MEDICAL STAFF CREDENTIALS POLICY

COVENANT HEALTH

December 2018

CREDENTIALS POLICY

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ARTICLE 1

GENERAL

1.A. TIME LIMITS

Time limits referred to in this Policy, the Medical Staff Bylaws and related policies and manuals are advisory only and are not mandatory, unless it is expressly stated.

1.B. DELEGATION OF FUNCTIONS

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

1.C. CONFIDENTIALITY AND PEER REVIEW PROTECTION

1.C.1. Confidentiality:

All professional review activity and recommendations will be strictly confidential. No disclosures of any such information (discussions or documentation) may be made outside of the meetings of the committees charged with such functions, except:

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

(b) as authorized by a policy; or

(c) as authorized by the CAO, the system CMO or by legal counsel to the Hospital.

Any breach of confidentiality may result in appropriate sanctions, including but not limited to a professional review action or appropriate legal action. Breaches of confidentiality will not constitute a waiver of any privilege. Any member of the Medical Staff or the APP who becomes aware of a breach of confidentiality is encouraged to inform the CAO, the CMO, or the Chief of Staff (or the Chief of Staff Elect if the Chief of Staff is the person committing the claimed breach).

1.C.2. Peer Review Protection:

Peer review committees include, but are not limited to:

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

(b) all departments;

(c) hearing and appellate review panels;

(d) the Board and its committees and service lines; and

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

All oral and written communications, reports, recommendations, actions, and minutes made or taken by peer review committees are confidential and covered by the provisions of applicable law and are deemed to be "professional review bodies" as that term is defined in the Health Care Quality Improvement Act of 1986 ("HCQIA"), 42 U.S.C. §11101 et seq, and as Quality Improvement Committees as that term is defined by Tennessee Code Annotated section § 68-11-272.

1.D. INDEMNIFICATION

The Hospital will provide a legal defense for, and will indemnify, all Medical Staff Leaders, peer review committees, members, and authorized representatives when engaged in those capacities, in accordance with applicable laws and the Hospital's Bylaws.

1.E. DEFINITIONS

The following definitions apply to terms used in this Policy:

(1) "ADVANCED PRACTICE PROFESSIONALS" ("APPs") means individuals other than members of the Medical Staff who are authorized by law and by the Hospital to provide patient care services. The categories of APPs are set forth in Appendix A.

For ease of use, when applicable to APPs, any reference to "appointment" or "reappointment" shall be interpreted as a reference to initial or continued permission to practice.

(2) "BOARD" means the Board of Directors of Covenant Health, which has the overall responsibility for the Hospital, or any committee of the Board to which the Board has specifically delegated rights and duties of the Board.

(3) "BOARD CERTIFICATION" is the designation conferred by one of the affiliated specialties of the American Board of Medical Specialties, the American Osteopathic Association, the American Board of Oral and Maxillofacial Surgery, or the American Board of Foot and Ankle Surgery ("ABFAS"), upon an individual, as applicable.

(4) "CHIEF ADMINISTRATIVE OFFICER" ("CAO") means the individual employed by Covenant Health to act on its behalf in the overall management of Hospital.

(5) "CHIEF EXECUTIVE OFFICER" means the President and CEO of Covenant Health.

(6) "CMO" means the individual employed by Covenant Health to act as the CMO of Covenant Health, in cooperation with the Chief of Staff.

(7) "DAYS" means calendar days.

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

(9) "HOSPITAL" means any Covenant Health facility adopting this Medical Staff Credentials Policy and Bylaws and holding a license as an acute care hospital in the State of Tennessee.

(10) "LEADERSHIP COUNCIL" members may include the Chief of Staff, Chief of Staff Elect, Immediate Past Chief of Staff, Chairman of the Credentials Committee, and Chairman of the Professional Quality and Peer Review Committee. The CAO and Quality Manager will also attend the meeting.

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

(12) "MEDICAL STAFF" means all physicians, dentists, oral surgeons, and podiatrists who have been appointed to the Medical Staff by the Board.

(13) "MEDICAL STAFF LEADER" means any Medical Staff officer, department chair, or committee chair.

(14) "MEDICAL STAFF OFFICE" may include, as applicable, a hospital office and a system central Credentials Verification Office ("CVO").

(15) "PATIENT CONTACTS" includes any admission, consultation, procedure, in-person (actual or via telemedicine, utilizing a Covenant Health approved virtual device) response to emergency call, evaluation, treatment, or service performed in any facility operated by the Hospital.

(16) "PHYSICIAN" includes both doctors of medicine ("M.D.s") and doctors of osteopathy ("D.O.s").

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

(18) "RELINQUISHMENT" means a temporary administrative suspension of clinical privileges that is reparable by the individual.

(19) "RESIGNATION" means the immediate termination of clinical privileges and/or staff membership.

(20) "RESTRICTION" means a professional review action based on clinical competence or professional conduct which results in the inability of a practitioner to exercise his or her own independent judgment for a period longer than 30 days (for example, a mandatory concurring consultation, where the consultant must approve the proposed procedure or treatment before privileges may be exercised, or other requirement that another physician must agree before privileges can be exercised).

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

(22) "SYSTEM CREDENTIALS AND CLINICAL STANDARDS COMMITTEE" means a committee of the Board with the authority to act on behalf of the Board with respect to credentialing, privileging, and clinical standards, all subject to the Corporate Bylaws of Covenant Health. The SCCS shall serve as a quality improvement committee within the meaning of Tennessee Code Annotated § 68-11-272.

