minutes made or taken by one of the above individuals or entities for purposes of Medical Peer Review are confidential and privileged records and proceedings of a medical peer review committee, medical committee and professional review body to the fullest extent permitted by Texas law, and are deemed to be Medical Peer Review.[5]

1.D. INDEMNIFICATION OF PRACTITIONERS

To the extent permissible under state law, the Hospital or an Affiliated Entity shall indemnify any present or former Practitioner engaged in Hospital business through committee appointments or other service, to the extent and in the manner set forth in the Medical Staff Bylaws, Credentials Policy, and Organization Manual. Indemnification may take the form of insurance and is intended to cover the cost of settlements or awards, as well as the costs of defending the individual, in any threatened or actual action, suit, or proceeding to which the Practitioner is made a party by virtue of his or her service on behalf of the Hospital, as a result of appointment or election to an office or committee or at the request of the Hospital. Indemnification pursuant to this provision shall not be deemed exclusive of any other rights or protections to which those Practitioners may be entitled under the Bylaws, an agreement, by determination of the Board of Trustees, or through insurance purchased by the Hospital.

[5] 42 U.S.C. §11101 *et seq*.

Indemnification shall not be provided in matters where the Practitioner is finally adjudged to be liable of willful misconduct amounting to bad faith. Also, indemnification pursuant to this provision shall not extend to the professional practice or clinical activities of any Practitioner.

ARTICLE 2
QUALIFICATIONS, CONDITIONS, AND RESPONSIBILITIES

2.A. QUALIFICATIONS[6]

2.A.1. Threshold Eligibility Criteria:

To be eligible to apply for or maintain Membership or Clinical Privileges, an individual must submit a Request for Consideration ("RFC"), Recredentialing Request for Consideration ("RRFC"), or other request for Clinical Privileges (on the forms provided by the CPC) to the Credentialing Processing Center ("CPC") and must continuously demonstrate satisfaction of all of the following threshold eligibility criteria, as applicable:

(1) have a current, unrestricted license to practice in this state that is not subject to any probationary terms or conditions not generally applicable to all licensees, and have never had a license to practice revoked, restricted or suspended by any professional licensing agency in any state or other jurisdiction. The license required in this Section may be from a state other than Texas only as follows:

(a) the individual is an active duty military member and will be practicing exclusively within the scope of his or her military duties for patients who are members of the armed forces or their dependents;

(b) If the applicant is an active duty military member and is deployed at Las Palmas Del Sol Healthcare (LPDSH) under an affiliation agreement, and will be practicing exclusively within the scope of military duties for all patients who present to LPDSH, then current, unlimited, unrestricted, active licensure from any State shall be accepted.

(b) the individual is seeking telemedicine Clinical Privileges, in which case the individual must either be licensed or meet the alternative licensing requirements applicable to telemedicine providers in both the state where the individual is located and the state where this Hospital is located; or

(c) the individual has obtained an official exception to the regular state licensing requirements from the Texas licensing agency or entity or holds a temporary or limited license, and is seeking to practice at the Hospital only in accordance with the exception or temporary or limited license that has been granted;

(2) if the individual is an Advanced Practice Professional that falls within a category that is granted licensure and prescriptive authority separately (whether in this state or in any other state that the individual has ever been licensed or practiced), the individual must have never had his or her prescriptive authority revoked, restricted, or suspended by any professional licensing agency in any state or other jurisdiction;

(3) satisfy the following professional education requirements:

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6 42 C.F.R. §482.22(c)(4)

(a) for a Physician, have successfully graduated from a school of medicine accredited by the Association of American Medical Colleges or the American Association of Colleges of Osteopathic Medicine. If the Physician is a foreign medical graduate, he or she must have successfully graduated from a foreign medical school and have completed the Education Commission for Foreign Medical Graduate (ECFMG) or an accredited Fifth Pathway Program;

(b) for a Dentist or an Oral Maxillofacial Surgeon, have successfully graduated from a school of dentistry accredited by the Commission on Accreditation of the American Dental Association;

(c) for a Podiatrist, have successfully graduated from a school of podiatry accredited by the Council on Podiatric Medical Education of the American Podiatric Medical Association; or

(d) for Advanced Practice Professionals, have satisfied the applicable education requirements, as established by Hospital policy and the relevant delineation of Clinical Privileges;

(4) satisfy the following professional training requirements:

(a) for a Physician, have successfully completed a residency and, if applicable to the Physician's subspecialty, a fellowship training program, both of which must be approved by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association in all specialties in which the Physician seeks Clinical Privileges;

(b) for a Dentist or an Oral Maxillofacial Surgeon, have successfully completed a training program accredited by the Commission on Dental Accreditation of the American Dental Association;

(c) for a Podiatrist, have successfully completed a podiatric residency program accredited by the Council on Podiatric Medical Education of the American Podiatric Medical Association; or

(d) for Advanced Practice Professionals, have satisfied the applicable training requirements, as established by Hospital policy and the relevant delineation of Clinical Privileges;

(5) satisfy the following Board Certification requirements for Physicians, Dentists, Oral Maxillofacial Surgeons, and Podiatrists:

(a) to be eligible for Membership or Clinical Privileges:

(i) be Board Certified (as defined in this Policy) in their primary area of practice at the Hospital. Individuals who are not Board Certified at the time of Application but who have completed their residency or fellowship

or other applicable training within the last seven years will be eligible for Medical Staff Membership or Clinical Privileges. However, in order to remain eligible, those individuals must achieve Board Certification in their primary area of practice within seven years from the date of completion of their residency, fellowship or other required training;

(ii) maintain Board Certification in their primary area of practice at the Hospital and, to the extent required by the applicable specialty/subspecialty board, satisfy recertification requirements. Recertification will be assessed at the time of renewal of Membership or Clinical Privileges; and

The above requirements will be applicable only to those individuals who submit an RFC and/or apply for initial Medical Staff Membership after the date of adoption of this Policy. Individuals already granted Medical Staff Membership or Clinical Privileges as of the date of adoption of this Policy will be governed by the Board Certification, recertification, and maintenance of certification requirements governing eligibility for Membership that were in effect at the time of their initial Membership or initial grant of Clinical Privileges.

(b) to be eligible for specific Clinical Privileges, satisfy any Board Certification, recertification, and maintenance of certification requirements set forth in the applicable delineation of Clinical Privileges and other Hospital and Medical Staff policies;

The above requirements will be applicable only to those individuals who submit an RFC, RRFC, RFINCP, or other request for Clinical Privileges that requests new or additional Clinical Privileges (Privileges not currently held by the individual) after the date of adoption of this Policy. Individuals already granted Clinical Privileges as of the date of adoption of this Policy will be governed by the Board Certification, recertification, and maintenance of certification requirements governing eligibility for Clinical Privileges that were in effect at the time those Privileges were initially granted to those individuals.

(6) have a current, unrestricted DEA registration that is linked to an address in Texas, as applicable to the Clinical Privileges being sought by the Practitioner;

(7) be lawfully authorized to work in the United States of America, whether through citizenship, permanent resident status, possession of a valid visa, or otherwise;

(8) have current, government-issued photographic identification which is either written in English or has been translated by a professional translation service and which, on its face, verifies the individual's identity;

(9) have current valid professional liability insurance coverage in a form and in amounts, as determined by the Hospital (Practitioners who are employees of any Federal agency, and Practitioners acting on behalf of a Federal agency in an official capacity, temporarily or

permanently in the service of the United States Government, whether with or without compensation, are immune from professional liability for malpractice committed within the scope of employment under the provisions of the Federal Tort Claims Act, and are therefore exempt from the requirement to have professional liability insurance coverage);

(10) meet any current privileging eligibility requirements that are applicable to the Clinical Privileges being sought;

(11) if applying for Clinical Privileges in an area that is covered by an exclusive contract or arrangement, meet the specific requirements set forth in the contract or Board resolution setting forth the decision to proceed with that arrangement;

(12) agree to, and fulfill, all responsibilities regarding emergency call for their specialty;

(13) demonstrate recent clinical activity in an acute care hospital, sufficient to support an evaluation of current clinical competence, during the last two years;

(14) be located (office and residence) close enough to fulfill Hospital and Medical Staff responsibilities, including responding to call as required, and to provide timely and continuous care for his or her patients in the Hospital;

(15) have an appropriate coverage arrangement, as determined by the Credentials Committee, with other Practitioners who are qualified and have the appropriate Clinical Privileges, for those times when the individual will be unavailable;

(16) if seeking to practice as an Advanced Practice Professional, have a written agreement with a Supervising/Collaborating Practitioner, which agreement must meet all applicable requirements of state law and Hospital policy and include delegated prescriptive authority if applicable;

(17) have never had membership or clinical privileges, or status as a participating provider denied, revoked, or terminated by any health care facility, including this Hospital, or health plan for reasons related to clinical competence or professional conduct;

(18) have never resigned membership or relinquished clinical privileges during an investigation or in exchange for not conducting an investigation at any health care facility, including this Hospital;

(19) have never had an RFC, RRFC, RFINCP, other request for Clinical Privileges, or Application for Membership or Clinical Privileges deemed ineligible for continued processing or denied by the Hospital, the CPC, or any Affiliated Entity due to a finding of material omission or misrepresentation;

(20) have never been expelled from a post-graduate training program (residency or fellowship or equivalent program for Advanced Practice Professionals), nor resigned from such a program during an investigation or in exchange for the program not conducting an Investigation;

(21) since the start of medical or professional education, have not been convicted of, or entered a plea of guilty or no contest to, any felony or misdemeanor related to controlled substances, illegal drugs, violent acts, sexual misconduct, moral turpitude, domestic, child or elder abuse, or Medicare, Medicaid, or other federal or state governmental or private third-party payer fraud or program abuse, nor have been required to pay a civil money penalty for any such fraud or program abuse;

(22) have never been, and not currently be, excluded or precluded from participation in Medicare, Medicaid, or other federal or state governmental health care program and is not otherwise an Ineligible Person; and

(23) have been elevated to Applicant status through the CPC after submitting an RFC/RRFC/RFINCP or other request for Clinical Privileges.

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

(1) Any individual or Applicant who does not satisfy one or more of the threshold eligibility criteria set forth in this Policy will be informed in writing of the threshold eligibility criteria not satisfied. Unless a waiver has been requested and granted, as outlined below, the RFC/RRFC/RFINCP, other request for Clinical Privileges, and/or Application will not be processed.

(2) Process for requesting and granting waivers:

(a) Any individual wishing to request a waiver may submit a written request, along with evidence of exceptional circumstances, to the Hospital's Medical Staff Office. Because waivers are intended to be used rarely and are an "exception to the rule," the Hospital and Medical Staff Leaders have no obligation to inform an individual of the right to request a waiver, nor to contact an individual to ask whether he or she wishes to request a waiver.

(b) Waivers of threshold eligibility criteria will not be granted routinely and will be considered only if the individual requesting waiver demonstrates that exceptional circumstances exist and that he or she is otherwise qualified. As a general rule, "exceptional" circumstances are those that are outside the norm (e.g., there is a demonstrated community or coverage need for the services provided by the individual and that need cannot reasonably be met by other practitioners, there has been a delay in the individual satisfying the relevant criterion due to a serious illness or injury affecting the individual or an immediate family member, or the individual has provided evidence of mitigating circumstances and/or remediation activities that are above and beyond the norm). Exceptional circumstances generally do not include situations where a waiver is sought for the convenience of the requesting individual (e.g., failure to achieve board certification or recertification due to being busy or forgetful).

(c) Requests for waiver will be considered by the Credentials Committee. In reviewing the request for a waiver, the Credentials Committee may consider

input from the relevant department chairperson and the best interests of the Hospital and the communities it serves. Additionally, the Credentials Committee may, in its discretion, consider any aspect of the Practitioner's qualifications, including information from the RFC/RRFC/RFINCP or other request for Clinical Privileges and/or application form, or other information supplied by the individual (for example, a re-entry plan submitted pursuant to the Policy for Practitioner Re-Entry to Practice).

The Credentials Committee will forward a recommendation to the Medical Executive Committee. The Credentials Committee's recommendation must articulate the basis for the waiver recommendation (e.g., if the Committee recommends that waiver be granted, the recommendation should articulate the exceptional circumstances supporting waiver; if it recommends that waiver not be granted, the recommendation should articulate why the request was not considered exceptional enough to support waiver).

The Medical Executive Committee will review the recommendation of the Credentials Committee and make a recommendation to the Board regarding whether to grant or deny the request for a waiver. As with the Credentials Committee, the Medical Executive Committee must articulate the basis for its recommendation.

The Board will consider the recommendation of the Medical Executive Committee and make a determination regarding whether to grant a waiver. The Board's determination is final.

(d) The individual who requested the waiver will be given Notice of the Board's determination.

(i) If the Board has granted a waiver, the individual will be deemed eligible and, in turn, processing of the RFC/RRFC/RFINCP or other request for Clinical Privileges and/or Application will proceed as set forth in this Policy, in the same manner that other eligible individuals are credentialed.

(iii) If the Board has not granted the waiver, the individual who requested the waiver will remain ineligible and the RFC/RRFC/RFINCP or other request for Clinical Privileges and/or Application will not be processed.

(e) A determination to grant a waiver does not mean that Membership or Clinical Privileges will be granted; only that the individual's RFC/RRFC/RFINCP or other request for Clinical Privileges and/or Application can be processed further.

(f) A determination to grant a waiver in a particular case is not intended to set a precedent for others seeking waivers, nor does it guarantee that a waiver will be permanent. To that end, there is no guarantee that:

(i) waiver of the criterion will be available to request in the future (i.e., the Hospital and Medical Staff may, at a future date, determine to no longer consider or grant waivers of any criteria or, alternatively, to no longer consider or grant waivers of the particular criterion in question);

(ii) the individual will be granted the same waiver if he or she requests it again at a future date (e.g., at the time an RRFC or reappointment Application is made, there is no guarantee that the same waiver will be granted); or

(iii) that the criteria for Membership or Clinical Privileges will remain unchanged and the individual will remain eligible indefinitely.

(g) A recommendation of the Medical Executive Committee or a determination of the Board not to grant a waiver of the threshold eligibility criteria is not a "denial" of Membership or Clinical Privileges.

(h) An individual who requests a waiver is not entitled to a hearing or appeal or any other due process pursuant to the Medical Staff Bylaws, Credentials Policy, or other rules, regulations, policies or procedures of the Medical Staff or Hospital for any matter related to the request, the Hospital and Medical Staff Leaders' consideration of the request, and/or the determination to grant a waiver or not to grant a waiver.

2.A.3. Burden of Providing Information:

(1) All Applicants, Members, and other Practitioners 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. This includes participating in personal or phone interviews in regard to an Application.

(2) All Applicants, Members, and other Practitioners have the burden of providing evidence that all the statements made and all information provided by them in support of the Application are accurate and Complete.

(3) Each Applicant is responsible for providing a Complete Application. An Application that is not Complete will not be processed. Any Application that continues to not be Complete 30 Days after the Applicant has been notified of the additional information required will be deemed to be withdrawn.

(4) During the credentialing process and throughout the term of any Membership and/or Clinical Privileges, Applicants and Practitioners are responsible for immediately (and in no event later than one business day after being provided notice of the change) notifying the President of the Medical Staff, the Chief Executive Officer, or the CPC, as applicable, of any change in status or any change in the information provided as part of the RFC/RRFC/RFINCP or other request for Clinical Privileges and Application including, and with the addition of, the following:

(a) any investigation commenced by another health care organization, state licensure agency, the federal DEA or a state drug control agency, or a specialty certification board;

(b) any payer contract termination;

(c) any criminal investigation commenced regarding the individual; or

(d) any investigation commenced or sanction imposed or recommended by any subdivision or office of the Department of Health and Human Services or any other federal or state health oversight entity.

2.A.4. Factors for Evaluation:

The following factors will be evaluated as part of the processes of considering individuals for Membership and Clinical Privileges:

(1) 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;

(2) 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;

(3) good reputation and character;

(4) ability, with or without reasonable accommodation, to safely and competently perform the Clinical Privileges requested and any other essential functions of Medical Staff Membership and/or the exercise of Clinical Privileges;

(5) ability to communicate in an understandable manner in English and maintain all medical record entries legibly and in English, sufficient for the safe delivery of patient care;

(6) 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

(7) 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.5. No Entitlement to Membership:

No one is entitled to receive an RFC/RRFC/RFINCP or other request for Clinical Privileges form, to be granted Membership in the Medical Staff, or to exercise or be granted particular Clinical Privileges merely because he or she:

(1) is employed by this Hospital or Affiliated Entities or has a contract with this Hospital;

(2) is or is not a member or employee of any particular Physician group;

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

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

(5) has had in the past, or currently has, medical staff membership or clinical privileges at any hospital or health care facility;

(6) resides in the geographic service area of the Hospital;

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

(8) is certified by any specialty certification board.

