MEDICAL STAFF BYLAWS AND POLICIES
OF

MUNSON HEALTHCARE
CHARLEVOIX HOSPITAL
MEDICAL STAFF
CREDENTIALS POLICY

FINAL VERSION

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ARTICLE 1

GENERAL

1.A. DEFINITIONS

The following definitions shall apply to terms used in this Policy:

(1) "ADVANCED PRACTICE PROVIDERS" or "APPs" means a type of provider who provides a medical level of care or performs surgical tasks consistent with granted clinical privileges, but who may be required by law and/or the Hospital to exercise some or all of those clinical privileges under the direction of, or in collaboration with, a Collaborating/Supervising Physician pursuant to a written supervision, collaborative, or practice agreement. See **Appendix A**.

(2) "APPOINTMENT" means the granting of membership to the Medical Staff by the Board to one of the defined categories outlined in Article 2 of the Medical Staff Bylaws. For ease of use, when applicable to an LIP, any references to "Appointment" shall be interpreted as a reference to initial permission to practice.

(3) "BOARD" means the Board of Trustees of the Hospital, or its designated committee.

(4) "CHIEF EXECUTIVE OFFICER" ("CEO") means the individual appointed by the Board to act on its behalf in the overall management of the Hospital.

(5) "CHIEF MEDICAL OFFICER" ("CMO") means the individual appointed by the CEO to act as the chief medical officer of the Hospital, in cooperation with the Chief of Staff.

(6) "CLINICAL PRIVILEGES" or "PRIVILEGES" means the authorization granted by the Board to render specific patient care services, for which the Medical Staff Leaders and Board have developed eligibility and other credentialing criteria and focused and ongoing professional practice evaluation standards.

(7) "COLLABORATING/SUPERVISING PHYSICIAN" means a physician member of the Medical Staff with clinical privileges, who has agreed to supervise, collaborate with, participate with, or function within a practice or collaborative agreement with, an APP and to accept responsibility for the actions of the APP while he or she is practicing in the Hospital.

(8) "COLLABORATION/SUPERVISION" means the supervision of, collaboration with, participation with, or functioning within the terms of a practice or collaborative agreement with, an APP by a Collaborating/Supervising Physician, that may or may not require the actual presence of the Collaborating/Supervising

Physician, but that does require, at a minimum, that the Collaborating/Supervising Physician be readily available for consultation as defined in the Medical Staff rules, regulations, and policies. The requisite level of Collaboration/Supervision shall be determined at the time each APP is credentialed and shall be consistent with any applicable written supervision, collaboration, or practice agreement that may exist.

(9) "CONFIDENTIAL FILE" means any file (paper or electronic) that is maintained by the Hospital which contains the credentialing, privileging, professional practice evaluation ("PPE")/peer review, or quality information related to an individual who has been granted clinical privileges and/or Medical Staff appointment. All Confidential Files are proprietary records of the Hospital and may only be accessed for legitimate credentialing, privileging, and PPE/peer review purposes or in accordance with Hospital policy.

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

(11) "DAYS" means calendar days.

(12) "DENTIST" means a Doctor of Dental Surgery ("D.D.S.") licensed by the State of Michigan or Doctor of Dental Medicine ("D.D.M.") licensed by the State of Michigan.

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

(14) "GOOD STANDING" means, at the time of assessment of standing, neither an individual's membership nor privileges are involuntarily limited, restricted, suspended, or otherwise encumbered for disciplinary reasons.

(15) "HOSPITAL" means Munson Healthcare Charlevoix Hospital.

(16) "LICENSED INDEPENDENT PRACTITIONER" or "LIP" means a type of provider who is permitted by law and by the Hospital to provide patient care services without direction or collaboration/supervision, within the scope of his or her license and consistent with the clinical privileges granted. See **Appendix B**.

(17) "MEDICAL DIRECTOR" means a member who is assigned administrative duties and who also performs clinical services for which clinical privileges are required.

(18) "MEDICAL EXECUTIVE COMMITTEE" ("MEC") means the Executive Committee of the Medical Staff.

(19) "MEDICAL STAFF" means all physicians, dentists, and APPs who have been appointed to the Medical Staff by the Board.

(20) "MEDICAL STAFF LEADER" means any Medical Staff Officer and committee chair.

(21) "MEDICAL STAFF SERVICES" means the Medical Staff Office at the Hospital or any delegated Credentials Verification Organization ("CVO").

(22) "MEDICAL STAFF MEMBER" means any physician, dentists, and APPs who has been granted Medical Staff Appointment by the Board.

(23) "MUNSON HEALTHCARE ENTITIES" means Entities that are controlled by or integrated with Munson Healthcare, including, but not limited to, the following entities, as well as those individuals, committees, and boards who act on their behalf:

- any Munson Healthcare hospital;
- any Munson Healthcare clinic or surgery center;
- any Munson Healthcare physician group; or
- any Munson Healthcare long term care entity.

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

(25) "ORGANIZED HEALTH CARE ARRANGEMENT" ("OHCA") means the term used by the HIPAA Privacy Rule which permits the Hospital and Medical Staff to use joint notice of privacy practices information when patients are admitted to the Hospital. Practically speaking, being part of an OHCA allows practitioners to rely upon the Hospital notice of privacy practices and therefore relieves them of their responsibility to provide a separate notice when they consult or otherwise treat Hospital inpatients.

(26) "PATIENT CONTACTS" includes any admission, evaluation, treatment, service, consultation, procedure, or response to emergency call performed in the Hospital or its outpatient facilities. It shall not include referrals for diagnostic or laboratory tests.

(27) "PERFORMANCE IMPROVEMENT PLAN" or "PIP" means a plan aimed at helping a practitioner improve his or her clinical performance or professionalism

when issues have been identified by the Medical Staff leaders. PIPs are voluntary in nature which means that no practitioner is obligated to participate in such a plan if he or she disagrees with the basis for the plan.

(28) "PERMISSION TO PRACTICE" means the authorization granted to an LIP to practice at the Hospital.

(29) "PHYSICIAN" means an individual with an M.D. or D.O. degree who is licensed by the State of Michigan to practice medicine.

(30) "PRACTITIONER" means any individual who has been granted clinical privileges and/or appointment by the Board, including, but not limited to, Medical Staff Members and LIPs.

(31) "PRESIDING OFFICER" means the individual who chairs a meeting of the Medical Staff or a committee.

(32) "REAPPOINTMENT" means the granting of continued Appointment to the Medical Staff, and LIP Staff by the Board. For ease of use, when applicable to an LIP, any reference to "Reappointment" shall be interpreted as a reference to continued permission to practice.

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

(34) "SPECIAL PRIVILEGES" means privileges that fall outside of the core privileges for a given specialty, which require additional education, training, and/or experience beyond that required for core privileges in order to demonstrate competence.

(35) "TELEMEDICINE" means the exchange of medical information from one site to another via electronic communications for the purpose of providing patient care, treatment, and services.

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

(37) "VOTING STAFF" means those practitioners who have been given the right to vote in all general and special meetings of the Medical Staff. Voting rights are defined in the prerogatives of each Medical Staff category in Article 2 of the Medical Staff Bylaws.

1.B. DELEGATION OF FUNCTIONS

(1) When an administrative function under this Policy is to be carried out by a member of Hospital management (i.e. the CEO or CMO), by a Medical Staff member or other practitioner, or by a Medical Staff committee, the individual, or the committee through its chair, may delegate performance of the function to a qualified designee who is a practitioner or Hospital employee (or a committee of such individuals). Any such designee is bound by all the terms, conditions and requirements of this Policy. However, the delegating individual or committee is responsible for ensuring the designee performs the function as required by this Policy. Any documentation created by the designee are records of the committee that is ultimately responsible for the review in a particular matter.

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

1.C. OTHER PRACTITIONERS

Unless specified otherwise, practitioners who seek permission to practice at the Hospital as an LIP shall be subject to the same terms and conditions of appointment and reappointment as specified for Medical Staff members. Applications for permission to practice as an LIP shall be submitted and processed in the same manner as outlined for Medical Staff members in this Policy.

ARTICLE 2

QUALIFICATIONS, CONDITIONS, AND RESPONSIBILITIES

2.A. QUALIFICATIONS

2.A.1. Threshold Eligibility Criteria:

(a) To be eligible to apply for initial appointment or reappointment to the Medical Staff or LIP Staff, individuals must:

(1) have a current, unrestricted license to practice in Michigan that is not subject to probation and have never had a license to practice revoked, denied, or suspended by any state licensing agency;

(2) where applicable to their practice, have a current, unrestricted DEA registration;

(3) be located (office and/or residence) close enough to fulfill Hospital and any assigned Medical Staff responsibilities in accordance with the timelines outlined in the Medical Staff Rules and Regulations and applicable policies;

(4) have current, valid professional liability insurance coverage in a form and in amounts determined by the Board;

(5) have never been convicted of, or entered a plea of guilty or no contest to, Medicare, Medicaid, or other federal or state governmental or private third-party payer fraud or program abuse, nor have been required to pay civil monetary penalties for the same;

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

(7) have never had Medical Staff appointment, permission to practice, or clinical privileges denied, suspended, revoked, or terminated by any health care facility or health plan for reasons related to clinical competence or professional conduct;

(8) have never resigned Medical Staff appointment, permission to practice, or clinical privileges, or relinquished privileges, during a Medical Staff investigation or in exchange for not conducting such an investigation;

(9) have never been convicted of, or entered a plea of guilty or no contest to, any felony; or to any misdemeanor relating to controlled substances, illegal drugs, insurance or health care fraud or abuse, child abuse, elder abuse, or violence;

(10) agree to personally fulfill all responsibilities regarding emergency service call coverage for their specialty or to obtain appropriate coverage (as determined by the MEC) by another practitioner;

(11) have or agree to make appropriate coverage arrangements (as determined by the MEC) with other practitioners for those times when the individual will be unavailable;

(12) demonstrate recent clinical activity in their primary area of practice during the last year;

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

(14) document compliance with all applicable training and educational protocols as well as orientation requirements that may be adopted by the MEC or required by the Board, including, but not limited to, those involving electronic medical records, computerized physician order entry ("CPOE"), the privacy and security of protected health information, infection control, and patient safety;

(15) document compliance with any health screening requirements (i.e., TB testing, mandatory flu vaccines, and infectious agent exposures);

(16) be able to safely and competently exercise the clinical privileges requested and perform the duties and responsibilities of appointment;

(17) have successfully completed:

i. a residency or fellowship training program approved by the Accreditation Council for Graduate Medical Education ("ACGME") or the American Osteopathic Association ("AOA") in the specialty in which the applicant seeks clinical privileges; or

ii. a dental or oral and maxillofacial surgery training program accredited by the Commission on Dental Accreditation of the American Dental Association ("ADA");

(18) be certified in their primary area of practice at the Hospital by the appropriate specialty/subspecialty board of the American Board of Medical Specialties ("ABMS"), the AOA, the American Board of Oral and Maxillofacial Surgery, or the American Board of Foot and Ankle

Surgery, as applicable. Those applicants who are not board certified at the time of application but who have completed their residency or fellowship training within the last five years shall be eligible for Medical Staff appointment. However, in order to remain eligible, those applicants must achieve board certification in their primary area of practice within five years from the date of completion of their residency or fellowship training; and*

(19) maintain board certification in their primary area of practice at the Hospital on a continuous basis, and satisfy all requirements of the relevant specialty/subspecialty board necessary to do so (board certification status will be assessed at reappointment).*

* The requirements pertaining to board certification are applicable to those individuals who apply for initial staff appointment after the adoption of this Policy and are not applicable to Medical Staff members who were appointed prior to that date. Those Medical Staff members shall be grandfathered and shall be governed by any board certification and residency training requirements that may have been in effect at the time of their initial appointments.

(b) In addition to the applicable criteria outlined in (a) above, an APP must:

(1) have a written collaboration/supervision agreement, as applicable, with a Collaborating/Supervising Physician in order to be eligible to apply for initial and continued permission for appointment and reappointed at the Hospital. Such agreement must meet all applicable requirements of state law and Hospital policy; and

(2) demonstrate applicable training and certification, as described in **Appendix C**.

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

(a) Any applicant who does not satisfy one or more of the threshold eligibility criteria outlined above may request that it be waived. The applicant requesting the waiver bears the burden of demonstrating (i) that he or she is otherwise qualified, and (ii) **exceptional** circumstances exist (e.g., the individual is not board certified but has been granted an exception by applicable payors or when there is a demonstrated Hospital or Medical Staff need for the services in question). Exceptional circumstances generally do not include situations where a waiver is sought for the convenience of an applicant (e.g., applicants who wish to defer taking board examinations).

(b) A request for a waiver shall be submitted to the Leadership Council for consideration. In reviewing the request for a waiver, the Leadership Council may

consider the specific qualifications of the applicant in question, and the best interests of the Hospital and the communities it serves. Additionally, the Leadership Council may, in its discretion, consider the application form and other information supplied by the applicant. The Leadership Council's recommendation will be forwarded to the MEC. Any recommendation to grant a waiver must include the specific basis for the recommendation.

(c) The MEC shall review the recommendation of the Leadership Council and make a recommendation to the Board regarding whether to grant or deny the request for a waiver. Any recommendation to grant a waiver must include the specific basis for the recommendation.

(d) No applicant is entitled to a waiver or to a hearing if the Board determines not to grant a waiver. A determination that an applicant is not entitled to a waiver is not a "denial" of appointment or clinical privileges. Rather, that individual is ineligible to request appointment or clinical privileges. A determination of ineligibility is not a matter that is reportable to either the state licensure board or the National Practitioner Data Bank.

(e) The granting of a waiver in a particular case does not set a precedent for any other applicant or group of applicants.

(f) An application for appointment that does not satisfy an eligibility criterion will not be processed until the Board has determined that a waiver should be granted.

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

2.A.3. Factors for Evaluation:

The six ACGME general competencies (patient care, medical knowledge, professionalism, system-based practice, practice-based learning, and interpersonal communications) will be evaluated as part of the appointment and reappointment processes, as reflected in the following factors:

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

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

(c) good reputation and character;

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

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

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

2.A.4. No Entitlement to Appointment:

No individual is entitled to receive an application for appointment or reappointment or to be granted particular clinical privileges merely because he or she:

(a) is employed by the Hospital or its subsidiaries or has a contract with the Hospital;

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

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

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

(e) has had in the past, or currently has, Medical Staff appointment, permission to practice, or privileges at any hospital or health care facility;

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

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

2.A.5. Nondiscrimination:

Neither the Hospital nor the Medical Staff shall discriminate in granting appointment, reappointment, and/or clinical privileges on the basis of national origin, culture, race, gender, sexual orientation, gender identity, ethnic background, religion, or disability unrelated to the provision of patient care to the extent the individual is otherwise qualified.