(23) "SYSTEM QUALITY COMMITTEE" means a committee of the Board with the authority to act on behalf of the Board with respect to quality matters, all subject to the Corporate Bylaws of Covenant Health. The SQC shall serve as a quality improvement committee within the meaning of Tennessee Code Annotated § 68-11-272.

(24) "SUPERVISING/COLLABORATING PHYSICIAN" means a medical staff member with clinical privileges who has agreed in writing to supervise or collaborate with an APPs and to accept full responsibility for the actions of the APP while he or she is practicing in the Hospital.

ARTICLE 2

QUALIFICATIONS, CONDITIONS, AND RESPONSIBILITIES

2.A. QUALIFICATIONS

2.A.1. Threshold Eligibility Criteria:

Appointment to the medical staff is a privilege, not a right. All requests for applications will be reviewed by the CAO or his/her designee. To be eligible to apply for initial appointment or clinical privileges, an applicant must, as applicable:

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

(b) have a current, unrestricted DEA registration, if applicable;

(c) for specialties where emergency response is required, the physician must be able to return to the hospital when called within 1 (one) hour or less if clinically indicated in order to fulfill Medical Staff responsibilities and to provide timely and continuous care for his or her patients;

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

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

(f) have never had Medical Staff or Advanced Practice Professional Staff appointment, clinical privileges, or status as a participating provider denied, revoked, or terminated by any health care facility, including this Hospital, or health plan for reasons related to clinical competence or professional conduct;

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

(h) have not been convicted of, or entered a plea of guilty or no contest to, any felony of any kind, or any misdemeanor related to: abuse of controlled substances, use of illegal drugs, violent acts, sexual misconduct, moral turpitude, child or adult abuse, or DUI;

(i) agree to fulfill all responsibilities regarding emergency call for their specialty;

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

(k) agree to comply with all applicable training and educational protocols applicable to all members of the Medical Staff that may be adopted by the MEC and required by the System Credentials and Clinical Standards Committee, including, but not limited to, those involving electronic medical records or patient safety (does not include training requirements specific to an individual's performance improvement plan);

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

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

(n) demonstrate recent clinical activity in their primary area of practice, in an acute care hospital, during the last two years;

(o) have successfully completed[1]:

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

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

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

(iv) for APPs, have satisfied the applicable training requirements as established by the Hospital;

(p) be certified in their primary area of training by the appropriate specialty/subspecialty board of the American Board of Medical Specialties, the American Osteopathic Association, the American Board of Oral and Maxillofacial

1 These requirements will be applicable only to those individuals who apply for initial staff appointment after the date of adoption of this Policy.

Surgery, the American Dental Association, or the American Board of Foot and Ankle Surgery ("ABFAS"), as applicable. 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 will be eligible for Medical Staff appointment. However, in order to remain eligible, those applicants must achieve board certification in their primary area of training within the guidelines established by the specialty board;

(q) if seeking to practice as an Advanced Practice Professional, have a written agreement with a Supervising/Collaborating Physician, which agreement must meet all applicable requirements of Tennessee law and Hospital policy.

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

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

(b) A request for a waiver must be submitted to the Credentials Committee for consideration. In reviewing the request for a waiver, the Credentials Committee may consider the specific qualifications of the applicant in question, input from the relevant chair, and the best interests of the Hospital and the communities it serves. Additionally, the Credentials Committee may, in its discretion, consider the application form and other information supplied by the applicant.

(c) The Credentials Committee will forward its recommendation, including the basis for such, to the MEC. Any recommendation to grant a waiver must include the specific basis for the recommendation.

(d) The MEC will review the recommendation of the Credentials Committee and make a recommendation to the System Credentials and Clinical Standards Committee 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.

(e) The System Credentials and Clinical Standards Committee's determination regarding whether to grant a waiver is final. A determination not to grant a waiver is not a "denial" of appointment or clinical privileges and the individual who requested the waiver is not entitled to a hearing. A determination to grant a waiver in a particular case is not intended to set a precedent. A determination to grant a waiver does not mean that appointment will be granted, but only that processing of the application can begin.

(f) If a waiver is granted, it is good for the duration of the applicant's medical staff membership.

2.A.3. Factors for Evaluation:

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

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

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

(c) good reputation and character;

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

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

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

2.A.4. No Entitlement to Appointment:

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

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

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

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

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

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

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

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

2.A.5. Nondiscrimination:

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

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

2.B.1. Basic Responsibilities and Requirements:

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

(a) to provide continuous and timely care;

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

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

(d) to provide emergency call coverage, consultations, and care for unassigned patients;

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

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

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

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

(i) to seek consultation whenever necessary;

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

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

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

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

(n) to satisfy continuing medical education requirements;

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

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

(q) to maintain a current e-mail address and mobile phone number with the Medical Staff Office, which will be the primary mechanism used to communicate all Medical Staff or APP information to the member;

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

(s) that, if the individual is a member of the Medical Staff who serves or plans to serve as a Supervising/Collaborating Physician to an APP, that the member of the Medical Staff will abide by the supervision requirements and conditions of practice set forth in Article 8; and

(t) that, if the individual is an APP, he or she will abide by the conditions of practice set forth in Article 8.

2.B.2. Burden of Providing Information:

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

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

(c) An application will be complete when all questions on the application form have been answered, all supporting documentation has been supplied, and all information has been verified from primary sources. An application will become incomplete if the need arises for new, additional, or clarifying information. Any application that continues to be incomplete 60 days after the applicant has been notified of the additional information required will be deemed to be withdrawn.

(d) Applicants are responsible for providing a complete application, including adequate responses from references and all information requested from third parties for a proper evaluation. An incomplete application will not be processed.