2.A.6. Nondiscrimination:

No one will be denied Membership or Clinical Privileges on the basis of race, color, sex, creed/religion, national origin, or any other grounds prohibited by law.[7]

2.B. GENERAL CONDITIONS OF MEMBERSHIP

2.B.1. Basic Responsibilities and Requirements:

As a condition of being granted initial or renewed Membership or Clinical Privileges and as a condition of ongoing Membership or Clinical Privileges, every individual specifically agrees to the following:

(1) to provide continuous and timely care at the generally recognized level of quality and efficiency and refrain from delegating responsibility for Hospital patients to any individual who is not appropriately licensed, qualified, supervised and, as applicable, granted the Clinical Privileges or scope of practice necessary to perform the delegated responsibility;

(2) that he or she is subject to and shall abide by the Bylaws, policies, and Rules and Regulations of the Hospital and Medical Staff[8], the Code of Conduct of HCA, the code of ethical business and professional behavior of the Hospital; all local, state, and federal laws and regulations applicable to the Hospital or to the Practitioner's professional practice; and the Joint Commission and other accreditation standards currently in existence or as may be adopted or amended in the future;

(3) to participate in Medical Staff affairs through committee service and participation in Medical Peer Review including, but not limited to, performance improvement, peer

7 MS.06.01.07, EP 3

8 42 C.F.R. §482.22(a)(2)

review, and professional practice evaluation activities, and to perform such other reasonable duties and responsibilities as may be assigned;

(4) to provide emergency call coverage (in accordance with the call plan established by the department and approved by the Medical Executive Committee and Board), consultations, and care for unassigned patients;

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

(6) to comply with or document the clinical reasons for variance from clinical practice or evidence-based protocols that have been adopted by the Hospital as part of its performance improvement program or for compliance with or reporting to regulatory or accrediting agencies or patient safety organizations, including those related to national patient safety initiatives, core measures, and other performance measures;

(7) to obtain, when requested, an appropriate fitness for practice evaluation, which may include diagnostic testing (such as blood, urine, or hair testing) or a complete physical, mental, and/or behavioral evaluation, as set forth in this Policy and other Medical Staff policies;

(8) to obtain, when requested, an evaluation of current clinical competence by a consultant or program selected by the Hospital;

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

(10) to seek consultation whenever necessary;

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

(12) to utilize the Hospital's applications and systems, including the electronic medical record, in accordance with all policies, procedures, rules and regulations, and protocols that have been adopted by the Hospital;

(13) to abide by all terms of the Confidentiality and Security Agreement (CSA), which includes exercising due diligence in following appropriate access, safeguarding confidential information, and protecting the individual's sole ability to access the Hospital's applications, including the electronic medical record, and systems;

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

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

(16) to satisfy continuing medical education requirements;[9]

[9] MS.12.01.01

(17) to attend and participate in any applicable orientation programs at the Hospital before participating in direct patient care;

(18) to comply with all applicable training and educational protocols that may be adopted by the Medical Executive Committee or required by the Hospital, including, but not limited to, those involving electronic medical records, computerized physician order entry ("CPOE"), the privacy and security of protected health information, patient safety, and EMTALA;

(19) prior to becoming eligible to begin exercising Clinical Privileges and engaging in any patient care at the Hospital, to comply with all health screening and immunization requirements set forth by Hospital policy;

(20) to cooperate with the Hospital in matters involving its fiscal responsibilities and policies, including those relating to payment or reimbursement by governmental and third-party payors;

(21) to maintain a current e-mail address with the Medical Staff Office, which may be used as the primary mechanism for communicating all information relevant to the individual's Membership status or Clinical Privileges;

(22) to provide and keep current valid contact information in order to facilitate verbal practitioner-to-practitioner communication (e.g., mobile phone number or valid answering service information);

(23) to disclose 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 that a Practitioner may request the Hospital to purchase or approve for use;

(24) if the individual is a Member of the Medical Staff who serves or plans to serve as a Supervising/Collaborating Practitioner to an Advanced Practice Professional, the Member of the Medical Staff will abide by the Supervision requirements and conditions of practice set forth in Article 8; and

(25) if the individual is an Advanced Practice Professional, the individual will also abide by the conditions of practice set forth in Article 8 and any delineation of privileges granted.

2.C. CONDITIONS OF APPLICATION AND CONSIDERATION

2.C.1. Scope of Conditions:

The terms set forth in this Section:

(1) commence with the individual's initial contact with the CPC or the Hospital, whether or not an RFC/RRFC/RFINCP or other request for Clinical Privileges form is furnished, an Application is processed, or Membership or Clinical Privileges are granted;

(2) apply throughout the credentialing process and the term of any initial or renewed Membership or Clinical Privileges; and

(3) continue, even if Membership or Clinical Privileges are denied, revoked, reduced, restricted, suspended, or otherwise affected as part of the Hospital's Medical Peer Review activities and even if the individual no longer maintains Membership or Clinical Privileges at the Hospital.

2.C.2. Misstatements and Omissions:

(1) Any material misstatement in, or omission from, an RFC/RRFC/RFINCP, other request for Clinical Privileges form, Application, or any other information submitted as part of the RFC/RRFC/RFINCP or Privileging or Application processes is grounds to stop the process. The Practitioner will be informed in writing of the nature of the misstatement or omission and permitted to provide a written response. The President of the Medical Staff and Chief Executive Officer will review the response and determine whether the misstatement or omission is material and the Application should be processed.

(2) If Membership or Clinical Privileges have been granted prior to the discovery of a misstatement or omission, Membership and Clinical Privileges shall be deemed to be automatically relinquished pursuant to this Policy.

(3) No action taken pursuant to this Section will entitle an Applicant or Practitioner to a hearing or appeal under the Medical Staff Bylaws, this Policy or otherwise.

2.C.3. Authorization to Obtain/Release Information:

(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 Membership or Clinical Privileges or the individual's qualifications for the same, including, but not limited to:

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

(b) any matter addressed on the RFC/RRFC/RFINCP, other request for Clinical Privileges, Application, or in the Medical Staff Bylaws, Credentials Policy, and other policies and Rules and Regulations of the Hospital, HCA Healthcare Entities, and its Medical Staff;

(c) any reports about the individual which are made to the National Practitioner Data Bank or relevant state licensing boards/agencies; and

(d) any references or peer evaluations received or given about the individual.

(2) Authorization for Background Check:

The individual agrees to sign consent forms to permit a consumer reporting agency to conduct a background check and report the results to the CPC and the Hospital.[10]

(3) Authorization to Share Information Among Affiliated Entities:

The individual specifically authorizes this Hospital and its Medical Staff Leaders and other HCA Healthcare Entities (as defined below) and their authorized agents to share with one another Medical Peer Review information including, but not limited to, any information maintained in any format (verbal, written, or electronic) that involves (i) the evaluation of the quality and efficiency of services ordered or performed by the individual, or (ii) the individual's professional qualifications, competence, conduct, health/ability to safely practice, experience, or patient care practices. This information and documentation may be shared at any time pursuant to Hospital policy, including, but not limited to, any initial evaluation of an individual's qualifications, any periodic reassessment of those qualifications, or when a question is raised about the individual.

For the purposes of this Section 2.C., an HCA Healthcare Entity means:

(a) any entity which:

(i) offers health care services through Practitioners who are credentialed by the CPC, excluding managed care entities for which the CPC provides services as part of a delegated credentialing agreement; and

(ii) has a formal peer review/professional practice evaluation process and an established peer review committee, as evidenced by internal bylaws or policy; and

(b) any entity not included in section (a) that provides patient care services and that:

(i) has a formal peer review/professional practice evaluation process and an established peer review committee, as evidenced by internal bylaws or policy; and

(ii) has appropriate provisions regarding the sharing of Confidential Information consistent with Ethics & Compliance Policy CSG.PPA.001: "*Sharing Credentialing, Privileging, and PPE Information Among HCA Healthcare Entities*" in a professional services contract or separate agreement with HCA Healthcare or an HCA Healthcare Entity identified in section (a).

(4) Authorization to Obtain Information from Third Parties:

[10] The Fair Credit Reporting Act, 15 U.S.C. §1681 *et seq.*

The individual authorizes the Hospital, its Medical Staff Leaders, the HCA Healthcare Entities and any of their representatives to request or obtain information from third parties and specifically authorizes third parties to release information to the Hospital and HCA Healthcare Entities.

(5) Authorization to Disclose Information to Third Parties:

The individual authorizes the Hospital, its Medical Staff Leaders, the HCA Healthcare Entities and any of their representatives to disclose information to other hospitals, any organization providing or managing health care services, managed care organizations and other payers, government regulatory and licensure boards or agencies, and their representatives to assist them in evaluating the individual's qualifications.

(6) Redisclosure of Drug/Alcohol Treatment Information:

In the course of performing credentialing or peer review functions, the Hospital may receive written or verbal information about the treatment of a Practitioner from a federally-assisted drug or alcohol abuse program, as defined by 42 C.F.R. Part 2. The Hospital will not redisclose such information without a signed authorization from the Practitioner. Appendix F to the Practitioner Health Policy includes an authorization that may be used for this purpose.

2.C.4. Hearing and Appeal Procedures:

The individual agrees that the hearing and appeal procedures set forth in this Policy will be the sole and exclusive remedy with respect to any Professional Review Action or other Medical Peer Review recommendation or action taken by the Medical Staff or the Hospital.

2.C.5. 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, HCA Healthcare Entities, the Board, the Medical Staff, their authorized representatives, any Members of the Medical Staff or members of the Board, any Practitioner, and any third party who provides information.

This immunity covers any actions, recommendations, reports, statements, communications, or disclosures that are made, taken, or received in the course of Medical Peer Review including, but not limited to, credentialing and peer review/professional practice evaluation activities or when using or disclosing information as described in this Section. Nothing herein shall be deemed to waive or limit any other immunity or privilege provided by federal or state law.

2.C.6. Legal Actions:

If, despite this Section, an individual institutes legal action challenging any Medical Peer Review including, but not limited to, credentialing, privileging, peer review/professional practice evaluation, or other Professional Review Action or activity and does not prevail, he or she will reimburse the Hospital and HCA Healthcare Entities, any Member of the Medical Staff or other Practitioner, or member of the Board, and any other defendant involved in the action for all costs

incurred in defending such legal action, including costs and attorney's fees, expert witness fees, and lost revenues.

ARTICLE 3
PROCEDURE FOR GRANTING MEMBERSHIP AND CLINICAL PRIVILEGES

3.A. PROCEDURE FOR GRANTING MEMBERSHIP AND CLINICAL PRIVILEGES[11]

3.A.1. Initial Review of Application:

(1) As a preliminary step, once an RFC/RRFC/RFINCP or other request for Clinical Privileges is submitted to the Medical Staff Office as an Application, the Medical Staff Office will review the Application to make sure that all questions have been answered and that the Applicant satisfies the threshold eligibility criteria set forth in this Policy. Applicants whose Applications are not Complete or fail to meet the threshold eligibility criteria set forth in this Policy will be notified that their Applications will not be processed. A determination of ineligibility does not entitle the individual to a hearing or appeal. The Applicant may request a waiver of a threshold eligibility criterion in accordance with Section 2.A.2 of this Policy.

(2) The Medical Staff Office will oversee the process of gathering additional information, if any, relating to the Applicant's character, professional competence, qualifications, behavior, and ethical standing, or any concerns assigned by the CPC. This information may be contained in the Application, and obtained from references and other available sources, including the Applicant's past or current department chairperson at other health care entities, 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, the Office of Inspector General List of Excluded Individuals/Entities or the General Services Administration's Excluded Parties List System (EPLS) and System for Award Management, and the Texas OIG Exclusion List will be queried, as required, and a background check will be obtained.

(3) An interview(s) with the Applicant may be conducted at this or any stage of the processing of the Application. The purpose of the interview is to discuss and review any aspect of the individual's Application, qualifications, and requested Clinical Privileges. This interview may be conducted by one or any combination of any of the following: the department chairperson, the division director, the Credentials Committee, a Credentials Committee representative, the Medical Executive Committee, the President of the Medical Staff, Chief Medical Officer, or the Chief Executive Officer.

(4) The Medical Staff Office will transmit the Complete Application and all supporting materials to the chairperson of each department in which the Applicant seeks Clinical Privileges (and, where applicable, to the division director).

3.A.2. Department Chairperson Procedure:

Within 30 days of his or her receipt of a Complete Application, the department chairperson will prepare a written report regarding whether the Applicant has satisfied all of the qualifications for Membership and the Clinical Privileges requested. The report will be on a form provided by the

[11] MS.01.01.01, EPs 26 & 27

Medical Staff Office. The Chief Nursing Executive will also review and report on the Applications for all advanced registered nurse practitioners.

3.A.3. Credentials Committee Procedure:

(1) For all Applicants, within 60 Days of receipt of a Complete Application, the Credentials Committee will consider the report prepared by the department chairperson(s) and, if applicable, the Chief Nursing Executive and will make a written recommendation.

(2) If additional information is required regarding the Applicant's qualifications, the Credentials Committee may use the expertise of the department chairperson(s), any Member of the department, or an outside consultant.[12]

(3) After determining that an Applicant is otherwise qualified for Membership and Clinical Privileges, if there is any question about the Applicant's ability to perform the Clinical Privileges requested and the responsibilities of Membership, the Credentials Committee may require a fitness for practice evaluation or a clinical competency evaluation by a practitioner or program satisfactory to the Credentials Committee. The results of this evaluation will be made available to the Committee.

(4) If the recommendation of the Credentials Committee is delayed longer than 60 Days, a letter will be sent to the Applicant, with a copy to the Chief Executive Officer, explaining the reasons for the delay.

3.A.4. Medical Executive Committee Recommendation:

(1) At its next regular meeting after receipt of the written report and recommendation of the department chairperson and Credentials Committee, but in no event later than 45 Days, the Medical Executive Committee will:

(a) adopt the report and recommendation of the Credentials Committee as its own; or

(b) refer the matter back to the Credentials Committee for further consideration of specific questions; or

(c) state its reasons for disagreement with the report and recommendation of the Credentials Committee.

(2) If the recommendation of the Medical Executive Committee is to grant Membership and/or Clinical Privileges, the recommendation will be forwarded to the Board.

(3) If the recommendation of the Medical Executive Committee would entitle the Applicant to request a hearing pursuant to the Hearing and Appeals Procedure Article set forth in this Policy, the Medical Executive Committee will forward its recommendation to the Chief Executive Officer, who will promptly send Special Notice to the Applicant in

[12] MS.07.01.03

accordance with that Article as set forth in this Policy. All further procedures shall be as set forth in that Article.

3.A.5. Board Action:

(1) Upon receipt of a recommendation, the Board may:

(a) grant Medical Staff Membership and/or Clinical Privileges as recommended; or

(b) refer the matter back to the Credentials Committee or Medical Executive Committee or to another source for additional research or information; or

(c) modify the recommendation.

(2) If the Board disagrees with the recommendation it has received, it should first discuss the matter with the chairperson of the Credentials Committee and the chairperson of the Medical Executive Committee. If the Board's determination would entitle the Applicant to request a hearing pursuant to the Hearing and Appeals Procedure Article set forth in this Policy, the Chief Executive Officer will promptly send Special Notice that the Applicant is entitled to request a hearing in accordance with that Article. All further procedures shall be as set forth in that Article.

(3) Any final decision by the Board to grant, deny, modify, or revoke Membership or Clinical Privileges, including the reason for any denial or restriction, will be communicated to the Applicant or Member in writing within 20 days13 and otherwise disseminated, both internally and externally, as appropriate or required.

3.A.7. Prerequisites to Commencing Medical Staff Membership Activities and Exercise of Clinical Privileges:

Prior to an individual commencing Medical Staff Membership activities or exercising any Clinical Privileges that have been granted to the individual, the individual must complete the orientation process, if applicable (e.g., new Members) and document compliance with all mandatory training and educational protocols that are applicable to the Practitioner and have been adopted by the Medical Executive Committee or Hospital, including, but not limited to, those involving electronic medical records, computerized physician order entry (CPOE), the privacy and security of protected health information, patient safety, and EMTALA.

3.A.8. Conditions on Membership and Clinical Privileges:

(1) At any time during the process of credentialing, the department chairperson, Credentials Committee, Medical Executive Committee, or Board may recommend/impose specific conditions on the Practitioner's Membership and/or Clinical Privileges. Those conditions may be related to behavior, health, or clinical issues. Those individuals and bodies may also recommend that Membership or Clinical Privileges be granted to a Practitioner for a period of less than two years in order to permit closer monitoring of a Practitioner's

13 Tex. Health & Safety Code Sec. 241.101(k).

clinical performance, professional conduct, and ongoing qualifications for Membership and Clinical privileges.

(2) In the case of a Practitioner seeking renewal of Membership or Clinical Privileges, if he or she is the subject of an Investigation or a hearing at the time of credentialing, Membership or Clinical Privileges may be granted for a period of less than two years or until the completion of that process, whichever occurs sooner.

(3) At the conclusion of any term of Membership or Clinical Privileges which was conditional or which had a term shorter than two years, the individual must be recredentialed in accordance with the terms of this Policy.

(4) The grant of Membership or Clinical Privileges for a term shorter than two years does not entitle a Practitioner to request a hearing or appeal or any other due process. The imposition of conditions on Membership or Clinical Privileges, as described in this Section, does not, in and of itself, entitle a Practitioner to the right to request a hearing or appeal or any other due process unless the condition itself is a restriction specifically listed in the Hearing and Appeals Procedure Article.

