St. Vincent St. Mary's St. Nicholas St. Clare

ALLIED HEALTH PROFESSIONALS

CREDENTIALS POLICY

January 2024

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ARTICLE 1

1. GENERAL

1.A. DEFINITIONS

The definitions that apply to terms used in all the Medical Staff documents are set forth in the Medical Staff Credentials Policy document.

1.B. TIME LIMITS

Time limits referred to in this Policy are advisory only and are not mandatory, unless it is expressly stated that a particular right is waived by failing to take action within a specified period.

1.C. DELEGATION OF FUNCTIONS

1. When a function is to be carried out by a member of Hospital management, by a Medical Staff member, or by a Medical Staff committee, the individual, or the committee through its chairperson, may delegate performance of the function to one or more designees.

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.

ARTICLE 2

2. SCOPE AND OVERVIEW OF POLICY

2.A. SCOPE OF POLICY

1. This Policy addresses those Allied Health Professionals who are permitted to provide services at the Hospital. It sets forth the credentialing process and the general practice parameters for these individuals, as well as guidelines for determining the need for additional categories of Allied Health Professionals at the Hospital.

2. This Policy shall not apply to Allied Health Professionals who are employed by the Hospital (except to the extent set forth in Article 9).

2.B. CATEGORIES OF ALLIED HEALTH PROFESSIONALS

Only those specific categories of Allied Health Professionals that have been approved by the Board of Directors shall be permitted to practice at the Hospital. All such categories shall be classified as either "Independent Clinicians," "Advanced Practice Clinicians," or "Dependent Clinicians," as defined in the Medical Staff Credentials Policy. See Appendices A, B, and C to this Policy for a current listing of the specific types of Allied Health Professionals functioning in each category. The Appendices may be modified or supplemented by action of the Board, after receiving the recommendation of the Executive Committee, without the necessity of further amendment of this Policy.

2.C. ADDITIONAL POLICIES

The Board shall adopt a separate credentialing protocol for each category of Allied Health Professionals that it approves to practice in the Hospital. These separate policies/directives shall supplement this Policy and shall address the specific matters set forth in Section 3.B of this Policy.

ARTICLE 3

3. GUIDELINES FOR DETERMINING THE NEED FOR NEW CATEGORIES OF ALLIED HEALTH PROFESSIONALS

3.A. DETERMINATION OF NEED

Whenever an Allied Health Professional in a category that has not been approved by the Board requests permission to practice at the Hospital, the Board shall appoint an ad hoc committee to evaluate the need for that particular category of Allied Health Professionals and to make a recommendation to the Board. As part of the process, the Allied Health Professionals 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. The ad hoc committee may consider the following factors when making a recommendation to the Board as to the need for the services of this category of Allied Health Professionals:

1. the nature of the services that could be offered;

2. any state license or regulation which outlines the scope of practice that the Allied Health Professionals is authorized by law to perform;

3. any state "non-discrimination" or "any willing provider" laws that would apply to the Allied Health Professionals;

4. the business and patient care objectives of the Hospital;

5. the community's needs and whether those needs are currently being met or could be better met if the services offered by the Allied Health Professionals were provided by the Hospital or as part of its facilities;

6. the type of training that is necessary to perform the services that could be offered and whether there are individuals with more training currently providing those services;

7. the availability of supplies, equipment, and other necessary Hospital resources;

8. the availability of trained staff;

9. patient convenience; and

10. the ability to appropriately supervise performance and monitor quality of care.

3.B. DEVELOPMENT OF POLICY

If the ad hoc committee determines that there is a need for the particular category of Allied Health Professionals at the Hospital, the committee shall recommend to the Board a separate policy/directive for these Clinicians that addresses: (1) any specific qualifications and/or training that they must possess beyond those set forth in this Policy; (2) a detailed description of their authorized scope of practice or clinical privileges; (3) any specific conditions that apply to their functioning within the Hospital; and (4) any supervision requirements, if applicable. In developing such policies/directives, the ad hoc committee shall consult the appropriate department chairperson(s) and applicable state law and may contact applicable professional societies or associations. The ad hoc committee may also recommend to the Board the number of Allied Health Professionals that are needed in a particular category.

ARTICLE 4

4. QUALIFICATIONS, CONDITIONS, AND RESPONSIBILITIES

4.A. QUALIFICATIONS

4.A.1. Eligibility Criteria

To be eligible to apply for initial and continued authorization to practice at the Hospital, an Allied Health Professionals must, where applicable:

a) where applicable to his or her practice, have a current, unrestricted license or certification to practice in Wisconsin and have never had a license or certification to practice revoked or suspended by any state licensing agency;

b) where applicable to his or her practice, have a current, unrestricted DEA registration;

c) be located (office and residence) close enough to fulfill his or her responsibilities as an Allied Health Professional and to provide timely and continuous care for his or her patients in the Hospital;

d) be available on a continuous basis to respond to the needs of patients in a prompt, efficient, and conscientious manner consistent with Hospital and Medical Staff policies pertaining to response times;

e) have current, valid professional liability insurance coverage in a form and in amounts satisfactory to the Hospital;

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

g) 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 or have been required to pay civil monetary penalties for the same;

h) have never had clinical privileges or scope of practice denied, revoked, or terminated by any health care facility or health plan for reasons related to clinical competence or professional conduct;

i) have never relinquished or resigned affiliation, clinical privileges or scope of practice during an investigation or in exchange for not conducting an investigation;

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

k) have completed a Background Information Disclosure form (HFS64) as required by the state of Wisconsin and, when required, have signed a disclosure and authorization to obtain criminal background reports;

l) satisfy all additional eligibility qualifications relating to his or her specific area of practice that may be established by the Hospital;

m) document compliance with all applicable training and/or educational protocols that may be adopted by the Executive Committee, including, but not limited to, those involving electronic medical records, patient safety, and infection control;

n) if seeking to practice as an Allied Health Professional, have a supervision agreement and/or collaborative agreement with a physician who is appointed to the Medical Staff; and

o) if seeking to practice as a Dependent Clinician, have a supervision agreement with a Medical Staff appointee or with an Independent Clinician.

4.A.2. Waiver of Eligibility Criteria

a) Any individual who does not satisfy one or more of the criteria outlined above may request a waiver.

b) A request for a waiver will be submitted to the Credentials Committee for consideration. 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.

c) In reviewing the request for a waiver, the Credentials Committee may consider the specific qualifications of the individual in question, input from the relevant department chairperson, and the best interests of the Hospital and the communities it serves. Additionally, the Credentials Committee may, in its discretion, consider the authorization form and other information supplied by the applicant. The Credentials Committee's recommendation will be forwarded to the Executive Committee. Any recommendation to grant a waiver must include the basis for such.

d) The Executive Committee will review the recommendation of the Credentials Committee and make a recommendation to the Board regarding whether to grant

or deny the request for a waiver. Any recommendation to grant a waiver must include the basis for such.

e) No individual is entitled to a waiver or to a hearing if the Executive Committee recommends and/or the Board determines not to grant a waiver.

f) A determination that an individual is not entitled to a waiver is not a "denial" of authorization to practice, clinical privileges, or scope of practice.

g) The granting of a waiver in a particular case is not intended to set a precedent for any other individual or group of individuals.

h) An authorization form that does not satisfy an eligibility criterion will not be processed until the Board has determined that a waiver should be granted.

4.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 applicable, as part of a request for permission to practice, as reflected in the following factors:

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

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

c) ability to safely and competently perform the clinical privileges or scope of practice requested;

d) good reputation and character;

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.