(e) Applicants and members are responsible for notifying the Chief of Staff or the CAO of any change in status or any change in the information provided on the application form. This information is required to be provided with or without request, at the time the change occurs (but within no later than 60 days), and includes, but not be limited to:

(i) any information on the application form;

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

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

(iv) changes in professional liability insurance coverage;

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

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

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

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

2.C. APPLICATION

2.C.1. Information:

(a) Application forms for appointment and reappointment will be approved by the System Credentials and Clinical Standards Committee. Clinical privilege forms will be approved by the System Credentials and Clinical Standards Committee upon recommendation of the Credentials Committee and the MEC.

(b) The applications for initial appointment, reappointment, and clinical privileges existing now and as may be revised are incorporated by reference and made a part of this Policy.

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

2.C.2. Misstatements and Omissions:

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

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

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

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

(a) Conditions Prerequisite to Application and Consideration:

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

(b) Use and Disclosure of Information about Individuals:

(1) Information Defined:

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

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

(ii) any matter addressed on the application form or in the Medical Staff Bylaws, Credentials Policy, and other Hospital or Medical Staff policies and rules and regulations;

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

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

(2) Authorization for Criminal Background Check:

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

(3) Authorization to Share Information within the System:

The individual staff member acknowledges that the system Chief Medical Officer (CMO) is an ex officio member of and may be consulted by and attend meetings of each system hospital's Medical Executive Committee (MEC), Credentials Committee and PQPR Committee in discharge of his duties and responsibilities to help assure that quality patient care and safety are consistently delivered across the entire health system. Each individual medical staff member therefore authorizes the system CMO to share information regarding quality of care or behavior concerns about that staff member at one facility with any other system facility PQPR Committee, Credentials Committee, MEC, or the Chair of any such committee, or the CAO of such facility, to the extent that the CMO believes that the demands of quality patient care and safety across the system may require. This authorization also extends to the Chief of Staff of the member's medical staff organization, in communication with any other Chief of Staff within the system. The extent of the sharing of such information shall be at the discretion of the CMO or the Chief of Staff and

no one facility or medical staff organization has the absolute right to require the CMO, and Chief of Staff, or any other system quality improvement committee to release any underlying peer review or quality improvement records or information as those terms may be defined by state or federal statutes and regulations.

(4) Authorization to Obtain Information from Third Parties:

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

(5) Authorization to Disclose Information to Third Parties:

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

(c) Hearing and Appeal Procedures:

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

(d) Immunity:

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

This immunity covers any actions, recommendations, reports, statements, communications, or disclosures that are made, taken, or received by the Hospital, CVO if applicable, its representatives, or third parties in the course of credentialing and peer review activities or when using or disclosing information as described in this Section. Nothing herein will be deemed to waive any other immunity or privilege provided by federal or Tennessee law.

ARTICLE 3

PROCEDURE FOR INITIAL APPOINTMENT AND PRIVILEGES

3.A. PROCEDURE FOR INITIAL APPOINTMENT AND PRIVILEGES

3.A.1. Application:

(a) Prospective applicants will be sent the application form and a letter that outlines the threshold eligibility criteria for appointment and the applicable criteria for clinical privileges.

(b) A completed application form with copies of all required documents must be returned to the Central Verification Office within 30 days after receipt. The application must be accompanied by the application fee.

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

3.A.2. Initial Review of Application:

(a) As a preliminary step, the application will be reviewed by the Central Verification Office to determine that all questions have been answered and that the applicant satisfies all threshold eligibility criteria. Applicants who fail to return completed applications will be notified that their applications will not be processed. Applications that fail to meet threshold criteria will be forwarded to the CAO for review in consultation with the Leadership Council (or medical staff leadership). A determination of ineligibility does not entitle the individual to a hearing and appeal. The applicant may request of waiver of threshold criteria through the process in Article 2.A.3 of this policy.

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

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

(d) An interview(s) with the applicant may be conducted. The purpose of the interview is to discuss and review any aspect of the applicant's application, qualifications, and requested clinical privileges. This interview will be conducted by one or any combination of any of the following: department chair, the Credentials Committee, a Credentials Committee representative, the MEC, the Chief of Staff, CMO, or the CAO.

3.A.3. Department Chair and Chief Nursing Officer Procedure:

The Medical Staff Office will transmit the complete application and all supporting materials to the chair of each department in which the applicant seeks clinical privileges. The chair will prepare a written report regarding whether the applicant has satisfied all of the qualifications for appointment and the clinical privileges requested. The report will be on a form provided by the Medical Staff Office. The Chief Nursing Officer will also review and report on the applications for all advanced practice registered nurses.

3.A.4. Credentials Committee Procedure:

(a) The Credentials Committee will consider the report prepared by the chair(s) and will make a recommendation.

(b) The Credentials Committee may use the expertise of the chair(s), or any member of the department, or an outside consultant, if additional information is required regarding the applicant's qualifications.

(c) After determining that an applicant is otherwise qualified for appointment and privileges, if there is any question about the applicant's ability to perform the privileges requested and the responsibilities of appointment, the Credentials Committee may require a fitness for practice evaluation by a physician(s) satisfactory to the Credentials Committee (at the applicant's expense). The results of this evaluation will be made available to the Committee. (see Article 6.E. Fitness for Practice Evaluation)

(d) The Credentials Committee may recommend the imposition of specific conditions related to behavior, health or clinical issues. The Credentials Committee may also recommend that appointment be granted for a period of less than two years in order to permit closer monitoring of the applicant's compliance with any conditions.