3.A.9. Time Periods for Processing:[14]

(1) Once an Application is deemed Complete, it is expected to be processed overall within 150 Days, unless it becomes not Complete. Except as provided below, this time period is intended to be a guideline only and will not create any right for the Applicant to have the Application processed within this precise time period.

(2) If the Credentials Committee has failed to take action on a Complete Application within 90 days of its receipt by the committee, the Practitioner is entitled to request mediation pursuant to the Texas Health & Safety Code.15 The Governing Board is required to take final action within 60 days of receiving the recommendation of the Credentials Committee.16 The Governing Board also must notify the Practitioner of its final decision within 20 days of the decision.17

14 MS.06.01.07, EP 4
15 Tex. Health & Safety Code Sec. 241.101(d),(k).
16 Id. at Sec. 241.101(k).
17 Id. at Sec. 241.101(k).

ARTICLE 4
CLINICAL PRIVILEGES

4.A. CLINICAL PRIVILEGES[18]

4.A.1. General:

(1) Membership will not confer any Clinical Privileges or right to practice at the Hospital. Only those Clinical Privileges granted by the Board may be exercised, subject to the terms of this Policy.

(2) Except as specifically set forth in this Policy,[19] requests for Clinical Privileges will be processed only when an individual satisfies the threshold eligibility criteria for Medical Staff Membership and Clinical Privileges set forth in Article 2 of this Policy. An individual who does not satisfy the threshold eligibility criteria for Clinical Privileges may request that the threshold eligibility criteria be waived as set forth in this Policy.

(3) 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 Board resolution.

(4) Requests for Clinical Privileges that are not part of the established delineation of privileges will only be considered if the Board has determined that the Hospital has the resources to offer or support the Clinical Privileges. If such a determination has not been made by the Board, no Practitioner will be considered eligible to request such Clinical Privileges.[20]

(5) Recommendations for Clinical Privileges will be based on consideration of the following:[21]

(a) 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;

(b) appropriateness of utilization patterns;

(c) information concerning the individual's ability to perform the Clinical Privileges requested competently and safely;

(d) information resulting from ongoing and focused professional practice evaluation and other performance improvement activities, as applicable;[22]

(e) availability of coverage in case of the individual's illness or unavailability;

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18 MS.01.01.01, EP 14

19 See, for example, the provisions governing the grant of temporary Clinical Privileges in this Article.

20 MS.06.01.01

21 MS.06.01.03 & MS.06.01.07; 42 C.F.R. §482.12(a)(6)

22 MS.08.01.03

(f) having current valid professional liability insurance coverage for the Clinical Privileges requested in a form and in amounts as determined by the Hospital;

(g) information about any previously successful or currently pending challenges to any licensure or registration, or the voluntary or involuntary relinquishment of such licensure or registration;

(h) any information concerning disciplinary or corrective action or other Medical Peer Review activities including, but not limited to, Professional Review Actions or voluntary or involuntary termination, limitation, reduction, or loss of staff membership or Clinical Privileges at another hospital or healthcare entity;

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

(j) morbidity and mortality data, when available;

(k) professional liability actions, especially any such actions that reflect an unusual pattern or number of actions; and

(l) the Hospital's need, available resources, and personnel.[23]

(6) Requests for new or additional Privileges ("Requests for Increased, New Clinical Privileges, or Changes in Prescriptive Authority" or "RFINCPs") must state the additional Clinical Privileges requested and provide information sufficient to establish eligibility. If the Practitioner is eligible and the request is Complete, it will be processed in the same manner as an RFC/Application for initial Clinical Privileges (and in all such cases, the CPC shall not only verify current professional liability coverage, but also that such coverage specifically applies to the new or increased Clinical Privileges). If the request for new or additional Privileges ("RFINCP") is made at or near the time of renewal of Membership or Clinical Privileges, it may be processed along with the RRFC/Application for Renewal of Membership or Clinical Privileges.

(7) When Clinical Privileges have been delineated by Core or specialty, a request for Clinical Privileges will only be processed if the individual applies for the full Core or specialty delineation. (This only applies to requests for Clinical Privileges within the individual's primary specialty.)

4.A.2. Privilege Waivers:

(1) In limited circumstances, the Hospital may consider a waiver of the requirement that Clinical Privileges be granted by Core or specialty. If an individual wants to request such a waiver, the request must be submitted in writing to the Medical Staff Office. The request must indicate the specific Clinical Privileges within the Core or specialty that the individual does not wish to provide, state a good cause basis for the request, and include

[23] MS.06.01.01

evidence that he or she does not provide the relevant patient care services in any health care facility.

(2) Requests for waivers related to Clinical Privileges will be processed in the same manner as requests for waivers of threshold eligibility criteria.

(3) The following factors, among others, may be considered in deciding whether to grant a waiver:

(a) the Hospital's mission and ability to serve the health care needs of the community by providing timely, appropriate care;

(b) the effect of the request on the Hospital's ability to comply with applicable regulatory requirements, including the Emergency Medical Treatment and Active Labor Act;

(c) the expectations of Practitioners who rely on the specialty;

(d) the interests of the individual requesting the waiver;

(e) fairness to other Members who serve on the call roster in the relevant specialty, including the effect that the modification would have on them; and

(f) the potential for gaps in call coverage that might result from an individual's removal from the call roster and the feasibility of safely transferring patients to other facilities.

(4) If the Board grants a waiver related to Clinical Privileges, it will specify the effective date.

(5) No one is entitled to a waiver or to a hearing or appeal if a waiver is not granted.

4.A.3. Relinquishment of Individual Clinical Privilege:

A request to relinquish any individual Clinical Privilege, whether or not part of the Core, must provide a good cause basis for the modification of Clinical Privileges. All such requests will be processed in the same manner as a request for waiver, as described above.

4.A.4. Resignation of Membership and Clinical Privileges:

A request to resign all Clinical Privileges must be submitted in writing to the Chief Executive Officer and: (a) specify the desired date of resignation, which must be at least 30 Days after the date of the request, and (b) provide evidence that the individual has completed all medical records and will be able to appropriately discharge or transfer responsibility for the care of any hospitalized patient. After consulting with the President of the Medical Staff, the Chief Executive Officer will act on the request. Failure to follow this process will be reflected in any future reference responses provided for the Practitioner.

4.A.5. Clinical Privileges for New Treatments, Procedures, or Therapies:

(1) Requests for Clinical Privileges to perform either a treatment, procedure, or therapy not currently being performed at the Hospital or a new technique to perform an existing treatment, procedure, or therapy ("New Procedure") will not be processed until a determination has been made that the New Procedure will be offered by the Hospital and criteria for the associated Clinical Privilege(s) have been adopted.

(2) As an initial step in the process, any individual proposing that the New Procedure be offered at the Hospital will prepare and submit information to the department chairperson and the Credentials Committee addressing at least the following:

(a) clinical indications for when the New Procedure is appropriate;

(b) whether there is empirical evidence of improved patient outcomes with the New Procedure or other clinical benefits to patients;

(c) whether the New Procedure is being performed at other similar hospitals and the experiences of those institutions;

(d) whether the New Procedure is investigational and, if so, whether there has been IRB approval; and

(e) whether the New Procedure has received any regulatory approval (e.g., FDA) and whether it has a favorable safety profile.

(3) The department chairperson and the Credentials Committee will review and, as necessary, verify this information and conduct additional research, including at least the following:

(a) whether proficiency for the New Procedure is volume-sensitive and if the requisite volume would be available; and

(b) whether the Hospital currently has the resources, including space, equipment, personnel, and other support services, to safely and effectively perform the New Procedure.

Based on this information, the department chairperson will make a recommendation to the Credentials Committee, which will make a preliminary recommendation as to whether the New Procedure should be offered at the Hospital.

(4) The Credentials Committee will forward its recommendations regarding whether the New Procedure should be offered at the Hospital to the Medical Executive Committee, which will review the matter and forward its recommendations to the Board for final action.

(5) If the Board determines that the New Procedure should be offered at the Hospital, it will refer the matter to the Credentials Committee, which will develop eligibility criteria for requesting the Clinical Privileges required to perform the New Procedure at the Hospital.

In developing the criteria, the Credentials Committee may conduct additional research and consult with experts, as necessary, and develop recommendations regarding:

(a) the minimum education, training, licensure, experience and, as applicable, additional eligibility criteria (such as an affiliation agreement with a Supervising/Collaborating Practitioner) necessary to perform the New Procedure;

(b) the clinical indications for when the New Procedure is appropriate; and

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

(6) The Credentials Committee will forward its recommendations regarding the eligibility criteria for Clinical Privileges to perform the New Procedure to the Medical Executive Committee, which will review the matter and forward its recommendations to the Board for final action.

4.A.6. Clinical Privileges That Cross Specialty or Practitioner Category Lines:

(1) Requests for Clinical Privileges that previously have been exercised only by Practitioners in another specialty or individuals in another Practitioner category (e.g., Podiatrists vs. advanced practice registered nurses vs. Physicians) will not be processed until the steps outlined in this Section have been completed and a determination has been made regarding the individual's eligibility to request the Clinical Privilege(s) in question.

(2) As an initial step in the process, any individual proposing that Clinical Privileges be available for members of a new specialty or Practitioner category will prepare and submit information to the Credentials Committee addressing at least the following:

(a) clinical indications for when the Clinical Privileges can be safely exercised by members of a new clinical specialty or category of practitioners; and

(b) whether individuals in the same specialty or category of practice are performing the Clinical Privilege at other similar hospitals and the experiences of those institutions.

(3) The Credentials Committee will then conduct additional research and consult with experts, as necessary, including those on the Medical Staff (e.g., department chairpersons and Practitioners with special interest and/or expertise) and those outside the Hospital (e.g., other hospitals, residency training programs, allied health training and certification programs, specialty societies).

(4) The Credentials Committee may or may not recommend that individuals from different specialties or Practitioner categories be permitted to request the Clinical Privileges at issue. If it does, the Committee may develop recommendations regarding:

(a) the minimum education, training, experience and, as applicable, additional eligibility criteria (such as an affiliation agreement with a Supervising/

Collaborating Practitioner) necessary to perform the Clinical Privileges in question;

(b) the clinical indications for when the procedure is appropriate to be performed by individuals in the new clinical specialty or practitioner category;

(c) the manner of addressing the most common complications that arise, which may be outside of the scope of the Clinical Privileges that have been granted to the requesting individual;

(d) the extent (time frame and mechanism) of focused monitoring and supervision that should occur if the Clinical Privileges are granted in order to confirm competence;

(e) the manner in which the procedure would be reviewed as part of the Hospital's ongoing and focused professional practice evaluation activities (which may include assessment of both long-term and short-term outcomes for all relevant specialties); and

(f) the impact, if any, on emergency call responsibilities.

(5) The Credentials Committee will forward its recommendations to the Medical Executive Committee, which will review the matter and forward its recommendations to the Board for final action.

4.A.7. Individuals in Training Programs:

(1) Individuals will not, by virtue of participation in training programs, be granted Membership in the Medical Staff or Clinical Privileges. Rather, individuals in training programs will be granted permission to perform clinical functions in the Hospital only as set forth in the curriculum requirements, affiliation agreements, and/or training protocols that have been approved by the Medical Executive Committee (or its designee) and the Graduate Medical Education Committee of the Hospital. Those documents will, at a minimum, require the applicable program director to verify and evaluate the qualifications of each individual in the training program[24] and require the program director or applicable clinical faculty or attending staff Members to direct and supervise the on-site or day-to-day patient care activities of trainees.

(2) Individuals in training programs who are seeking to practice outside of their training program must apply for Clinical Privileges as set forth in this Policy.

[24] MS.04.01.01

4.A.8. Telemedicine Clinical Privileges:[25]

(1) "Telemedicine" is the provision of clinical services to Hospital patients by Practitioners from a distance via electronic communications. The distant-site telemedicine physician or practitioner provides clinical services to the hospital patient either simultaneously, as is often the case with teleICU services, for example, or non-simultaneously, as may be the case with many teleradiology services.26 Under Texas law, "telemedicine medical service" is defined as a health care service delivered by a physician licensed in this state, or a health professional acting under the delegation and supervision of a physician licensed in this state, and acting within the scope of the physician's or health professional's license to a patient at a different physical location than the physician or health professional using telecommunications or information technology.27

(2) A qualified individual may be granted telemedicine Clinical Privileges, but is not eligible for Membership on the Medical Staff.

(3) Requests for telemedicine Clinical Privileges will be processed through the same process for RFCs/RRFCs/Applications for Membership and Clinical Privileges, as set forth in this Policy. The individual must satisfy all qualifications and requirements set forth in this Policy, except those relating to geographic location, coverage arrangements, and responsibility for serving on the emergency call roster that the Hospital maintains for purposes of complying with the Emergency Medical Treatment and Active Labor Act (EMTALA). In addition, telemedicine Practitioners must demonstrate satisfaction of these additional threshold eligibility criteria:

(a) if located in a different state than the patient, the Practitioner must be licensed as set forth in Section 2.A.1. of this Policy28; and

(b) the Practitioner must evidence current clinical competence in the use of the applicable telemedicine equipment.

(4) Telemedicine Clinical Privileges, if granted, will be for a period of not more than two years.

(5) Practitioners granted telemedicine Clinical Privileges will be subject to the Hospital's professional practice evaluation activities. The results of these activities, including any adverse events and complaints filed about the Practitioner providing telemedicine services from patients, other Practitioners or staff, may be shared with the entity providing telemedicine services subject to Medical Peer Review confidentiality requirements.

(6) Telemedicine Clinical Privileges granted in conjunction with a contractual agreement will be incident to, coterminous with, and subject to the provisions of the agreement.

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25 MS.13.01.01 & MS.13.01.03; 42 C.F.R. §482.22(a)(3)-(4); 42 C.F.R. §482.12(a)(8)-(9)

26 42 C.F.R. Sec. 482.12(a)(8) Interpretive Guidelines

27 Tex. Occ. Code Sec. 111.001(4)

28 42 C.F.R. Sec. 482.11(c)

4.A.9. Focused Professional Practice Evaluation for Initial Clinical Privileges:[29]

(1) All initial grants of Clinical Privileges, at any time, will be subject to focused professional practice evaluation by the department chairperson or by a Practitioner(s) designated by the Credentials Committee.

(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 Credentials Committee.

(3) The newly-granted Clinical Privileges will expire if a Practitioner fails to fulfill the applicable focused professional practice evaluation clinical activity requirements within the time frame recommended by the Credentials Committee, which may include reasonable extensions, within the Credentials Committee's discretion. In such case, the individual may not reapply for those same Clinical Privileges for two years. Expiration of Clinical Privileges due to failure to fulfill clinical activity requirements does not entitle the Practitioner to the rights in the Hearing and Appeal Article in this Policy.

(4) 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 Practitioner will be entitled to a hearing and appeal.

4.B. TEMPORARY PRIVILEGES[30]

In approving these Bylaws, the Board of Trustees authorizes the Chief Executive Officer on the Board's behalf to grant temporary Privileges in accordance with the following procedures.

4.B.1. Temporary Privileges for Initial Applicants:

(1) Temporary Privileges may be granted to Applicants for initial Membership or initial Clinical Privileges whose Complete Application is pending review by the Medical Executive Committee and Board.

(2) To be eligible for temporary Privileges, the Applicant must satisfy all qualifications and requirements set forth in this Policy. In addition, Applicants must demonstrate satisfaction of these additional criteria in order to be eligible for temporary Privileges for initial Applicants:

(a) a demonstrated ability to perform the Clinical Privileges requested; and

[29] MS.08.01.01, EP 1

[30] MS.06.01.13

(b) that the Applicant has had no (i) current or previously successful challenges to licensure or registration or (ii) involuntary restriction, reduction, denial or termination of membership or clinical privileges at another health care facility.

(3) Requests for temporary Privileges for Applicants will be processed through the same process for RFCs/RRFCs/Applications for Membership and Clinical Privileges, as set forth in this Policy. Once an Applicant who is eligible for temporary Privileges has received a favorable recommendation of the Credentials Committee as part of that process, a subcommittee of the Board of Directors consisting of the Chief Executive Officer (or authorized designee who is a Board member) and a President of the Medical Staff may grant that Applicant temporary Privileges, which shall be effective immediately upon Notice to the Practitioner.

(4) Temporary Privileges for initial Applicants will be granted until final action by the Board on the Application, not to exceed a term of 120 Days. Temporary Privileges for new Applicants will not be renewed.

4.B.2. Temporary Privileges for an Important Patient Care Need:

(1) Temporary Privileges may be granted to individuals who are not requesting consideration for Medical Staff Membership or ongoing Clinical Privileges when there is an important patient care, treatment, or service need. This includes, but is not limited to, the following situations:

(a) for the care of a specific patient;

(b) when necessary to prevent a lack of services in a needed specialty area;

(c) for proctoring or teaching; or

(d) when serving in a locum tenens capacity for another Practitioner.

(2) To be eligible for temporary Privileges for an important patient care need, an individual must satisfy all qualifications and requirements set forth in this Policy, except the following:

(a) those criteria relating to geographic location, coverage arrangements, compliance with education and training protocols, and responsibility for serving on the emergency call roster that the Hospital maintains for purposes of complying with the Emergency Medical Treatment and Active Labor Act (EMTALA); and

(b) any qualifications or requirements waived by the Chief Executive Officer, upon recommendation of the President of the Medical Staff, balancing the impact of waiving such criteria against the importance of the patient care need justifying the grant of temporary Privileges.