4.A.4. No Entitlement to Medical Staff Appointment

Allied Health Professionals shall not be appointed to the Medical Staff or entitled to the rights, privileges, and/or prerogatives of Medical Staff appointment.

4.A.5. Non-Discrimination Policy

No individual shall be denied permission to practice at the Hospital on the basis of gender, race, religion, creed, or national origin.

4.A.6. Ethical and Religious Directives

All Allied Health Professionals shall abide by the terms of the Ethical and Religious Directives for Catholic Health Care Services promulgated by the National Conference of Catholic Bishops with respect to their practice at the Hospital. No activity prohibited by said directives shall be engaged in at the Hospital by any Allied Health Professionals.

4.B. GENERAL CONDITIONS OF PRACTICE

4.B.1. Assumption of Duties and Responsibilities

As a condition of authorization to practice at the Hospital, all Allied Health Professionals (and their Supervising Clinicians, as applicable) shall specifically agree to the following:

a) to attend and participate in any required orientation program at the Hospital before actively seeing or treating patients;

b) to provide continuous and timely quality care to all patients in the Hospital for whom the individual has responsibility, including fulfilling any specific time requirements set forth in Hospital policies/directives;

c) to abide by all applicable bylaws, policies/directives, rules and regulations of the Medical Staff and Hospital;

d) to accept committee assignments and such other reasonable duties and responsibilities as may be assigned;

e) to provide, on a timely basis, proof of compliance with health testing requirements established by policies/directives (e.g., TB tests). Failure to do so shall result in automatic relinquishment of clinical privileges or scope of practice as set forth in Section 7.D of this Policy.

f) to maintain a current e-mail address with the Medical Staff Office, which will be the primary mechanism used to communicate all Medical Staff information to the individual;

g) to inform the President of the Medical Staff or designee (through notification of the Medical Staff Services office), in writing, of any change in the Clinician's status or any change in the information provided on the Clinician's application form. This information will be provided with or without request, at the time the change occurs, and will include, but not be limited to:

- changes in licensure or certification status, DEA controlled substance authorization, or professional liability insurance coverage;
- the filing of a professional liability lawsuit against the Clinician;
- changes in the Clinician's status at any other hospital or health care entity as a result of peer review activities;
- arrest, charge, indictment, conviction, or a plea of guilty or no contest in any criminal matter;
- exclusion or preclusion from participation in Medicare/Medicaid or any sanctions imposed;
- any changes in the Clinician's ability to safely and competently exercise clinical privileges, scope of practice or to perform the duties and responsibilities of permission to practice 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 Clinicians health policy); and
- any charge of, or arrest for, driving under the influence ("DUI"); any DUI incident will be reviewed by the President of the Medical Staff or designee and the CEO or designee so that they may understand the circumstances surrounding it. If they have any concerns after doing so, they will forward the matter for further review under the Clinicians health policy or this AHP Policy.

h) to immediately submit to an appropriate evaluation which may include diagnostic testing (such as blood and/or urine test) or to 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 and request such testing and/or evaluation. The health care professional(s) to perform the testing

and/or evaluations will be determined by the Medical Staff Leaders, and the Allied Health Professional will execute all appropriate releases to permit the sharing of information with the Medical Staff Leaders;

i) to acknowledge that the individual has had an opportunity to read a copy of this Policy and any other applicable bylaws, policies/directives, rules and regulations and agrees to be bound by them;

j) to comply with all applicable training and/or educational protocols that may be adopted by the Executive Committee, including, but not limited to, those involving electronic medical records, patient safety, and infection control;

k) to strictly comply with the standards of practice applicable to the functioning of Advanced Practice and Dependent Clinicians in the inpatient hospital setting, as set forth in Section 6.A of this Policy;

l) to appear for personal interviews in regard to an application for permission to practice as may be requested;

m) to refrain from illegal fee splitting or other illegal inducements relating to patient referral as prohibited by the Wisconsin Medical Practice Act (Wis. Stat. §448.08);

n) to refrain from assuming responsibility for diagnosis or care of hospitalized patients for which he or she is not qualified or without adequate supervision;

o) to refrain from deceiving patients as to the individual's status as an Allied Health Professional;

p) to seek consultation when appropriate;

q) to participate in the performance improvement and quality monitoring activities of the Hospital;

r) to complete, in a timely and legible manner, the medical and other required records, containing all information required by the Hospital;

s) to perform all services and conduct himself/herself at all times in a cooperative and professional manner;

t) to satisfy applicable continuing education requirements;

u) to pay any applicable application fees and assessments;

v) to cooperate with all utilization oversight activities;

w) to constructively participate in the development, review, and revision of clinical protocols and evidence-based medicine guidelines pertinent to his or her specialty, including those related to national patient safety initiatives and core measures; and

x) that, if there is any misstatement in, or omission from, the authorization or reauthorization application form, the Hospital may stop processing the form (or, if authorization to practice has been granted prior to the discovery of a misstatement or omission, the authorization may be deemed to be automatically relinquished). In either situation, there shall be no entitlement to the procedural rights provided in this Policy. The individual will be informed in writing of the nature of the misstatement or omission and permitted to provide a written response for the Credentials Committee's consideration.

4.B.2. Burden of Providing Information

a) Allied Health Professionals seeking authorization or reauthorization to practice shall 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 such qualifications.

b) Allied Health Professionals seeking authorization or reauthorization have the burden of providing evidence that all the statements made, and information given on the application are accurate.

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

d) It is the responsibility of the individual seeking authorization or reauthorization to practice, to provide a complete application including adequate responses from references. An incomplete application will not be processed.

4.C. APPLICATION

4.C.1. Information

a) The authorization and reauthorization application forms for both initial and renewed authorization to practice as an Allied Health Professional shall require detailed information concerning the applicant's professional qualifications. The

Allied Health Professional application forms existing now and as may be revised are incorporated by reference and made a part of this Policy. In addition to other information, the applications shall seek the following:

1. information as to whether the applicant's clinical privileges, scope of practice, authorization to practice, and/or affiliation has ever been voluntarily or involuntarily relinquished, withdrawn, denied, revoked, suspended, reduced, subjected to probationary or other conditions, limited, terminated, or not renewed at any hospital or health care facility, or is currently being investigated or challenged;

2. information as to whether the applicant's license or certification to practice any profession in any state, Drug Enforcement Administration registration, or any state controlled substance license (if applicable) is or has ever been voluntarily or involuntarily relinquished, suspended, modified, terminated, restricted, or is currently being investigated or challenged;

3. information concerning the applicant's professional liability litigation experience and/or any professional misconduct proceedings involving the applicant, in this state or any other state, whether such proceedings are closed or still pending, including the substance of the allegations of such proceedings or actions, the substance of the findings of such proceedings or actions, the ultimate disposition of any such proceedings or actions that have been closed, and any additional information concerning such proceedings or actions as the Credentials Committee, Executive Committee or Board may deem appropriate;

4. current information regarding the applicant's ability to perform, safely and competently, the scope of practice or clinical privileges requested and the duties of Allied Health Professionals; and

5. a copy of a government-issued photo identification.

b) The applicant shall sign the application and certify that he or she is able to perform the scope of practice or clinical privileges requested and the responsibilities of Allied Health Professionals.