(e) If the recommendation of the Credentials Committee is delayed longer than 60 days, the chair of the Credentials Committee will send a letter to the applicant, with a copy to the CAO, explaining the reasons for the delay.

3.A.5. MEC Recommendation:

(a) At its next regular meeting after receipt of the written report and recommendation of the Credentials Committee, the MEC will:

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

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

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

(b) If the recommendation of the MEC is to appoint, the recommendation will be forwarded to the System Credentials and Clinical Standards Committee.

(c) If the recommendation of the MEC would entitle the applicant to request a hearing, the MEC will forward its recommendation to the CAO, who will promptly send special notice to the applicant. The CAO will then hold the application until after the applicant has requested or waived a hearing.

3.A.6. System Credentials and Clinical Standards Committee Action:

(a) Upon receipt of a recommendation from the MEC that the applicant be granted appointment and clinical privileges, the System Credentials and Clinical Standards Committee may:

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

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

(3) modify the recommendation.

(b) If the System Credentials and Clinical Standards Committee disagrees with a favorable recommendation from the MEC, it will promptly send that recommendation to the CAO. If the System Credentials and Clinical Standards Committee's determination remains unfavorable, the CAO will promptly send special notice that the applicant is entitled to request a hearing

(c) Any final decision by the System Credentials and Clinical Standards Committee to grant, deny, modify, or revoke appointment or clinical privileges will be disseminated to appropriate individuals and, as required, reported to appropriate entities.

3.A.7. Time Periods for Processing:

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

ARTICLE 4

CLINICAL PRIVILEGES

4.A. CLINICAL PRIVILEGES

4.A.1. General:

(a) Appointment or reappointment will not confer any clinical privileges or right to practice at the Hospital. Only those clinical privileges granted by the System Credentials and Clinical Standards Committee may be exercised, subject to the terms of this Policy.

(b) A request for privileges will be processed only when an applicant satisfies threshold eligibility criteria for the delineated privileges. An individual who does not satisfy the eligibility criteria for clinical privileges may request that the criteria be waived.

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

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

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

(2) appropriateness of utilization patterns;

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

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

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

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

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

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

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

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

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

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

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

4.A.2. Podiatrists:

Surgical procedures performed by podiatrists shall be under the overall supervision of the Chairman of the applicable Department. If the patient is admitted to the hospital following podiatric surgery, medical consultation by an Active or Courtesy member of the Medical Staff is required.

4.A.3. Dentists:

Surgical procedures performed by dentists shall be under the overall supervision of the Chairman of the Department of Surgery. An adequate and appropriate medical history and physical examination of the patient shall be made and recorded by a physician who holds an appointment to the Medical Staff before dental surgery shall be performed, and a designated physician shall be responsible for the medical care of the patient throughout the period of hospitalization.

4.A.4. Privilege Waivers:

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

(b) In limited circumstances, the Hospital may request that the System Credentials and Clinical Standards Committee waive the requirement that clinical privileges

be granted by core or specialty. If an individual wants to request such a waiver, the request must be submitted in writing to the Medical Staff Office. The request must indicate the specific clinical privileges within the core or specialty that the individual does not wish to provide, state a good cause basis for the request, and include evidence that he or she does not provide the relevant patient care services in any health care facility.

(c) Requests for waivers will be processed in the same manner as requests for waivers of appointment criteria.

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

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

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

(3) the expectations of members who rely on the specialty;

(4) fairness to the individual requesting the waiver;

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

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

(e) If the System Credentials and Clinical Standards Committee grants a waiver related to privileges, it will specify the effective date. In addition, the System Credentials and Clinical Standards Committee will determine whether the individual granted the waiver must continue to participate in the general on-call schedule for the relevant specialty and maintain sufficient competency to assist the Emergency Medicine physicians in assessing and stabilizing patients who require services within that specialty. If, upon assessment, a patient needs a service that is no longer provided by the individual pursuant to the waiver, the individual will work cooperatively with the Emergency Medicine physician(s) in arranging for another individual with appropriate clinical privileges to care for the patient or, if such an individual is not available, in arranging for the patient's transfer.

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

4.A.5. Relinquishment of Individual Clinical Privileges:

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

4.A.6. Resignation of Appointment and Clinical Privileges:

A request to resign all clinical privileges must (a) specify the desired date of resignation, at least 30 days from the date of the request, and (b) provide evidence that the individual has completed all medical records and will be able to appropriately discharge or transfer responsibility for the care of any hospitalized patient. After consulting with the Chief of Staff, the CAO will act on the request and no further action is required.

4.A.7. 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 ("new procedure") will not be processed until a determination has been made that the procedure will be offered by the Hospital and criteria for the clinical privilege(s) have been adopted.

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

(1) minimum 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.

The chair and the Credentials Committee will review this report, conduct additional research as necessary, consider information from the service line, if applicable, and make a preliminary recommendation as to whether the new procedure should be offered at the Hospital.

(c) If the preliminary recommendation is favorable, the Credentials Committee will then develop threshold credentialing criteria to determine those individuals who are eligible to request the clinical privileges. In developing the criteria, the Credentials Committee may conduct additional research and consult with experts, as necessary, and develop recommendations regarding:

(1) the minimum 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; 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 Credentials Committee will forward its recommendations to the MEC, which will review the matter and forward its recommendations to the System Credentials and Clinical Standards Committee for final action.