2.B. GENERAL CONDITIONS OF APPOINTMENT AND REAPPOINTMENT

2.B.1. Basic Responsibilities and Requirements:

As a condition of being granted appointment or reappointment, and as a condition of ongoing membership, every Medical Staff and LIP Staff member specifically agrees to the following:

(a) to provide continuous and timely quality care to all patients for whom the individual has responsibility;

(b) to abide by all Bylaws, policies, and Rules and Regulations of the Hospital, the Medical Staff, and Munson Healthcare, including the Code of Conduct Policy, that are in force during the time the individual is appointed;

(c) to participate in Medical Staff affairs through committee service, participation in quality improvement and professional practice evaluation activities, and by performing such other reasonable duties and responsibilities as may be assigned;

(d) within the scope of his or her clinical privileges and/or Medical Staff category, to provide emergency service call coverage or arrange appropriate coverage for an already established patient and in addition if required by Hospital employment contract, provide consultations, and care for unassigned patients (a member must complete all scheduled emergency service call obligations or arrange appropriate coverage);

(e) to comply with clinical practice or evidence-based medicine protocols that are established by, and must be reported to, regulatory or accrediting agencies or patient safety organizations, including those related to national patient safety initiatives and core measures, or clearly document the clinical reasons for variance;

(f) to comply with clinical practice or evidence-based medicine protocols pertinent to his or her medical specialty, as may be adopted by the Medical Staff or the Medical Staff Leadership, or to clearly document the clinical reasons for variance;

(g) to comply with all applicable training and educational protocols as well as orientation requirements that may be adopted by the MEC and the Board, including, but not limited to, those involving electronic medical records, computerized physician order entry ("CPOE"), the privacy and security of protected health information, infection control, and patient safety;

(h) to inform Medical Staff Services, in writing, as soon as possible, but in all cases within 10 days, of any change in the practitioner's status or any change in the information provided on the individual's application form. This information shall be provided with or without request and shall include, but not be limited to:

- changes in licensure status, DEA controlled substance authorization, or professional liability insurance coverage,

- the filing of a professional liability lawsuit against the practitioner,

- changes in the practitioner's status (appointment or privileges) at any other hospital or health care entity as a result of peer review activities or in order to avoid initiation of peer review activities,

- changes in the practitioner's employment status at any medical group or hospital as a result of issues related to clinical competence or professional conduct,

- knowledge of a criminal investigation involving the individual, arrest, charge, indictment, conviction, or a plea of guilty or no contest in any criminal matter other than a misdemeanor traffic citation,

- knowledge of any investigation involving the individual in federal fraud and abuse laws (i.e., the False Claims Act, the Anti-Kickback Statute, the Physician Self-Referral Law (aka, the Stark Law), the Exclusion Authorities, and the Civil Monetary Penalties Law),

- exclusion or preclusion from participation in Medicare/Medicaid or any sanctions imposed,

- any changes in the practitioner's ability to safely and competently exercise clinical privileges or perform the duties and responsibilities of appointment because of health status issues, including, but not limited to, impairment due to addiction, alcohol use, or other similar issue (all of which shall be referred for review under the appropriate Medical Staff policy),

- any referral to the Michigan Health Professional Recovery Program or another state board health-related program, and

- any charge of, or arrest for, driving under the influence ("DUI") (which shall be referred for review under the Medical Staff health policy);

(i) to immediately submit to an appropriate evaluation, which may include diagnostic testing (including, but not limited to, a blood and/or urine test) and/or a complete physical, mental, and/or behavioral evaluation, if at least two Medical Staff Leaders (or one Medical Staff Leader and one member of the Administrative team) are concerned with the individual's ability to safely and competently care for patients. The health care professional(s) to perform the testing and/or evaluations shall be determined by the Medical Staff Leaders, and the practitioner must execute all appropriate releases to permit the sharing of information with the Medical Staff Leaders;

(j) to meet with Medical Staff Leaders and/or Hospital administration upon request, to provide information regarding professional qualifications upon written request, and to participate in collegial efforts with Medical Staff leaders and/or Hospital administration as may be requested;

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

(l) to maintain and monitor a current Munson Healthcare e-mail account, which will be the primary mechanism used to communicate all Medical Staff information to the practitioner;

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

(n) to refrain from illegal fee splitting or other illegal inducements relating to patient referral;

(o) to refrain from delegating responsibility for hospitalized patients to any individual who is not qualified or adequately supervised;

(p) to refrain from deceiving patients as to the identity of any individual providing treatment or services;

(q) to seek consultation whenever required or necessary;

(r) with respect to health care delivered in the Hospital, and in accordance with all Hospital policies and rules and regulations and accreditation standards, to complete in a timely and legible manner all medical and other required records, containing all information required by the Hospital;

(s) to utilize the electronic medical record as required;

(t) to cooperate with all care management activities;

(u) to participate in an Organized Health Care Arrangement with the Hospital and abide by the terms of the Hospital's Notice of Privacy Practices with respect to health care delivered in the Hospital;

(v) to perform all services and conduct himself or herself at all times in a cooperative and professional manner;

(w) to promptly pay any application fees and/or dues;

(x) to satisfy continuing medical education requirements; and

(y) that, if there is believed to be an intentional misstatement in, or omission from, the application, the Hospital may stop processing the application (or, if appointment has been granted prior to the discovery of a misstatement or omission, appointment and privileges may be deemed to be automatically relinquished). In either situation, there shall be no entitlement to a hearing or appeal. The individual will be informed in writing of the nature of the misstatement or omission and permitted to provide a written response for the Leadership Council's consideration. If the determination is made to not process an application or that appointment and privileges should be automatically relinquished pursuant to this provision, the individual may not reapply for appointment for a period of at least two years.

2.B.2. Burden of Providing Information:

(a) Individuals seeking appointment and reappointment 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 about an individual's qualifications. The information to be produced includes such quality data and other information as may be needed to assist in an appropriate assessment of overall qualifications for appointment, reappointment, and current clinical competence for any requested clinical privileges, including, but not limited to, information from other hospitals, information from the individual's office practice, information from insurers or managed care organizations in which the individual participates, and/or receipt of confidential evaluation forms completed by referring/referred to physicians.

(b) Individuals seeking appointment and reappointment have the burden of providing evidence that all the statements made, and information given on the application are accurate and complete.

(c) An application shall be complete when all questions on the application form have been answered, all supporting documentation has been supplied, all information has been verified from primary sources, and all application fees and dues have been paid. An application shall become incomplete if the need arises for new, additional, or clarifying information at any time during the credentialing process. Whenever there is a need for new, additional, or clarifying information – outside of the normal, routine credentialing process – the application will not be processed until the information is provided. If the application continues to be incomplete 30 days after the individual has been notified of the need for new, additional, or clarifying information, the application shall be deemed to be withdrawn.

(d) The individual seeking appointment or reappointment is responsible for providing a complete application, including adequate responses from references. An incomplete application shall not be processed.

2.C. APPLICATION

2.C.1. Information:

(a) Applications for appointment and reappointment shall contain a request for specific clinical privileges and shall require detailed information concerning the individual's professional qualifications. The applications for initial appointment and reappointment existing now and as may be revised are incorporated by reference and made a part of this Policy.

(b) In addition to other information, the applications shall seek the following:

(1) information as to whether the applicant's Medical Staff appointment or clinical privileges have been voluntarily or involuntarily relinquished, withdrawn, denied, revoked, suspended, subjected to probationary or other conditions, reduced, limited, terminated, or not renewed at any other hospital, health care facility, or other organization, or are currently being investigated or challenged;

(2) information as to whether the applicant's license to practice any relevant profession in any state, DEA registration, or any state's controlled substance license has been voluntarily or involuntarily suspended, modified, terminated, restricted, or relinquished or is currently being investigated or challenged;

(3) information concerning the applicant's professional liability litigation experience, including past and pending claims, final judgments, or settlements; the substance of the allegations as well as the findings and the ultimate disposition; and any additional information concerning such proceedings or actions as the MEC, or the Board may request; and

(4) current information regarding the applicant's ability to safely and competently exercise the clinical privileges requested.

(c) The applicant shall sign the application and certify that he or she is able to perform the privileges requested and the responsibilities of appointment.

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

By requesting an application and/or applying for appointment, reappointment, or clinical privileges, the individual expressly accepts the conditions set forth in this Section:

(a) Immunity:

To the fullest extent provided by law, the individual releases from any and all liability, extends immunity to, and agrees not to sue the Hospital or the Board, any practitioner or member of the Board, their authorized representatives, and third parties who provide information for any matter relating to appointment, reappointment, clinical privileges, or the individual's qualifications for the same. This immunity covers any actions, recommendations, communications, and/or disclosures involving the individual that are made or taken by the Hospital, its authorized agents, or third parties in the course of credentialing and peer review activities. This immunity also extends to any reports that are made to government regulatory and licensure boards or agencies pursuant to federal or state law.

(b) Authorization to Obtain Information from Third Parties:

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

(c) Authorization to Release Information to Third Parties:

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

(d) Authorization to Share Information within Munson Healthcare:

In accordance with the Munson Healthcare System Peer Review Policy and Charter, the individual specifically authorizes Munson Healthcare Entities to share credentialing, peer review, and other information and documentation pertaining to the individual's clinical competence, professional conduct and health. This information and documentation may be shared at any time, 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. The sharing of any such information pursuant to this section does not waive any associated privilege and all such

disclosures shall be made with the understanding that the receiving entity will only use such information for appropriate purposes.

(e) Hearing and Appeal Procedures:

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

(f) Legal Actions:

In accordance with the Health Care Quality Improvement Act ("HCQIA"), if, despite this Section, an individual institutes legal action challenging any credentialing, privileging, peer review, or other action affecting appointment or privileges, or any report that may be made to a regulatory board or agency, and does not prevail, he or she shall reimburse the Hospital and any practitioner or member of the Board involved in the action for all costs incurred in defending such legal action, including reasonable attorney's fees, expert witness fees, and lost revenues.

(g) Scope of Section:

All of the provisions in this Section 2.C.2 are applicable in the following situations:

(1) whether or not appointment or clinical privileges are granted;

(2) throughout the term of any appointment or reappointment period and thereafter;

(3) should appointment, reappointment, or clinical privileges be revoked, reduced, restricted, suspended, and/or otherwise affected as part of the Hospital's professional review activities;

(4) as applicable, to any third-party inquiries received after the individual leaves the Hospital about his or her tenure as a practitioner; and

(5) as applicable, to any reports that may be made to government regulatory and licensing boards or agencies pursuant to federal or state law.

ARTICLE 3

PROCEDURE FOR INITIAL APPOINTMENT

3.A. PROCEDURE FOR INITIAL APPOINTMENT

3.A.1. Request for Application:

(a) An individual seeking initial appointment will be sent information that (i) outlines the threshold eligibility criteria for appointment outlined earlier in this Policy, (ii) outlines the applicable criteria for the clinical privileges being sought, and (iii) provides access to the application form.

(b) Residents or fellows a year in advance pending the successful completion of their training may apply to the Medical Staff. Such applications may be processed, but final action on the applications shall not become effective until all applicable threshold eligibility criteria are satisfied.

3.A.2. Initial Review of Application:

(a) A completed application form with copies of all required documents must be returned to Medical Staff Services within 30 days after receipt if the individual desires further consideration. The application must be accompanied by the application fee.

(b) As a preliminary step, the application shall be reviewed by Medical Staff Services to determine that all questions have been answered and that the individual satisfies all threshold eligibility criteria. Incomplete applications shall not be processed. Individuals who fail to return completed applications or fail to meet the threshold eligibility criteria shall be notified that their applications shall not be processed. A determination of ineligibility does not entitle the individual to the hearing and appeal rights outlined in this Policy and is not reportable to any state agency or to the National Practitioner Data Bank.

(c) For all applications, Medical Staff Services shall oversee the process of gathering and verifying relevant information (i.e., primary source verification) in accordance with applicable policies. Medical Staff Services shall also confirm that all references and other information or materials deemed pertinent have been received. Once an application is complete, it shall be transmitted, along with all supporting documentation, to the applicable Chief of Staff.

3.A.3. Chief of Staff Procedure:

(a) The Chief of Staff shall evaluate the applicant's education, relevant training, and experience. Such evaluation shall include inquiries directed to the applicant's

past and current department chair(s) (if applicable), residency training director, and others who may have knowledge about the applicant.

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

(c) The Chief of Staff shall prepare a report concerning the applicant's qualifications. This report shall address whether the applicant satisfies the current criteria for the clinical privileges or the scope of practice requested.

3.A.4. MEC Procedure:

(a) The MEC shall review and consider the report prepared by the Chief of Staff and shall make a recommendation.

(b) After determining that an applicant is otherwise qualified for appointment and privileges, the MEC may require the applicant to undergo a physical, mental, and/or behavioral examination by a physician(s) satisfactory to the MEC if there is any question about the applicant's ability to perform the privileges requested and the responsibilities of appointment. The results of this examination shall be made available to the committee for its consideration. Failure of an applicant to undergo an examination within a reasonable time after being requested to do so in writing by the MEC shall be considered a voluntary withdrawal of the application and all processing of the application shall cease. The cost of the health assessment will be borne by the applicant.

(c) The MEC may recommend specific conditions on Medical Staff appointment and/or clinical privileges. These conditions may relate to behavior (e.g., personal code of conduct) or to clinical issues (e.g., general consultation requirements, appropriate documentation requirements, proctoring, completion of CME requirements). The MEC may also recommend that appointment be granted for a period of less than two years in order to permit closer monitoring of an individual's compliance with any conditions. Unless these matters involve the specific recommendations set forth in Section 7.A.1(a) of this Policy, such conditions do not entitle an individual to request the procedural rights set forth in Article 7 of this Policy.

(d) If the recommendation of the MEC is to appoint, the recommendation shall be forwarded to the Board, through the CEO, including the findings and recommendation of the Chief of Staff. The MEC's recommendation must specifically address the clinical privileges requested by the applicant, which may be qualified by any probationary or other conditions or restrictions relating to such clinical privileges.

(e) If the recommendation of the MEC is unfavorable and would entitle the applicant to request a hearing in accordance with Section 7.A.1(a) of this Policy, the MEC shall forward its recommendation to the CEO, who shall promptly send special notice to the applicant. The CEO shall then hold the application until after the applicant has completed or waived a hearing and appeal.

3.A.5. Board Action:

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

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

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

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

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

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

(1) appoint the applicant and grant clinical privileges as recommended; or

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

(3) reject or modify the recommendation.

(c) If the Board determines to reject a favorable recommendation, it should first discuss the matter with the Chief of Staff. If the Board's determination remains unfavorable to the applicant, the CEO shall promptly send special notice to the applicant that the applicant is entitled to request a hearing.

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

3.A.6. Time Periods for Processing:

Once an application is deemed complete and verified, it is expected to be processed within 120 days, unless it becomes incomplete. This time period is intended to be a guideline only and shall not create any right for the applicant to have the application processed within this precise time period.

3.A.7. Duration of Appointment:

All initial appointments and any other initial grants of clinical privileges pursuant to this Policy shall be for a duration of not more than two years.

3.B. FPPE TO CONFIRM COMPETENCE AND PROFESSIONALISM

All initially-granted clinical privileges, whether at the time of initial appointment, reappointment, or during the term of appointment, will be subject to focused professional practice evaluation ("FPPE") in order to confirm competence. The FPPE process for these situations is outlined in the relevant Medical Staff policy.

ARTICLE 4

CLINICAL PRIVILEGES

4.A. CLINICAL PRIVILEGES

4.A.1. General:

(a) Appointment or reappointment shall not confer any clinical privileges or right to admit or treat patients at the Hospital. Practitioners are entitled to exercise only those clinical privileges specifically granted by the Board.