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

By requesting an application and/or applying for permission to practice, the individual expressly accepts the following conditions:

a) Immunity:
To the fullest extent permitted by law, the individual releases from any and all liability, extends absolute immunity to, and agrees not to sue the Hospital or the

Board, any member of the Medical Staff or the Board, their authorized representatives, and third parties for any matter relating to permission to practice, clinical privileges, or scope of practice or the individual's qualifications for the same. This immunity covers any actions, recommendations, reports, statements, communications, and/or disclosures involving the individual that are made, taken, or received by the Hospital, its authorized agents, or third parties in the course of credentialing and peer review activities.

b) Authorization to Obtain Information from Third Parties:
The individual specifically authorizes the Hospital, Medical Staff Leaders, and their authorized representatives (1) to consult with any third party who may have information bearing on the individual's professional qualifications, credentials, clinical competence, character, ability to perform safely and competently, ethics, behavior, or any other matter reasonably having a bearing on his or her qualifications for initial and continued authorization to practice at the Hospital, 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 other hospitals, health care facilities, managed care organizations, government regulatory and licensure boards or agencies, and their agents when information is requested in order to evaluate his or her professional qualifications for permission to practice, clinical privileges, scope of practice and/or participation at the requesting organization/facility, and any licensure or regulatory matter. The specific process for release of information will be coordinated by the Medical Staff Office.

d) Authorization to Share Information Between Hospitals:
The individual specifically authorizes St. Vincent Hospital, St. Mary's Hospital Medical Center, St. Nicholas Hospital, and St. Clare Memorial Hospital to share credentialing and peer review information pertaining to the individual's clinical competence and/or professional conduct. This information may be shared at initial authorization or reauthorization and at any other time during the individual's appointment.

e) Procedural Rights:
The Allied Health Professional agrees that the procedural rights 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:
If, despite this Section, an individual institutes legal action challenging any credentialing, privileging, peer review, or other action affecting an individual's authorization to practice and does not prevail, he or she will reimburse the Hospital and any member of the Medical Staff or Board involved in the action for all costs incurred in defending such legal action, including reasonable attorney's fees and lost revenues.

g) Scope of Section:
All of the provisions in this Section 4.C.2 are applicable in the following situations:

1. whether or not permission to practice and clinical privileges or scope of practice are granted;

2. throughout the term of any affiliation with the Hospital and thereafter;

3. should permission to practice, clinical privileges or scope of practice be denied, revoked, reduced, restricted, suspended, and/or otherwise affected as part of the Hospital's professional review activities; and

4. as applicable, to any third-party inquiries received after the individual leaves the Hospital about his or her tenure as a member of the Allied Health Professionals staff.

ARTICLE 5

5. CREDENTIALING PROCEDURE

5.A. PROCESSING OF INITIAL APPLICATION TO PRACTICE

5.A.1. Request for Application

a) Any individual requesting an application for permission to practice as an Allied Health Professional shall be sent a letter that outlines the eligibility criteria for permission to practice and the application form.

b) An Allied Health Professional who is in a category of Clinicians that has not been approved by the Board to practice at the Hospital shall be ineligible to receive an application. A determination of ineligibility does not entitle an Allied Health Professional to the procedural rights outlined in Article 8 of this Policy.

5.A.2. Initial Review of Application

a) A completed application, with copies of all required documents, must be returned to the Medical Staff Office or designated Credentials Verification Office ("CVO") within 90 days. The application must be accompanied by the application processing fee.

b) As a preliminary step, the Medical Staff Office or CVO shall review the application to determine that the individual satisfies all threshold criteria. An individual who fails to meet the eligibility criteria set forth in Section 4.A.1 of this Policy shall be notified that his or her application shall not be processed. A determination of ineligibility does not entitle an Allied Health Professional to the procedural rights outlined in Article 8 of this Policy.

c) The Medical Staff Office or CVO shall also review the application to determine if all questions have been answered, all references and other information or materials have been received, and pertinent information provided on the application has been verified with primary sources. If an application is complete, it shall be transmitted, along with all supporting documentation, to the applicable department chairperson.

5.A.3. Department Chairperson Procedure

a) The Medical Staff Office shall transmit the complete application and all supporting materials to the appropriate department chairperson or the individual to whom the chairperson has assigned this responsibility. Each chairperson shall prepare a written report regarding whether the applicant has satisfied all of the qualifications

for authorization to practice and the clinical privileges or scope of practice requested. As part of the process of making this report, the department chairperson has the right to meet with the applicant and the Supervising Clinicians (if applicable) to discuss any aspect of the application, qualifications, and requested scope of practice or clinical privileges. The department chairperson may also confer with experts within the department and outside of the department in preparing the report (e.g., other physicians, relevant Hospital department heads, nurse managers). In the event that the department chairperson or the individual to whom the department chairperson has assigned the responsibility is unavailable or unwilling to prepare a written report, the Chairperson of the Credentials Committee or the President of the Medical Staff shall appoint an individual to prepare the report.

b) The department chairperson shall be available to the Credentials Committee, Executive Committee, or the Board to answer any questions that may be raised with respect to that chairperson's report and findings.

5.A.4. Credentials Committee Procedure

a) The Credentials Committee shall review the report from the appropriate department chairperson and the information contained in references given by the applicant and from other available sources. The Credentials Committee shall examine evidence of the applicant's character, professional competence, qualifications, prior behavior, and ethical standing and shall determine whether the applicant has established and satisfied all of the necessary qualifications for the clinical privileges or scope of practice requested.

b) The Credentials Committee may use the expertise of any individual on the Medical Staff or in the Hospital, or an outside consultant, if additional information is required regarding the applicant's qualifications. The Credentials Committee may also meet with the applicant and, when applicable, the supervising physician. The appropriate department chairperson may participate in this interview.

c) After determining that an applicant is otherwise qualified for authorization to practice and the scope of practice or clinical privileges requested, the Credentials Committee shall review the applicant's Ability to Perform Privileges/Scope of Practice Requested form to determine if there is any question about the applicant's ability to perform the scope of practice or privileges requested and the responsibilities of permission to practice. If so, the Credentials Committee may require the applicant to undergo a physical, mental, and/or behavioral examination by a physician(s) satisfactory to the Credentials Committee. 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 Credentials Committee shall be considered an incomplete application and all processing of the application shall cease.

d) Applicants over the age of 65 must obtain appropriate health assessments as part of the process of requesting permission to practice. Specifically, applicants over the age of 65 will be required to have a physical and mental health assessment performed by a physician, APRN or PA-C who is acceptable to the Credentials Committee. The examining provider shall provide a written report, addressing whether the individual has any physical or mental condition that may affect his/her ability to safely and competently exercise the scope of practice or clinical privileges requested, discharge the responsibilities of authorization to practice, or work cooperatively in a hospital setting. The examining provider shall provide this report directly to the Chairperson of the Credentials Committee and shall be available to discuss any questions or concerns that the Committee may have.

e) The Credentials Committee may recommend the imposition of specific conditions. These conditions may relate to behavior (e.g., personal code of conduct) or to clinical issues (e.g., general consultation requirements, appropriate documentation requirements, proctoring, completion of education requirements). The Credentials Committee may also recommend that permission to practice be granted for a period of less than two years in order to permit closer monitoring of an individual's compliance with any conditions.

f) The Credentials Committee's recommendation will be forwarded to the Executive Committee.

5.A.5. Executive Committee Procedure

a) At its next meeting, after receipt of the written findings and recommendation of the Credentials Committee, the Executive Committee shall:

    1. adopt the findings and recommendations of the Credentials Committee as its own; or

    2. refer the matter back to the Credentials Committee for further consideration and responses to specific questions raised by the Executive Committee; or

    3. set forth in its report and recommendation clear and convincing reasons, along with supporting information for its disagreement with the Credentials Committee's recommendation.

b) If the Executive Committee's recommendation is favorable to the applicant, the Committee shall forward its recommendation to the Board, through the CEO or CPE

or designee, including the findings and recommendation of the department chairperson and the Credentials Committee. The Executive Committee's recommendation must specifically address the clinical privileges or scope of practice requested by the applicant, which may be qualified by any probationary or other conditions or restrictions relating to such clinical privileges or scope of practice.

c) If the Executive Committee's recommendation is unfavorable and would entitle the applicant to the procedural rights set forth in this Policy, the Executive Committee shall forward its recommendation to the CEO or CPE or designee, who shall notify the applicant of the recommendation and his or her procedural rights. The CEO or CPE shall then hold the Executive Committee's recommendation until after the individual has completed or waived the procedural rights outlined in this Policy.