(3) Requests for temporary Privileges for an important patient care need will be processed through a modified process:

(a) RFCs/RRFCs/Applications for temporary Privileges will be verified through the same process for RFCs/RRFCs/Applications for Membership and Clinical Privileges, as set forth in this Policy.

(b) Following verification, the Chief Executive Officer, upon recommendation of the President of the Medical Staff, may grant the individual temporary Privileges, based on:

(i) the individual's satisfaction of applicable threshold eligibility criteria;

(ii) the individual's documented experience and current competence; and

(iii) in the case of temporary Privileges for teaching purposes, the expertise, extent of clinical experience, and reputation of the individual, as well as the Hospital's need for Practitioners trained in the respective procedure/skill.

(c) Temporary Privileges for an important patient care need will be effective immediately upon Notice to the Practitioner and shall be granted for a period of time correlating to the important patient care need, not to exceed a term of 120 Days.

4.B.3. Conditions Applicable to Temporary Privileges:

(1) Prior to any temporary Privileges being granted, the individual must sign and return the CMS-required[31] Practitioner Acknowledgment Statement and agree in writing that he or she is subject to and will abide by the Bylaws, policies, and Rules and Regulations, procedures and protocols of the Medical Staff and the Hospital, as may be amended from time to time.

(2) Temporary Privileges are granted as a temporary courtesy only and do not give rise to any expectation of continued Clinical Privileges at the Hospital. They may be withheld or withdrawn, at any time, at the discretion of the subcommittee of the Board of Directors, consisting of the Chief Executive Officer (or authorized designee who is a Board member) and a President of the Medical Staff, or the chairperson of the Credentials Committee or the department chairperson. If temporary Privileges are withdrawn, the department chairperson or the President of the Medical Staff will assign to another Practitioner with appropriate Clinical Privileges responsibility for the care of patients until they are discharged. Whenever possible, consideration will be given to the wishes of the patient in the selection of a substitute Practitioner.

(3) The first time any particular temporary Privileges are granted to a Practitioner, the Practitioner shall be subject to the focused professional practice evaluation process applicable to all initially granted Clinical Privileges.

[31] 42 C.F.R. §412.46

4.C. EMERGENCY SITUATIONS

(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 Practitioner may administer treatment to the extent permitted by his or her license, regardless of Membership status, department status, or specific grant of Clinical Privileges.

(3) When the emergency situation no longer exists, the patient will be assigned by the department chairperson or the President of the Medical Staff to a Member with appropriate Clinical Privileges, considering the wishes of the patient.

4.D. DISASTER PRIVILEGES[32]

(1) When the Hospital Emergency Operations Plan has been implemented and the immediate needs of patients in the facility cannot be met, the Hospital Emergency Incident Commander (the Chief Executive Officer or his or her designee) or the Operations Chief (if that position is activated as part of the Hospital Emergency Operations Plan) may, after consulting with the President of the Medical Staff or the Emergency Operations Plan's designated Medical Staff Director, grant disaster Privileges to eligible volunteer licensed independent Practitioners ("volunteers") using the modified credentialing process set forth. The grant of disaster Privileges by the Chief Executive Officer is on behalf of and authorized by the Board of Trustees in its approval of this Policy.

(2) Before disaster Privileges are granted, the Hospital will obtain:

(a) the volunteer's valid, government-issued photo identification (e.g., driver's license or passport); and

(b) one of the following:

(i) a current picture or identification card from a health care organization that clearly identifies professional designation;

(ii) a current license to practice;

(iii) primary source verification of licensure;

(iv) identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT), the Medical Reserve Corps (MRC), the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP), or other recognized state or federal response organization or group;

[32] EM.02.02.13

(v) identification indicating that the individual has been granted authority by a government entity to provide patient care, treatment, or services in disaster circumstances; or

(vi) confirmation by a licensed independent practitioner currently privileged by the Hospital or by a staff member with personal knowledge of the volunteer practitioner's ability to act as a licensed independent practitioner during a disaster.

(3) Primary source verification of the following qualifications of the volunteer 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:

(a) current, unrestricted license to practice, which is recognized in this state (*e.g.*, an in-state license, or out-of-state license when authorized through a special waiver issued by the state licensing agency, or by the Governor of this state), that is not subject to any Restrictions, probationary terms, or conditions not generally applicable to all licensees;

(b) current, unrestricted DEA registration (linked to a license recognized in this state), as applicable to the disaster Privileges being sought by the Practitioner;

(c) current, valid professional liability insurance coverage in a form and in amounts, as determined by the Hospital;

(d) evidence of relevant training, experience, and current competence;

(e) the results of a query to the National Practitioner Data Bank; and

(f) confirmation that the individual is not an Ineligible Person by viewing the Office of Inspector General List of Excluded Individuals/Entities or the General Services Administration's Excluded Parties List System (EPLS) and System for Award Management, and Texas OIG Exclusion List.

(4) In extraordinary circumstances when primary source verification of the volunteer's qualifications 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) Disaster Privileges are granted as a temporary courtesy only and do not give rise to any expectation of continued Clinical Privileges at the Hospital. They may be withheld or withdrawn, at any time, in the discretion of the Hospital Emergency Incident Commander (the Chief Executive Officer or his or her designee) or the Operations Chief (if that position is activated as part of the Hospital Emergency Operations Plan), after consulting with the

President of the Medical Staff or the Emergency Operations Plan's designated Medical Staff Director. Disaster Privileges may continue as long as disaster-related patient care coverage needs still exist, up to 120 days. Disaster Privileges do not automatically terminate once the facility Emergency Operations Center (EOC) discontinues operations. disaster Privileges shall terminate automatically, upon Notice to the volunteer, when the disaster is resolved and the immediate needs of patients in the facility can be met by Medical Staff Members and other Practitioners, or if the Hospital finds it is unable to confirm the volunteer's qualifications through the primary source verification process. When disaster Privileges are withdrawn or terminated, the department chairperson or the President of the Medical Staff will assign to another Practitioner with appropriate Clinical Privileges responsibility for the care of patients until they are discharged. Whenever possible, consideration will be given to the wishes of the patient in the selection of a substitute Practitioner.

(6) The following safeguards must be in place to verify that patient safety is assured while care is being provided by volunteers pursuant to disaster Privileges:

(a) Upon granting disaster Privileges to a Practitioner, the Hospital will issue the Practitioner appropriate Hospital security identification and assign that Practitioner to a Medical Staff Member, if possible, with whom to collaborate in the care of disaster victims.

(b) The Medical Staff will oversee the care provided by volunteer Practitioners. The President of the Medical Staff or the Emergency Operations Plan's designated Medical Staff Director will assign a Member of the Medical Staff to provide oversight to each Practitioner who has been granted disaster Privileges. This oversight will be conducted through direct observation, mentoring, clinical record review, or other appropriate mechanism developed by the Medical Staff and Hospital.

4.E. EXCLUSIVE ARRANGEMENTS

(1) From time to time, the Hospital may enter into exclusive contracts or arrangements ("exclusive 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 in accordance with the terms of this Policy.

(2) To the extent that the Board of Trustees by resolution or other arrangement confers the exclusive right to perform specified services to one or more Practitioners or groups of Practitioners or otherwise closes the department or service, then no Practitioners except those authorized by or pursuant to the resolution or arrangement may exercise Clinical Privileges to perform the specified services. Only Practitioners so authorized are eligible to apply for the Clinical Privileges included in the resolution or arrangement.

(3) Prior to the Hospital entering into any exclusive arrangement in a clinical service that has not previously been subject to such arrangement, the Board of Trustees will request the Medical Executive Committee (or a subcommittee of its members appointed by the

Chairperson of the Medical Executive Committee) to review the proposal under consideration by the Board of Trustees and comment on the quality of care and clinical service implications of the proposed arrangement.[33] After providing the Medical Executive Committee the opportunity to comment, the Board of Trustees will consider whether or not to proceed with the exclusive arrangement.

(4) If the Board of Trustees makes a preliminary determination to proceed with an exclusive arrangement that would have the effect of preventing a Practitioner from exercising or renewing Clinical Privileges that had previously been granted, the affected Practitioner is entitled to the following notice and review procedures:

(a) Notice of the proposed exclusive arrangement and the right to request to meet with the Board to discuss the matter prior to the proposed arrangement being executed or finalized.

(b) At the meeting, which shall be at a time and place specified by the Board, the affected Practitioner will be entitled to present information relevant to the decision to enter into the arrangement.

(c) If, following this meeting, the Board determines to enter into the exclusive arrangement, the affected Practitioner will be notified that he or she is ineligible to continue to exercise or to renew the Clinical Privileges covered by the exclusivity. The ineligibility begins on the date specified by the Board.

(d) The procedural rights outlined above will be the Practitioner's exclusive remedy. The provisions in Article 7 of this Policy are inapplicable to this administrative determination.

(e) The inability of a Practitioner to exercise Clinical Privileges because of an exclusive contract or arrangement is not a matter that requires a report to the state licensure board or to the National Practitioner Data Bank.

(5) After the procedures set forth in (3) and (4) of this Section, the Board will make a final determination regarding whether to proceed with the exclusive arrangement.

(6) In the event of any conflict between this Policy or the Medical Staff Bylaws and the terms of any contract or Board resolution, the terms of the contract or Board resolution will control.

4.F. USE OF OUTPATIENT ANCILLARY SERVICES BY NON-PRIVILEGED PRACTITIONERS

Non-Privileged Practitioners may order outpatient diagnostic tests and other outpatient services at the Hospital only in accordance with state and federal law and any Hospital policy governing the use of outpatient ancillary services by Non-Privileged Healthcare Practitioners.

[33] LD.04.03.09

ARTICLE 5
PROCEDURE FOR RENEWAL OF MEMBERSHIP AND CLINICAL PRIVILEGES

5.A. PROCEDURE FOR RENEWAL OF MEMBERSHIP AND CLINICAL PRIVILEGES

All terms, conditions, requirements, and procedures relating to initial Membership and Clinical Privileges will also apply to renewal and continuation of Membership and Clinical Privileges.

5.B. RENEWAL CRITERIA

5.B.1. Eligibility for Renewal:

To be eligible for renewal of Membership and Clinical Privileges and have an Application regarding the same processed, an individual must have, during the previous term of Membership and Clinical Privileges:

(1) completed all medical records such that he or she is not delinquent, as per the Medical Staff Rules and Regulations and Hospital policy, at the time he or she submits the RRFC and Application for renewal of Membership or Clinical Privileges and was not deemed delinquent more than three times during the prior term of Membership or Clinical Privileges.;

(2) completed all continuing medical education requirements;

(3) satisfied all responsibilities applicable to Medical Staff Members and other Practitioners, including payment of any fines and assessments;

(4) continued to meet all qualifications and criteria for Membership and the Clinical Privileges requested;

(5) paid any applicable Application processing fee; and

(6) had sufficient Patient Contacts to enable the assessment of current clinical judgment and competence for any Clinical Privileges requested. Any Practitioner seeking renewal of Membership or Clinical Privileges who has had insufficient Patient Contacts, as determined by Hospital or Medical Staff policy, or who has been requested to submit additional evidence of current clinical competence, must submit such information as has been requested. The Application will not be considered Complete and processed further until the evidence has been received, reviewed, and deemed satisfactory. Information which may be requested includes, but is not limited to, a copy of the individual's confidential quality profile from his or her primary hospital or other organization, clinical information from his or her private office practice or other organization, or a quality profile from a managed care organization or insurer.

5.B.2. Factors for Evaluation:

In considering an Application for renewal of Membership or Clinical Privileges, the factors listed in Section 2.A.4 of this Policy will be considered. Additionally, the following factors will be evaluated as part of the renewal process:

(1) compliance with the Bylaws, rules and regulations, and policies of the Medical Staff and the Hospital;

(2) participation in Medical Staff duties, including committee assignments and emergency call;

(3) the results of the Hospital's performance improvement activities, taking into consideration Practitioner-specific information compared to aggregate information concerning other individuals in the same or similar specialty (provided that, other Practitioners will not be identified);

(4) any ongoing and focused professional practice evaluations, peer review activity, and other evaluations;

(5) feedback received from patients and their families, visitors, or staff; and

(6) other reasonable indicators of continuing qualifications.

5.C. RENEWAL PROCESS

5.C.1. Request for Renewal of Membership and/or Clinical Privileges:

(1) Membership terms and terms of Clinical Privileges will not extend beyond two years.[34] As set forth in Article 3 of this Policy, Membership terms and terms of Clinical Privileges may be for a term that is shorter than two years and may be subject to other conditions.

(2) Practitioners will be provided notification of the need to apply for renewal of Membership and/or Clinical Privileges at least 120 days prior to the expiration of their current term of Membership and/or Clinical Privileges.

(3) Failure to cause a Complete Application for renewal of Membership and/or Clinical Privileges to be submitted to the Medical Staff Office within the prescribed deadline, which shall be included in the renewal notification that is sent to the Practitioner, may result in the automatic expiration of Membership and Clinical Privileges at the end of the then current term.

(4) Applications for Renewal of Membership and/or Clinical Privileges shall be processed in the same manner as Applications for Initial Membership and Clinical Privileges, as outlined in this Policy.

[34] MS.06.01.07, EP 9

5.C.2. Potential Adverse Recommendation:

(1) If the Credentials Committee or the Medical Executive Committee is considering a recommendation to deny the renewal of Membership or Clinical Privileges or to reduce or restrict Clinical Privileges, the committee chairperson will notify the Practitioner of the possible recommendation and invite the Practitioner to meet prior to any final recommendation being made.

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

(3) At the meeting, the Practitioner 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.

(4) This meeting is not an Investigation or hearing, and none of the procedural rules for Investigations or hearings will apply. The Practitioner will not have the right to be represented by legal counsel at this meeting.

ARTICLE 6
MANAGING CONCERNS ABOUT PRACTITIONERS

6.A. OVERVIEW AND GENERAL PRINCIPLES

6.A.1. Options Available to Medical Staff Leaders and Hospital Administration:

(1) This Policy empowers Medical Staff Leaders and Hospital Administration to use various options to gather information and address and resolve concerns about Practitioners. The various options available to Medical Staff Leaders and Hospital Administration and the mechanisms they may use when concerns pertaining to competence, health or behavior are raised are outlined below and include, but are not limited to, the following:

(a) ongoing and focused professional practice evaluation;

(b) clinical competency evaluation;

(c) fitness for practice evaluation;

(d) collegial intervention and progressive steps;

(e) mandatory meetings;

(f) preliminary fact finding;

(g) automatic relinquishment of Membership and Clinical Privileges;

(h) leaves of absence;

(i) precautionary suspension; and

(j) Investigation.

(2) In addition to these options, Medical Staff Leaders and Hospital Administration also have the discretion to determine whether a matter should be handled in accordance with another policy (e.g., the Medical Staff's policies on professionalism, health, and professional practice evaluation/peer review or should be referred to the Medical Executive Committee for further action.

6.A.2. Documentation:

(1) Except as otherwise expressly provided, Medical Staff Leaders and Hospital Administration will document any meeting with a Practitioner that may take place pursuant to the processes and procedures outlined in this Article.

(2) Medical Staff Leaders and Hospital Administration may prepare a letter to the Practitioner summarizing the meeting held with the Practitioner, and the Practitioner may respond to it.

(3) The initial documentation, any letter, and any response to the letter provided by the Practitioner will be maintained in the Practitioner's confidential file.

6.A.3. No Recordings of Meetings:

It is the policy of the Hospital to maintain the confidentiality of all Medical Staff meetings, including, but not limited to, all Medical Peer Review with its discussions relating to credentialing, quality assessment, performance improvement, peer review, and professional practice evaluation activities. The discussions that take place at such meetings are conducted with the expectation of privacy. In addition to existing bylaws and policies governing confidentiality, individuals in attendance at such meetings are prohibited from making audio or video recordings at such meetings unless authorized to do so in writing by the individual chairing the meeting or by the Chief Executive Officer, in which case a copy of the recording must be promptly provided to the Chief Executive Officer following the meeting. This does not prevent or apply to recording by the Medical Staff Services department staff for the sole purpose of preparing minutes of meetings, following which recordings are destroyed.

6.A.4. No Right to Counsel:

(1) The processes and procedures outlined in this Article are designed to be carried out in a non-adversarial manner. Therefore, lawyers will not be present for any meeting that takes place pursuant to this Article. By agreement of the President of the Medical Staff and Chief Executive Officer, an exception may be made to this general rule, in which case both parties will be allowed to have lawyers present.

(2) If the Practitioner refuses to meet without his or her lawyer present, the meeting will be canceled and it will be reported to the Medical Executive Committee that the individual declined to attend the meeting.

6.A.5. No Right to the Presence of Others:

All Medical Peer Review activities, including all activities set forth in this Article, are confidential and privileged to the fullest extent permitted by law. Accordingly, except as permitted in this Article, the Practitioner may not be accompanied by friends, relatives or colleagues when attending a meeting that takes place pursuant to this Article.