(e) All initial grants of clinical privileges, whether at the time of appointment, reappointment, or during the term of an appointment, will be subject to focused professional practice evaluation by the department chair or by a physician(s) designated by the Credentials Committee. (Refer to section 4.A.9)

4.A.8. Clinical Privileges That Cross Specialty Lines:

(a) Requests for clinical privileges that previously have been exercised only by members in another specialty will not be processed until the steps outlined in this section have been completed and a determination has been made regarding the member's eligibility to request the clinical privilege(s) in question.

(b) As an initial step in the process, the individual seeking the privilege will submit a report to the Credentials Committee that provides the minimum qualifications needed to perform the procedure safely and competently, whether the individual's specialty is performing the clinical privilege at other similar hospitals, and the experiences of those other hospitals.

(c) The Credentials Committee may then conduct additional research and consult with experts, as necessary, including those on the Medical Staff (e.g., chairs, 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 Credentials Committee may or may not recommend that individuals from different specialties be permitted to request the clinical privileges at issue. If it does, the Committee may develop recommendations regarding:

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

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

(3) the 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 Credentials Committee will forward its recommendations to the MEC, which will review the matter and forward its recommendations to the System Credentials and Clinical Standards Committee for final action.

4.A.9. Physicians in Training:

Physicians in training will not be granted appointment to the Medical Staff or clinical privileges. The program director, clinical faculty, or attending staff member will be responsible for the direction and supervision of the on-site or day-to-day patient care activities of each trainee, who will be permitted to perform only those clinical functions set out in current Covenant policy, curriculum requirements, affiliation agreements, or training protocols approved by the MEC or its designee. The applicable program director will be responsible for verifying and evaluating the qualifications of each physician in training.

4.A.10. Telemedicine Privileges:

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

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

(1) A request for telemedicine privileges may be processed through the same process for Medical Staff applications, 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 alternative process that relies on the credentialing information from the distant hospital or telemedicine entity. In such cases, the Hospital must ensure, through a written agreement that the distant hospital or telemedicine entity complies with all applicable Medicare regulations and accreditation standards. The distant hospital or telemedicine entity must provide:

(i) confirmation that the practitioner is licensed in the state where the Hospital is located;

(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 received about the individual requesting telemedicine privileges will be provided to the Credentials Committee for review and recommendation to the MEC. The MEC will review and make a recommendation to the System Credentials and Clinical Standards Committee 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, will be for a period of not more than two years.

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

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

4.A.11. Focused Professional Practice Evaluation for Initial Privileges:

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

(b) This focused professional practice evaluation may include chart review, monitoring, proctoring, external review, peer review, discussion with other individuals involved in the patient care, and other information. The clinical activity requirements, including numbers and types of cases to be reviewed, will be determined by the Credentials Committee.

(c) The focused evaluation shall begin with the applicant's first performance of the newly requested privilege and should be completed within the first few months, dependent upon the level of activity. This will allow for further evaluation, if indicated.

(d) If a newly appointed member has no activity within the first six (6) months, the focused evaluation will be put on hold until such time the practitioner begins to exercise their privileges.

(e) If a member who has been granted clinical privileges fails to fulfill the clinical activity requirement within the recommended time frame, the practitioner's

clinical privileges, volume and established criteria will be reviewed by the Credentials Committee for a recommendation to the MEC.

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

4.B. TEMPORARY CLINICAL PRIVILEGES

4.B.1. Temporary Clinical Privileges:

(a) Temporary privileges may be granted by the CAO, upon recommendation of the Chief of Staff, to:

(1) applicants for initial appointment whose complete application is pending review by the MEC and System Credentials and Clinical Standards Committee, following a favorable recommendation of the Credentials Committee. In order to be eligible for temporary clinical privileges, an applicant must have demonstrated ability to perform the clinical privileges requested and have had no (i) current or previously successful challenges to licensure or registration or (ii) involuntary restriction, reduction, denial or termination of membership or clinical privileges at another health care facility.

(2) non-applicants, when there is an important patient care, treatment, or service need, including the following:

(i) the care of a specific patient;

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

(iii) proctoring; or

(iv) when serving as a locum tenens for a member of the Medical Staff or APP.

(b) The following verified information will be considered prior to the granting of any temporary clinical privileges: current licensure, relevant training, experience, current competence, current professional liability coverage acceptable to the Hospital, and results of a query to the National Practitioner Data Bank.

(c) The Chief Administrative Officer may also grant temporary privileges for a limited time, not to exceed 120 days, to applicants who have been recommended

by the Credentials Committee following all completed verifications of the application and are likely to be favorably acted upon by the MEC and System Credentials and Clinical Standards Committee.

(d) For non-applicants, who are granted temporary locum tenens privileges, the individual may exercise locum tenens privileges for a maximum of 120 days. Non-applicants may be granted temporary privileges for additional 120 day intervals as required to fulfill patient care needs, subject to the following conditions:

(1) the individual must notify the Medical Staff Office at least 15 days prior to exercising these privileges (exceptions for shorter notice periods may be considered in situations involving health issues); and

(2) the individual must inform the Medical Staff Office of any change that has occurred to the information provided on the application form for locum tenens privileges.

(e) Prior to any temporary clinical 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) The granting of temporary clinical privileges is a courtesy that may be withdrawn by the CAO at any time, after consulting with the Chief of Staff, the chair of the Credentials Committee or the department chair.

(g) The department chair or the Chief of Staff will assign to another member of the Medical Staff responsibility for the care of patients until they are discharged. Whenever possible, consideration will be given to the wishes of the patient in the selection of a substitute physician.