5.A.6. Board Action

a) Expedited Review: The Board may delegate to a committee, consisting of at least two Board members, action on applications if there has been a favorable recommendation from the Credentials Committee or designee and the Executive Committee or designee 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 privileges or scope of practice 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 grant the clinical privileges or scope of practice requested will be effective immediately and will be forwarded to the Board for ratification at its next meeting.

b) Full Board Review: When there has been no delegation to a Board committee, upon receipt of a recommendation that the applicant be granted the clinical privileges or scope of practice requested, the Board may:

    1. grant the applicant authorization to practice and clinical privileges or scope of practice as recommended; or

    2. refer the matter back to the Credentials Committee or Executive Committee or to another source inside or outside the Hospital 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 Chairperson of the Credentials Committee and the President of the Medical Staff. If the Board's determination remains unfavorable to the applicant, the CEO or designee will promptly send special notice to the applicant that the applicant is entitled to request the procedural rights as outlined in this Policy.

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

5.B. CLINICAL PRIVILEGES AND SCOPES OF PRACTICE

5.B.1. General

The clinical privileges recommended to the Board for Independent Clinicians and Allied Health Professionals will be based upon consideration of the following factors:

a) 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 the same;

b) ability to perform the privileges requested competently and safely;

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

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

e) the Hospital's available resources and personnel;

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

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

h) Clinicians-specific data as compared to aggregate data, when available;

i) morbidity and mortality data, when available; and

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

5.B.2. Focused Professional Practice Evaluation

All new clinical privileges for Independent and Allied Health Professionals, regardless of when they are granted (initial authorization to practice, renewal of authorization to practice, or at any time in between), will be subject to focused professional practice evaluation in order to confirm competence. The focused professional practice evaluation process for these situations is outlined in the Professional Practice Evaluation Policy.

5.C. TEMPORARY CLINICAL PRIVILEGES OR SCOPE OF PRACTICE

5.C.1. Eligibility to Request Temporary Clinical Privileges or Temporary Scope of Practice

a) Locum Tenens.

The CEO or designee, upon recommendation of the President of the Medical Staff, the applicable department chairperson, and the Credentials Committee, may grant temporary privileges to an Independent Clinicians or Allied Health Professionals or temporary scope of practice to a Dependent Clinicians serving as a locum tenens, for an appointee of the Allied Health Professionals staff to attend patients of that appointee, or may grant locum tenens privileges to provide coverage in a specialty area in which there is no coverage or a shortage of individuals to provide coverage to meet the patient care need. The following conditions apply:

1. the applicant has submitted an appropriate application, along with the application fee;

2. the verification process is complete, including verification of current licensure or certification, relevant training or experience, current competence (verification of good standing in all hospitals where the individual practiced for at least the previous two years), ability to exercise the privileges or scope of practice requested, and current professional liability coverage; and consideration of information from the National Clinicians Data Bank, from a criminal background check, and from OIG queries and appropriate provider health immunities per policy;

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 membership or involuntary limitation, reduction, denial, or loss of clinical privileges, at another health care facility;

4. applicants granted temporary privileges will be subject to any focused professional practice requirements established by the Hospital; and

5. the individual may exercise locum tenens temporary privileges or scope of practice for a maximum of 120 days, consecutive, in exceptional situations, this period of time may be extended up to an additional 120 days at the discretion of the CEO or designee and the President of the Medical Staff, subject to the following conditions:

    i. the individual must notify the Medical Staff Office prior to each time that he or she will be exercising these privileges; and

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

b) Patient Care Need. Temporary privileges or scope of practice may also be granted in other limited situations by the CEO or designee, upon recommendation of the President of the Medical Staff and the applicable department chairperson, when there is an important patient care, treatment, or service need. Specifically, temporary privileges or scope of practice may be granted for situations such as the following:

    1. the care of a specific patient;

    2. when a proctoring or consulting Clinicians is needed, but is otherwise unavailable; or

    3. when necessary to prevent a lack or lapse of services in a needed specialty area.

    The following factors will be considered and verified prior to the granting of temporary privileges in these situations: a complete application, payment of application fee, current licensure or certification, relevant training or experience, current competence (verification of good standing in all hospitals where the individual practiced for at least the previous two years) and ability to perform the privileges requested, current professional liability coverage acceptable to the

Hospital, and results of a query to the National Clinicians Data Bank, from a criminal background check, and from OIG queries and appropriate provider health immunities per policy.

The applicant demonstrates that there are no current or previously successful challenge to licensure or registration, no subjection to involuntary termination of medical staff membership at another organization, no subjection to involuntary limitation, reduction, denial, or loss of clinical privileges. The grant of clinical privileges in these situations will not exceed 120 days. In exceptional situations, this period of time may be extended in the discretion of the CEO or designee and the President of the Medical Staff.

c) Individuals who are granted temporary privileges will be subject to the Hospital policy/directive regarding focused professional practice evaluation.

5.C.2. Withdrawal of Temporary Clinical Privileges or Scope of Practice

The CEO or designee may, at any time after consulting with the President of the Medical Staff, the Chairperson of the Credentials Committee, or the department chairperson, withdraw temporary privileges or scope of practice for any reason.

5.D. PROCESSING APPLICATIONS FOR RENEWAL TO PRACTICE

5.D.1. Submission of Application

a) The grant of permission to practice will be for a period not to exceed two years. A request to renew clinical privileges or scope of practice will be considered only upon submission of a completed renewal application.

b) At least four months prior to the date of expiration of an Advanced Practice Clinician's clinical privileges or scope of practice, the Medical Staff Office or CVO will notify the individual of the date of expiration and provide the individual with a renewal application. A completed renewal application must be returned to the Medical Staff Office or designated CVO within 30 days.

c) Failure to return a completed application within 30 days shall result in the assessment of a renewal late fee. In addition, failure to submit a complete application at least two months prior to the expiration of the individual's current term will result in automatic expiration of clinical privileges or scope of practice at the end of the then current term, unless the application can still be processed in the normal course, without extraordinary effort on the part of the Medical Staff Office and the Medical Staff Leaders.

d) Once an application for renewal of clinical privileges or scope of practice has been completed and submitted, it will be evaluated following the same procedures outlined in this Policy regarding initial applications.

5.D.2. Renewal Process for Independent and Allied Health Professionals

a) The procedures pertaining to an initial request for clinical privileges, including eligibility criteria and factors for evaluation, will be applicable in processing requests for renewal for these Clinicians.

b) As part of the process for renewal of clinical privileges, the following factors will be considered:

1. an assessment prepared by the applicable department chairperson;

2. an assessment prepared by a peer, if possible;

3. results of the Hospital's performance improvement and ongoing and focused professional practice evaluation activities, taking into consideration, when applicable, Clinicians specific information compared to aggregate information concerning other individuals in the same or similar specialty (provided that, other Clinicians will not be identified);

4. resolution of any verified complaints received from patients or staff; and

5. any focused professional practice evaluations.

c) In addition to the above, for Allied Health Professionals, the following information will be considered:

1. an assessment prepared by the Supervising Clinicians(s); and

2. an assessment prepared by the applicable Hospital supervisor (i.e., OR Supervisor, Nursing Supervisor).