(b) For privilege requests to be processed, the applicant must satisfy any applicable threshold eligibility criteria.

(c) Requests for clinical privileges that are subject to an exclusive contract will not be processed except as consistent with the contract.

(d) Requests for clinical privileges that have been grouped into core privileges will not be processed unless the individual has applied for the full core and satisfied all threshold eligibility criteria (or has obtained a waiver in accordance with Section 4.A.2).

(e) The clinical privileges recommended to the Board shall be based on consideration of the following factors:

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

(2) appropriateness of utilization patterns;

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

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

(5) availability of other qualified practitioners with appropriate privileges (as determined by the MEC) to provide coverage in case of the applicant's illness or unavailability;

(6) adequate professional liability insurance coverage for the clinical privileges requested;

(7) the Hospital's available resources and personnel;

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

(9) any information concerning professional review actions or voluntary or involuntary termination, limitation, reduction, or loss of appointment or clinical privileges at another hospital;

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

(11) morbidity and mortality data related to the specific individual, and when statistically and qualitatively significant and meaningful, when available; and

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

(f) Core privileges, special privileges, privilege delineations, and/or the criteria for the same shall be developed by the MEC (or a task force appointed by the MEC), which will forward its recommendations to the Board for final action.

(g) The applicant has the burden of establishing his or her qualifications and current competence for all clinical privileges requested.

(h) The report of the Chief of Staff regarding any clinical privileges requested shall be forwarded to the MEC and processed as a part of the initial application for staff appointment.

4.A.2. Privilege Modifications, Waivers, and Resignations:

(a) Scope. This Section applies to all requests for modification of clinical privileges during the term of appointment (requests to add or give up individual clinical privileges), waivers related to eligibility criteria for privileges or the scope of those privileges, and resignations of all clinical privileges and appointment to the Medical Staff. Any such requests should be submitted in writing or via e-mail to Medical Staff Services.

(b) Requests for Additional Clinical Privileges.

(1) Requests for increased privileges must state the specific additional clinical privileges requested and provide information sufficient to establish eligibility, as specified in applicable criteria, and current clinical competence.

(2) If the individual is eligible and the application is complete, it will be processed in the same manner as an application for initial clinical privileges.

(c) Requests to Give Up Individual Clinical Privileges.

A request to give up any individual clinical privilege, whether or not part of the core, will be processed in accordance with the following:

(1) Formal Request: The individual must forward a written or electronic request to Medical Staff Services, which must indicate the specific patient care services that the individual does not wish to provide and the basis for the request (e.g., the individual's practice focuses exclusively on a sub-specialty within his or her specialty).

(d) The report of the Chief of Staff regarding any clinical privileges requested shall be forwarded to the MEC and processed as a part of the initial application for staff appointment.

(1) Review Process: Any request to give up any individual clinical privileges shall be submitted to the MEC for consideration. In reviewing the request, the MEC will obtain input from the relevant practitioners, as needed, and may consider factors such as the following when evaluating the reasonableness of the request:

(i) the impact to patient care services in the Hospital and in the community;

(ii) the circumstances of the individual making the request (e.g., practice patterns, other demands placed on the individual, etc.);

(iii) any gaps in call coverage that might/would result from an individual's removal from the call roster for the relevant privilege, the impact such a decision would have on other Medical Staff members in the same specialty, and the feasibility and safety of transferring patients to other facilities, if needed;

(iv) the expectations of other practitioners who are in different specialties but who rely on the specialty in question in the care of patients who present to the Hospital; and

(v) how the request may affect the Hospital's ability to comply with applicable regulatory requirements, including the Emergency Medical Treatment and Active Labor Act.

Upon completion of its review, the MEC shall make a recommendation to the Board regarding whether the request can be honored. Any recommendation to grant a request should include the specific basis for the recommendation and may include conditions requiring the individual to participate in the general on-call schedule for his or her relevant specialty and to maintain sufficient competency to assist other physicians on the Medical Staff in assessing and stabilizing patients who require services within that specialty, where necessary.

(2) Effective Date. If the Board grants a relinquishment of privileges, it shall specify the date that the relinquishment will be effective. Failure of a practitioner to request a relinquishment in accordance with this section shall, as applicable, result in the practitioner retaining his or her clinical privileges and all associated responsibilities.

(e) Waivers.

(1) Any individual who does not satisfy one or more eligibility criteria for clinical privileges may request that it be waived. The individual requesting the waiver bears the burden of demonstrating **exceptional** circumstances, and that his or her qualifications are equivalent to, or exceed, the criterion in question. All such requests will be processed in accordance with the process described in Section 2.A.2.

(2) If the individual is requesting a waiver of the requirement that each practitioner apply for the full core of privileges in his or her specialty, the process set forth in paragraph (c) above shall be followed.

(f) Resignation of Appointment and Privileges.

(1) Any individual who wishes to resign all of his or her clinical privileges and appointment shall provide notification of such decision to Medical Staff Services. This notification should indicate the individual's specific resignation date.

(2) On the effective date of the individual's resignation, completion of the following Medical Staff obligations will be confirmed, recorded in the individual's credentials file, and divulged in response to any future credentialing inquiries concerning the individual and/or reported to the Michigan Board of Medicine, as required:

(i) completion of all medical records;

(ii) appropriate management of any hospitalized patients who were under the individual's care at the time of resignation (i.e., patients

were discharged or transferred to another practitioner with appropriate clinical privileges); and

(iii) completion of any scheduled emergency service call (or arrangement for appropriate coverage) prior to resigning.

(g) Procedural Rights. No individual is entitled to a modification or waiver related to privileges. Individuals are also not entitled to a hearing or appeal or other process if a waiver or a modification related to a relinquishment of privileges is not granted.

4.A.3. Clinical Privileges for New Procedures:

(a) Requests for clinical privileges to perform either a procedure not currently being performed at the Hospital or a new technique to perform an existing procedure (hereafter, "new procedure") shall not be processed until (1) a determination has been made that the procedure shall be offered by the Hospital, and (2) criteria to be eligible to request those clinical privileges have been established as set forth in this Section.

(b) As an initial step in the process, the individual seeking to perform the new procedure will prepare and submit a report to the CMO addressing the following:

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

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

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

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

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

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

Hospital administration shall review this report and consult with the Chief of Staff and shall make a preliminary determination as to whether the new procedure should be offered to the community.

(c) If the preliminary determination of the Hospital is favorable, the MEC will determine whether the request constitutes a "new procedure" as defined by this Section or if it is an extension of an existing privilege. If it is determined that it does constitute a "new procedure," the MEC will then develop threshold credentialing criteria to determine those individuals who are eligible to request the clinical privileges at the Hospital. In developing the criteria, the MEC may conduct additional research and consult with experts, as necessary, and develop recommendations regarding:

(1) the appropriate education, training, and experience necessary to perform the procedure or service;

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

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

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

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

(e) The Board will make a reasonable effort to render the final decision within 60 days of receipt of the MEC's recommendation. If the Board determines to offer the procedure or service, it will then establish the minimum threshold qualifications that an individual must demonstrate in order to be eligible to request the clinical privileges in question.

(f) Once the foregoing steps are completed, specific requests from eligible practitioners who wish to perform the procedure or service may be processed.

4.A.4. Clinical Privileges That Cross Specialty Lines:

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

(b) As an initial step in the process, the individual seeking the privilege will prepare and submit a report to the MEC that specifies the minimum qualifications needed to perform the procedure safely and competently, whether the individual's specialty is performing the privilege at other similar hospitals, and the experiences of those other hospitals in terms of patient care outcomes and quality of care.

(c) The MEC shall then conduct additional research and consult with experts, as necessary, including those on the Medical Staff (e.g., individuals on the Medical Staff with special interest and/or expertise) and those outside the Hospital (e.g., other hospitals, residency training programs, specialty societies).

(d) The MEC may or may not recommend that individuals from different specialties be permitted to request the privileges at issue. If it does, the committee may develop recommendations regarding:

(1) the appropriate education, training, and experience necessary to perform the clinical privileges in question;

(2) the clinical indications for when the procedure is appropriate;

(3) 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;

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

(5) 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

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

(e) The MEC shall then forward its recommendations to the Board for final action. The Board shall make a reasonable effort to render the final decision within 60 days of receipt of the MEC's recommendation.

(f) Once the foregoing steps are completed, specific requests from eligible practitioners who wish to exercise the privileges in question may be processed.

4.A.5. Clinical Privileges for Dentists:

(a) For any patient who meets the classification of ASA 1 (normal, healthy patients) or ASA 2 (patients with mild systemic disease with no functional limitations), dentists may admit such patients, perform a complete admission history and physical examination, and assess the medical risks of any surgical procedure to be performed or the medical management of the patient's condition, if they are deemed qualified to do so by the Credentials Committee and MEC. They must, nevertheless, have a relationship with a physician on the Medical Staff (established and declared in advance) who is available to respond and become

involved with that individual's care should any medical issue arise with the patient that is outside of their scope of practice.

(b) For any patient who meets ASA 3 or 4 classifications, a medical history and physical examination of the patient shall be made and recorded by a physician on the Medical Staff before dental surgery may be performed. In addition, a designated physician shall be responsible for the medical care of the patient throughout the period of hospitalization.

(c) The dentist shall be responsible for the oral surgery care of the patient, including the appropriate history and physical examination, as well as all other appropriate elements of the patient's record. Dentists may write orders within the scope of their licenses and consistent with relevant Hospital policies and Rules and Regulations.

4.A.6. Physicians in Training:

(a) Physicians in training programs (i.e., residency or fellowship) shall not hold appointments to the Medical Staff and shall not be granted clinical privileges. The program director, clinical faculty, and/or attending staff member shall be responsible for the direction and supervision of the on-site and/or day-to-day patient care activities of each trainee, who shall be permitted to perform only those clinical functions set out in curriculum requirements, affiliation agreements, and/or training protocols approved by the Hospital and the MEC or their designee(s). The applicable program director shall be responsible for verifying and evaluating the qualifications of each physician in training.

(b) A physician in training at the residency or fellowship level may request clinical privileges in an area for which he or she has already completed training such that he or she can demonstrate that all necessary eligibility criteria for the clinical privileges requested have been met. Requests for privileges shall be reviewed in accordance with the initial credentialing process outlined in this Policy and, if granted, shall be subject to all relevant oversight provisions, including ongoing and focused professional practice evaluation. Physicians in training at the residency or fellowship level may only be granted clinical privileges in those areas for which they can demonstrate current clinical competence.

4.A.7. Telemedicine Privileges:

(a) A qualified individual may be granted telemedicine privileges regardless of whether the individual is appointed to the Medical Staff and LIP Staff.

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

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

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

(i) confirmation that the practitioner is licensed in Michigan (or meets the alternative licensing requirements applicable to telemedicine providers in both the state where the individual is located and Michigan) and has current professional liability coverage;

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

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

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

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

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

This information shall be provided to the MEC for review and recommendation to the Board for final action. Notwithstanding the process set forth in this subsection, the Hospital may determine that an applicant for telemedicine privileges is ineligible for appointment or clinical privileges if the applicant fails to satisfy the threshold eligibility criteria set forth in this Policy.

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

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

(e) Telemedicine privileges granted in conjunction with a contractual agreement shall be incident to and coterminous with the agreement.

4.B. TEMPORARY CLINICAL PRIVILEGES

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

The qualification and verification factors for each type of temporary privilege are summarized in the chart attached as **Appendix D** to this Policy.

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

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

(2) the verification process is complete, including, but not limited to: verification of current licensure, relevant training or experience, current competence (i.e., verification of hospital affiliations and work history for at least the last five years), ability to exercise the privileges requested, and current professional liability coverage; compliance with privileges criteria; and consideration of information from the National Practitioner Data Bank, from a criminal background check, and from OIG queries;

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

(4) the application is pending review by the MEC and the Board, following a favorable recommendation by the Chief of Staff; and

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

(b) Locum Tenens. The CEO may grant temporary privileges to an individual serving as a locum tenens for a practitioner who is on vacation, attending an educational seminar, or ill, and/or otherwise needs coverage assistance for a period of time, under the following conditions:

(1) the applicant has submitted an appropriate application, along with any application fee;

(2) the applicant meets the relevant threshold eligibility criteria outlined in Section 2.A.1 of this Policy;

(3) the verification process is complete, including, but not limited to: verification of current licensure, current competence (i.e., verification of hospital affiliations and work history for at least the last five years), ability to exercise the privileges requested, and current professional liability coverage; compliance with privileges criteria; and consideration of information from the National Practitioner Data Bank, from a criminal background check, and from OIG queries;

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

(5) the applicant has received a favorable recommendation from the Chief of Staff;

(6) the applicant will be subject to any focused professional practice requirements established by the Hospital; and

(7) the individual may exercise locum tenens privileges for a maximum of 180 days, consecutive or not, anytime during the 24-month period following the date they are granted, subject to the following conditions:

(i) the individual must notify Medical Staff Services at least 10 days prior to each time that he or she will be exercising these privileges (exceptions for shorter notice periods may be considered in situations involving health issues); and

(ii) along with this notification, the individual must inform Medical Staff Services of any change that has occurred to any of the information provided on the initial application for locum tenens privileges.

Individuals who are granted locum tenens privileges are not granted appointment and shall not be required to perform any responsibilities related to appointment.

(c) Visiting. The CEO, upon recommendation of the Chief of Staff, may also grant temporary privileges in other limited situations when there is an important patient care, treatment, or service need, under the following circumstances:

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

(2) the verification process is complete, including, but not limited to: current licensure, relevant training or experience, current competence (i.e., verification of hospital affiliations and work history for at least the last five years), current professional liability coverage acceptable to the Hospital, and results of a query to the National Practitioner Data Bank, and from OIG queries; and

(3) the grant of clinical privileges in these situations will not exceed 60 days.

The verifications for such grants of privileges shall generally be accomplished in advance; however, in an emergency situation, where life-threatening circumstances exist, the verifications listed above may be completed immediately after the grant of privileges. In exceptional situations, this period of time may be extended in the discretion of the CEO and the Chief of Staff. Any individual currently appointed in good standing to another Munson Healthcare Hospital with a grant of clinical privileges relevant to the request for visiting privileges shall be immediately authorized to exercise a grant of visiting privileges upon the completion of a query to the National Practitioner Data Bank. Under such circumstances, the Hospital will rely on the granting of privileges at the individual's primary Munson Healthcare Hospital (i.e., as long as the individual meets the eligibility criteria for the relevant privileges at his or her primary Munson Healthcare Hospital, the Hospital will recognize those privileges as visiting privileges).

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

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

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

4.B.2. Supervision Requirements:

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

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

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

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

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 a 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 specific grant of clinical privileges, in accordance with Hospital policy.

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

4.D. DISASTER PRIVILEGES

(1) In accordance with Hospital policy, when the disaster plan has been implemented and the immediate needs of patients in the facility cannot be met, the CEO, the CMO, or the Chief of Staff may use a modified credentialing process to grant disaster privileges to eligible volunteer licensed independent practitioners ("volunteers"). Safeguards must be in place to verify that volunteers are competent to provide safe and adequate care.