4.C. EMERGENCY SITUATIONS

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

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

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

4.D. DISASTER PRIVILEGES

(1) When the disaster plan has been implemented and the immediate needs of patients in the facility cannot be met, the CAO 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: (1) current Hospital picture ID card that clearly identifies the individual's professional designation; (2) current license to practice; (3) primary source verification of the license; (4) identification indicating that the individual has been granted authority to render patient care in disaster circumstances or is a member of a Disaster Medical Assistance Team, the Medical Resource Corps, the Emergency System for Advance Registration of Volunteer Health Professionals, or other recognized state or federal organizations or groups; or (5) identification by a current Hospital employee, Medical Staff member or APP 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 will be conducted through direct observation, mentoring, clinical record review, or other appropriate mechanism developed by the Medical Staff and Hospital.

ARTICLE 5

PROCEDURE FOR REAPPOINTMENT

5.A. PROCEDURE FOR REAPPOINTMENT

All terms, conditions, requirements, and procedures relating to initial appointment will apply to continued appointment and clinical privileges except as follows:

(a) Board certification requirements for new applicants as stated in Article 2 shall not apply to providers on staff at the time the new credentials policy goes into effect, and for the duration of their medical staff membership those provides shall be grandfathered regarding their board certification status;

(b) Applicants for reappointment are not required to maintain their board certification status as required at the time of initial appointment.

5.B. REAPPOINTMENT CRITERIA

5.B.1. Eligibility for Reappointment:

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

(a) completed all medical records;

(b) completed all continuing medical education requirements;

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

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

(e) paid any applicable reappointment processing fee; and

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

5.B.2. Factors for Evaluation:

In considering an application for reappointment, the factors listed in Section 2.A.4 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 and emergency call;

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

(d) any focused professional practice evaluations;

(e) a history of validated, inappropriate behavior; and

(f) other reasonable indicators of continuing qualifications.

5.C. REAPPOINTMENT PROCESS

5.C.1. Reappointment Application Form:

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

(b) An application for reappointment will be furnished to members at least three months prior to the expiration of their current appointment term. A completed reappointment application must be returned to the Medical Staff Office within 30 days.

(c) Failure to return a completed application within 30 days will result in the assessment of a reappointment processing fee. Failure to return a complete application within 60 days of receipt may result in the automatic expiration of appointment and clinical privileges at the end of the then current term of appointment.

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

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

5.C.2. Conditional Reappointments:

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

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

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

5.C.3. Potential Adverse Recommendation:

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

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

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

(d) This meeting is not a hearing, and none of the procedural rules for hearings will apply. The member will not have the right to be represented by legal counsel at this meeting.

ARTICLE 6

QUESTIONS INVOLVING MEDICAL STAFF MEMBERS AND APPs

6.A. OVERVIEW AND GENERAL PRINCIPLES

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

(a) Medical Staff Leaders and Hospital Administration are authorized to use various options to address and resolve questions that may be raised about members of the Medical Staff and APPs. The various options available to Medical Staff Leaders and Hospital Administration and the mechanisms they may use when questions pertaining to competence, health or behavior are raised are outlined below and include, but are not limited to, the following:

(1) collegial intervention and progressive steps;

(2) ongoing and focused professional practice evaluations;

(3) mandatory meeting;

(4) fitness for practice evaluation (including blood and/or urine test);

(5) automatic relinquishment of appointment and clinical privileges;

(6) leave of absence;

(7) precautionary suspension; and

(8) formal investigation.

(b) In addition to these options, Medical Staff Leaders and Hospital Administration also have the discretion to determine whether a matter should be handled in accordance with another policy (e.g., code of conduct policy, practitioner health policy, peer review policy) or should be referred to the MEC for further action.

6.A.2. Documentation:

(a) Except as otherwise expressly provided, Medical Staff Leaders and Hospital Administration may use their discretion to decide whether to document any meeting with an individual that may take place pursuant to the processes and procedures outlined in this Article.

(b) Documentation of action taken that is prepared will be shared with the individual. The individual will have an opportunity to review the documentation and respond

to it. The initial documentation, along with any response, will be maintained in the individual's confidential quality file or behavioral file.

6.A.3. No Recordings of Meetings:

All meetings and informal discussions under this Article, including, but not limited to, discussions relating to credentialing, quality assessment, performance improvement, and peer review activities, are confidential. The discussions that take place at such meetings are private conversations that occur in a private place. In addition to existing bylaws and policies governing confidentiality, individuals in attendance at such meetings are prohibited from making audio or video recordings at such meetings unless authorized to do so in writing by the individual chairing the meeting or by the CAO.

6.A.4. No Right to Counsel:

(a) The processes and procedures outlined in this Article are designed to be carried out in an informal manner. Therefore, lawyers will not be present for any meeting that takes place pursuant to this Article. By agreement of the Chief of Staff and CAO, an exception may be made to this general rule.

(b) If the individual refuses to meet without his or her lawyer present, it will be reported to the MEC that the individual failed to attend the meeting.

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

Peer review activities are confidential and privileged to the fullest extent permitted by law. Accordingly, the individual may not be accompanied by friends, relatives or colleagues when attending a meeting that takes place pursuant to this Article. By agreement of the Chief of Staff and CAO, an exception may be made to this general rule.

6.A.6. Involvement of Supervising/Collaborating Physician in Matters Pertaining to APPs:

If any peer review activity pertains to the clinical competence or professional conduct of an APP, the Supervising/Collaborating Physician will be notified and expected to participate.

6.B. COLLEGIAL INTERVENTION AND PROGRESSIVE STEPS

(1) The use of collegial intervention efforts and progressive steps by Medical Staff Leaders and Hospital Administration is encouraged.