6.A.6. Involvement of Supervising/Collaborating Practitioner in Matters Pertaining to Practitioners Under Their Supervision:

If any Medical Peer Review activity, including any activity pursuant to this Article, pertains to the clinical competence or professional conduct of a Practitioner with a Supervising/Collaborating Practitioner, that Supervising/ Collaborating Practitioner will be notified and may be invited to participate subject to compliance with confidentiality requirements.

6.B. ONGOING AND FOCUSED PROFESSIONAL PRACTICE EVALUATION

(1) Practitioners who are initially granted Clinical Privileges, whether at the time of the initial grant, renewal, or during the term of Clinical Privileges, will be subject to focused professional practice evaluation to confirm their competence.[35]

(2) All Practitioners who provide patient care services at the Hospital, pursuant to Clinical Privileges that have been granted, will have their care evaluated on an ongoing basis.[36] This ongoing professional practice evaluation process may include an analysis of data to provide feedback, to validate clinical competence and to identify issues in an individual's professional performance, if any.

(3) Concerns raised about a Practitioner's practice through the ongoing professional practice evaluation process or through a specialty-specific performance measure, a reported concern, or other triggers (e.g., clinical trend or specific case that requires further review, patient feedback, or sentinel event) will be evaluated or otherwise addressed through the focused professional practice evaluation process, as applicable.

(4) Ongoing and focused professional practice evaluation may utilize resources available on the Hospital Medical Staff, other Hospital personnel, or other individuals or organizations outside the Hospital, including external clinical reviewers and other outside consultants. All external/outside individuals or organizations performing ongoing and focused professional practice evaluation activities are doing so on behalf of the Hospital and its Medical Staff leaders and shall be subject to Medical Peer Review confidentiality.

(5) Issues and concerns that cannot be appropriately and constructively resolved through collegial intervention or the relevant policy (e.g., professional practice evaluation/peer review; professionalism; health) shall be referred to the Medical Executive Committee for its review in accordance with Section 6.J of this Policy. Such collegial interventions and other progressive steps, however, are not mandatory prerequisites to Medical Executive Committee review.

6.C. CLINICAL COMPETENCY EVALUATION

(1) A Practitioner may be requested to immediately submit to a partial or complete clinical competency evaluation to determine his or her ability to competently exercise Clinical Privileges.

(2) A request for an evaluation may be made as follows:

(a) of an Applicant, by the Credentials Committee in accordance with Section 3.A.4 of this Policy;

(b) of any Practitioner who has been granted Clinical Privileges, by the Investigating Committee, during an Investigation;

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[35] MS.08.01.01, EP 1

[36] MS.08.01.03

(c) of any Practitioner who has been granted Clinical Privileges, by any one of the following groups, if the group is concerned with the individual's current clinical competence:

(i) at least two Medical Staff Leaders;

(ii) one Medical Staff Leader and one Member of the Hospital Administration;

(iii) any Hospital or Medical Staff committee that conducts Medical Peer Review activities; or

(iv) the Board of Trustees.

(3) The Medical Staff Leaders or committee that requests the evaluation will: (i) identify the individual or program to conduct 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 the reasons for the evaluation with the individual/program performing the evaluation and to allow the individual/program to discuss and report the results of that evaluation to the Medical Staff Leaders or relevant committee.

(4) Failure to obtain the requested evaluation and to do so within the required time frame may result in an Application being withdrawn or an automatic relinquishment of Membership and Clinical Privileges as set forth below.

6.D. FITNESS FOR PRACTICE EVALUATION

(1) A Practitioner may be requested to immediately submit to a partial or complete fitness for practice evaluation to determine his or her ability to safely practice.

(2) A request for an evaluation may be made as follows:

(a) of an Applicant, by the Credentials Committee, in accordance with Section 3.A.4 of this Policy;

(b) of any Medical Staff Member or Practitioner who has been granted Clinical Privileges, by the Investigating Committee, during an Investigation;

(c) of any Practitioner who is requesting reinstatement from a leave of absence that was taken for health reasons;

(d) of any Medical Staff Member or Practitioner who has been granted Clinical Privileges, by any one of the following groups, if the group is concerned with the Practitioner's ability to safely and competently care for patients:

(i) at least two Medical Staff Leaders;

(ii) one Medical Staff Leader and one Member of the Hospital Administration;

(iii) any Hospital or Medical Staff committee that conducts Medical Peer Review activities; or

(iv) the Board of Trustees.

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

(4) Failure to obtain the requested evaluation and to do so within the required time frame may result in an Application being withdrawn or an automatic relinquishment of Membership and Clinical Privileges as set forth below.

6.E. COLLEGIAL INTERVENTION AND PROGRESSIVE STEPS

(1) The use of collegial intervention efforts and progressive steps by Medical Staff Leaders and Hospital Administration is encouraged. All such efforts are fundamental and integral components of the Hospital's professional practice evaluation activities and are confidential and protected in accordance with state law.

(2) The goal of those efforts is to arrive at voluntary, responsive actions by the Practitioner to resolve an issue that has been raised. Collegial efforts and progressive steps may be carried out, within the discretion of Medical Staff Leaders and Hospital Administration, but are not mandatory.

(3) Collegial intervention efforts and progressive steps are part of the Hospital's ongoing and focused professional practice evaluation activities and may include, but are not limited to, the following:

(a) sharing and discussing applicable policies, such as policies regarding appropriate behavior, emergency call obligations, and the timely and adequate completion of medical records;

(b) counseling, mentoring, monitoring, proctoring, consultation, and education, including formal retraining programs;

(c) facilitating a formal collegial intervention meeting (i.e., a planned, face-to-face meeting between an individual and one or more Medical Staff Leaders, Hospital

administrators, and/or Board members) in order to directly discuss a matter and the steps that need to be taken to resolve it;

(d) sharing comparative quality, utilization, and other relevant information, including any variations from clinical protocols or guidelines, in order to assist an individual to conform his or her practice to appropriate norms;

(e) communicating expectations for professionalism and behaviors that promote a culture of safety;

(f) informational letters of guidance, education, or counseling; and

(g) developing a performance improvement plan, which may include a variety of tools and techniques that can result in a constructive and successful resolution of the concern.

6.F. MANDATORY MEETING

(1) Whenever there is a concern regarding a Practitioner's clinical practice or professional conduct, Medical Staff Leaders or members of Hospital administration may require the Practitioner to attend a mandatory meeting.

(2) Special Notice will be given at least three Days prior to the meeting and will inform the Practitioner that attendance at the meeting is mandatory and that an automatic relinquishment will be imposed for failure to attend as provided below.

(3) Failure of a Practitioner to attend a mandatory meeting will result in an automatic relinquishment of Membership and Clinical Privileges as set forth below.

6.G. AUTOMATIC RELINQUISHMENT[37]

Any of the occurrences described in this Section will constitute grounds for the automatic relinquishment of a Practitioner's Membership and Clinical Privileges. An automatic relinquishment, while taken in the course of Medical Peer Review, does not entitle the Practitioner to the rights in Article 7 of this Policy. It is not subject to mandatory reporting to the Practitioner's state licensing agency or the National Practitioner Data Bank.

Except as otherwise provided below, an automatic relinquishment of Membership and Clinical Privileges will be effective immediately upon actual or Special Notice to the Member.

6.G.1. Failure to Complete Medical Records:

Failure of a Practitioner to complete medical records in accordance with applicable policies and rules and regulations, after notification by the medical records department of delinquency, will result in automatic relinquishment of all Clinical Privileges.

[37] MS.01.01.01, EP 28

6.G.2. Failure to Satisfy Threshold Eligibility Criteria:

Failure of a Practitioner to continuously evidence satisfaction of any of the threshold eligibility criteria set forth in Section 2.A.1 of this Policy will result in automatic relinquishment of Membership and Clinical Privileges.

6.G.3. Failure to Provide Information:

(1) Failure of a Practitioner to notify in writing, immediately (and in no event later than one business day after being provided notice of the change), the President of the Medical Staff or Chief Executive Officer of any change in any information provided on or in conjunction with an RFC, RRFC, RFINCP, other request for Clinical Privileges form, or Application for initial or renewed Membership or Clinical Privileges or of their failure to satisfy any of the threshold eligibility criteria set forth in Article 2 of this Policy or failure to provide the additional information required by Section 2.A.3.(3) of this Policy will result in the automatic relinquishment of Membership and Clinical Privileges.

(2) Failure of a Practitioner to provide information pertaining to that Practitioner's qualifications for Membership or Clinical Privileges in response to a written request from the Leadership Council, Credentials Committee, Professional Practice Evaluation Committee, Medical Executive Committee, Board, or any other authorized committee will result in the automatic relinquishment of Membership and Clinical Privileges. The information must be provided within the time frame established by the requesting party. Any relinquishment will continue in effect until the information is provided to the satisfaction of the requesting party.

6.G.4. Criminal Activity:

The occurrence of specific criminal actions will result in the automatic relinquishment of Membership and Clinical Privileges. Specifically, with respect to any felony or misdemeanor pertaining to the following items: (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) domestic, child or elder abuse:

(1) a conviction, plea of guilty or plea of no contest will result in an automatic relinquishment of Membership and all Clinical Privileges; and

(2) an arrest, charge, or indictment will result in automatic relinquishment of Membership and all Clinical Privileges until such time as the appropriate individual or body (MEC, Board, CEO, or CMO) can review the matter to determine whether the circumstances surrounding the arrest, charge, or indictment are such that reinstatement pending resolution of the matter can be granted without affecting patient safety, quality of care, and hospital operations. The burden is on the Practitioner to provide evidence showing that reinstatement is appropriate despite the unresolved concerns raised by the arrest, charge, or indictment. Reinstatement will be within the discretion of the appropriate individual or body (MEC, Board, CEO, or CMO), the decision of which shall be final without recourse to the hearing and appeal processes or any other procedures.

6.G.5. Failure to Attend a Mandatory Meeting:

Failure to attend a mandatory meeting requested by the Medical Staff Leaders or Hospital Administration, after appropriate Special Notice has been given, will result in the automatic relinquishment of Membership and Clinical Privileges. The relinquishment will remain in effect until the Practitioner attends the mandatory meeting and reinstatement is granted as set forth below.

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

Failure of a Practitioner to comply with or complete within required time limits training and educational requirements that are adopted by the Medical Executive Committee and/or required by the Board, including, but not limited to, those pertinent to electronic medical records or patient safety or EMTALA requirements, will result in the automatic relinquishment of Membership and Clinical Privileges.

6.G.7. Failure to Comply with Request for Fitness for Practice Evaluation or a Clinical Competency Evaluation:

Failure of an Applicant or Practitioner to undergo a requested fitness for practice evaluation or clinical competency evaluation and to do so within the requested time frame, to submit to diagnostic testing (such as blood, urine, or hair testing) immediately upon request, 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, for Applicants, be considered a voluntary withdrawal of the Application or, for Practitioners, will result in the automatic relinquishment of Membership and Clinical Privileges.

6.G.8. Reinstatement from Automatic Relinquishment and Automatic Resignation:

(1) A request for reinstatement from an automatic relinquishment following completion of all delinquent records will be processed in accordance with applicable policies and rules and regulations. Failure to complete the medical records that caused relinquishment within the time required will result in automatic resignation from the Medical Staff and resignation of all Clinical Privileges.

(2) Requests for reinstatement from an automatic relinquishment following the expiration or lapse of a license, controlled substance authorization, insurance coverage, or any other failure to satisfy any of the threshold eligibility criteria by virtue of the natural expiration of the Practitioner's qualification, will be processed by the Medical Staff Office. If any questions or concerns are noted, the Medical Staff Office will refer the matter for further review in accordance with subsection (4) of this Section, below.

(3) Requests for reinstatement from an automatic relinquishment related to a criminal arrest or charge will be as set forth in 6.G.4(2) above.

(4) All other requests for reinstatement from an automatic relinquishment will be reviewed by the relevant department chairperson, the chairperson of the Credentials Committee,

the President of the Medical Staff, the Chief Medical Officer, and the Chief Executive Officer. If all these individuals make a favorable recommendation on reinstatement, the Practitioner may immediately resume clinical practice at the Hospital. If, however, any of the individuals reviewing the request have any questions or concerns, those questions will be noted and the reinstatement request will be forwarded to the full Credentials Committee, Medical Executive Committee and Board for review and recommendation.

(5) The Practitioner requesting reinstatement bears the burden of demonstrating that the matter leading to automatic relinquishment has been resolved.

(6) Failure, within 90 Days of a relinquishment, to resolve the matter leading to the automatic relinquishment, provide notice to the Medical Staff Office of the resolution, provide any additional requested information, and be reinstated as set forth above, will result in an automatic resignation from the Medical Staff and resignation of all Clinical Privileges.

(7) An automatic resignation, while taken in the course of Medical Peer Review, does not entitle the Practitioner to the rights in Article 7 of this Policy. It is not subject to mandatory reporting to the Practitioner's state licensing agency or the National Practitioner Data Bank.

6.H. LEAVES OF ABSENCE

6.H.1. Initiation:

(1) A leave of absence of up to two years may be requested by submitting a written request to the Chief Executive Officer. The request should, when possible, state the beginning and ending dates and the reasons for the leave. Except in extraordinary circumstances, the request must be submitted in writing at least 30 Days prior to the anticipated start of the leave.

(2) The Chief Executive Officer will determine whether a request for a leave of absence will be granted, after consulting with the President of the Medical Staff, the relevant department chairperson, and any other individual or committee deemed necessary or desirable. The granting of a leave of absence or reinstatement may be conditioned upon the individual's completion of all medical records.

(3) Practitioners must report to the Chief Executive Officer any time they are away from Medical Staff or patient care responsibilities for longer than 30 consecutive 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 by report of the Practitioner or otherwise), the Chief Executive Officer and/or CMO, in consultation with the President of the Medical Staff, may trigger an automatic medical leave of absence at any point after becoming aware of the Practitioner's absence from patient care. The Practitioner will be sent Special Notice informing him or her that a leave of absence has been triggered.

(4) Except for leaves of absence to fulfill military service obligations, which shall be granted routinely upon receipt of evidence showing deployment orders, 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.H.2. Duties of Practitioners on Leave:

During a leave of absence, the individual will not exercise any Clinical Privileges at the Hospital and will be excused from Medical Staff prerogatives and responsibilities (e.g., meeting attendance, committee service, emergency service call obligations).

6.H.3. Reinstatement:

(1) All Practitioners who have been on a leave of absence must be processed for reinstatement prior to resuming practice at the Hospital.

(2) Practitioners requesting reinstatement will submit a written summary of their activities during the leave, an attestation that no changes have occurred in any information the Practitioner provided on his or her last Application or, if changes have occurred, a detailed description of such changes, and any other information that may be requested by the Hospital.

(3) In addition, if the leave of absence was for health reasons (except for maternity leave), the request for reinstatement must be accompanied by a report from the Physician or other treating health care professional treating the Practitioner, indicating that the Practitioner is capable of resuming a hospital practice and safely exercising the Clinical Privileges requested.

(4) Requests for reinstatement will then be reviewed by the relevant department chairperson, the chairperson of the Credentials Committee, the President of the Medical Staff, the Chief Medical Officer and the Chief Executive Officer. Any of them may request additional information, including a fitness for practice evaluation.

(5) If a favorable recommendation on reinstatement is made, the Chief Executive Officer may grant reinstatement on behalf of the Board and the Practitioner may immediately resume clinical practice. However, if any of the individuals reviewing the request have any questions, those questions will be noted and the reinstatement request will be forwarded to the full Credentials Committee, Medical Executive Committee, and Board.

(6) If a Practitioner's current Membership and/or Clinical Privileges are due to expire during the leave, they will expire at the end of their natural term. The Practitioner will be required to submit an Application for renewal of Membership and Clinical Privileges as part of the reinstatement process.

6.I. PRECAUTIONARY SUSPENSION OR RESTRICTION OF CLINICAL PRIVILEGES[38]

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

(1) Whenever failure to take action may result in imminent danger to the health and/or safety of any individual, the Chief Executive Officer, the President of the Medical Staff, the chairperson of the relevant clinical department, the Chief Medical Officer, the Medical Executive Committee, or the Board Chairperson is authorized to immediately suspend or restrict all or any portion of a Practitioner's Clinical Privileges. On imposition of the precautionary suspension or restriction, the Practitioner is considered under Investigation.

(2) A precautionary suspension or restriction can be imposed at any time, including as a result of a specific concern, the occurrence of a specific event, a pattern of events, or a recommendation by the Medical Executive Committee that would entitle the Practitioner to request a hearing. When possible, prior to the imposition of a precautionary suspension, the person(s) considering the suspension or restriction will meet with the Practitioner and review the concerns that support the suspension or restriction and afford the Practitioner an opportunity to respond.

(3) Precautionary suspension or restriction is taken in the course of Medical Peer Review, but is an interim step and does not imply any final finding regarding the concerns supporting the suspension or restriction.

(4) A precautionary suspension or restriction is effective immediately and will be promptly reported to the Chief Executive Officer, the Chief Medical Officer and the President of the Medical Staff. The Chief Executive Officers and Chief Medical Officers of both campuses also shall be promptly notified. A precautionary suspension or restriction will remain in effect unless it is modified by the Chief Executive Officer or Medical Executive Committee.