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

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

(b) A volunteer's license may be verified in any of the following ways: (i) current Hospital picture ID card that clearly identifies the individual's professional designation; (ii) current license to practice; (iii) primary source verification of the license; (iv) identification indicating that the individual has been granted authority to render patient care in disaster circumstances or is a member of a Disaster Medical Assistance Team, the Medical Reserve Corps, the Emergency System for Advance Registration of Volunteer Health Professionals, or other recognized state or federal organizations or groups; or (v) identification by a current Hospital employee or Medical Staff member who possesses personal knowledge regarding the individual's ability to act as a volunteer during a disaster.

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

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

(5) The Medical Staff will oversee the care provided by volunteer licensed independent practitioners. This oversight shall be conducted through direct observation, mentoring, clinical record review, or other appropriate mechanism developed by the Medical Staff and Hospital.

4.E. CONTRACTS FOR SERVICES

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

(2) To the extent that:

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

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

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

(3) Prior to the Hospital signing any exclusive contract in a new specialty area and/or passing any Board resolution described in paragraph (2) in a specialty service and/or specialty area that has not previously been subject to such a contract or resolution, the Board will request the MEC's review of the matter. The MEC (or a subcommittee of its members appointed by the Chief of Staff) will review the quality of care and service implications of the proposed exclusive contract or Board resolution, and provide a report of its findings and recommendations to the Board within 30 days of the Board's request. As part of its review, the MEC (or subcommittee) may obtain relevant information concerning quality of care and service matters from (i) practitioners in the applicable specialty involved, (ii) practitioners in other specialties who directly utilize or rely on the specialty in question, and (iii) Hospital administration. However, the actual terms of any such exclusive arrangement or employment contract, and any financial information related to them, including but not limited to the remuneration to be paid to practitioners who may be a party to the arrangement, are not relevant and shall neither be disclosed to the MEC nor discussed as part of the MEC's review.

(4) After receiving the MEC's report, the Board shall make a preliminary determination on whether or not to proceed with the exclusive contract or Board resolution. If the Board makes a preliminary determination to pursue an arrangement that would have the effect of preventing an existing practitioner from exercising clinical privileges that had previously been granted, the affected individual is entitled to the following notice and review procedures (Note: if more than one individual in a relevant specialty area will be affected by the determination of the Board, the following procedures will be coordinated to address all requested meetings in a combined and consolidated manner):

(a) The affected individual shall be given notice of the proposed arrangement and the right to request to meet with the Board (or a committee designated by the Board) to discuss the matter prior to the contract in question being signed by the Hospital or the Board resolution becoming effective. Any

such meeting must be requested by the affected individual within 30 days of the notice. Once requested, the meeting will be held on a date and time that is mutually agreeable to the Board and the affected individual.

(b) At the meeting, the affected individual shall be entitled to present any information that he or she deems relevant to the Board's final decision to enter into the exclusive contract or enact the resolution.

(c) If, following this meeting, the Board determines to enter into the exclusive contract or enact the Board resolution, the affected individual shall be notified that he or she will be ineligible to continue to exercise the clinical privileges covered by the exclusive contract or Board resolution. The affected individual's ineligibility will begin on a date specified by the Board, but no sooner than 180 days after the date of the notice.

(d) The affected individual shall not be entitled to any procedural rights beyond those outlined above with respect to the Board's decision or the effect of the decision on his or her clinical privileges, notwithstanding the provisions in Article 7 of this Policy.

(e) The inability of a practitioner to exercise clinical privileges because of an exclusive contract or resolution is not a matter that requires a report to the Michigan Board of Medicine or to the National Practitioner Data Bank.

(5) The ability to practice at the Hospital is contingent upon continued appointment and is also constrained by the extent of an individual's clinical privileges. An individual's right to use the Hospital's facilities is automatically terminated if his or her appointment expires or is terminated. Similarly, no individual under contract may exceed the limit of his or her clinical privileges, notwithstanding the terms of the contract. An exclusive contract may provide for automatic termination of an individual's appointment and clinical privileges in the event that the contract is terminated or the individual's affiliation with the contract group terminates, with no entitlement to a hearing or appeal.

(6) Except as provided in paragraph (1), in the event of any conflict between this Policy or the Medical Staff Bylaws and the terms of any contract, the terms of the contract shall control.

ARTICLE 5

PROCEDURE FOR REAPPOINTMENT

5.A. PROCEDURE FOR REAPPOINTMENT

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

5.A.1. Eligibility for Reappointment:

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

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

(b) completed all continuing medical education requirements;

(c) satisfied all Medical Staff responsibilities, including payment of dues, fines, and assessments;

(d) continued to meet all qualifications and criteria for appointment and the clinical privileges requested, including those set forth in Section 2.A.1 of this Policy;

(e) if applying for clinical privileges, had sufficient patient contacts to enable the assessment of current clinical judgment and competence for the privileges requested. Any individual seeking reappointment who has minimal activity at the Hospital must submit such information as may be requested (such as a copy of his or her confidential quality profile from his or her primary hospital, clinical information from the individual's private office practice, and/or a quality profile from a managed care organization or insurer) before the application shall be considered complete and processed further; and

(f) paid the reappointment processing fees and dues.

5.A.2. Factors for Evaluation:

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

(a) compliance with the Bylaws, Rules and Regulations, and policies of the Medical Staff and the Hospital;

(b) participation in Medical Staff duties, including committee assignments, emergency call, consultation requests, timely and completeness of medical record documentation, cooperation with case management, participation in quality improvement, utilization activities, and professional practice evaluation activities, and such other reasonable duties and responsibilities as assigned;

(c) the results of the Hospital's performance improvement and professional practice evaluation 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);

(d) any focused professional practice evaluations;

(e) verified complaints received from patients, families, and/or staff; and

(f) other reasonable indicators of continuing qualifications.

5.A.3. Reappointment Application:

(a) An application for reappointment shall be furnished to practitioners at least three months prior to the expiration of their current appointment term. A completed reappointment application must be returned to Medical Staff Services within 30 days.

(b) Failure to submit a complete application within 30 days may result in the assessment of a reappointment late fee, which must be paid prior to the application being processed, and the automatic expiration of appointment and clinical privileges at the end of the then current term of appointment unless the application can still be processed in the normal course, without extraordinary effort on the part of Medical Staff Services and the Medical Staff Leaders. If an individual's privileges lapse due to a processing delay, subsequent Board action may be to grant reappointment and renewal of clinical privileges using the filed application, in accordance with the expedited process set forth in Section 3.A.7(a).

(c) Reappointment shall be for a period of not more than two years.

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

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

5.A.4. Processing Applications for Reappointment:

(a) Complete applications for reappointment and privileges will be transmitted to the Chief of Staff, who will review the individual's education, training, and experience and prepare a written report stating whether the individual continues to meet all qualifications. This report will be forwarded to the MEC.

(b) If the applicant has experienced any of the following events during his or her last appointment cycle, Medical Staff Services will flag the application and contact the relevant Medical Staff leader(s) to request a confidential summary report for inclusion in the applicant's reappointment file:

(1) was the subject of an automatic relinquishment of appointment or clinical privileges (except for those relinquishments that result from incomplete medical records);

(2) voluntarily agreed to modify clinical privileges or to refrain from exercising some or all clinical privileges for a period of time for reasons related to the applicant's qualifications or performance;

(3) was the subject of a written letter of warning or reprimand;

(4) participated in a Performance Improvement Plan;

(5) resigned any or all clinical privileges while clinical care, professional conduct, or health status was being reviewed under this Policy or other Medical Staff policy;

(6) resigned any or all clinical privileges while under, or in exchange for not conducting, an investigation under this Policy;

(7) was the subject of a precautionary suspension of clinical privileges;

(8) was the subject of a formal investigation in accordance with this Policy;

(9) was subject to a malpractice judgment or settlement that involved an unexpected death or significant injury to a patient;

(10) if employed by the Hospital or Munson Healthcare, was subject to an employment action or corrective action plan related to clinical competence or professional conduct; and/or and/or

(11) was involved in any other event which, in the discretion of Medical Staff Services, after consulting with the CMO, raises a significant concern about

the applicant's clinical competence, professional conduct, or ability to safely practice.

(c) The MEC will then review the applicant's reappointment file (i.e., the reappointment application, the Chief of Staff's report, any confidential summary report, quality profiles and data, and any other supporting materials) and make a recommendation.

(d) If the recommendation of the MEC is to grant reappointment and privileges, it will be forwarded to the Board for final action. If the recommendation of the MEC is unfavorable, the individual will be notified by the CEO of the right to request a hearing, after taking the steps described in Section 5.A.6.

(e) If a favorable recommendation has been made regarding an application that has been flagged by Medical Staff Services as described in paragraph (b) above, the applicant's complete reappointment file, along with the recommendation of the MEC, will be made available to the Board when the application is presented for final action. All other applications that have received a favorable recommendation will be included on the consent agenda for the Board's approval of all routine applications.

5.A.5. Conditional Reappointments:

(a) Recommendations for reappointment and renewed privileges may be contingent upon an individual's compliance with certain specific conditions that have been recommended. These conditions may relate to behavior (e.g., personal code of conduct) or to clinical issues (e.g., general consultation requirements, appropriate documentation requirements, including timely completion of medical records, proctoring, completion of CME requirements). Unless the conditions involve the matters set forth in Section 7.A.1(a) of this Policy, such conditions do not entitle an individual to request the procedural rights set forth in Article 7 of this Policy.

(b) Reappointments may be recommended for periods of less than two years in order to permit closer monitoring of an individual's compliance with any conditions that have been recommended. A recommendation for reappointment for a period of less than two years does not, in and of itself, entitle an individual to the procedural rights set forth in Article 7.

(c) In addition, in the event the applicant for reappointment is the subject of an unresolved professional practice evaluation concern, a formal investigation, or a hearing at the time reappointment is being considered, a conditional reappointment for a period of less than two years may be granted pending the completion of that process.

5.A.6. Potential Adverse Recommendation:

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

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

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

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

5.A.7. Time Periods for Processing:

Once an application is deemed complete and verified, it is expected to be processed within 120 business days, unless it becomes incomplete. This time period is intended to be a guideline only and shall not create any right for the applicant to have the application processed within this precise time period. If reappointment processing has not been completed by the expiration date, through no fault of the Medical Staff appointee, the appointee will maintain current status and clinical privileges until processing is complete, unless corrective action is taken with respect to all or any part thereof. If the delay is attributable to the individual's failure to provide information required this Section, the Medical Staff appointment will terminate on the expiration date for such individual, unless explicitly extended as provided therein. Reappointment does not give rise to a right of automatic reappointment for successive terms.

5.B. FPPE TO CONFIRM COMPETENCE AND PROFESSIONALISM

All initially-granted clinical privileges, whether at the time of initial appointment, reappointment, or during the term of appointment, will be subject to focused professional practice evaluation ("FPPE") in order to confirm competence. The FPPE process for these situations is outlined in the relevant Medical Staff policy.

ARTICLE 6

QUESTIONS INVOLVING PRACTITIONERS

6.A. INITIAL COLLEGIAL LEADERSHIP EFFORTS AND PROGRESSIVE STEPS

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

(2) Initial collegial leadership efforts include activities such as:

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

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

There is no expectation that these efforts be documented, though documentation may be created in the discretion of the Medical Staff Leader and maintained in the individual's Confidential File.

(3) Progressive steps are defined as follows:

(a) addressing minor performance issues through informational letters;

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

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

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

All progressive steps shall be documented in a constructive manner (e.g., a follow-up letter) and included in an individual's Confidential File. Any written responses to any of these progressive steps by the individual shall also be included in the individual's Confidential File.

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

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

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

(b) refer the matter for review in accordance with the relevant Medical Staff Policy (e.g., Peer Review, Code of Conduct, etc.); or

(c) refer it to the MEC for its review and consideration in accordance with Section 6.D of this Article.

(6) Should any recommendation be made or an action taken that entitles an individual to a hearing in accordance with this Policy, the individual is entitled to be accompanied by legal counsel at that hearing. However, practitioners do not have the right to be accompanied by counsel when the Medical Staff Leaders and Hospital management are engaged in initial collegial leadership efforts or other progressive steps, as these efforts are intended to resolve issues in a constructive manner and do not involve the formal hearing process. Nevertheless, a practitioner may request that another practitioner be allowed to accompany him or her as an advisor. Any such individual must agree to maintain all information as confidential and should understand that he or she may be removed from the meeting by the Medical Staff leadership if his or her presence or conduct is deemed to be disruptive, provided that a clear warning is first given, requesting that the disruptive actions cease, before he or she is removed. Finally, there shall be no recording (audio or video) of any meetings that involve informal leadership efforts or progressive steps activities.

6.B. PROFESSIONAL PRACTICE EVALUATION ACTIVITIES

Professional practice evaluation activities shall be conducted in accordance with the relevant Medical Staff policy (e.g., Peer Review, Code of Conduct, etc.). Matters that are not satisfactorily resolved through collegial intervention efforts or through one of these policies shall be referred to the MEC for its review in accordance with Section 6.D below. Such interventions and evaluations, however, are not mandatory prerequisites to MEC review.

6.C. PRECAUTIONARY SUSPENSION OR RESTRICTION OF CLINICAL PRIVILEGES

6.C.1. Grounds for Precautionary Suspension or Restriction/Requests to Voluntarily Refrain:

(a) Whenever, in their sole discretion, failure to take such action may result in imminent danger to the health and/or safety of any individual, the MEC, the Leadership Council, OR any Medical Staff Officer, acting in conjunction with the CEO or the CMO, shall have the authority to proceed as follows:

(1) request that the individual agree to voluntarily refrain from exercising all or some of his or her clinical privileges pending further review of the circumstances by the Leadership Council in accordance with Section 6.C.2 of this Policy; or

(2) if the individual is unwilling to voluntarily refrain from practicing pending further review, to suspend or restrict all or any portion of the individual's clinical privileges as a precaution, which actions shall be reviewed by the MEC in accordance with Section 6.C.3 of this Policy.

(b) The above actions can be taken at any time, including, but not limited to, immediately after the occurrence of an event that causes concern, following a pattern of occurrences that raises concern, or following a recommendation of the MEC that would entitle the individual to request a hearing.

(c) Precautionary suspension or restriction, or an agreement to refrain, is an interim step in the professional review activity, but it is not a complete professional review action in and of itself. It shall not imply any final finding of responsibility for the situation that caused the suspension, restriction, or agreement.

(d) These actions shall become effective immediately, shall promptly be reported in writing to the CEO, the CMO, and the Chief of Staff, and shall remain in effect unless the action is modified by the CEO or MEC.

(e) The individual in question shall be provided a letter via Special Notice that memorializes the individual's agreement to voluntarily refrain from practicing or the imposition of a precautionary suspension and terms related to the same. The correspondence shall also contain 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), within three days of the action.

6.C.2. Leadership Council Review Process for an Agreement to Voluntarily Refrain from Practicing:

(a) The Leadership Council shall review the matter resulting in an individual's agreement to voluntarily refrain from exercising all or some of his or her clinical privileges within a reasonable time under the circumstances, not to exceed 14 days. As part of this review, the individual shall be given an opportunity to meet with the Leadership Council. Neither the Leadership Council nor the individual shall be accompanied by legal counsel at this meeting, and no recording (audio or video) or transcript of the meeting shall be permitted or made; however, minutes of the meeting shall be prepared.