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

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

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

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

(c) voluntary participation in counseling, mentoring, monitoring, consultation, and education;

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

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

6.C. ONGOING AND FOCUSED PROFESSIONAL PRACTICE EVALUATION

(1) Individuals who are 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 to confirm their competence.

(2) All individuals who provide patient care services at the Hospital will have their care evaluated on an ongoing basis. This ongoing professional practice evaluation process may include an analysis of data to provide feedback and to identify issues in an individual's professional performance, if any.

(3) When concerns are raised about an individual's practice through the ongoing practice evaluation process or through a specialty-specific trigger, a reported concern, or other triggers (i.e., clinical trend or specific case that requires further review, patient complaint, corporate compliance issue, or sentinel event), a focused professional practice evaluation may be undertaken to evaluate the concern.

(4) The Professional Quality and Peer Review Committee (PQPR) is responsible for approval of Medical Staff-wide OPPE data elements as well as department specific data elements. PQPR Committee is also responsible for FPPE plans when indicated through the peer review process.

(5) The Credentials Committee reviews OPPE and FPPE data in making recommendations for privileging.

6.D. MANDATORY MEETING

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

(2) Special notice will be given at least three days prior to the meeting and will inform the individual that attendance at the meeting is mandatory.

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

6.E. FITNESS FOR PRACTICE EVALUATION

(1) An individual may be requested to submit to an appropriate evaluation (such as blood and/or urine test), or a complete fitness for practice evaluation to determine his or her ability to safely practice.

(2) A request for an evaluation may be made of an applicant during the initial appointment or reappointment processes or of a member during an investigation. A request for an evaluation may also be made when at least two Medical Staff Leaders (or one Medical Staff Leader and one member of the Hospital Administration) are concerned with the individual's ability to safely and competently care for patients.

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

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

6.F. AUTOMATIC RELINQUISHMENT

The occurrences described in this Section will constitute grounds for either the automatic relinquishment of an individual's appointment and clinical privileges, or may be deemed a voluntary resignation. 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.

Except as otherwise provided below, an automatic relinquishment of appointment and privileges will be effective immediately upon actual or special notice to the individual and shall not constitute grounds for a fair hearing.

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

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

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

Failure of an individual to satisfy the specific threshold eligibility criteria listed in this sub-section will result in automatic relinquishment of appointment and clinical privileges:

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

2. have a current, unrestricted DEA registration, if applicable;

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

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

5. have an appropriate coverage arrangement, as determined by the Credentials Committee, with other appropriately privileged members of the Medical Staff for those times when the individual will be unavailable;

6. agree to comply with all applicable training and educational protocols applicable to all members of the Medical Staff that may be adopted by the MEC and required by the System Credentials and Clinical Standards Committee, including, but not limited to, those involving electronic medical records or patient safety (does not include training requirements specific to an individual's performance improvement plan);

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

8. if seeking to practice as an Advanced Practice Professional, have a written agreement with a Supervising/Collaborating Physician, which agreement must meet all applicable requirements of Tennessee law and Hospital policy.

6.F.3. Resignation Due to Failure to Respond to an Emergency Call or to Accept an Emergency Call Rotation

The refusal of an on-call physician to respond to an emergency call situation, either in the Emergency Department or elsewhere on the hospital premises, will be reviewed by the MEC, and may be deemed by the MEC to be a voluntary resignation. This includes a member's refusal to accept an Emergency Department call rotation scheduled by his or her Department.

6.F.4. Failure to Provide Information:

(a) Failure of an individual to notify the Chief of Staff or CAO of any change in any information provided on an application for initial appointment or reappointment may, as determined by the MEC, result in the automatic relinquishment of appointment and clinical privileges.

(b) Failure of an individual to provide information pertaining to an individual's qualifications for appointment or clinical privileges in response to a written request from the Credentials Committee, the MEC, or any other authorized committee may, as determined by the MEC, result in the automatic relinquishment of appointment and clinical privileges until the information is provided to the satisfaction of the requesting party.

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

Failure to attend a mandatory meeting requested by the Medical Staff Leaders or Hospital Administration, after appropriate notice has been given, may, as determined by the MEC, result in the automatic relinquishment of appointment and clinical privileges. The relinquishment will remain in effect until the individual attends the mandatory meeting and reinstatement is granted as set forth below.

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

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

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

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

for the evaluation and to allow the health care professional to report the results to the Medical Staff Leaders or relevant committee) will be considered a voluntary withdrawal of the application.

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

6.F.8 Failure to Comply with Mandatory Immunization Requirements:

(a) Failure of an applicant to comply with mandatory immunization requirements will be considered a voluntary withdrawal of the application.

(b) Failure of a member to comply with mandatory immunization requirements will result in an automatic suspension of all clinical privileges. (Refer to the Covenant Health Influenza Vaccination policy.)

6.F.9. Reinstatement from Automatic Relinquishment:

(a) If an individual believes that the matter leading to the automatic relinquishment of appointment and privileges has been resolved within 60 days of the relinquishment, the individual may request to be reinstated.

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

(c) Requests for reinstatement from an automatic relinquishment following the expiration or lapse of a license, controlled substance authorization, or insurance coverage will be processed by the Medical Staff Office. If any questions or concerns are noted, the Medical Staff Office will refer the matter for further review in accordance with (d) below.

(d) All other requests for reinstatement from an automatic relinquishment will be reviewed by the relevant chair, the chair of the Credentials Committee, the Chief of Staff, and the CAO. If all these individuals make a favorable recommendation on reinstatement, the individual may immediately resume clinical practice at the Hospital. This determination will then be forwarded to the Credentials Committee, the MEC, and System Credentials and Clinical Standards Committee for ratification. If, however, any of the individuals reviewing the request have any questions or concerns, those questions will be noted and the reinstatement

request will be forwarded to the full Credentials Committee, MEC and System Credentials and Clinical Standards Committee for review and final action.