5.D.3. Renewal Process for Dependent Clinicians

a) The procedures pertaining to an initial request for a scope of practice, including eligibility criteria and factors for evaluation, will be applicable in processing requests for renewal for these Clinicians.

b) As part of the process for renewal of scope of practice, the following factors will be considered:

1. the annual competency assessments of the individual performed by the Supervising Clinicians(s) and/or the applicable Hospital department heads (i.e., OR Supervisor, Nursing Supervisor); and

2. resolution of any validated complaints received from patients or staff.

ARTICLE 6

6. CONDITIONS OF PRACTICE APPLICABLE TO ADVANCED PRACTICE AND DEPENDENT CLINICIANS

6.A. STANDARDS OF PRACTICE FOR THE UTILIZATION OF ADVANCED PRACTICE AND DEPENDENT CLINICIANS IN THE INPATIENT HOSPITAL SETTING

1. Advanced Practice and Dependent Clinicians are not permitted to function independently in the inpatient Hospital setting. As a condition of being granted permission to practice at the Hospital, all Advanced Practice and Dependent Clinicians 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 Advanced Practice and Dependent Clinicians in the Hospital, all individuals who serve as Supervising Clinicians to such individuals also specifically agree to abide by the standards set forth in this Section.

2. The following standards of practice apply to the functioning of Advanced Practice and Dependent Clinicians in the inpatient Hospital setting:

    a) Admitting Privileges. Advanced Practice and Dependent Clinicians are not granted inpatient admitting privileges and therefore may not admit patients independent of the Supervising Clinicians.

    b) Consultations. Advanced Practice and Dependent Clinicians may not independently provide patient consultations in lieu of the Clinician's Collaborating/Supervising Physician. A credentialed Advanced Practice Clinician may perform and document assessments in the medical record. The APC must document their discussion with the collaborating physician (i.e. diagnostic tests, plan of care, treatment plan, etc.). The sponsoring physician is required to document that he/she concurs with the assessment and that he/she has physically examined the patient and/or completed a thorough review of radiographic/diagnostic studies and documented the consultation in the patient's medical record within 24 hours (or more timely in the case of any emergency consultation request).

    c) Emergency On-Call Coverage. Advanced Practice and Dependent Clinicians may not independently participate in the emergency on-call roster (formally, or informally by agreement with their Supervising Clinicians), in lieu of the Supervising Clinicians. The Supervising Clinicians (or their covering Clinicians) must personally respond to all calls in a timely manner, in accordance with requirements set forth in the Medical Staff Credentials Policy. Following discussion with the Emergency Department, the Supervising Clinicians may direct an Advanced Practice or Dependent Clinicians to see the patient, gather

data, and order tests for further review by the Supervising Clinicians. However, the Supervising Clinicians must still personally see the patient when requested by the Emergency Department physician.

d) Calls Regarding Supervising Clinician's Hospitalized Inpatients. Advanced Practice and Dependent Clinicians may not independently respond to calls from the floor or special care units regarding hospitalized inpatients (formally, or informally by agreement with their Supervising Clinicians), in lieu of the Supervising Clinicians. It shall be within the discretion of the Hospital personnel requesting assistance whether it is appropriate to contact an Advanced Practice or Dependent Clinician prior to the Supervising Clinicians. However, the Supervising Clinician must personally respond to all calls directed to him or her in a timely manner.

6.B. OVERSIGHT BY SUPERVISING CLINICIANS

1. Any activities permitted to be performed at the Hospital by an Advanced Practice or Dependent Clinician shall be performed only under the supervision or direction of a Supervising Clinician.

2. Advanced Practice or Dependent Clinicians may function in the Hospital only so long as (i) they are supervised by a Supervising Clinician who is currently appointed to the Medical Staff or is an Independent Clinician, and (ii) they have a current, written supervision or collaborating agreement with the Supervising Clinician. In addition, should the Medical Staff appointment or clinical privileges of the Supervising Clinician be revoked or terminated, the Advanced Practice or Dependent Clinician's permission to practice at the Hospital and clinical privileges or scope of practice shall be automatically relinquished (unless the individual will be supervised by another approved individual).

3. As a condition of clinical privileges or a scope of practice, an Advanced Practice or Dependent Clinician and the Supervising Clinician must provide the Hospital with a copy of their written supervision or collaboration agreement as well as notice of any revisions or modifications that are made to such agreements between them. This notice must be provided to the Medical Staff Office within three days of any such change.

6.C. QUESTIONS REGARDING AUTHORITY OF AN ADVANCED PRACTICE OR DEPENDENT CLINICIANS

1. 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 Advanced Practice or Dependent Clinician, either to act or to issue instructions outside the physical presence of the Supervising Clinician in a particular instance, the Medical Staff member or Hospital employee shall have the right to require that the Advanced

Practice or Dependent Clinician's Supervising Clinician validate, either at the time or later, the instructions of the Advanced Practice or Dependent Clinician. Any act or instruction of the Advanced Practice or Dependent Clinician shall be delayed until such time as the staff member or Hospital employee can be certain that the act is clearly within the scope of the Advanced Practice or Dependent Clinician's activities as permitted by the Board. In these situations, the Medical Staff member or Hospital employee shall first discuss the matter with the Supervising Clinician. If that does not resolve the matter, the President of the Medical Staff will be contacted.

2. Any question regarding the clinical practice or professional conduct of an Advanced Practice or Dependent Clinician shall be immediately reported to the President of the Medical Staff, the Chairperson of the Credentials Committee, the relevant department chair, or the CEO or designee, who shall undertake such action as may be appropriate under the circumstances. The individual to whom the concern has been reported will also discuss the matter with the Supervising Clinician.

6.D. RESPONSIBILITIES OF SUPERVISING CLINICIANS

1. Physicians who wish to utilize the services of an Advanced Practice or Dependent Clinician in their clinical practice at the Hospital must notify the Medical Staff Office of this fact in advance and must ensure that the individual has been appropriately credentialed in accordance with this Policy before the Advanced Practice or Dependent Clinician participates in any clinical or direct patient care of any kind in the Hospital.

2. The Supervising Clinician will remain responsible for all care provided by the Advanced Practice or Dependent Clinician in the Hospital.

3. Supervising Clinicians who wish to utilize the services of Advanced Practice or Dependent Clinicians in the inpatient setting specifically agree to abide by the standards of practice set forth in Section 6.A above.

4. The number of Advanced Practice or Dependent Clinicians acting under the supervision of one Supervising Clinician, as well as the care they may provide, will be consistent with applicable state statutes and regulations and any other policies adopted by the Hospital. The Supervising Clinician will make all appropriate filings with the State Board of Medicine regarding the supervision and responsibilities of the Advanced Practice or Dependent Clinician, to the extent that such filings are required, and shall provide a copy of the same to the Medical Staff Office.

5. It will be the responsibility of the Supervising Clinician to ensure that the Advanced Practice or Dependent Clinician maintains professional liability insurance coverage in amounts required by the Board. The insurance must cover any and all activities of the Advanced Practice or Dependent Clinicians in the Hospital. The Supervising Clinician will

furnish evidence of such coverage to the Hospital. The Advanced Practice or Dependent Clinicians will act in the Hospital only while such coverage is in effect.