(5) The Practitioner will be notified orally or in writing of the precautionary suspension or restriction as soon as possible. Within three Days of the imposition of a suspension or restriction, the Practitioner 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 Special Notice will advise the Practitioner that suspensions or restrictions lasting longer than 30 Days must be reported to the National Practitioner Data Bank and, if applicable, the Practitioner's licensing agency.

(6) If the Practitioner has a Supervising/Collaborating Practitioner, that Supervising/ Collaborating Practitioner will be notified.

6.I.2. Medical Executive Committee Procedure:

(1) Within a reasonable time, not to exceed 14 Days after the imposition of the suspension or restriction, the Medical Executive Committee will review the reasons for the suspension or restriction.

[38] MS.01.01.01, EP 29; The Health Care Quality Improvement Act, 42 U.S.C. §11112(c)

(2) As part of this review, the Practitioner will be invited to meet with the Medical Executive Committee. In advance of the meeting, the Practitioner may submit a written statement and other information to the Medical Executive Committee.

(3) At the meeting, the Practitioner may provide information to the Medical Executive Committee and should respond to any questions that may be raised by committee members. The Practitioner may provide information to the Medical Executive Committee, including alternatives to the precautionary suspension or restriction which will protect patients, employees or others while the matter is being reviewed.

(4) After considering the reasons for the suspension or restriction and the Practitioner's response, if any, the Medical Executive Committee will determine whether there is sufficient information to warrant a final recommendation or whether it is necessary to conduct further Investigation in accordance with Section 6.J. below, and whether the precautionary suspension or restriction should be continued, modified, or lifted during that Investigation.

(5) If the Medical Executive Committee decides to continue the suspension or restriction during further Investigation, it will send the Practitioner written Notice of its decision, including the basis for it.

(6) If the Medical Executive Committee determines it has sufficient information to make a final recommendation, the Medical Executive Committee also shall address whether the precautionary suspension or restriction should be continued, modified or lifted. If the Medical Executive Committee's final recommendation entitles the Practitioner to the procedural rights in Article 7, the procedures in that Article shall apply. If the Medical Executive Committee's final recommendation does not entitle the Practitioner to the procedural rights in Article 7, the recommendation shall be forwarded to the Board for a final decision. The Medical Executive Committee's recommendation on the precautionary suspension or restriction shall be effective immediately pending action by the Board.

(7) There is no right to a hearing under Article 7 or the Bylaws based on a precautionary suspension or restriction itself. The procedures outlined above are deemed to be fair under the circumstances.

(8) Upon the imposition of a precautionary suspension or restriction, the President of the Medical Staff will assign responsibility for the care of any hospitalized patients to another Practitioner with appropriate Clinical Privileges and the Practitioner will be removed from the call schedule. Whenever possible, consideration will be given to the wishes of the patient in the selection of a covering Practitioner with appropriate Clinical Privileges.

6.J. INQUIRIES AND INVESTIGATIONS[39]

6.J.1. Initial Inquiry:

(1) Whenever a serious question has been raised, where collegial efforts have not resolved an issue, or a precautionary suspension or Restriction has been continued regarding any of the following, the matter may be referred to the President of the Medical Staff, the department chairperson, the chairperson of a standing committee, the Chief Medical Officer, the Chief Executive Officer, or the chairperson of the Board:[40]

(a) clinical competence or clinical practice, including patient care, treatment or management and failure to follow adopted protocols and guidelines;

(b) the known or suspected violation of applicable internal and external ethical standards, or the bylaws, policies, rules and regulations, and other adopted standards of the Hospital or the Medical Staff, or applicable laws and regulations;

(c) conduct that is considered lower than the standards of the Hospital or disruptive to the orderly operation of the Hospital or its Medical Staff, including the inability of the Practitioner to work harmoniously with others;

(d) ability to perform, with or without reasonable accommodation, the essential functions of Medical Staff Membership and/or Clinical Privileges; or

(e) the qualifications of the individual for Medical Staff Membership or Clinical Privileges.

(2) The person or committee to whom the concern is referred will make a sufficient inquiry to determine whether the concern is credible and, if so, may forward it to the Medical Executive Committee. If the Practitioner has a Supervising/ Collaborating Practitioner, that Supervising/Collaborating Practitioner may also be notified.

(3) To preserve impartiality, the person to whom the matter is directed shall not be a member of the same practice as, or a relative of, the person that is being reviewed, unless such restriction is deemed not practicable, appropriate, or relevant by the President of the Medical Staff.

(4) No inquiry or other action taken pursuant to this Section will constitute an Investigation.

6.J.2. Initiation of Investigation:

(1) The Medical Executive Committee will review the matter in question, may discuss the matter with the Practitioner, and will determine whether to conduct an Investigation or direct that the matter be handled pursuant to another policy. An Investigation will commence only after a determination by the Medical Executive Committee or the Board.

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39 MS.09.01.01

40 MS.01.01.01, EP 30

(2) The Medical Executive Committee will inform the Practitioner that an Investigation has begun. In rare instances, notification may be delayed if, in the judgment of the Medical Executive Committee, informing the Practitioner immediately might compromise the integrity of the Investigation or disrupt the operation of the Hospital or Medical Staff.

(3) The Board may also determine to commence an Investigation and may delegate the Investigation to the Medical Executive Committee, a subcommittee of the Board, or an ad hoc committee.

6.J.3. Investigative Procedure:

(1) Once a determination has been made to begin an Investigation, the Medical Executive Committee will investigate the matter itself or appoint an individual or committee to do so. The individual or committee conducting the Investigation, including the Medical Executive Committee, will be referred to as the "Investigating Committee" throughout this Article. The Investigating Committee may include individuals who are not Members of the Medical Staff and have not been granted Clinical Privileges at the Hospital. The Investigating Committee will not include any individual who:

(a) is in direct economic competition with the Practitioner being investigated;

(b) is professionally associated with, a relative of, or involved in a referral relationship with, the Practitioner being investigated;

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

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

(2) Whenever the questions raised concern the clinical competence of the Practitioner under review, the Investigating Committee will include a peer of the Practitioner (e.g., Physician, Dentist, Oral Maxillofacial Surgeon, or Podiatrist).

(3) The Investigating Committee may:

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

(b) conduct interviews;

(c) use outside consultants, as needed; or

(d) 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.

(4) As part of the Investigation, the Practitioner will have an opportunity to meet with the Investigating Committee. Prior to this meeting, the Practitioner will be given Special Notice at least 7 Days in advance of the concerns being investigated and will be invited to discuss, explain, or refute the questions or to submit a written statement prior to, or in lieu of, the meeting. A summary of the interview will be made and included with the Investigating Committee's report. This meeting is not a hearing, and none of the procedural rules for hearings will apply. Lawyers will not be present at this meeting.

(5) The Investigating Committee will make a reasonable effort to complete its portion of the Investigation and issue its report within 30 Days, provided that an outside review is not necessary. When an outside review is used, the Investigating Committee will make a reasonable effort to complete its portion of the Investigation and issue its report within 30 Days of receiving the final results of the outside review. These time frames are intended to serve as guidelines and, as such, will not be deemed to create any right for a Practitioner to have the Investigating Committee complete its portion of the Investigation or issue its report within such time periods.

(6) At the conclusion of the Investigating Committee's portion of the Investigation, it will prepare a report to the Medical Executive Committee with its findings, conclusions, and recommendations. The Practitioner is not entitled to the report or any documents included with the report.

6.J.4. MEC Recommendation:

(1) The Medical Executive Committee may accept, modify, or reject any recommendation it receives from an Investigating Committee and shall make a recommendation to the Board in accordance with (2) and (3) of this Section, as set forth below. Specifically, the Medical Executive Committee may:

(a) determine that additional information, inquiry, or Investigation is required and refer the matter to the appropriate individual or body;

(b) determine that no corrective action is indicated;

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

(d) impose conditions for continued Membership and Clinical Privileges;

(e) require monitoring, proctoring or consultation;

(f) require additional training or education;

(g) recommend reduction or restriction of Clinical Privileges;

(h) recommend suspension of Clinical Privileges for a specified period of time;

(i) recommend revocation of Membership or Clinical Privileges; or

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

Recommendations (d)-(j) would be considered corrective action.

(2) Unless the recommendation by the Medical Executive Committee entitles the Practitioner to request a hearing in accordance with Article 7 and except as provided in Section 6.I.2. for a precautionary suspension or restriction, the recommendation will be considered a final action, which will take effect immediately and will remain in effect, unless modified by the Board.

(3) A recommendation by the Medical Executive Committee that would entitle the Practitioner to request a hearing will be forwarded to the Chief Executive Officer, who will promptly inform the individual by Special Notice. All further procedures shall be as set forth in Article 7.

(4) If the Board makes a modification to the recommendation of the Medical Executive Committee that would entitle the Practitioner to request a hearing, the Chief Executive Officer will inform the Practitioner by Special Notice. All further procedures shall be as set forth in Article 7.

(5) If final action has been taken on any matter that was subject to an Investigation or if the Board formally resolves to close an Investigation, the Investigation will be considered concluded.

6.K. Actions Occurring at Other Affiliated Entities

In accordance with Section 2.C.3(3) of this Policy and any other policy governing the sharing of credentialing and other Medical Peer Review information among Affiliated Entities, all Affiliated Entities may share with each other information regarding Medical Peer Review/ professional practice evaluation activities, including but not limited to any activity set forth in this Article 6.

ARTICLE 7
HEARING AND APPEAL PROCEDURES[41]

The procedures set forth in this Article apply only to Members of the Medical Staff and to Physicians, Dentists and Oral Maxillofacial Surgeons, and Podiatrists applying to the Medical Staff or for Clinical Privileges or who have been granted Clinical Privileges. Procedures applicable to Advanced Practice Professionals are set forth in Article 8.

7.A. INITIATION OF HEARING

7.A.1. Grounds for Hearing:

(1) An individual is entitled to request a hearing whenever the Medical Executive Committee makes one of the following recommendations:

(a) denial of initial Medical Staff Membership, renewed Medical Staff Membership, or requested Clinical Privileges;

(b) revocation of Membership or Clinical Privileges;

(c) suspension of Clinical Privileges for more than 30 Days (other than precautionary suspension);

(d) restriction of clinical privileges for more than 30 days that is the result of a professional review action based on clinical competence or professional conduct that leads to the inability of a practitioner to exercise his or her own independent judgment in a professional setting (e.g., a mandatory concurring consultation requirement);

(e) denial of reinstatement from a leave of absence as set forth in Section 6.H.(3), if the reasons relate to professional competence or conduct; or

(f) any other professional review action based on clinical competence or professional conduct for more than 30 days that, if final, is subject to mandatory reporting to the National Practitioner Data Bank, but not including a surrender of Clinical Privileges while under Investigation or in return for not conducting an Investigation or taking a professional review action.

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

(3) If the Board determines to take any of these actions without an adverse recommendation by the Medical Executive Committee, an individual is entitled to request a hearing. For ease of use, this Article refers to adverse recommendations of the Medical Executive Committee. When a hearing is triggered by an adverse proposed action of the Board, any reference in this Article to the "Medical Executive Committee" will be interpreted as a reference to the "Board."

[41] MS.10.01.01; MS.01.01.01, EP 34

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

None of the following actions, including without limitation any others noted in the Bylaws or this Policy, constitute grounds for a hearing. These actions take effect without hearing or appeal. The individual is entitled to submit a written statement regarding these actions for inclusion in his or her file:

(1) a letter of guidance, counsel, warning, or reprimand or placement on probation that does not involve a restriction of Clinical Privileges;

(2) conditions such as monitoring, proctoring, or a general consultation requirement, or that do not require approval of another Practitioner, or any conditions that are imposed during initial FPPE;

(3) a lapse, withdrawal of, or decision not to grant temporary Privileges;

(4) automatic suspension, relinquishment or resignation of Membership or Clinical Privileges;

(5) a requirement for additional training or continuing education during which the Practitioner may continue to exercise Clinical Privileges;

(6) precautionary suspension or restriction;

(7) denial of a request for leave of absence or for an extension of a leave, or activation of a leave of absence on behalf of a Practitioner, by the Chief Executive Officer and/or CMO, in accordance with this Policy;

(8) imposition of any restriction or revocation of Clinical Privileges that is imposed on all similarly situated Practitioners regardless of clinical competence or professional conduct;

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

(10) the voluntary acceptance of a performance improvement plan;

(11) determination that an Application is not Complete or determination that an Application will not be processed due to a misstatement or omission;

(12) a requirement to undergo an appropriate fitness for practice evaluation, which may include diagnostic testing (such as blood, urine, or hair testing) or a complete physical, mental, and/or behavioral evaluation, or therapy or treatment;

(13) determination of ineligibility based on a failure to meet threshold eligibility criteria, a lack of Hospital need or resources, or because of an exclusive contract;

(14) changes to Medical Staff Membership prerogatives (e.g., voting rights, eligibility for committee membership); or

(15) any other collegial intervention as defined in Section 6.E.

7.A.3. Notice of Recommendation:

Within seven (7) Days of the action, the Chief Executive Officer will give Special Notice of a recommendation which entitles an individual to request a hearing.[42] This Special Notice will contain:

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

(2) a statement that the individual has the right to request a hearing on the recommendation within 30 Days of receipt of this Special Notice;[43] and

(3) a summary of the individual's rights at the hearing as set out in Section 7.C.3.(1) and a copy of this Article.

7.A.4. Request for Hearing:

An individual has 30 Days following receipt of the Special Notice to request a hearing, in writing, to the Chief Executive Officer, including the name, address, and telephone number of the individual's counsel, if any. Failure to request a hearing within the required time frame will constitute waiver of the right to a hearing, and the recommendation will be transmitted to the Board for final action.

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

(1) The Chief Executive Officer will schedule the hearing and provide to the individual requesting the hearing, by Special Notice, the following:[44]

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

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

(c) the names of the Hearing Panel members and Presiding Officer (or Hearing Officer) if known; and

(d) a statement of the specific reasons for the recommendation, including a list of patient records (if applicable), and 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.

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42 The Health Care Quality Improvement Act, 42 U.S.C. §11112(b)(1)

43 MS.06.01.09, EP 5 & MS.10.01.01, EP 2

44 The Health Care Quality Improvement Act, 42 U.S.C. §11112(b)(2)

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

7.A.6. Hearing Panel, Presiding Officer, and Hearing Officer:[45]

(1) Hearing Panel:[46]

The Chief Executive Officer, after consulting with the President of the Medical Staff, will appoint a Hearing Panel in accordance with the following guidelines:

(a) The Hearing Panel will consist of at least three members, one of whom will be designated as chairperson. The chairperson will serve as the Presiding Officer when one has not been appointed.

(b) The Hearing Panel may include any combination of:

(i) Members of the Medical Staff; and

(ii) Physicians, Dentists, Oral Maxillofacial Surgeons, Podiatrists, other health care professionals, ~~or laypersons~~ not connected with the Hospital.

(c) Knowledge of the underlying peer review matter, in and of itself, will not preclude the individual from serving on the Hearing Panel.

(d) Employment by, or other contractual arrangement with, the Hospital or an Affiliated Entity will not preclude an individual from serving on the Panel.

(e) The Hearing Panel will not include any individual who:

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

(ii) is professionally associated with, a relative of, or involved in a referral relationship with, 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.

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45 The Health Care Quality Improvement Act, 42 U.S.C. §11112(b)(3)

46 MS.01.01.01, EP 35 & MS.10.01.01, EP 4

(2) Presiding Officer:

(a) The Chief Executive Officer, after consultation with the President of the Medical Staff, may appoint an attorney to serve as Presiding Officer. The Presiding Officer will not act as an advocate for either side at the hearing.

(b) 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.

(c) The Presiding Officer may participate in the private deliberations of the Hearing Panel, may 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.

(3) Hearing Officer:

(a) 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 rules, regulations or policies and not issues of clinical competence, knowledge, or technical skill, the Chief Executive Officer, after consulting with and obtaining the agreement of the President of the Medical Staff, may appoint a Hearing Officer. The Hearing Officer, who should preferably 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.

(b) If a Hearing Officer is appointed instead of a Hearing Panel, all references in this Article to the "Hearing Panel" or "Presiding Officer" will be deemed to refer to the Hearing Officer.

(4) Objections:

Any objection to any member of the Hearing Panel, to the Hearing Officer, or to the Presiding Officer, will be made in writing, within ten Days of receipt of Notice, to the Chief Executive Officer. The objection must include reasons to support it. A copy of the objection will be provided to the President of the Medical Staff. The President of the Medical Staff will be given a reasonable opportunity to comment.

The Chief Executive Officer will rule on any objection to a Presiding Officer or Hearing Officer and give Notice to the parties. The Chief Executive Officer may request that the Presiding Officer make a recommendation as to the validity of the objection. If there is a Presiding Officer, the Presiding Officer will rule on any objections to members of the Hearing Panel.

7.A.7. Counsel:

The Presiding Officer, Hearing Officer, and counsel for either party may be attorneys at law licensed to practice, in good standing, in the state in which the Hospital is located.

7.A.8. Representative:

The President of the Medical Staff or his or her designee will represent the Medical Executive Committee at the hearing. The Chief Executive Officer may appoint an attorney to assist and accompany the MEC representative in the hearing.