(b) After considering the matter resulting in an individual's agreement to voluntarily refrain and the individual's response, if any, the Leadership Council shall determine the appropriate next steps, which may include, but not be limited to, commencing a focused review, referring the matter for review pursuant to another policy, referring the matter to the MEC with a recommendation to initiate a formal investigation, or taking some other action that is deemed appropriate under the circumstances. The Leadership Council shall also determine whether the agreement to voluntarily refrain from exercising all or some of the individual's clinical privileges should be continued throughout any further review process.

(c) There is no right to a hearing based on an individual's agreement to voluntarily refrain from practicing in accordance with this Section.

6.C.3. MEC Review Process for Precautionary Suspensions or Restrictions:

(a) The MEC shall review the matter resulting in a precautionary suspension or restriction within a reasonable time under the circumstances, not to exceed 14 days. As part of this review, the individual shall be given an opportunity to meet with the MEC. The individual may propose ways other than precautionary suspension or restriction to protect patients and/or employees, depending on the circumstances. Neither the MEC nor the individual shall be accompanied by legal counsel at this meeting, and no recording (audio or video) or transcript of the meeting shall be permitted or made; however, minutes of the meeting shall be prepared.

(b) After considering the matters resulting in the suspension or restriction and the individual's response, if any, the MEC shall determine the appropriate next steps, which may include, but not be limited to, commencing a focused review or a formal investigation, or recommending some other action that is deemed appropriate under the circumstances. The MEC shall also determine whether the precautionary suspension or restriction should be continued, modified, or

terminated pending the completion of the focused review or investigation (and hearing and appeal, if applicable).

(c) The imposition of a precautionary suspension does not entitle an individual to the hearing rights set forth in Article 7 of this Policy unless the suspension is in effect for more than 15 days.

6.C.4. Care of Patients:

(a) Immediately upon the imposition of a precautionary suspension or restriction, the Chief of Staff shall assign to another individual with appropriate clinical privileges responsibility for care of the suspended individual's hospitalized patients, or to otherwise aid in implementing the precautionary restriction, as appropriate. The assignment shall be effective until the patients are discharged. The wishes of the patient shall be considered in the selection of a covering physician.

(b) All practitioners have a duty to cooperate with the Chief of Staff, the MEC, the CMO, and the CEO in enforcing precautionary suspensions or restrictions.

6.D. FORMAL INVESTIGATIONS

6.D.1. Initial Review:

(a) Where initial collegial leadership efforts or progressive steps under one or more of the policies referenced in this Article have not resolved an issue and/or when there is a single instance of such severity that in the discretion of Medical Staff Leaders it requires further review, regarding:

(1) the clinical competence or clinical practice of any practitioner, including the care, treatment or management of a patient or patients;

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

(3) the known or suspected violation by any practitioner of applicable ethical standards or the Bylaws, Rules and Regulations, and policies of the Hospital or the Medical Staff; and/or

(4) conduct by any practitioner 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 individual to work harmoniously with others,

the matter may be referred to the Chief of Staff, the chair of a standing committee, or the CEO.

(b) In addition, if the Board becomes aware of information that raises concerns about any practitioner, the matter shall be referred to the Chief of Staff, the chair of a standing committee, or the CEO for review and appropriate action in accordance with this Policy.

(c) The person to whom the matter is referred shall conduct or arrange for an inquiry to determine whether the question raised has sufficient credibility to warrant further review and, if so, shall forward it in writing to the MEC.

(d) No action taken pursuant to this Section shall constitute an investigation.

6.D.2. Initiation of Formal Investigation:

(a) When a question involving clinical competence or professional conduct is referred to, or raised by, the MEC, the MEC shall review the matter and determine whether to conduct a formal investigation (hereinafter a "Formal Investigation"), to direct the matter to be handled pursuant to another relevant Medical Staff policy (e.g., Peer Review, Code of Conduct, etc.), or to proceed in another manner. Prior to making its determination, the MEC may discuss the matter with the individual. A Formal Investigation shall begin only after the MEC votes to do so. The MEC's determination shall be recorded in the minutes of the meeting where the determination is made.

(b) The MEC shall inform the individual that a Formal Investigation has begun. The notification shall include:

(1) the date on which the Formal Investigation was commenced and that if the individual resigns his or her appointment or clinical privileges during this time, a report to the National Practitioner Data Bank will be triggered;

(2) the committee that will be conducting the Formal Investigation, if already identified;

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

(4) a copy of Section 6.D.3 of this Policy, which outlines the process for Formal Investigations.

This notification may be delayed if, in the MEC's judgment, informing the individual immediately would compromise the Formal Investigation or disrupt the operation of the Hospital or Medical Staff.

6.D.3. Formal Investigative Procedure:

(a) Selection of Investigating Committee.

Once a determination has been made to begin a Formal Investigation, the MEC shall either investigate the matter itself or appoint an ad hoc committee to conduct the Formal Investigation, keeping in mind the conflict of interest guidelines outlined in Article 9. Any ad hoc committee may include individuals not on the Medical Staff. Whenever the questions raised concern the clinical competence of the individual under review, the ad hoc committee shall include a peer of the individual (e.g., physician, dentist, PA, nurse practitioner, etc.).

(b) Investigating Committee's Review Process.

(1) The committee conducting the Formal Investigation ("investigating committee") shall have the authority to review relevant documents and interview individuals. A summary of each interview will be prepared and the interviewee will be asked to review, revise, and sign his or her summary, which will then be included as an attachment to the investigating committee's report.

(2) The investigating committee shall also have available to it the full resources of the Medical Staff and the Hospital, including the authority to arrange for an external review, if needed. An external review may be used whenever the Hospital and investigating committee determine that:

(i) there are ambiguous or conflicting findings by internal reviewers;

(ii) the clinical expertise needed to conduct the review is not available on the Medical Staff;

(iii) an external review is advisable to prevent allegations of bias, even if unfounded; or

(iv) the thoroughness and objectivity of the Formal Investigation would be aided by such an external review.

If a decision is made to obtain an external review, the individual under Formal Investigation shall be notified of that decision and the nature of the external review. Upon completion of the external review, the individual shall be provided a copy of the reviewer's report.

(3) The investigating committee may require a physical, mental, and/or behavioral examination of the individual by a health care professional(s) acceptable to it. The individual under Formal Investigation shall execute a release (in a form approved or provided by the investigating committee)

allowing (i) the investigating committee (or its representative) to discuss with the health care professional(s) conducting the examination the reasons for the examination; and (ii) the health care professional(s) conducting the examination to discuss and provide documentation of the results of such examination directly to the investigating committee. The cost of such health examination shall be borne by the individual.

(c) Meeting with the Investigating Committee.

(1) The individual under Formal Investigation shall have an opportunity to meet with the investigating committee before it makes its report. Prior to this meeting, the individual shall be informed of the general questions being investigated. The investigating committee may also ask the individual to provide written responses to specific questions related to the Formal Investigation and/or a written explanation of his or her perspective on the events that led to the Formal Investigation for review by the investigating committee prior to the meeting.

(2) This meeting is not a hearing, and none of the procedural rules for hearings shall apply. No recording (audio or video) or transcript of the meeting shall be permitted or made. Neither the individual being investigated nor the investigating committee will be accompanied by legal counsel at this meeting.

(3) At the meeting, the individual shall be invited to discuss, explain, or refute the questions that gave rise to the Formal Investigation or that have been identified by the investigating committee during its review. A summary of the interview shall be prepared by the investigating committee and included with its report. The interview summary will be shared with the individual prior to the investigating committee finalizing its report, so that he or she may review it and recommend suggested changes. A suggested change should only be accepted if the investigating committee believes it more accurately reflects what occurred at the meeting.

(d) Time Frames for Formal Investigation.

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

(e) Investigating Committee's Report.

(1) At the conclusion of the Formal Investigation, the investigating committee shall prepare a report of the Formal Investigation. The report should include a summary of the review process (e.g., a list of documents that were reviewed, any individuals who were interviewed, etc.), specific findings and conclusions regarding each concern that was under review, and the investigating committee's recommendations.

(2) In making its recommendations, the investigating committee shall strive to achieve a consensus as to what is in the best interests of patient care and the smooth operation of the Hospital, while balancing fairness to the individual, recognizing that fairness does not require that the individual agree with the recommendation. Specifically, the committee may consider:

(i) relevant literature and clinical practice guidelines, as appropriate;

(ii) all of the opinions and views that were expressed throughout the review, including report(s) from any external review(s);

(iii) any information or explanations provided by the individual under review; and

(iv) other information as deemed relevant, reasonable, and necessary by the investigating committee.

6.D.4. Recommendation:

(a) The MEC may accept, modify, or reject any recommendation it receives from an ad hoc investigating committee if one was appointed by the MEC. In either case, at the conclusion of the Formal Investigation, the MEC may:

(1) determine that no action is justified;

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

(3) impose conditions for continued appointment;

(4) impose a requirement for monitoring, proctoring, or consultation;

(5) impose a requirement for additional training or education;

(6) recommend reduction of clinical privileges;

(7) recommend suspension of clinical privileges for a term;

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

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

(b) A recommendation by the MEC that would entitle the individual to request a hearing shall be forwarded to the CEO, who shall promptly inform the individual by special notice. The CEO shall hold the recommendation until after the individual has completed or waived a hearing and appeal.

(c) If the determination of the MEC does not entitle the individual to request a hearing, it shall take effect immediately and shall remain in effect unless modified by the Board.

(d) In the event the Board considers a modification to the recommendation of the MEC that would entitle the individual to request a hearing, the CEO shall inform the individual by special notice. No final action shall occur until the individual has completed or waived a hearing and appeal.

(e) When applicable, any recommendations or actions that are the result of a Formal Investigation or hearing and appeal shall be monitored by Medical Staff Leaders on an ongoing basis through the Hospital's performance improvement activities or pursuant to the applicable policies regarding conduct, as appropriate.

6.E. AUTOMATIC RELINQUISHMENT/ACTIONS

6.E.1. General:

(a) Any of the occurrences described in this Section will constitute grounds for the automatic relinquishment of an individual's appointment and clinical privileges. An automatic relinquishment is considered an administrative action and, as such, it does not trigger an obligation on the part of the Hospital to file a report with the National Practitioner Data Bank and will take effect without hearing or appeal.

(b) Except as otherwise provided below, an automatic relinquishment of appointment and clinical privileges or scope of practice will be effective immediately upon actual or Special Notice to the individual. Such notice will be provided after confirmation of the event(s) that led to the automatic relinquishment by the Chief of Staff, the CMO and/or CEO.

6.E.2. Action by Government Agency or Insurer and Failure to Satisfy Threshold Eligibility Criteria:

(a) Any action taken by any licensing board, professional liability insurance company, court or government agency regarding any of the matters set forth below, or any failure to satisfy any of the threshold eligibility criteria set forth in

this Policy, must be promptly reported by the affected individual to Medical Staff Services.

(b) An individual's appointment and clinical privileges shall be automatically relinquished, without the right to the procedural rights outlined in this Policy, if an individual fails to satisfy any of the threshold eligibility criteria set forth in Section 2.A.1 of this Policy on a continuous basis (except for board certification requirements, which shall be assessed at time of reappointment). This includes, but is not limited to, the following occurrences:

(1) Licensure: Revocation, expiration, suspension, the placement of restrictions on an individual's license, or an individual's license being placed on probationary status.

(2) Controlled Substance Authorization: Revocation, expiration, suspension or the placement of restrictions on an individual's DEA controlled substance authorization.

(3) Insurance Coverage: Termination or lapse of an individual's professional liability insurance coverage, or other action causing the coverage to fall below the minimum required by the Hospital or cease to be in effect, in whole or in part.

(4) Medicare and Medicaid Participation: Debarment, proposed debarment, termination, exclusion, or preclusion by government action from participation in the Medicare/Medicaid or other federal or state health care programs.

(5) Criminal Activity: Arrest, charge, indictment, conviction, or a plea of guilty or no contest pertaining to any felony; or to any misdemeanor involving (i) controlled substances; (ii) illegal drugs; (iii) Medicare, Medicaid, or insurance or health care fraud or abuse; (iv) child abuse; (v) elder abuse; or (vi) violence against another. (DUIs will be reviewed in accordance with the relevant Medical Staff policy.)

(c) Automatic relinquishment shall take effect immediately upon written notice to the individual provided via Special Notice, and shall continue until the matter is resolved and the individual is reinstated, if applicable.

(d) If the underlying matter leading to automatic relinquishment is resolved within 60 days, the individual may request reinstatement. Failure to resolve the matter within 60 days of the date of relinquishment shall result in an automatic resignation from the Medical Staff.

6.E.3. Failure to Complete Medical Records:

Failure to complete medical records, after notification by the medical records department of delinquency, may result in automatic relinquishment of all clinical privileges in accordance with the time frames as set forth in the Medical Staff Rules and Regulations (except that the individual must complete all scheduled emergency service obligations or arrange appropriate coverage). Relinquishment shall continue until all delinquent records are completed and reinstatement accomplished in accordance with applicable policies and rules and regulations. Failure to complete the medical records that caused relinquishment within the time required by applicable policies and rules and regulations shall result in automatic resignation of appointment and clinical privileges.

6.E.4. Failure to Provide Requested Information:

Failure to provide information pertaining to a practitioner's qualifications for continued appointment or clinical privileges, in response to a written request from the CEO, the CMO, the MEC, the Leadership Council, or any other committee authorized to request such information, shall result in a requirement that the individual meet with the Leadership Council to discuss why the requested input was not provided.

6.E.5. Failure to Complete or Comply with Training, Educational, or Orientation Requirements:

(a) Failure to complete or comply with training, educational, or orientation requirements that are adopted by the MEC or required by the Board, including, but not limited to, those pertinent to electronic medical records, computerized physician order entry ("CPOE"), the privacy and security of protected health information, infection control, or patient safety, shall result in a requirement that the individual meet with the Leadership Council to discuss the individual failed to complete/comply with the required content.

(b) Failure of the practitioner to either: (i) meet with the Leadership Council and convince it that the compliance is not necessary; or (ii) provide evidence of compliance prior to the meeting will result in the automatic relinquishment of the individual's clinical privileges until the individual demonstrates completion or compliance with the relevant requirement. If the individual fails to do so within 30 days of the automatic relinquishment, the individual's appointment and clinical privileges will be deemed to have been automatically resigned.

6.E.6. Failure to Attend Special Meeting:

(a) Whenever there is a concern regarding the clinical practice or professional conduct involving any individual, the CEO, the CMO, the MEC, the Leadership Council, or any other authorized committee may require the individual to attend a special meeting with one or more of the Medical Staff Leaders and/or with a standing or ad hoc committee of the Medical Staff.

(b) No legal counsel shall be present at this meeting, and no recording (audio or video) or transcript shall be permitted or made.

(c) The notice to the individual regarding this meeting shall be given by special notice at least three days prior to the meeting and shall inform the individual that attendance at the meeting is mandatory.