ARTICLE 7

7. PROCEDURES FOR QUESTIONS INVOLVING ALLIED HEALTH PROFESSIONALS

7.A. COLLEGIAL INTERVENTION

1. As part of the Hospital's performance improvement and professional practice evaluation activities, this Policy encourages the use of collegial efforts and progressive steps with Allied Health Professionals (and their Supervising Clinicians, as applicable) by Medical Staff Leaders and the Administrative team in order to arrive at voluntary, responsive actions by individuals to resolve questions that have been raised. Collegial intervention efforts are not mandatory and shall be within the discretion of the appropriate Medical Staff Leaders.

2. Collegial intervention efforts may include, but are not limited to, counseling, sharing of comparative data, monitoring, and additional training or education. All such efforts shall be documented in an individual's confidential file.

3. Collegial intervention efforts are a part of ongoing and focused professional practice evaluation activities.

4. The President of the Medical Staff, shall determine whether to direct that a matter be handled in accordance with another policy (e.g., policy on Clinicians health, code of conduct policy, OPPE Policy, FPPE Policy) or to direct the matter to the Executive Committee for further review and/or investigation.

7.B. ONGOING AND FOCUSED PROFESSIONAL PRACTICE EVALUATIONS

All ongoing and focused professional practice evaluations shall be conducted in accordance with the Professional Practice Evaluation Policy. Matters that are not satisfactorily resolved through collegial intervention or through the Professional Practice Evaluation Policy shall be referred to the Executive Committee for its review in accordance with Section 7.C below. Such interventions and evaluations, however, are not mandatory prerequisites to Executive Committee review.

7.C. INVESTIGATIONS

7.C.1. Initiation of Investigation

When a question involving clinical competence or professional conduct of an Allied Health Professional is referred to, or raised by, the Executive Committee, the Executive Committee

will review the matter and determine whether to conduct an investigation, to direct the matter to be handled pursuant to another policy, or to proceed in another manner.

7.C.2. Investigative Procedure

a) The Executive Committee will either investigate the matter itself, request that the Credentials Committee conduct the investigation, or appoint an ad hoc committee to conduct the investigation ("investigating committee"). The investigating committee will not include relatives or financial partners of the Allied Health Professional or the Advanced Practice Clinician's Supervising Clinician (where applicable).

b) The investigating committee will have the authority to review relevant documents and interview individuals. It will also have available to it the full resources of the Medical Staff and the Hospital.

c) The investigating committee will also have the authority to use outside consultants, if needed.

d) 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 being investigated 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.

e) The individual will have an opportunity to meet with the investigating committee before it makes its report. Prior to this meeting, the individual will be informed of the general questions being investigated. At the meeting, the individual will be invited to discuss, explain, or refute the questions that gave rise to the investigation. No recording (audio or video) or transcript of the meeting shall be permitted or made. A summary of the interview will be prepared. This meeting is not a hearing, and none of the procedural rules for hearings will apply. The individual being investigated will not have the right to be represented by legal counsel at this meeting.

f) The investigating committee will make a reasonable effort to complete the investigation and issue its report within 30 days of the commencement of the investigation, provided that an outside review is not necessary. When an outside review is necessary, the investigating committee will make a reasonable effort to complete the investigation and issue its report within 30 days of receiving the results of the outside review. These time frames are intended to serve only as guidelines.

g) At the conclusion of the investigation, the investigating committee will prepare a report with its findings, conclusions, and recommendations.

7.C.3. Recommendation

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

1. determine that no action is justified;
2. issue a letter of guidance, counsel, warning, or reprimand;
3. impose conditions for continued permission to practice;
4. impose a requirement for monitoring, proctoring, or consultation;
5. impose a requirement for additional training or education;
6. recommend reduction of clinical privileges or scope of practice;
7. recommend suspension of clinical privileges or scope of practice for a term;
8. recommend revocation of clinical privileges or scope of practice; or
9. make any other recommendation that it deems necessary or appropriate.

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

c) If the Executive Committee makes a recommendation that does not entitle the individual to request a hearing, it will take effect immediately and will remain in effect unless modified by the Board.

7.D. ADMINISTRATIVE SUSPENSION

1. The President of the Medical Staff, the appropriate department chairperson, the CEO or designee, and the Executive Committee will each have the authority to impose an administrative suspension of all or any portion of the scope of practice or clinical privileges of any Allied Health Professionals whenever a question has been raised about such individual's clinical care or professional conduct.

2. An administrative suspension will become effective immediately upon imposition, will immediately be reported in writing to the CEO or designee and the President of the Medical Staff, and will remain in effect unless or until modified by the CEO or designee or the Executive Committee. The imposition of an administrative suspension does not entitle an Allied Health Professional to the procedural rights set forth in Article 8 of this Policy.

3. Upon receipt of notice of the imposition of an administrative suspension, the CEO or designee and President of the Medical Staff will forward the matter to the Executive Committee which will review and consider the question(s) raised and thereafter make a recommendation to the Board.

7.E. AUTOMATIC RELINQUISHMENT OF SCOPE OF PRACTICE OR CLINICAL PRIVILEGES

1. An Advanced Practice Clinician's clinical privileges or scope of practice shall be automatically relinquished, without entitlement to the procedural rights outlined in this Policy, in the following circumstances:

    a) the Allied Health Professional no longer satisfies any of the threshold eligibility criteria set forth in Section 4.A.1 or any additional threshold credentialing qualifications set forth in the specific Hospital policy/directive relating to his or her discipline;

    b) the Allied Health Professional is arrested, charged, indicted, convicted, or enters a plea of guilty or no contest 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 addressed in the manner outlined in Section 4.B.1(g) of this Policy);

    c) the Allied Health Professional fails to provide information pertaining to his or her qualifications for the scope of practice or clinical privileges, including proof of compliance with health testing requirements, in response to a written request from the Credentials Committee, the Professional Practice Evaluation Committee, the Executive Committee, the CEO or designee, or any other committee authorized to request such information;

    d) the Allied Health Professional fails to complete or comply with required training or educational requirements;

    e) a determination is made that there is no longer a need for the services of a particular discipline or category of Allied Health Professionals;

f) an Advanced Practice or Dependent Clinician fails, for any reason, to maintain an appropriate relationship with a Supervising Clinician as defined in this Policy; or

g) any Allied Health Professional employed by the Hospital has his or her employment terminated.

2. Requests for reinstatement

a) Requests for reinstatement following the expiration of a license or certification, controlled substance authorization, insurance coverage, proof of compliance with health testing requirements (e.g., TB tests), or certifications required by an individual's clinical privileges (e.g., ACLS) will be processed by the CVO or Medical Staff Office. If any questions or concerns are noted by the CVO, the CVO will refer the matter to the Medical Staff Office for further review in accordance with (2)(b) below.

b) All other requests for reinstatement shall be reviewed by the relevant department chairperson and the President of the Medical Staff. If these individuals make a favorable recommendation on reinstatement, the Allied Health Professional may immediately resume clinical practice at the Hospital. This determination shall then be forwarded to the Credentials Committee, Executive Committee, and the Board for ratification. If, however, either of these individuals reviewing the request have any questions or concerns, those questions shall be noted, and the reinstatement request shall be forwarded to the full Credentials Committee, Executive Committee, and Board for review and recommendation.

7.F. LEAVE OF ABSENCE

1. Allied Health Professionals must request a leave of absence for any absence from patient care responsibilities for longer than 60 days, for a reason that is unrelated to physical or mental health or otherwise to the individual's ability to care for patients safely and competently. (Leaves of absence for health-related matters are addressed in provision (2) below.)

2. Except for maternity leaves, Allied Health Professionals must report to the CEO or designee any time they are away from patient care responsibilities for longer than 14 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, the CEO or designee, in consultation with the President of the Medical Staff, may trigger an automatic medical leave of absence if the individual does not request such a leave on his or her own behalf.