7.B. PRE-HEARING PROCEDURES

7.B.1. General Procedures:

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

7.B.2. Witness List:

(1) At least 15 Days before the pre-hearing conference, the parties will exchange a written list of the names of witnesses expected to offer testimony on their behalf.

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

(3) The witness list of either party may, in the discretion of the Presiding Officer, be amended at any time during the course of the hearing, provided that Notice of the change is given to the other party.

7.B.3. Time Frames:

The following time frames, unless modified by mutual written agreement of the parties, will govern the timing of pre-hearing procedures:

(1) the pre-hearing conference will be scheduled at least 14 Days prior to the hearing;

(2) the parties will exchange proposed exhibits at least 10 Days prior to the pre-hearing conference; and

(3) any objections to witnesses and/or proposed exhibits must be provided to the Presiding Officer at least five Days prior to the pre-hearing conference.

7.B.4. Provision of Relevant Information:

(1) Prior to receiving any confidential documents, the individual requesting the hearing and his or her counsel, if any, 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 his or her counsel and any expert(s) have executed Business Associate Agreements in connection with any patient Protected Health Information contained in any documents provided.

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

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

(b) reports of experts relied upon by the Medical Executive Committee that will be presented at the hearing; and

(c) copies of any other documents relied upon by the Medical Executive Committee that will be presented at the hearing.

The provision of this information is not intended to waive any privilege.

(3) The individual will have no right to discovery beyond the above information. Minutes of Medical Staff or other committees may not be introduced in a hearing and are not available to a Practitioner in discovery. No information will be provided regarding other Practitioners. In addition, there is no right to depose, interrogate, or interview witnesses or other individuals prior to the hearing.

(4) Neither the individual, nor any other person acting on behalf of the individual, may contact Hospital employees or Practitioners whose names appear on the Medical Executive Committee's witness list or in documents provided pursuant to this Section concerning the subject matter of the hearing, until the Hospital has been notified and has contacted the individuals about their willingness to be interviewed. The Hospital will advise the individual who requested the hearing once it has contacted such employees or Practitioners, and confirmed their willingness to meet. Any employee or Practitioner may agree or decline to be interviewed by or on behalf of the individual who requested a hearing. The employee or Practitioner may also request to have counsel for the Hospital or MEC present during any meeting.

7.B.5. Pre-Hearing Conference:

(1) The Presiding Officer will require the individual and the Medical Executive Committee (or a representative of each, who may be counsel) to participate in a pre-hearing conference.

(2) 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.

(3) At the pre-hearing conference, the Presiding Officer will resolve all procedural questions, including any objections to exhibits or witnesses, and admit exhibits.

(4) Evidence unrelated to the reasons for the recommendation or to the individual's qualifications for Membership or the relevant Clinical Privileges will be excluded.

(5) The Presiding Officer will establish the time to be allotted to each witness's testimony and cross-examination.

7.B.6. Stipulations:

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

7.B.7. Provision of Information to the Hearing Panel:

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

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

(2) exhibits offered by the parties following the pre-hearing conference (without the need for authentication) that have been admitted at the pre-hearing conference; and

(3) stipulations agreed to by the parties.

7.C. THE HEARING

7.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. Considering the complexity of the case and fundamental fairness, the Presiding Officer may, after considering any objections, modify the time frame for the hearing.

7.C.2. 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.

7.C.3. Rights of Both Sides and the Hearing Panel at the Hearing:[47]

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

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

(b) to introduce exhibits;

(c) to cross-examine any witness;

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

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

(f) to submit proposed findings, conclusions and recommendations to the Hearing Panel.

(2) If the individual who requested the hearing does not testify, he or she may be called and questioned.

(3) The Hearing Panel and the Presiding Officer may question witnesses, request the presence of additional witnesses, or request documentary evidence.

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

The Medical Executive Committee will first present 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 credible evidence.

7.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 evidence that is relevant to the individual's qualifications for Membership and Clinical Privileges will be admitted if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs.

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[47] The Health Care Quality Improvement Act, 42 U.S.C. §11112(b)(3)

7.C.6. Persons to Be Present:

The hearing will be restricted to those individuals involved in the proceeding. The presence of the individual who requested the hearing is mandatory. Administrative personnel may be present as requested by the Chief Executive Officer or the President of the Medical Staff. Witnesses other than parties may not be present in the hearing except when testifying.

7.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 certify that he or she read the entire transcript of the portion of the hearing from which he or she was absent.

7.C.8. Failure to Appear:

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

7.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 Chief Executive Officer for a reasonable period of time and on a showing of good cause.

7.D. HEARING CONCLUSION, DELIBERATIONS, AND RECOMMENDATIONS

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

Consistent with the burden set forth in Section 7.C.4, as well as the burden on the individual to demonstrate that he or she satisfies, on a continuing basis, all criteria for initial Membership, renewed Membership, and Clinical Privileges, the Hearing Panel will recommend in favor of the Medical Executive Committee 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 credible evidence.

7.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 any post-hearing statements or, if requested by the Hearing Panel, the hearing transcript, 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 its findings and recommendation, accompanied by a written report, which will contain a statement of the basis for its recommendation.

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

The Hearing Panel will deliver its report to the Chief Executive Officer. The Chief Executive Officer will send by Special Notice a copy of the report to the individual who requested the hearing. The Chief Executive Officer will also provide a copy of the report to the President of the Medical Staff.

7.E. APPEAL PROCEDURE[48]

7.E.1. Time for Appeal:

(1) Within 10 Days after receipt of Special Notice of the Hearing Panel's recommendation, either party may request an appeal. The request will be in writing, delivered to the Chief Executive Officer by Special Notice, and will include a statement of the reasons for appeal and the specific facts or circumstances which justify further review.

(2) 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.

7.E.2. Grounds for Appeal:

The grounds for appeal will be limited to the following:

(1) there was substantial failure by the Hearing Panel or the Presiding Officer to comply with this Article, so as to deny a fair hearing; or

(2) the recommendations of the Hearing Panel were made arbitrarily or capriciously or were not supported by credible evidence.

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

Whenever an appeal is requested, the chairperson of the Board will schedule and arrange for the appellate review. The individual and the representative of the Medical Executive Committee 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.

7.E.4. Nature of Appellate Review:

(1) The Board may serve as the Appellate Review Panel or the chairperson of the Board may appoint a Review Panel of at least three individuals, composed of members of the Board or others, including but not limited to reputable persons outside the Hospital.

(2) 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 Medical Executive Committee and Hearing Panel and any other

[48] MS.10.01.01, EP 5

information that it deems relevant, and make written findings on the grounds for appeal to the Board.

(3) Each party will have the right to present a written statement in support of its position on appeal. The party requesting the appeal will submit a statement first on the date established by the Review Panel, and the other party will then have 10 Days to respond. In its sole discretion, the Review Panel may allow each party or its representative to appear personally and make oral argument not to exceed 30 minutes.

(4) 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, relevant evidence that was not available at the time of the hearing or that any opportunity to admit it at the hearing was improperly denied.

7.F. BOARD ACTION

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

(1) The Board will take final action within 30 Days after it (i) considers the appeal as a Review Panel, (ii) receives the written findings from a separate Review Panel, or (iii) receives the Hearing Panel's report when no appeal has been requested.

(2) The Board may review any information that it deems relevant, including, but not limited to, the findings and recommendations of the Medical Executive Committee, Hearing Panel, and Review Panel (if applicable).

(3) Consistent with its ultimate legal authority for the operation of the Hospital and the quality of care provided, the Board may adopt, modify, or reverse any recommendation that it receives or refer the matter for further review.

(4) The Board will render its final decision in writing, including the basis for its decision, and will send Special Notice to the individual within 20 Days of the final decision.[49] A copy will also be provided to the President of the Medical Staff.

(5) 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.

7.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.

49 Tex. Health & Safety Code Sec. 241.101(k).

7.G. MEDIATION

7.G.1. Statutory Provision:

(1) A Physician, Dentist, Oral Maxillofacial Surgeon, or Podiatrist who requests and is entitled to mediation under state law[50] based on either:

(a) being subject to a recommendation or action by the Medical Board or the Board of Directors which entitles the individual to a hearing as provided in this Article; or

(b) a belief that the Credentials Committee has not acted on the individual's Complete Application for Medical Staff membership or Clinical Privileges within 90 days of its receipt by the committee

("Eligible Practitioner"), shall be provided with an opportunity for mediation as set forth below.

(2) The Hospital shall have no obligation to offer mediation to Practitioners who are not Eligible Practitioners or to notify an Eligible Practitioner of the statutory right to request mediation.

7.G.2. Request:

(1) The Eligible Practitioner must submit a request for mediation by Special Notice to the Campus Chief Executive Officer within 14 days of:

(a) receipt of the notice of a recommendation or action that entitles the Practitioner to request a hearing as provided by Section 7.A.3. above; or

(b) the 90th day from the Credentials Committee's receipt of a Complete Application.

(2) If both a request for mediation and a request for hearing have been submitted, the mediation shall be conducted first and the timelines for scheduling the hearing temporarily suspended until the mediation is completed.

7.G.3. Conditions of Mediation:

(1) The mediation must be scheduled within 30 days of receipt of the Eligible Practitioner's request, and started and completed within 75 days of receipt of the request.

(2) The Eligible Practitioner and the Hospital will share the costs of the mediator equally. The mediator will be selected by mutual agreement of the Eligible Practitioner and the Chief Executive Officer, and must be qualified as required by state law[51] unless otherwise agreed by the Eligible Practitioner and the Chief Executive Officer.

(3) The mediation shall occur at either the Hospital or the mediator's office, and shall be limited to a half-day of mediation unless otherwise agreed by the Eligible Practitioner and the Chief Executive Officer.

50 Tex. Health & Safety Code Sec. 241.101(d)
51 Tex. Health & Safety Code Sec. 241.101(d)

(4) The Medical Executive Committee or Board, whichever recommended the action entitling the Eligible Practitioner to a hearing, or the Credentials Committee shall be represented in the mediation by the Chief Executive Officer and the President of the Medical Staff, or their designees. Attorneys for the parties may attend and participate in the mediation, as may the Chair of the Board.

7.G.4. Mediation Agreement:

(1) Unless otherwise provided by the Board for a specific mediation, the Hospital's representatives at the mediation shall not have the authority to bind the Hospital to any agreement with the Eligible Practitioner. Any agreement reached during mediation shall be characterized as "proposed," and shall be in writing, signed by the Eligible Practitioner and the Hospital's representatives, and signed by any participating attorneys.

(2) The proposed mediation agreement shall be presented to the Medical Executive Committee at the next available opportunity for a recommendation. The Medical Executive Committee's recommendation and the proposed mediation agreement shall then be presented to the Board for consideration. If the Board approves the proposed mediation agreement, it shall become binding and final, and the Eligible Practitioner will be deemed to have waived all of his or her remaining rights regarding the subject of the mediation including, if applicable, the right to a hearing under the Bylaws. The Chief Executive Officer shall provide the Eligible Practitioner with Special Notice of the approval.

(3) If the Board does not approve the proposed mediation agreement, the Chief Executive Officer will provide the Eligible Practitioner with Special Notice of the lack of approval. In such case, the Eligible Practitioner will retain any applicable procedural rights provided by the Bylaws but has no right to further mediation. Any time lines for procedural rights contained in the Bylaws that were temporarily suspended as a result of the mediation will resume on the date of the Special Notice of the lack of approval.

(4) Under no circumstances may a mediation agreement require any action not permitted by law or require the Hospital, Medical Staff, or Board to violate any legal or accreditation requirement.

ARTICLE 8
CONDITIONS OF PRACTICE APPLICABLE TO
ADVANCED PRACTICE PROFESSIONALS

8.A. CONDITIONS OF PRACTICE APPLICABLE TO ADVANCED PRACTICE PROFESSIONALS

8.A.1. General:

(1) The Board, following consultation with the Medical Executive Committee, shall determine what categories of health care professionals are eligible for Clinical Privileges as Advanced Practice Professionals. Those categories that have been approved are set forth in Appendix A to this Policy. In addition to approving the categories, the Board, following consultation with the Medical Executive Committee, shall approve for each category of APP the delineation of privileges available, the qualifications required, and the level of Supervision required.

(2) As a condition of being granted permission to practice at the Hospital, all Advanced Practice Professionals specifically agree to abide by the standards of practice set forth in the privilege delineation that they have been granted by the Board and the terms of any agreement with their Supervising/Collaborating Practitioner. In addition, as a condition of being permitted to utilize the services of Advanced Practice Professionals in the Hospital, all Practitioners who serve as Supervising/Collaborating Practitioners to such individuals also specifically agree to abide by the applicable standards set forth in this Article and the terms of their agreements.

8.A.2. Oversight by Supervising/Collaborating Practitioner:

(1) If the Medical Staff Membership or Clinical Privileges of a Supervising/Collaborating Practitioner are resigned, revoked or terminated, or the Advanced Practice Professional fails, for any reason, to maintain an appropriate Supervision relationship with a Supervising/Collaborating Practitioner as defined in this Policy, the Advanced Practice Professional's Clinical Privileges will be automatically relinquished, unless he or she has another Supervising/ Collaborating Practitioner who has been approved as part of the credentialing process.

(2) As a condition of Clinical Privileges, an Advanced Practice Professional and the Supervising/Collaborating Practitioner must provide the Hospital with Notice of any revisions or modifications that are made to the agreement between them, as well as any changes in the Supervising/Collaborating Practitioner. This Notice must be provided to the Medical Staff Office within three Days of any such change.

8.A.3. Questions Regarding the Authority of an Advanced Practice Professional:

(1) Should any Member of the Medical Staff, or any employee of the Hospital who is licensed or certified by the state, have a reasonable question regarding the clinical competence or authority of an Advanced Practice Professional to act or issue instructions outside the presence of the Supervising/Collaborating Practitioner, such individual will have the right to request that the Supervising/Collaborating Practitioner validate, either at the time or

later, the instructions of the Advanced Practice Professional. Any act or instruction of the Advanced Practice Professional will be delayed until such time as the individual with the question has ascertained that the act is clearly within the Clinical Privileges granted to the individual and the agreement with the Supervising/Collaborating Practitioner.

(2) Any question regarding the conduct of an Advanced Practice Professional will be reported to the President of the Medical Staff, the Chairperson of the Credentials Committee, the relevant department chair, the Chief Medical Officer, or the Chief Executive Officer for appropriate action. The individual to whom the concern has been reported will also discuss the matter with the Supervising/Collaborating Practitioner as soon as feasible.

8.A.4. Responsibilities of Supervising/Collaborating Practitioners:

(1) Practitioners who wish to utilize the services of an Advanced Practice Professional in their clinical practice at the Hospital must notify the Medical Staff Office of this fact in advance and must ensure that the individual has been appropriately credentialed in accordance with this Policy before the Advanced Practice Professional performs services or engages in any kind of activity in the Hospital.

(2) The number of Advanced Practice Professionals acting under the Supervision of one Practitioner, as well as the care they may provide, will be consistent with applicable state statutes and regulations and any other policies adopted by the Hospital. The Supervising/Collaborating Practitioner will make all appropriate filings with state licensing agencies regarding the Supervision and responsibilities of the Advanced Practice Professional, to the extent that such filings are required.

8.B. PROCEDURAL RIGHTS FOR ADVANCED PRACTICE PROFESSIONALS

8.B.1. Notice of Recommendation and Hearing Rights:

(1) In the event of a recommendation by the Medical Executive Committee that an initial application for Clinical Privileges by an Advanced Practice Professional be denied or restricted, the recommendation shall be forwarded directly to the Board for a final decision. If the Board approves the recommendation, the Advanced Practice Professional will receive Special Notice of the decision, including a statement of the reason for the denial or restriction, within 20 Days of the final decision. The Advanced Practice Professional is not entitled to any other procedural rights under this Policy in connection with the denial or restriction.

(2) In the event a recommendation is made by the Medical Executive Committee that the Clinical Privileges previously granted to an Advanced Practice Professional be restricted, terminated, or not renewed, the individual will receive Special Notice of the recommendation. The Special Notice will include a general statement of the reasons for the recommendation and will advise the individual that he or she may request the procedural rights provided in this Section.

(3) The rights and procedures in this Section will also apply if the Board, without a prior adverse recommendation from the Medical Executive Committee, makes a

recommendation not to grant Clinical Privileges or that the Clinical Privileges previously granted be restricted, terminated, or not renewed. In this instance, all references in this Article to the Medical Executive Committee will be interpreted as a reference to the Board.

(4) If the Advanced Practice Professional is entitled to and wants to request a hearing, the request must be made in writing, directed to the Chief Executive Officer, within 30 Days after receipt of written notice of the adverse recommendation.

(4) The hearing will be convened as soon as is practical, but no sooner than 30 Days after the Special Notice to the Advanced Practice Professional of the time, date and place of the hearing, unless an earlier hearing date has been specifically agreed to by the parties.

8.B.2. Hearing Panel:

(1) If a request for a hearing is made timely, the Chief Executive Officer, in consultation with the President of the Medical Staff, will appoint a Hearing Panel composed of up to three individuals (including, but not limited to, Members of the Medical Staff, Hospital management, individuals not connected with the Hospital, or any combination of these individuals). A peer of the Advanced Practice Professional will be included if feasible. The Hearing Panel will not include anyone who previously participated in the recommendation, any relatives or practice partners, including the Supervising/Collaborating Practitioner of the Advanced Practice Professional, or any competitors of the affected individual.