(d) Failure of the individual to attend the meeting shall result in the automatic relinquishment of all clinical privileges until such time as the individual does attend the special meeting. If the individual does not attend the special meeting within 30 days of the date of relinquishment, it shall result in automatic resignation of appointment and clinical privileges.

6.E.7. Request for Reinstatement:

(a) Requests for reinstatement following the expiration or lapse of a license, controlled substance authorization, and/or insurance coverage will be processed by Medical Staff Services. If any questions or concerns are noted, Medical Staff Services will refer the matter for further review in accordance with (b) below.

(b) All other requests for reinstatement shall be reviewed by the Leadership Council. If the Leadership Council makes a favorable recommendation on reinstatement, the practitioner may immediately resume clinical practice at the Hospital. This determination shall then be forwarded to the MEC, and the Board for ratification. If, however, the Leadership Council has any questions or concerns, those questions shall be noted and the reinstatement request shall be forwarded to the, MEC, and Board for review and recommendation.

6.F. LEAVES OF ABSENCE

6.F.1. Initiation:

(a) A practitioner may request a leave of absence by submitting a written request to Medical Staff Services. The request must state the beginning and ending dates of the leave, which shall not exceed one year, and the reasons for the leave.

(b) The CMO shall determine whether a request for a leave of absence shall be granted. In determining whether to grant a request, the CMO shall consult with the Chief of Staff. The granting of a leave of absence, or reinstatement, as appropriate, may be conditioned upon the individual's completion of all medical records.

(c) Except for maternity leaves, practitioners must report to the CMO any time they are away from Hospital and/or patient care responsibilities for longer than 30 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. Under such circumstances, an automatic medical leave of absence may be triggered.

6.F.2. Duties of Practitioners on Leave:

During the leave of absence, the individual shall not exercise any clinical privileges. In addition, the individual shall be excused from all Medical Staff responsibilities (e.g., meeting attendance, committee service, emergency service call obligations) during this period.

6.F.3. Reinstatement:

(a) Individuals requesting reinstatement shall submit a written summary of their professional activities during the leave, and any other information that may be requested by the Hospital. Requests for reinstatement shall then be reviewed by the Leadership Council. If the Leadership Council makes a favorable recommendation on reinstatement, the practitioner may immediately resume clinical practice at the Hospital. This determination shall then be forwarded to the MEC, and the Board for ratification. If, however, the Leadership Council has any questions or concerns, those questions shall be noted and the reinstatement request shall be forwarded to the MEC, and Board for review and recommendation. If a request for reinstatement is not granted, for reasons related to clinical competence or professional conduct, the individual shall be entitled to request a hearing and appeal.

(b) If the leave of absence was for health reasons (except for maternity leave), the Leadership Council may request any additional information or documentation that it believes is necessary to evaluate the individual's ability to safely and competently exercise clinical privileges before acting on an individual's request for reinstatement or to resume practicing. This may include requiring the individual to undergo a health assessment conducted by a physician or entity chosen by the Leadership Council in order to obtain a second opinion on the individual's ability to practice safely and competently.

(c) Absence for longer than one year shall result in automatic relinquishment of appointment and/or clinical privileges unless an extension is granted by the CMO. Extensions shall be considered only in extraordinary cases where the extension of a leave is in the best interest of the Hospital.

(d) If an individual's current appointment is due to expire during the leave, the individual must apply for reappointment, or appointment and clinical privileges shall lapse at the end of the appointment period.

(e) Failure to request reinstatement from a leave of absence in a timely manner shall be deemed a voluntary resignation of appointment and clinical privileges.

(f) 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 shall be final, with no recourse to a hearing and appeal.

6.G. ACTION AT ANOTHER MUNSON HEALTHCARE HOSPITAL

(1) Each Munson Healthcare Hospital will share information regarding the implementation or occurrence of any of the following actions with all other Munson Healthcare Hospitals at which an individual maintains appointment, clinical privileges, or any other permission to care for patients:

(a) **automatic relinquishment or resignation** of appointment or clinical privileges for any reason set forth in the Credentials Policy or other Medical Staff policies (except for those relinquishments or resignations that result from incomplete medical records or the failure to provide requested information in a timely manner);

(b) **voluntary agreement to modify clinical privileges** or **to refrain from exercising** some or all clinical privileges for a period of time for reasons related to the individual's clinical competence, conduct or health;

(c) participation in a **Performance Improvement Plan**;

(d) a grant of **conditional appointment or privileges** (either at initial appointment or reappointment), or conditional continued appointment or clinical privileges;

(e) a grant of **leave of absence** related to a health issue; and/or

(f) any **denial, suspension, revocation, or termination** of appointment and/or clinical privileges.

(2) Upon receipt of notice that any of the actions set forth in Paragraph (1) have occurred at any Munson Healthcare Hospital, that action will either:

(a) automatically and immediately take effect at the Munson Healthcare Hospital receiving the notice; or

(b) be cause for the Munson Healthcare Hospital receiving the notice to determine that the individual no longer satisfies the eligibility criteria set forth in this Policy and has therefore automatically relinquished his or her appointment and privileges.

The automatic effectiveness of any such action, or an automatic relinquishment based on such action, will not entitle the individual to any additional procedural

rights (including advance notice, additional peer review, Formal Investigation, hearing, or appeal) other than what occurred at the Munson Healthcare Hospital taking the original action.

(3) The Board may waive the automatic effectiveness of an action or an automatic relinquishment at the receiving Munson Healthcare Hospital based on a recommendation to do so from the MEC at that Hospital. However, the automatic effectiveness or relinquishment will continue until such time as a waiver has been granted and the practitioner has been notified in writing of such. Waivers are within the discretion of the Board and are final. They will be granted only as follows:

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

(b) after a full review of the specific circumstances and any relevant documents (including peer review documents) from the Munson Healthcare Hospital where the action first occurred. The burden is on the affected practitioner to provide evidence showing that a waiver is appropriate.

The denial of a waiver pursuant to this Section will not entitle the individual to any procedural rights, including advance notice, additional peer review, Formal Investigation, hearing, or appeal.

ARTICLE 7

HEARING AND APPEAL PROCEDURES

7.A. INITIATION OF HEARING

7.A.1. Grounds for Hearing:

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

(1) denial of initial appointment;

(2) denial of reappointment;

(3) revocation of appointment;

(4) denial of requested clinical privileges;

(5) revocation of clinical privileges;

(6) suspension of clinical privileges for more than 15 days;

(7) mandatory concurring consultation requirement (i.e., the consultant must approve the course of treatment in advance); or

(8) denial of reinstatement from a leave of absence if the reasons relate to clinical competence or professional conduct.

(b) No other recommendations shall entitle the individual to a hearing.

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

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

None of the following actions shall constitute grounds for a hearing, and they shall take effect without hearing or appeal, provided that the individual shall be entitled to submit a written explanation to be placed into his or her file:

(a) determination that an applicant for appointment fails to meet the threshold eligibility qualifications or criteria outlined in Section 2.A.1 of this Policy;

(b) ineligibility to request appointment or privileges, or to continue privileges, because a relevant specialty is closed under a Medical Staff development plan or is covered under an exclusive provider agreement;

(c) failure to process a request for a privilege when the individual does not meet the eligibility criteria to hold the privilege;

(d) determination that an application is incomplete or untimely;

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

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

(g) expiration of appointment and clinical privileges as a result of failure to submit an application for reappointment within the allowable time period;

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

(i) determination that conditions, monitoring, supervision, proctoring, or a general consultation requirement (i.e., the individual must obtain a consult but need not get prior approval for the treatment) is appropriate for a practitioner;

(j) determination that a requirement for additional training or continuing education is appropriate for an individual;

(k) the voluntary acceptance of a Performance Improvement Plan;

(l) any requirement to complete a health assessment, diagnostic testing, a complete physical, mental or behavioral evaluation, or a clinical competency evaluation pursuant to any Bylaws-related document;

(m) conducting a Formal Investigation into any matter or the appointment of an ad hoc investigating committee;

(n) grant of conditional appointment or reappointment or of an appointment or reappointment period that is less than two years;

(o) refusal of the Hospital to consider a request for appointment, reappointment, or privileges within five years of a final adverse decision regarding such request;

(p) precautionary suspension that is in effect for 15 days or less;

(q) automatic relinquishment of appointment or privileges or automatic resignation;

(r) denial of a request for a leave of absence, for an extension of a leave or for reinstatement from a leave if the reasons do not relate to clinical competence or professional conduct;

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

(t) withdrawal of temporary privileges;

(u) requirement to appear for a special meeting;

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

(w) any other action that is not specifically listed in Section 7.A.1(a).

7.B. THE HEARING

7.B.1. Notice of Recommendation:

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

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

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

(c) a copy of this Article.

7.B.2. Request for Hearing:

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

7.B.3. Notice of Hearing and Statement of Reasons:

(a) The CEO shall schedule the hearing and provide, by special notice to the individual requesting the hearing, the following:

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

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

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

(4) a statement of the specific reasons for the recommendation, including a list of patient records (if applicable), and a general description of the information supporting the recommendation. This statement does not bar presentation of additional evidence or information at the hearing, so long as the additional material is relevant to the recommendation or the individual's qualifications and the individual has a sufficient opportunity to review and rebut the additional information.

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

7.B.4. Hearing Panel, Presiding Officer, and Hearing Officer:

(a) Hearing Panel:

The CEO, after consulting with the Chief of Staff, shall appoint a Hearing Panel in accordance with the following guidelines:

(1) The Hearing Panel shall consist of at least three members and may include any combination of:

(i) any practitioner, provided he or she has not actively participated in the matter at any previous level; and/or

(ii) practitioners or laypersons not connected with the Hospital (i.e., physicians not on the Medical Staff or laypersons not affiliated with the Hospital).

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

(3) Employment by, or other contractual arrangement with, the Hospital or an affiliate shall not preclude an individual from serving on the Panel.

(4) The Panel shall not include any individual who is in direct economic competition with the individual requesting the hearing.

(5) The Panel shall not include any individual who is demonstrated to have an actual bias, prejudice, or conflict of interest that would prevent the individual from fairly and impartially considering the matter.

(6) In addition, the appointment of the Hearing Panel shall comply with the guidelines set forth in the conflict of interest provisions found in Article 8 of this Policy.

(b) Presiding Officer:

(1) The CEO, after consulting with the Chief of Staff, shall appoint a Presiding Officer who shall be an attorney. The Presiding Officer may not be, or represent clients who are, in direct competition with the individual who requested the hearing and may not currently represent the Hospital in any legal matters. The Presiding Officer shall not act as an advocate for either side at the hearing.

(2) The Presiding Officer shall:

(i) 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;

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

(iii) maintain decorum throughout the hearing;

(iv) determine the order of procedure;

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

(vi) conduct argument by counsel on procedural points within or outside the presence of the Hearing Panel at the Presiding Officer's discretion.

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

(4) The Presiding Officer may participate in the private deliberations of the Hearing Panel and be a legal advisor to it, but shall not be entitled to vote on its recommendations.

(c) Hearing Officer:

(1) As an alternative to a Hearing Panel, for matters limited to issues involving professional conduct, the CEO, after consulting with the Chief of Staff, may appoint a Hearing Officer, preferably an attorney, to perform the functions of a Hearing Panel. The Hearing Officer may not be, or represent clients who are, in direct economic competition with the individual requesting the hearing.

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

(d) Objections:

Any objection to any member of the Hearing Panel, to the Presiding Officer, or to the Hearing Officer, shall be made in writing, within 10 days of receipt of notice, to the CEO. A copy of such written objection must be provided to the Chief of Staff and must include the basis for the objection. The Chief of Staff shall be given a reasonable opportunity to comment. The CEO shall rule on the objection and give notice to the parties. The CEO may request that the Presiding Officer make a recommendation as to the validity of the objection.

(e) Compensation:

The Hearing Panel, Presiding Officer, and/or Hearing Officer may be compensated by the Hospital, but the individual requesting the hearing may take responsibility for part of the cost of any such compensation should the individual wish to do so.

7.B.5. Counsel:

The Presiding Officer, Hearing Officer, and counsel for either party may be an attorney at law who is licensed to practice, in good standing, in any state.

7.C. PRE-HEARING PROCEDURES

7.C.1. General Procedures:

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

(b) The hearing shall last no more than 15 hours, with each side being afforded approximately seven and one 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 shall be concluded after a maximum of 15 hours. The

Presiding Officer may, after considering any objections, grant limited extensions upon a demonstration of good cause and to the extent compelled by fundamental fairness.

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

(d) Neither the individual who has requested the hearing, nor any other person acting on behalf of the individual, may contact Hospital employees or practitioners whose names appear on the MEC's witness list or in documents provided pursuant to this Article concerning the subject matter of the hearing, until the Hospital has been notified and has contacted the individuals about their willingness to be interviewed. The Hospital will advise the individual who has 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. If an employee or practitioner who is on the MEC's witness list agrees to be interviewed pursuant to this provision, counsel for the MEC may be present during the interview.

7.C.2. Time Frames:

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

(a) the pre-hearing conference shall be scheduled at least 14 days prior to the hearing;

(b) the parties shall exchange witness lists and proposed documentary exhibits at least 10 days prior to the pre-hearing conference; and

(c) any objections to witnesses and/or proposed documentary exhibits must be provided at least five days prior to the pre-hearing conference.

7.C.3. Witness List:

(a) At least 10 days before the pre-hearing conference, the individual requesting the hearing shall provide a written list of the names of witnesses expected to offer testimony on his or her behalf.

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

(c) 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.C.4. Provision of Relevant Information:

(a) Prior to receiving any confidential documents, the individual requesting the hearing must agree that all documents and information shall be maintained as confidential and shall 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.

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

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

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

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

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

The provision of this information shall not waive any privilege under the state peer review protection statutes.

(c) The individual shall have no right to discovery beyond the above information. No information shall be provided regarding other practitioners at the Hospital.

(d) At least 10 days prior to the pre-hearing conference (or as otherwise agreed upon by both sides), each party shall provide the other party with its proposed exhibits. All objections to documents or witnesses shall be submitted in writing at least five days in advance of the pre-hearing conference. The Presiding Officer shall not entertain subsequent objections unless the party offering the objection demonstrates good cause.

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

7.C.5. Pre-Hearing Conference:

The Presiding Officer shall require the individual and the MEC or their representatives (who may be counsel) to participate in a pre-hearing conference, which shall be held no later than 14 days prior to the hearing. At the pre-hearing conference, the Presiding Officer shall establish the time to be allotted to each witness's testimony and cross-

examination and shall resolve all procedural questions, including any objections to exhibits, witnesses, or the time limitation for the hearing.

7.C.6. Stipulations:

The parties and their counsel, if applicable, shall use their best efforts to develop and agree upon stipulations, so as to provide for a more orderly and efficient hearing by narrowing the issues on which live testimony is reasonably required.

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

The following documents shall be provided to the Hearing Panel in advance of the hearing: (a) a pre-hearing statement that either party may choose to submit; (b) exhibits offered by the parties following the pre-hearing conference (without the need for authentication); and (c) any stipulations agreed to by the parties.