3. An Allied Health Professional may request a leave of absence by submitting a written request to the CEO or designee. Except in extraordinary circumstances, this request will be submitted at least 30 days prior to the anticipated start of the leave. The request must state the beginning and ending dates of the leave, which shall not exceed one year, and the reasons for the leave.

4. The CEO or designee will determine whether a request for a leave of absence shall be granted. In determining whether to grant a request, the CEO or designee shall consult with the President of the Medical Staff and the relevant department chairperson. The granting of a leave of absence, or reinstatement, as appropriate, may be conditioned upon the individual's completion of all medical records.

5. During the leave of absence, the individual shall not exercise any clinical privileges and shall be excused from any committee service or other Hospital obligations during this period.

6. 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 relevant department chairperson, the Chairperson of the Credentials Committee, the President of the Medical Staff, and the CEO or designee. If all these individuals make a favorable recommendation on reinstatement, the Allied Health Professional may immediately resume clinical practice at the Hospital. This determination shall then be forwarded to the Credentials Committee, the Executive Committee, and the Board for ratification. If, however, any of the individuals reviewing the request have any questions or concerns, those questions shall be noted, and the reinstatement request shall be forwarded to the full Credentials Committee, Executive Committee, 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.

7. With the exception of maternity leaves, if the leave of absence was for health reasons, the request for reinstatement must be accompanied by a report from the individual's treating physician indicating that the individual is physically and/or mentally capable of resuming a hospital practice and safely exercising the clinical privileges requested.

8. Absence for longer than one year shall result in automatic relinquishment of clinical privileges unless an extension is granted by the CEO or designee. Extensions will be considered only in extraordinary cases where the extension of a leave is in the best interest of the Hospital.

9. If an individual's clinical privileges are due to expire during the leave, the individual must apply for renewed clinical privileges or they will lapse at the end of the current term.

10. Failure to request reinstatement from a leave of absence in a timely manner shall be deemed a voluntary resignation of clinical privileges.

11. 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. In such case, the individual shall revert to his or her previous status unless one of the other provisions above (e.g., the individual failed to apply for renewed clinical privileges timely) applies.

ARTICLE 8

8. PROCEDURAL RIGHTS FOR ALLIED HEALTH PROFESSIONALS

8.A. PROCEDURAL RIGHTS FOR INDEPENDENT CLINICIANS AND ALLIED HEALTH PROFESSIONALS

8.A.1. Notice of Recommendation and Hearing Rights

a) In the event a recommendation is made by the Executive Committee that an Independent Clinicians or Allied Health Professional not be granted clinical privileges or that the privileges previously granted be restricted for a period of more than 30 days, terminated, or not renewed, the individual will receive special notice of the recommendation. The special notice will include a general statement of the reasons for the recommendation and will advise the individual that he or she may request a hearing.

b) The rights and procedures in this Section will also apply if the Board, without a prior adverse recommendation from the Executive Committee, makes a recommendation not to grant clinical privileges or that the privileges previously granted be restricted, terminated, or not renewed. In this instance, all references in this Article to the Executive Committee will be interpreted as a reference to the Board.

c) If the Independent Clinicians or Allied Health Professional wants to request a hearing, the request must be in writing, directed to the CEO or designee, within 30 days after receipt of written notice of the adverse recommendation.

d) The hearing will be convened as soon as is practical, but no sooner than 30 days after the notice of the hearing, unless an earlier hearing date has been specifically agreed to by the parties.

8.A.2. Hearing Committee

a) If a request for a hearing is made timely, the CEO or designee, in consultation with the President of the Medical Staff, will appoint a Hearing Committee composed of up to three individuals (including, but not limited to, members of the Medical Staff, Allied Health Professionals, Hospital management, individuals not connected with the Hospital, or any combination of these individuals). The Hearing Committee will not include anyone who previously participated in the recommendation, any relatives or practice partners of the Independent Clinicians or Allied Health Professionals, or any competitors of the affected individual.

b) The CEO or designee, in consultation with the President of the Medical Staff, will appoint a Presiding Officer, who may be legal counsel to the Hospital. The role of the

Presiding Officer will be to allow the participants in the hearing to have a reasonable opportunity to be heard and to present evidence, subject to reasonable limits on the number of witnesses and duration of direct and cross examination. The Presiding Officer will maintain decorum throughout the hearing.

c) As an alternative to a Hearing Committee, the CEO or designee, in consultation with the President of the Medical Staff, may appoint a Hearing Officer to perform the functions that would otherwise be carried out by the Hearing Committee. The Hearing Officer will preferably be an attorney at law. The Hearing Officer may not be in direct economic competition with the individual requesting the hearing and will not act as a prosecuting officer or as an advocate to either side at the hearing. If the Hearing Officer is an attorney, he or she shall not represent clients who are in direct economic competition with the affected individual. In the event a Hearing Officer is appointed instead of a Hearing Committee, all references in this Article to the Hearing Committee or Presiding Officer will be deemed to refer instead to the Hearing Officer, unless the context would clearly otherwise require.

d) The hearing shall be convened as soon as is practical, but no sooner than 30 days after the notice of the hearing, unless an earlier hearing date has been specifically agreed to by the parties.

8.A.3. Hearing Process

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

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

c) At the hearing, a representative of the Executive Committee will first present the reasons for the recommendation. The Independent Clinician or Allied Health Professional will be invited to present information to refute the reasons for the recommendation.

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

e) The Independent Clinician or Allied Health Professional and the Executive Committee may be represented at the hearing by legal counsel. However, while counsel may be present at the hearing, counsel will not call, examine, or cross examine witnesses or present the case.

f) The Independent Clinicians or Allied Health Professionals will have the burden of demonstrating, by clear and convincing evidence, that the recommendation of the Executive Committee was arbitrary, capricious, or not supported by substantial evidence. The quality of care provided to patients and the smooth operation of the Hospital will be the paramount considerations.

g) The Independent Clinicians or Allied Health Professionals and the Executive Committee will have the right to prepare a post-hearing memorandum for consideration by the Hearing Committee. The Presiding Officer will establish a reasonable schedule for the submission of such memoranda.

8.A.4. Hearing Committee Report

a) Within 20 days after the conclusion of the proceeding or submission of the post hearing memoranda, whichever date is later, the Hearing Committee will prepare a written report and recommendation. The Hearing Committee will forward the report and recommendation, along with all supporting information, to the CEO or designee. The CEO or designee will send a copy of the written report and recommendation by special notice to the Independent Clinicians or Allied Health Professionals and to the Executive Committee.

b) Within ten days after notice of such recommendation, the Independent Clinicians or Allied Health Professionals and/or the Executive Committee may make a written request for an appeal. The request must include a statement of the reasons, including specific facts, which justify an appeal.

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

d) The request for an appeal will be delivered to the CEO or designee by special notice.

e) If a written request for appeal is not submitted timely, the appeal is deemed to be waived and the recommendation and supporting information will be forwarded to the Board for final action. If a timely request for appeal is submitted, the CEO or designee will forward the report and recommendation, the supporting information and the request for appeal to the Board. The Chairperson of the Board will arrange for an appeal.

8.A.5. Appellate Review

a) An Appellate Review Committee appointed by the Chairperson of the Board will consider the record upon which the adverse recommendation was made. New or

additional written information that is relevant and could not have been made available to the Hearing Committee may be considered at the discretion of the Appellate Review Committee. This review will be conducted within 30 days after receiving the request for appeal.

b) The Independent Clinician or Allied Health Professional and the Executive Committee will each have the right to present a written statement on appeal.

c) At the sole discretion of the Appellate Review Committee, the Independent Clinician or Allied Health Professional and a representative of the Executive Committee may also appear personally to discuss their position.