(2) The Chief Executive Officer, in consultation with the President of the Medical Staff, may appoint a Presiding Officer ("Presiding Officer"), who may be an attorney. The role of the Presiding Officer will be to 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. The Presiding Officer will maintain decorum throughout the hearing and provide guidance to the Hearing Panel. The Presiding Officer may also require a pre-hearing exchange of exhibits for the hearing and filing of objections. If a Presiding Officer is not appointed, the Chief Executive Officer shall designate a member of the Hearing Panel to serve as chair and carry out the same functions.

(3) As an alternative to a Hearing Panel in matters in which the underlying recommendation is based upon concerns involving behavior, sexual harassment, and/or compliance with Medical Staff rules, regulations and/or policies, and does not involve issues of clinical competence, the Chief Executive Officer, in consultation with the President of the Medical Staff, may appoint a Hearing Officer to perform the functions that would otherwise be carried out by the Hearing Panel. The Hearing Officer will preferably be an attorney at law. The Hearing Officer may not be in direct economic competition with the individual requesting the hearing and will not act as a prosecuting officer or as an advocate to either side at the hearing. In the event a Hearing Officer is appointed instead of a Hearing Panel, all references in this Article to the Hearing Panel or Presiding Officer will be deemed to refer instead to the Hearing Officer, unless the context would clearly otherwise require.

8.B.3. Hearing Process:

(1) A record of the hearing will be maintained by a stenographic reporter or by a recording of the proceedings, at the selection of the Hospital. Copies of the transcript will be available at the individual's expense.

(2) The hearing will last no more than six hours, with each side being afforded approximately three hours to present its case, in terms of both direct and cross-examination of witnesses.

(3) At the hearing, a representative of the Medical Executive Committee (through an appointed representative) will first present the reasons for the recommendation. The Advanced Practice Professional will be invited to present information to refute the reasons for the recommendation.

(4) Both parties will have the right to present witnesses. The Presiding Officer will permit reasonable questioning of such witnesses.

(5) The Advanced Practice Professional and the Medical Executive Committee may be represented at the hearing by legal counsel. However, while counsel may be present at the hearing, counsel will not call, examine, or cross-examine witnesses or present the case.

(6) The Advanced Practice Professional will have the burden of demonstrating, by clear and convincing evidence, that the recommendation that prompted the hearing was arbitrary, capricious, or not supported by substantial evidence.

(7) The Advanced Practice Professional and the Medical Executive Committee will have the right to submit proposed findings, conclusions, and recommendations, as well as a post-hearing statement, for consideration by the Hearing Panel. The Presiding Officer will establish a reasonable schedule for the submission of these items. The hearing will be considered to have concluded on the date that any post-hearing statements are required by the Hearing Officer to be submitted.

(8) The personal presence of the Advanced Practice Professional who requested the hearing is mandatory. If such individual does not testify, he or she may be called and questioned. Failure to appear shall constitute a waiver of the right to a hearing and any other rights of review.

(9) The Hearing Panel may question witnesses, request the presence of additional witnesses, or request documentary evidence.

8.B.4. Hearing Panel Report:

(1) Within 20 Days after the conclusion of the hearing, the Hearing Panel will prepare a written report of its findings and recommendation, which shall include the reason for the recommendation. The Hearing Panel will forward the report and recommendation, along with all supporting information, to the Chief Executive Officer. The Chief Executive Officer will send a copy of the written report and recommendation by Special Notice to the Advanced Practice Professional and to the President of the Medical Staff and the Medical Executive Committee's representative.

(2) Within 10 Days after Special Notice of such recommendation, the Advanced Practice Professional and/or the Medical Executive Committee may make a written request for an appeal. The request must include a statement of the reasons, including specific facts, which justify an appeal.

(3) The grounds for appeal will be limited to an assertion that there was substantial failure to comply with this Policy during the hearing, so as to deny a fair hearing, and/or that the recommendation of the Hearing Panel was arbitrary, capricious, or not supported by substantial evidence.

(4) The request for an appeal will be delivered to the Chief Executive Officer by Special Notice.

(5) If a written request for appeal is not submitted timely, the appeal is deemed to be waived and the recommendation and supporting information will be forwarded to the Board for final action. If a timely request for appeal is submitted, the Chief Executive Officer will forward the report and recommendation, the supporting information and the request for appeal to the Board. The Chairperson of the Board will arrange for an appeal.

8.B.5. Appellate Review:

(1) An Appellate Review Committee appointed by the Chairperson of the Board will consider the record upon which the adverse recommendation was made and any written statements as provided below. New or additional written information that is relevant and could not have been made available to the Hearing Panel may be considered at the discretion of the Appellate Review Committee. This review will be conducted within 30 Days after receiving the request for appeal.

(2) The Advanced Practice Professional and the Medical Executive Committee will each have the right to present a written statement on appeal. The party appealing shall be required to submit a statement first on the date established by the Appellate Review Committee. The other party may file a written statement in response within 10 Days of receipt of that statement.

(3) Upon completion of the review, the Appellate Review Committee will provide a written report of its findings to the full Board for action. The Board will then make its final decision based upon the Board's ultimate legal responsibility to grant Clinical Privileges and to authorize the performance of clinical activities at the Hospital.

(4) The Advanced Practice Professional will receive Special Notice of the Board's action within 20 days of the final action.[52] A copy of the Board's final action will also be sent to the Medical Executive Committee for information.

52 Tex. Health & Safety Code Sec. 241.101(k).

ARTICLE 9
CONFLICTS OF INTEREST

* Appendix B includes a chart that provides guidance for implementing these conflict of interest rules.

(1) General Principles:

(a) Anyone involved in Medical Peer Review activities, including, but not limited to, credentialing, professional practice evaluation or other hospital or medical staff activities must be sensitive to potential conflicts of interest in order to be fair to the individual 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 Medical Peer Review activities in order for these activities to be meaningful and effective. Therefore, whether and how an individual can participate must be evaluated reasonably, taking into consideration common sense and objective principles of fairness.

(2) Practitioner and Immediate Family Members:

No Practitioner may participate in the review of his or her own Application or the professional practice evaluation of care he or she provided, except to provide information. No immediate family member (spouse or domestic partner, parent, child, sibling, or in-law) of a Practitioner whose Application or provision of care is being reviewed will participate in any aspect of the review process, except to provide information.

(3) Relevant Treatment Relationship:

An individual who has provided professional health services to a Practitioner whose Application or provision of care is under review shall not participate in the review process regarding the Practitioner except as follows:

(a) if the patient-physician relationship has terminated and the review process does not involve the health condition for which the Practitioner sought professional health services;

(b) to provide information that was not obtained through the treatment relationship; or

(c) to provide information that was obtained through the treatment relationship, as authorized by the Practitioner.

(4) Employment by or Contractual Relationship with the Hospital:

Employment by, or other contractual arrangement with, the Hospital or an Affiliated Entity will not, in and of itself, preclude an individual from participating in Medical Peer Review activities. Rather, participation by such individuals will be evaluated as outlined in the paragraphs below.

(5) Actual or Potential Conflict Situations:

With respect to a Practitioner whose Application or provision of care is under review, actual or potential conflict situations involving other Practitioners include, but are not limited to, the following. Any individual who has an actual or potential conflict listed below shall be referred to as an "Interested Person" in the remainder of this Article, for ease of reference:

(a) significant financial relationship (e.g., members of small, single specialty group; significant referral relationships; partners in business venture);

(b) direct competition;

(c) close friendship;

(d) a history of personal conflict;

(e) personal involvement in the care that is subject to review;

(f) raising the concern that triggered the review; and

(g) prior participation in the review of the matter at a previous level.

(6) Guidelines for Participation in Medical Peer Review Activities:

An Interested Person will have the obligation to disclose any actual or potential conflict of interest. When an actual or potential conflict situation exists as outlined in the paragraph above, the following guidelines will be used.

(a) Initial Reviewers. An Interested Person may participate as an initial reviewer in situations where a check and balance is provided by subsequent review by a Medical Staff committee. For example, this applies, but is not limited to, the following situations:

(i) participation in the review of Applications for initial and renewed Membership and Clinical Privileges (which are subsequently reviewed by the Credentials Committee and/or Medical Executive Committee); and

(ii) participation as a case reviewer in professional practice evaluation activities (which are subsequently reviewed by the Professional Practice Evaluation Committee, Investigating Committee, and/or Medical Executive Committee).

(b) Credentials Committee, Professional Practice Evaluation Committee, or Leadership Council Member. An Interested Person may fully participate as a member of these committees because these committees do not make any final recommendation that could adversely affect the Clinical Privileges of a Practitioner, which is only within the authority of the Medical Executive Committee. However, the chairs of these committees always have the discretion to recuse an Interested Person if they determine that the Interested Person's presence would inhibit full and fair discussion of the issue, would skew the

recommendation or determination of the committee, or otherwise be unfair to the Practitioner under review.

(c) Investigating Committee. Once an Investigation has been initiated, additional precautions are required. Therefore, an Interested Person may not be appointed as a member of an investigating committee, but may be interviewed and provide information to the investigating committee if necessary for the committee to conduct a full and thorough Investigation.

(d) Medical Executive Committee. An Interested Person will be recused and may not participate as a member of the Medical Executive Committee when the Medical Executive Committee is considering a recommendation that could adversely affect the Clinical Privileges of a Practitioner, subject to the rules for recusal outlined below.

(e) Board. An Interested Person will be recused and may not participate as a member of the Board when the Board is considering a recommendation that could adversely affect the Clinical Privileges of a Practitioner, subject to the rules for recusal outlined below.

(7) Guidelines for Participation in Development of Privileging Criteria:

Recognizing that the development of privileging criteria can have a direct or indirect financial impact on particular Practitioners, the following guidelines apply. Any individual who has a personal interest in privileging criteria, including criteria for Clinical Privileges that cross specialty lines or Practitioner categories or criteria for New Procedures, as defined in Article 4, Part A of this Policy, may:

(a) provide information and input to the Credentials Committee, or an ad hoc committee charged with development of such criteria;

(b) participate in the discussions or actions of the Credentials Committee, or an ad hoc committee charged with development of such criteria because these committees do not make the final recommendation regarding the criteria (however, the chairperson of the Credentials Committee or ad hoc committee always has the discretion to recuse an Interested Person in a particular situation); but

(c) not participate in the discussions or action of the Medical Executive Committee when it is considering its final recommendation to the Board regarding the criteria or participate in the final discussions or action of the Board related to the criteria.

(8) Rules for Recusal:

(a) When determining whether recusal in a particular situation is required, the President of the Medical Staff or Board or committee chair will consider whether the Interested Person's presence would inhibit full and fair discussion of the issue, would skew the recommendation or determination of the committee, or otherwise be unfair to the Practitioner under review.

(b) Any Interested Person who is recused from participating in a committee or Board meeting must leave the meeting room prior to the committee's or Board's final deliberation and determination, but may answer questions and provide input before leaving.

(c) Any recusal will be documented in the committee's or Board's minutes.

(d) Whenever possible, an actual or potential conflict should be brought to the attention of the President of the Medical Staff or committee/Board chair, a recusal determination made, and the Interested Person informed of the recusal determination prior to the meeting.

(9) <u>Other Considerations</u>:

(a) Any Practitioner who is concerned about a potential conflict of interest on the part of any other Practitioner, including but not limited to the situations noted in the paragraphs above, must call the conflict of interest to the attention of the President of the Medical Staff or the applicable committee/Board chair. The Member's failure to notify will constitute a waiver of the claimed conflict. The President of the Medical Staff or the applicable committee/Board chair has the authority to make a final determination as to how best to manage the situation, guided by this Article, including recusal of the Interested Person, if necessary. If the President of the Medical Staff or the applicable committee/Board is the individual reported to have a conflict of interest, the Vice-President, vice chairperson of the committee, or another officer of the Board (as determined by the corporate bylaws), as applicable, shall be authorized to make final determinations regarding management of the conflict.

(b) No Practitioner has a right to compel the disqualification of another Practitioner or Hospital representative based on an allegation of conflict of interest. Rather, the determination is within the discretion of the Medical Staff Leaders or Board chair, guided by this Article.

(c) The fact that an individual chooses to refrain from participation or is excused from participation in any Medical Peer Review activity will not be interpreted as a finding of actual conflict that inappropriately influenced the review process.

ARTICLE 10
ADOPTION AND AMENDMENTS

(1) This Policy is adopted and made effective upon approval of the Board, superseding and replacing any and all other conflicting policies and rules and regulations of the Medical Staff or Hospital pertaining to the subject matter thereof.

(2) The amendment process for this Policy is set forth in the Bylaws.

Adopted by the Medical Staff: **July 15, 2020**

Approved by the Board of Trustees: **July 28, 2020**

APPENDIX A
ADVANCED PRACTICE PROFESSIONALS

The Advanced Practice Professionals currently practicing at the Hospital are as follows:

Physician Assistants (PAs)
Nurse Practitioners (NPs)
Certified Registered Nurse Anesthetists (CRNAs)
Clinical Psychologists
Clinical Nurse Specialists (CNSs)

APPENDIX B

CONFLICT OF INTEREST GUIDELINES

Potential Conflicts	Levels of Participation								
	Provide Information	Individual Reviewer Application/ Case	Committee Member					Hearing Panel	Board
			Credentials	Leadership Council	PPEC	MEC[53]	Investigating Committee		
Employment/contract relationship with hospital	Y ‡	Y ‡	Y ‡	Y ‡	Y ‡	Y ‡	Y ‡	Y ‡	Y ‡
Self or family member	Y ‡	N ★	R ☀	R ☀	R ☀	R ☀	N ★	N ★	R ☀
Relevant treatment relationship*	Y ‡	N ★	R ☀	R ☀	R ☀	R ☀	N ★	N ★	R ☀
Significant financial relationship	Y ‡	Y ◊	Y ◊	Y ◊	Y ◊	R ☀	N ★	N ★	R ☀
Direct competitor	Y ‡	Y ◊	Y ◊	Y ◊	Y ◊	R ☀	N ★	N ★	R ☀
Close friends	Y ‡	Y ◊	Y ◊	Y ◊	Y ◊	R ☀	N ★	N ★	R ☀
History of conflict	Y ‡	Y ◊	Y ◊	Y ◊	Y ◊	R ☀	N ★	N ★	R ☀
Provided care in case under review (but not subject of review)	Y ‡	Y ◊	Y ◊	Y ◊	Y ◊	R ☀	N ★	N ★	R ☀
Involvement in prior PIP or disciplinary action	Y ‡	Y ◊	Y ◊	Y ◊	Y ◊	R ☀	N ★	N ★	R ☀
Formally Raised the concern	Y ‡	Y ◊	Y ◊	Y ◊	Y ◊	R ☀	N ★	N ★	R ☀

‡ **Y** – (green "Y") means the Interested Member may serve in the indicated role; no extra precautions are necessary.

◊ **Y** – (yellow "Y") means the Interested Member may generally serve in the indicated role. It is legally permissible for Interested Members to serve in these roles because of the check and balance provided by the multiple levels of review and the fact that the Credentials Committee, Leadership Council, and PPEC have no disciplinary authority. In addition, the Chair of the Credentials Committee, Leadership Council, or PPEC always has the authority and discretion to recuse a member in a particular situation if the Chair determines that the Interested Member's presence would (i) inhibit the full and fair discussion of the issue before the committee, (ii) skew the recommendation or determination of the committee, or (iii) otherwise be unfair to the Practitioner under review.

★ **N** – (red "N") means the Interested Member should not serve in the indicated role.

☀ **R** – (red "R") means the Interested Member should be recused, in accordance with the guidelines on the next page.

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RULES FOR RECUSAL	
STEP 1 Confirm the conflict of interest	The Committee Chair or Board Chair should confirm the existence of a conflict of interest relevant to the matter under consideration.
STEP 2 Participation by the Interested Member at the meeting	The Interested Member may participate in any part of the meeting that does not involve the conflict of interest situation. When the matter implicating the conflict of interest is ready for consideration, the Committee Chair or Board Chair will note that the Interested Member will be excused from the meeting prior to the group's deliberation and decision-making. Prior to being excused, the Interested Member may provide information and answer any questions regarding the following: (i) any factual information for which the Interested Member is the original source; (ii) clinical expertise that is relevant to the matter under consideration; (iii) any policies or procedures that are applicable to the committee or Board or are relevant to the matter under consideration; (iv) the Interested Member's prior involvement in the review of the matter at hand (for example, an Investigating Committee member may describe the Investigating Committee's activities and present the Investigating Committee's written report and recommendations to the MEC prior to being excused from the meeting); and (v) how the committee or Board has, in the past, managed issues similar or identical to the matter under consideration.
STEP 3 The Interested Member is excused from the meeting	The Interested Member will then be excused from the meeting (i.e., physically leave the meeting room and/or disconnect from any telephone or other electronic connection) prior to the committee's or Board's deliberation and decision-making.
STEP 4 Record the recusal in the minutes	The recusal should be documented in the minutes of the committee or Board. The minutes should reflect the fact that the Interested Member was excused from the meeting prior to deliberation and decision-making.