7.D. HEARING PROCEDURES

7.D.1. Rights of Both Sides and the Hearing Panel at the Hearing:

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

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

(2) to introduce exhibits;

(3) to cross-examine any witness on any matter relevant to the issues;

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

(5) to submit proposed findings, conclusions and recommendations to the Hearing Panel as part of the Post-Hearing statement referenced in this Article, following the close of the hearing session(s).

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

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

7.D.2. Record of Hearing:

A stenographic reporter shall be present to make a record of the hearing. The cost of the reporter shall be borne by the Hospital. Copies of the transcript shall be available at the individual's expense. Oral evidence shall be taken only on oath or affirmation administered by any person entitled to notarize documents in this state.

7.D.3. Failure to Appear:

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

7.D.4. Presence of Hearing Panel Members:

A majority of the Hearing Panel shall be present throughout the hearing. In unusual circumstances when a Hearing Panel member must be absent from any part of the hearing, he or she shall read the entire transcript of the portion of the hearing from which he or she was absent.

7.D.5. Persons to Be Present:

The hearing shall be restricted to those individuals involved in the proceeding, the Chief of Staff, and the CEO. In addition, administrative personnel may be present as requested by the CEO or the Chief of Staff.

7.D.6. Order of Presentation:

The MEC shall first present evidence in support of its recommendation. Thereafter, the burden shall shift to the individual who requested the hearing to present evidence.

7.D.7. Admissibility of Evidence:

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

7.D.8. Post-Hearing Statement:

Each party shall have the right to submit a written statement, and the Hearing Panel may request that statements be filed, following the close of the hearing.

7.D.9. Postponements and Extensions:

Postponements and extensions of time may be requested by anyone, but shall be permitted only by the Presiding Officer or the CEO on a showing of good cause.

7.E. HEARING CONCLUSION, DELIBERATIONS, AND RECOMMENDATIONS

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

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

7.E.2. Deliberations and Recommendation of the Hearing Panel:

Within 20 days after final adjournment of the hearing (which may be designated as the time the Hearing Panel receives the hearing transcript or any post-hearing statements, whichever is later), the Hearing Panel shall conduct its deliberations outside the presence of any other person except the Presiding Officer. Thereafter, the Hearing Panel shall render a recommendation, accompanied by a report, which shall contain a concise statement of the basis for its recommendation.

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

The Hearing Panel shall deliver its report to the CEO. The CEO shall send by special notice a copy of the report to the individual who requested the hearing. The CEO shall also provide a copy of the report to the MEC.

7.F. APPEAL PROCEDURE

7.F.1. Time for Appeal:

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

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

7.F.2. Grounds for Appeal:

The grounds for appeal shall be limited to the following:

(a) there was substantial failure by the Hearing Panel to comply with this Policy and/or the Medical Staff Bylaws during the hearing, so as to deny a fair hearing; and/or

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

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

Whenever an appeal is requested as set forth in the preceding Sections, the Chair of the Board (or the CEO on behalf of the Chair) shall schedule and arrange for an appeal. The individual shall be given special notice of the time, place, and date of the appeal. The appeal shall be held as soon as arrangements can reasonably be made, taking into account the schedules of all the individuals involved.

7.F.4. Nature of Appellate Review:

(a) The Board may serve as the Review Panel or the Chair of the Board may appoint a Review Panel composed of not less than three persons, either members of the Board or others, including but not limited to reputable persons outside the Hospital, to consider the record upon which the recommendation before it was made and recommend final action to the Board.

(b) Each party shall have the right to present a written statement in support of its position on appeal. The party requesting the appeal shall submit a statement first and the other party shall then have ten 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.

(c) 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. Such additional evidence shall be accepted only if the Review Panel determines that the party seeking to admit it has demonstrated that it is relevant, new evidence that could not have been presented at the hearing, or that any opportunity to admit it at the hearing was improperly denied.

7.G. BOARD ACTION

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

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

(b) The Board may review any information that it deems relevant, including, but not limited to, the findings and recommendations of the MEC, Hearing Panel, and Review Panel (if applicable). The Board may adopt, modify, or reverse any recommendation that it receives or, in its discretion, refer the matter to any individual or committee for further review and recommendation, or make its own decision based upon the Board's ultimate legal authority for the operation of the Hospital and the quality of care provided.

(c) The Board shall render its final decision in writing, including specific reasons, and shall send special notice to the individual. A copy shall also be provided to the MEC for its information.

7.G.2. Further Review:

Except where the matter is referred by the Board for further action and recommendation by any individual or committee, the final decision of the Board shall be effective immediately and shall not be subject to further review. If the matter is referred for further action and recommendation, such recommendation shall be promptly made to the Board in accordance with the instructions given by the Board.

7.G.3. Right to One Hearing and One Appeal Only:

No practitioner shall be entitled to more than one hearing and one appellate review on any matter. If the Board denies initial appointment or reappointment or revokes the appointment and/or clinical privileges of a current practitioner, that individual may not apply for appointment or for those clinical privileges for a period of five years unless the Board provides otherwise.

ARTICLE 8

ADVANCED PRACTICE PROVIDERS AND OTHER PRACTITIONERS

8.A. DETERMINATION OF NEED

(1) Whenever a practitioner (LIP or APP) in a category that has not been approved by the Board requests permission to practice at the Hospital, the Board shall ask the Leadership Council to evaluate the need for that particular category of LIPs and APPs and to make a recommendation to the MEC for its review and recommendation and then to the Board for final action.

(2) As part of the process of determining need, the individual requesting permission to practice shall be invited to submit information about the nature of the proposed practice, why Hospital access is sought, and the potential benefits to the community by having such services available at the Hospital.

(3) The Leadership Council will review any information submitted by the individual requesting permission to practice and consider the following factors:

(a) the nature of the services that would be offered;

(b) any state license or regulation which outlines the scope of practice that the practitioner is authorized by law to perform;

(c) any state "non-discrimination" or "any willing provider" laws that would apply to the practitioner;

(d) the business and patient care objectives of the Hospital, including patient convenience;

(e) the community's needs and whether those needs are currently being met or could be better met if the services offered by the practitioner were provided at the Hospital;

(f) the type of training that is necessary to perform the services that would be offered and whether there are individuals with more training currently providing those services;

(g) the availability of supplies, equipment, and other necessary Hospital resources;

(h) the need for, and availability of, trained staff to support the services that would be offered; and

(i) the ability to appropriately supervise performance and monitor quality of care.

(4) The Leadership Council will then forward its recommendation on whether there is a need for the particular category of practitioner at the Hospital to the MEC, which will review the matter and forward its recommendation to the Board for final action.

8.B. DEVELOPMENT OF POLICY

(1) If the Leadership Council determines that there is a need for the particular category of practitioner at the Hospital, the committee shall recommend to the MEC and the Board a separate policy for these practitioners that addresses:

(a) any specific qualifications and/or training that they must possess beyond those set forth in this Policy;

(b) a detailed description of their authorized scope of practice or clinical privileges;

(c) any specific conditions that apply to their functioning within the Hospital beyond those set forth in this Policy; and

(d) any Collaboration/Supervision requirements, if applicable.

(2) In developing such policies, the Leadership Council shall consult the appropriate Medical Staff Leaders and consider relevant state law and may contact applicable professional societies or associations. The Leadership Council may also recommend to the Board the number of practitioners that are needed in a particular category.

8.C. STANDARDS OF PRACTICE FOR THE UTILIZATION OF APPs IN THE INPATIENT HOSPITAL SETTING

(1) Standards of Practice for the Utilization of APPs in the Hospital

(a) As a condition of being granted permission to practice at the Hospital, all APPs specifically agree to abide by the standards of practice set forth in this Section. In addition, as a condition of being permitted to utilize the services of APPs in the Hospital, all Medical Staff members who serve as Collaborating/Supervising Physicians to such individuals also specifically agree to abide by the standards set forth in this Section.

(b) The following standards of practice apply to the functioning of APPs in the inpatient Hospital setting unless a waiver or special privileges are otherwise recommended by the MEC and approved by the Board. This is

expected to occur rarely and only when exceptional circumstances exist (e.g., there is a demonstrated service need):

(1) Exercise of Clinical Privileges. APPs may exercise those clinical privileges as have been granted pursuant to their approved delineation of clinical privileges, which delineations specify the requisite levels of supervision that apply to their privileges (general, direct, or personal, which terms are defined in this Policy), of which only "personal" supervision requires the actual physical presence of the Collaborating/Supervising Physician.

(2) Admitting Privileges. APPs are not granted inpatient admitting privileges. However, an APP is permitted to write inpatient admission orders on behalf of a Collaborating/Supervising Physician who has inpatient admitting privileges, so long as the order is cosigned by the Collaborating/Supervising Physician.

(3) Consultations. An APP may see a patient, gather data, order tests, and generate documentation in response to a request for a consultation. However, the Collaborating/Supervising Physician must still personally see the patient if requested by the physician requesting the consultation.

(4) Emergency On-Call Coverage. APPs may participate in the emergency on-call roster and be designated as a Collaborating/Supervising Physician's first contact. If contacted by the Emergency Department, the Collaborating/Supervising Physicians (or their covering physician) must personally respond to all calls in a timely manner. Following discussion with the Emergency Department, the Collaborating/Supervising Physician may direct an APP to see the patient, gather data, order tests, and generate documentation for further review by the Collaborating/Supervising Physician.

(5) Calls Regarding Collaborating/Supervising Physician's Hospitalized Inpatients. APPs may, in collaboration with their Collaborating/ Supervising Physician, respond to calls from the floor or special care units regarding hospitalized inpatients in lieu of the Collaborating/Supervising Physician. It shall be within the discretion of the Hospital personnel requesting assistance whether it is appropriate to contact an APP prior to the Collaborating/Supervising Physician. However, the Collaborating/ Supervising Physician must personally respond to all calls that have been specifically directed to him or her in a timely manner.

(6) Daily Inpatient Rounds for Attending Physicians. An APP is permitted to perform daily inpatient rounds; however, the Collaborating/Supervising Physician is ultimately responsible for all care provided by the APP.

(2) Oversight By Supervising Physician

(a) Any activities permitted to be performed at the Hospital by an APP shall be performed only in collaboration or participation with, or under the supervision or direction of, a Collaborating/Supervising Physician.

(b) An APP may function in the Hospital only so long as he or she (i) is appropriately supervised by, collaborating with, or is functioning within a practice agreement with, a Collaborating/Supervising Physician who is currently appointed to the Medical Staff, and (ii) has a current, written supervision, collaborative, or practice agreement with the Collaborating/Supervising Physician. In addition, should the Medical Staff appointment or clinical privileges of the Collaborating/Supervising Physician be revoked or terminated, the APP's permission to practice at the Hospital and clinical privileges shall be automatically relinquished (unless the individual will be supervised by or will participate with another physician on the Medical Staff who meets the necessary requirements for such supervision or participation).

(c) As a condition of clinical privileges, an APP and the Collaborating/Supervising Physician must provide the Hospital with a copy of any written supervision, collaborative, or practice agreement that may be required by the state as well as notice of any revisions or modifications that are made to any such agreements between them. This notice must be provided to Medical Staff Services within three days of any such change.

(3) Questions Regarding the Authority of an APP

(a) Should any Medical Staff Member or Hospital employee who is licensed or certified by the state have any question regarding the clinical competence or authority of an APP, either to act or to issue instructions outside the physical presence of the Collaborating/Supervising Physician in a particular instance, the Medical Staff Member or Hospital employee shall have the right to require that the APP or APP's Collaborating/Supervising Physician validate, either at the time or later, the instructions of the APP. Any act or instruction of an APP shall be delayed until such time as the Medical Staff Member or Hospital employee can be certain that the act is clearly within the scope of the APP's activities as permitted by the Board.

(b) Any question regarding the clinical practice or professional conduct of an APP shall be immediately reported to a Medical Staff Leader or the CMO who shall undertake such action as may be appropriate under the circumstances. The individual to whom the concern has been reported may also discuss the matter with the Collaborating/Supervising Physician.

(4) Responsibilities of Collaborating/Supervising Physician

(a) Physicians who wish to utilize the services of an APP in their clinical practice at the Hospital must notify Medical Staff Services of this fact in advance and must ensure that the individual has been appropriately credentialed in accordance with this Policy before the APP participates in any clinical or direct patient care of any kind in the Hospital.

(d) The Collaborating/Supervising Physician will be responsible for all care provided by the APP in the Hospital.

(e) The Collaborating/Supervising Physician who wishes to utilize the services of an APP in the inpatient setting specifically agrees to abide by the standards of practice set forth in Section 6.A above.

(f) The number of APPs acting in collaboration with, under the supervision of, or functioning within a practice agreement with, a Collaborating/Supervising Physician, 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.

(g) It will be the responsibility of the Collaborating/Supervising Physician to ensure that an APP maintains professional liability insurance in amounts required by the Board. The insurance must cover any and all activities of the APP. The Collaborating/Supervising Physician will furnish evidence of such coverage to the Hospital. The APP will act in the Hospital only while such coverage is in effect.

ARTICLE 9

CONFLICT OF INTEREST GUIDELINES FOR CREDENTIALING, PRIVILEGING, AND PROFESSIONAL PRACTICE EVALUATION ACTIVITIES

9.A.1. General Principles:

(a) All those involved in credentialing, privileging, and professional practice evaluation activities (referred to collectively as "Medical Staff Functions" in this Article) must be sensitive to potential conflicts of interest ("COI") 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 review processes.

(b) It is also essential that peers participate in Medical Staff Functions 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.

(c) A potential conflict of interest depends on the situation and not on the character of the individual. To promote this understanding, any individual with a potential conflict of interest shall be referred to as an "Interested Member."

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

(e) The fact that any individual chooses to refrain from participation, or is excused from participation, in any Medical Staff Function shall not be interpreted as a finding of an actual conflict that inappropriately influenced the review process.

(f) **Appendix E** to this Policy is a chart that outlines the conflict of interest guidelines that are applicable to Medical Staff Functions at the Hospital. The remainder of this Article is intended to supplement **Appendix E** and expand upon the guidelines that are summarized in the chart.

9.A.2. Process for Identifying Conflicts of Interest:

(a) Self-Disclosure. Any individual involved in Medical Staff Functions must disclose all personal conflicts of interest relevant to those activities to the committee chair or CMO.

(b) Identification by Others. Any individual who is concerned about a potential conflict of interest on the part of any other individual who is involved in Medical Staff Functions should inform the committee chair or CMO.

(c) Identification by Individual under Review. An individual who is the subject of review during any Medical Staff Functions is obligated to notify the committee chair or CMO of any known or suspected conflicts of interest by others who are involved in such activities. Any potential conflict of interest that is not raised timely by the individual under review shall be deemed waived.

9.A.3. Implementation of Conflict of Interest Guidelines in **Appendix E**:

This section describes how to implement the Conflict of Interest Guidelines found in **Appendix E** of this Policy:

- Paragraph (a) identifies the three COI situations that require special treatment and rules during the performance of Medical Staff Functions, irrespective of the Interested Member's level of participation in the process (e.g., individual reviewer, MEC member, etc.);

- Paragraph (b) describes the other common situations that raise COI issues during the performance of Medical Staff Functions; and

- Paragraph (c) describes how to apply the guidelines in **Appendix E** to the common COI situations outlined in (b) at each level of the review processes.