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

e) The Independent Clinician or Allied Health Professional will receive special notice of the Board's action. A copy of the Board's final action will also be sent to the Executive Committee for information.

8.B. PROCEDURAL RIGHTS FOR DEPENDENT CLINICIANS

1. In the event that a recommendation is made by the Executive Committee that a Dependent Clinician not be granted the scope of practice requested or that a scope of practice previously granted be restricted or terminated, the individual shall be notified of the recommendation. The notice shall include a specific statement of the reasons for the recommendation and shall advise the individual that he or she may request a meeting with the Executive Committee before its recommendation is forwarded to the Board for final action.

2. If the Dependent Clinician desires to request a meeting, he or she must make such request in writing and direct it to the CEO or designee within 30 days after receipt of the written notice of the adverse recommendation.

3. If a meeting is requested in a timely manner, it shall be scheduled to take place within a reasonable time frame. The meeting shall be informal and shall not be considered a hearing. The Dependent Clinician and his or her Supervising Clinician shall both be permitted to attend and participate in the meeting. However, no counsel for either the Dependent Clinician or the Executive Committee shall be present.

4. Following this meeting, the Executive Committee shall make its final recommendation to the Board.

ARTICLE 9

9. HOSPITAL EMPLOYEES

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

B. A request for clinical privileges or scope of practice, on an initial basis or for renewal, submitted by an Independent Clinician, Allied Health Professional, or a Dependent Clinician who performs surgical tasks, who is seeking employment or who is employed by the Hospital, shall be processed in accordance with the terms of this Policy. A report regarding each Clinician's qualifications shall then be made to Hospital Administration or Employed Staff (as appropriate) to assist the Hospital in making employment decisions.

C. A request for a scope of practice on an initial basis or for renewal from a Dependent Clinician who is seeking employment or is employed by the Hospital shall be evaluated by the Hospital through the Employed Staff policies/directives and procedures, using the same qualifications set forth in Section 4.A.1 of this Policy.

D. If a concern about an employed Advanced Practice Clinician's clinical conduct or competence originates with the Medical Staff, the concern will be reviewed and addressed in accordance with Articles 7 and 8 of this Policy, after which a report will be provided to Hospital Administration or Employed Staff (as appropriate).

ARTICLE 10

10. AMENDMENTS

Proposed amendments to this Policy shall be presented to the Executive Committees for the four hospitals. This Policy may then be amended by a majority vote of the members of each Executive Committee present and voting at any meeting of that committee where a quorum exists. Notice of all proposed amendments shall also be posted on the Medical Staff bulletin board for each hospital at least 14 days prior to the Executive Committee meeting and any member of the Medical Staff may submit written comments to the Executive Committee. If there is any disagreement between the Executive Committees, a joint meeting shall be scheduled to discuss and resolve the disagreement. No amendment shall be effective unless and until it has been approved by the Board of each hospital.

ARTICLE 11

11. ADOPTION

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

Originally adopted by the Medical Staffs:

HSHS St. Vincent Hospital	June 27, 2006
HSHS St. Mary's Hospital Medical Center	July 25, 2006
HSHS St. Nicholas Hospital	February 24, 2011
HSHS St. Clare Memorial Hospital	December 15, 2015
HSHS Libertas Treatment Center	February 22, 2017 termed as of 9.29.2023

Originally approved by the Boards:

HSHS St. Vincent Hospital	July 31, 2006
HSHS St. Mary's Hospital Medical Center	July 26, 2006
HSHS St. Nicholas Hospital	March 17, 2011
HSHS St. Clare Memorial Hospital	January 13, 2016
HSHS Libertas Treatment Center	March 22, 2017 termed as of 9.29.2023

Revisions adopted by the Medical Staffs:

HSHS St. Vincent Hospital	February 28, 2012, June 26, 2012, August 28, 2012, April 23, 2013, February 24, 2015, January 26, 2016, January 24, 2017, June 26, 2018, October 27, 2020, January 19, 2023, May 23, 2023, June 27, 2023, January 23, 2024, April 23, 2024
HSHS St. Mary's Hospital	February 28, 2012, June 26, 2012, August 28, 2012, April 23, 2013, February 24, 2015, January 26, 2016, January 24, 2017, June 26, 2018, October 27, 2020, January 19, 2023, May 23, 2023, June 27, 2023, January 23, 2024, April 23, 2024
HSHS St. Nicholas Hospital	February 23, 2012, August 30, 2012, April 25, 2013, February 26, 2015, January 28, 2016, January 26, 2017, September 28, 2107, June 28, 2018, November 19, 2020, February 23, 2023, May 25, 2023, June 22, 2023, April 25, 2024
HSHS St. Clare Memorial Hospital	January 4, 2017, June 19, 2018, November 17, 2020, February 21, 2023, May 16, 2023, June 20, 2023, April 16, 2024
HSHS Libertas Treatment Center	June 27, 2018 – termed as of 9.29.2023

Revisions approved by the Board:

HSHS St. Vincent Hospital	March 21, 2012, June 28, 2012, September 17, 2012, May 15, 2013, March 18, 2015, March 23, 2016, March 22, 2017, July 18, 2018, November 18, 2020, March 15, 2023, July 19, 2023, May 15, 2024
HSHS St. Mary's Hospital	March 21, 2012, June 28, 2012, September 17, 2012, May 15, 2013, March 18, 2015, March 23, 2016, March 22, 2017, July 18, 2018, November 18, 2020, March 15, 2023, July 19, 2023, May 15, 2024
HSHS St. Nicholas Hospital	March 22, 2012, September 18, 2012, May 16, 2013, March 19, 2015, March 10, 2016, March 23, 2017, November 16, 2017, July 19, 2018, January 21, 2021, March 16, 2023, July 20, 2023, May 16, 2024
HSHS St. Clare Memorial Hospital	March 8, 2017, July 11, 2018, November 18, 2020, March 15, 2023, July 19, 2023, May 15, 2024
HSHS Libertas Treatment Center	July 18, 2018 – termed as of 9.29.2023

APPENDIX A

Those individuals currently or have the potential to practicing as Independent Clinicians at HSHS St. Vincent Hospital, HSHS St. Mary's Hospital Medical Center, HSHS St. Nicholas Hospital and HSHS St. Clare Memorial Hospital are as follows:

Audiologists

APPENDIX B

Those individuals currently or have the potential to practicing as Advanced Practice Clinician at HSHS St. Vincent Hospital, HSHS St. Mary's Hospital Medical Center, HSHS St. Nicholas Hospital and St. Clare Memorial Hospital are as follows:

Advanced Practice Registered Nurses

Certified Nurse Midwives

Certified Physician Assistants

Certified Registered Nurse Anesthetists

Surgical Technologists Specialist

Certified First Assistant (CFA)/Certified Surgical Assistant (CSA)

Registered Nurse First Assistant (RNFA)

Those individuals currently or have the potential to practicing as Advanced Practice Clinician at HSHS St. Vincent Hospital, HSHS St. Mary's Hospital Medical Center, and HSHS St. Nicholas Hospital are as follows:

Certified Anesthesiologist Assistant

APPENDIX C

Those individuals currently or have the potential to practicing as Dependent Clinicians at HSHS St. Vincent Hospital, HSHS St. Mary's Hospital Medical Center, HSHS St. Nicholas Hospital and HSHS St. Clare Memorial Hospital are as follows:

Dental Technicians

Dialysis Social Workers

Licensed Practical Nurses

Registered Nurses

Medical Assistants

Procedural Assistants
i.e., Electroneurodiagnostic Technologists