(a) Three COI Situations That Require Special Treatment and Rules, Irrespective of an Interested Member's Level of Participation:

(1) Employment or Contractual Arrangement with the Hospital. Because Medical Staff Functions are performed on behalf of the Hospital, the interests of those who are employed by, or under contract with, the Hospital are aligned with the Hospital's interest in seeing that those activities are performed effectively, efficiently, and lawfully. As such, employment by, or other contractual arrangement with, the Hospital or any of its affiliated entities does not, in and of itself, preclude an Interested Member from participating in Medical Staff Functions.

(2) Self or Family Member. While Interested Members may provide information to other individuals involved in the review process, an Interested Member should not otherwise participate in the review of his or her own application or the professional practice evaluation of the care he or she provided or in any such activities involving an immediate family member (spouse or domestic partner, parent, child, sibling, or in-law).

(3) Relevant Treatment Relationship. As a general rule, an Interested Member who has provided professional health services to a practitioner whose application or provision of care is under review should not participate in the review process regarding the practitioner. However, 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, the Interested Member may participate fully in all Medical Staff Functions.

Furthermore, even if a current patient-physician relationship exists, the Interested Member may provide information to others involved in the review process if:

(i) the information was not obtained through the treatment relationship, or

(ii) the information was obtained through the treatment relationship, but the disclosure was authorized by the practitioner under review through the execution of a HIPAA-compliant authorization form.

(b) Other Common Situations That Raise COI Issues During the Performance of Medical Staff Functions:

Participation by any Interested Member who is in one of the following situations – as it relates to the practitioner under review – will be evaluated under the guidelines outlined in Paragraph (c) and **Appendix E**:

(1) Significant Financial Relationship (e.g., when the Interested Member and other practitioners: are members of a small, single specialty group; maintain a significant referral relationship; are partners in a business venture; or, are individuals practicing in a specialty for which a policy matter – such as clinical privileging criteria – is being considered);

(2) Direct Competitor (e.g., practitioners in the same specialty, but in different groups);

(3) Close Friendships;

(4) History of Personal Conflict (e.g., former partner, ex-spouse, or where there has been demonstrated animosity);

(5) Personal Involvement in the Care That Is Subject to Review (e.g., where the Interested Member provided care in the case under review, but is not the subject of the review);

(6) Active Involvement in Certain Prior Interventions with the Individual under Review (e.g., where the Interested Member was involved in the development of a prior Performance Improvement Plan or in a disciplinary action involving the individual under review. This situation does not include participation in initial education or collegial intervention efforts

(e.g., sending an educational letter; meeting collegially with a colleague and sending a follow-up letter)); and/or

(7) Formally Raised the Concern about Another Individual (e.g., where the Interested Member's concern triggered the review of another practitioner, as evidenced by the Interested Member's written report regarding the concern (i.e., sent a written concern to a Medical Staff Officer or CMO, or filed a report through the Hospital's electronic reporting system)).

(c) Application of the Guidelines in **Appendix E** to the Performance of Medical Staff Functions:

(1) Individual Reviewers in Credentialing and Professional Practice Evaluation Activities

An Interested Member may participate as an individual reviewer so long as a check and balance is provided by subsequent review by a Medical Staff committee. This includes, but is not limited to, the following:

(i) participation in the review of applications for appointment, reappointment, and clinical privileges (which is subsequently reviewed by the MEC); and

(ii) participation as a case reviewer in professional practice evaluation activities (which is subsequently reviewed by the Leadership Council, Investigating Committee, and/or MEC).

(2) Leadership Council, or Peer Review Committee Members

As a general rule, an Interested Member may fully participate as a member of the Leadership Council or a System or Local Peer Review Committee because these committees do not possess any disciplinary authority and do not make any final recommendation that could adversely affect the appointment or clinical privileges of a practitioner, which is only within the authority of the MEC and Board.

However, the chairs of these committees always have the discretion to recuse an Interested Member if they determine that the Interested Member's presence or participation would inhibit full and fair discussion of the issue, would skew the recommendation or determination of the committee, or would otherwise be unfair to the practitioner under review.

(3) Medical Executive Committee

As a general rule, an Interested Member may fully participate as a member of the MEC when it is approving routine and favorable recommendations

regarding the granting of initial appointment, reappointments, and clinical privileges.

However, an Interested Member should be recused from the MEC when that committee is considering a matter that could result in an adverse professional review action affecting the appointment or clinical privileges of a practitioner. The Interested Member's participation in MEC meetings will be governed by the guidelines regarding recusal that are set forth in **Appendix E**.

(4) Investigating Committees

Once a Formal Investigation has been initiated by the MEC, additional steps to manage conflicts of interest should be taken as a precaution. Therefore, an Interested Member should not be appointed as a member of an investigating committee and should not participate in the committee's deliberations or decision-making but may be interviewed and provide information if necessary for the committee to conduct a full and thorough Formal Investigation.

(5) Hearing Panel

An Interested Member should not be appointed as a member of a Hearing Panel and should not participate in the Panel's deliberations or decision-making.

(6) Board

As a general rule, an Interested Member may fully participate as a member of the Board when it is approving routine and favorable recommendations regarding the granting of initial appointment, reappointments, and clinical privileges.

However, an Interested Member should be recused from the Board when the Board is considering action that will adversely affect appointment or clinical privileges of a practitioner. The Interested Member's participation in Board meetings will be governed by the guidelines regarding recusal that are set forth in **Appendix E**.

ARTICLE 10

CONFIDENTIALITY AND PEER REVIEW PROTECTION

10.A. CONFIDENTIALITY

Actions taken and recommendations made pursuant to the Medical Staff Bylaws and this Policy shall be strictly confidential. Individuals participating in, or subject to, credentialing and professional practice evaluation activities (including collegial interventions, investigations, and hearings) shall make no disclosures of any such information (discussions or documentation) outside of committee meetings, except:

(1) when the disclosures are to another authorized practitioner or authorized Hospital employee and are for the purpose of researching, investigating, or otherwise conducting legitimate credentialing and professional practice evaluation activities;

(2) when the disclosures are authorized by a Medical Staff or Hospital policy; or

(3) when the disclosures are authorized, in writing, by the CEO or by legal counsel to the Hospital.

Any breach of confidentiality may result in a professional review action and/or appropriate legal action. Such breaches are unauthorized and do not waive the peer review privilege. Any practitioner who becomes aware of a breach of confidentiality must immediately inform the CEO or the Chief of Staff (or the Vice Chief of Staff if the Chief of Staff is the person committing the claimed breach).

10.B. PEER REVIEW PROTECTION

(1) All credentialing and professional practice evaluation activities pursuant to this Policy and related Medical Staff documents shall be performed by "peer review committees" in accordance with Michigan law. These committees include, but are not limited to:

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

(b) hearing panels;

(c) the Board and its committees; and

(d) any individual acting for or on behalf of any such entity, including but not limited to committee chairs and members, officers of the Medical Staff, the CMO, all Hospital personnel, and experts or consultants retained to assist in peer review activities.

All oral or written communications, reports, recommendations, actions, and minutes made or taken by peer review committees are confidential and covered by the applicable provisions of state law.

(2) All peer review committees shall also be deemed to be "professional review bodies" as that term is defined in the Health Care Quality Improvement Act of 1986, 42 U.S.C. §11101 *et seq.*

ARTICLE 11

HOSPITAL EMPLOYEES

(a) Except as provided below, the employment of an individual by the Hospital shall be governed by the Hospital's employment policies and manuals and the terms of the individual's employment relationship and/or written contract. To the extent that the Hospital's employment policies or manuals, or the terms of any applicable employment contract, conflict with this Policy, the employment policies, manuals and descriptions and terms of the individual's employment relationship and/or written contract will apply.

(b) Except as noted in (a) above, Hospital-employed practitioners are bound by all of the same conditions and requirements in this Policy that apply to non-Hospital employed practitioners.

(c) A request for appointment, reappointment, clinical privileges, or scope of practice, submitted by an applicant or practitioner who is seeking employment or who is employed by the Hospital, shall be processed in accordance with the terms of this Policy and the Medical Staff leadership shall determine whether the individual is qualified for the privileges requested. A report regarding each practitioner's qualifications shall then be made to Hospital management or Human Resources (as appropriate) to assist the Hospital in making employment decisions.

(d) If a concern about an employed practitioner's clinical competence, conduct or behavior arises, then the concern may be reviewed and addressed in accordance with this Policy, in which event a report will be provided to Hospital management or Human Resources (as appropriate). Conversely, if Hospital management or Human Resources becomes aware of a concern regarding an employed practitioner's clinical competence, conduct, or behavior, the concern should be shared with the Leadership Council for its consideration. This provision does not preclude Hospital management or Human Resources from addressing an issue in accordance with the Hospital's employment policies/manuals or in accordance with the terms of any applicable employment contract.

ARTICLE 12

AMENDMENTS AND ADOPTION

(a) The amendment process for this Policy is set forth in Article 9 of the Medical Staff Bylaws.

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

Adopted by the Medical Staff: 4/20/2021

Approved by the Board: 4/27/2021

APPENDIX A

The categories of APPs currently practicing at the Hospital are as follows:

(a) Physician Assistant (PA)

(b) Nurse Practitioner (NP)

(c) Certified Registered Nurse Anesthetist (CRNA)

(d) Physical Therapist (PT)

APPENDIX B

The categories of LIPs currently practicing at the Hospital are as follows:

(a) Outpatient Rehabilitation Specialist;

(b) Speech Pathologist;

(c) Occupational Therapist;

(d) Physical Therapy Assistant;

(e) Pharmacist;

(f) Physical Therapist;

(g) Surgical Technologist;

(h) Ultrasonographer;

(i) Registered Sleep Technician;

(j) Respiratory Therapist;

(k) Cardiovascular Technician;

(l) Nuclear Med Technologist;

(m) Certified Athletic Trainer;

(n) Central Processing Technician;

(o) Medical Lab Technician; and

(p) PhD Psychologist.

APPENDIX C

TRAINING AND CERTIFICATION REQUIREMENTS FOR APPs

In accordance with Section 2.A.1(b)(2), APPs must demonstrate training and certification, as applicable and as follows:

- a certified registered nurse anesthetist (CRNA) must have graduated from an approved program of anesthesia accredited by the Council on Accreditation of Nurse Anesthesia Educational Programs or a predecessor or successor agency. Certification by the National Board on Certification and Recertification for Nurse Anesthetists (NBCRNA), or by a predecessor or successor agency to either is required for initial applicants (or be actively seeking initial certification and obtain the same on the first examination for which eligible) and reapplicants;

- a nurse practitioner (NP) must have completed a masters, post-masters, or doctorate degree in a nurse practitioner program (acute care is preferred) accredited by the Commission on Collegiate Nursing Education (CCNE) or the Accreditation Commission for Education in Nursing (ACEN). Current certification by the American Nurses Credentialing Center (ANCC) or the American Association of Critical Care Nurses (AACN) or an equivalent body is required for initial applicants (or be actively seeking certification and obtain the same on the first examination for which he or she is eligible) and reapplicants;

- a physician assistant (PA) must have completed an Accreditation Review Commission on Education for the Physician Assistant (ARC-PA) approved program (prior to January 2001 – Commission on Accreditation of Allied Health Education Programs). Current certification by the National Commission on Certification of Physician Assistants (NCCPA) as a PA-C is required for initial applicants and reapplicants.

APPENDIX D

SUMMARY OF TYPES OF TEMPORARY PRIVILEGES

	APPLICANTS	LOCUM TENENS	VISITING
Purpose:	Individuals awaiting processing of application for initial appointment	Individuals serving as locum tenens for Practitioners who are on vacation, attending an educational seminar, or ill, and/or otherwise need coverage assistance for a period of time	Individuals seeking privileges for situations where there is an important patient care, treatment, or service need
Verification Factors:	• current licensure; • current competence (i.e., verification of hospital affiliations and work history for at least the last five years); • ability to exercise the privileges requested; • current professional liability coverage; • compliance with privileges criteria; and • results of queries from the NPDB, a criminal background check, and OIG queries.	• current licensure; • current competence (i.e., verification of hospital affiliations and work history for at least the last five years); • ability to exercise the privileges requested; • current professional liability coverage; • compliance with privileges criteria; and • results of queries from the NPDB, a criminal background check, and OIG queries.	• current licensure; • relevant training or experience; • current competence (verification of hospital affiliations and work history for at least the last five years); • current professional liability coverage acceptable to the Hospital; and • results of queries from the NPDB and OIG queries.
Other Qualifications:	• the applicant has submitted a complete application, along with any application fee; • the applicant demonstrates that: (i) there are no current or previously successful challenges to his or her licensure or registration; and (ii) he or she has not been subject to involuntary termination of Medical Staff membership or	• the applicant has submitted an appropriate application, along with any application fee; • the applicant meets the relevant threshold eligibility criteria outlined in Section 2.A.1 of this Policy; • the applicant demonstrates that: (i) there are no current or previously successful challenges to his or her licensure or registration; and	• Any individual currently appointed in good standing to another Munson Healthcare Hospital with a grant of clinical privileges relevant to the request for visiting privileges shall be immediately authorized to exercise a grant of visiting privileges upon the completion of a query to the NPDB. • Under such circumstances, the Hospital will rely on the granting of privileges at the individual's

	involuntary limitation, reduction, denial, or loss of clinical privileges, at another health care facility; and • the application is pending review by the MEC and the Board, following a favorable recommendation by the Chief of Staff .	(ii) he or she has not been subject to involuntary termination of Medical Staff membership or involuntary limitation, reduction, denial, or loss of clinical privileges, at another health care facility; and • the applicant has received a favorable recommendation from the Chief of Staff .	primary Munson Healthcare Hospital (i.e., as long as the individual meets the eligibility criteria for the relevant privileges at his or her primary Munson Healthcare Hospital, the Hospital will recognize those privileges as visiting privileges).
Time Limitations:	Grant of temporary privileges for a maximum period of ***120 consecutive days.***	May exercise locum tenens privileges for ***a maximum of 180 days***, consecutive or not, anytime during the 24-month period following the date they are granted, subject to the following conditions: • the individual must notify Medical Staff Services at least 10 days prior to each time that he or she will be exercising these privileges (exceptions for shorter notice periods may be considered in situations involving health issues); and • along with this notification, the individual must inform Medical Staff Services of any change that has occurred to any of the information provided on the initial application for locum tenens privileges.	Grant of visiting privileges will not exceed ***60 days***.

APPENDIX E

CONFLICT OF INTEREST GUIDELINES

Potential Conflicts	Levels of Participation								
	Provide Information	Individual Reviewer Application/ Case	Committee Member					Hearing Panel	Board
			Credentials	Leadership Council	System/ Local PRC	MEC	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 Leadership Council or a System or Local Peer Review Committee have no disciplinary authority.

In addition, the Chair of the Leadership Council or a System or Local Peer Review Committee 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.

***** Special rules apply both to the provision of information and participation in the review process in this situation. See Section 9.A.3 of the Credentials Policy.

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. As set forth in the Medical Staff Bylaws, once a quorum has been established, the business of the meeting may continue and actions taken will be binding regardless of whether any subsequent recusal of members causes the number of individuals present at the meeting to fall below the number required for a quorum.