(e) Failure to resolve a matter leading to an automatic relinquishment within 60 days of the relinquishment, and to be reinstated as set forth above, will result in an automatic resignation from the Medical Staff or APP Staff and shall not constitute grounds for a fair hearing.

(f) If it is deemed appropriate by the MEC, an additional 30 days may be granted to resolve the matter leading to the automatic relinquishment.

6.G. LEAVES OF ABSENCE

6.G.1. Initiation:

(a) A leave of absence of up to one year must be requested in writing and submitted to the CAO. The request should, when possible, state the beginning and ending dates and the reasons for the leave. Except in extraordinary circumstances, the request must be submitted at least 30 days prior to the anticipated start of the leave.

(b) The CAO will determine whether a request for a leave of absence will be granted, after consulting with the Chief of Staff and the relevant department chair. The granting of a leave of absence or reinstatement may be conditioned upon the individual's completion of all medical records. (see Section 6.J. of this policy)

(c) Members of the Medical Staff must report to the CAO any time they are away from Medical Staff 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. Upon becoming aware of such circumstances, the CAO, in consultation with the Chief of Staff, may trigger an automatic medical leave of absence at any point after becoming aware of the Medical Staff member's absence from patient care.

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

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

During a leave of absence, the individual will not exercise any clinical privileges and will be excused from Medical Staff responsibilities (e.g., meeting attendance, committee

service, emergency service call obligations). The obligation to pay dues will continue during a leave of absence except that a member granted a leave of absence for U.S. military service will be exempt from this obligation.

6.G.3. Reinstatement Following a Leave of Absence:

(a) Individuals requesting reinstatement will submit a written summary of their professional activities during the leave and any other information that may be requested by the Hospital. Requests for reinstatement will then be reviewed by the relevant department chair, the chair of the Credentials Committee, the Chief of Staff, and the CAO.

(b) If a favorable recommendation on reinstatement is made, the individual may immediately resume clinical practice. However, if any of the individuals reviewing the request have any questions, those questions will be noted and the reinstatement request will be forwarded to the full Credentials Committee, MEC, and System Credentials and Clinical Standards Committee.

(c) If the leave of absence was for health reasons (except for maternity leave), the request for reinstatement must be accompanied by a report from the individual's physician indicating that the individual is capable of resuming a hospital practice and safely exercising the clinical privileges requested.

(d) Absence for longer than one year will result in resignation of Medical Staff appointment and clinical privileges unless an extension is granted by the CAO. Extensions will be considered only in extraordinary cases where the extension of a leave is in the best interest of the Hospital.

(e) If an individual's current appointment is due to expire during the leave, the individual's appointment and clinical privileges will expire at the end of the appointment period, and the individual will be required to apply for reappointment.

6.H. PRECAUTIONARY SUSPENSION OR RESTRICTION OF CLINICAL PRIVILEGES

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

(a) Whenever failure to take action may result in imminent danger to the health and/or safety of any individual, the CAO, the Chief of Staff, the MEC, or System Credentials and Clinical Standards Committee chair is authorized to (1) afford the individual an opportunity to voluntarily refrain from exercising clinical privileges for a limited period of time while the matter is being reviewed; or (2) suspend or restrict all or any portion of an individual's clinical privileges.

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

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

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

(e) Within three days of the imposition of a suspension, the individual will be provided with a brief written description of the reason(s) for the action. The notice will advise the individual that suspensions lasting longer than 30 days must be reported to the National Practitioner Data Bank.

(f) The relevant Supervising/Collaborating Physician will be notified when the affected individual is an APP.

6.H.2. MEC Procedure:

(a) Within a reasonable time, not to exceed 7 days of the imposition of the suspension, the MEC will review the reasons for the suspension.

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

(c) After considering the reasons for the suspension and the individual's response, if any, the MEC will determine whether the precautionary suspension should be continued, modified, or lifted. The MEC may also determine whether to begin an investigation.

(d) If the MEC decides to continue the suspension, it will send the individual written notice of its decision, including the basis for it.

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

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

6.I. INVESTIGATIONS

6.I.1. Initial Review:

(a) Whenever a serious question has been raised regarding the following, or where collegial efforts have not resolved an issue regarding the following, the matter may be referred for review to the Chief of Staff, the relevant department chair, the chair of a standing committee, the CMO, the CAO, MEC or the chair of the System Credentials and Clinical Standards Committee:

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

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

(3) the known or suspected violation of applicable ethical standards or the bylaws, policies, rules and regulations of the Hospital or the Medical Staff; or

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

(b) In addition, if the System Credentials and Clinical Standards Committee becomes aware of information that raises concerns about the qualifications of any Medical Staff member or APP, the matter will be referred to the Chief of Staff, the CMO, or the CAO.

(c) The person to whom the question is referred will make a sufficient inquiry to determine whether the question is credible and, if so, may forward it to the MEC. If the question pertains to an APP, the Supervising/Collaborating Physician will also be notified.

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

6.I.2. Initiation of Investigation:

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

(b) The MEC will inform the individual that an investigation has begun. Notification may be delayed if, in the judgment of the MEC, informing the individual immediately might compromise the investigation or disrupt the operation of the Hospital or Medical Staff.

(c) The System Credentials and Clinical Standards Committee may also determine to commence an investigation and may delegate the investigation to the MEC, a subcommittee of the System Credentials and Clinical Standards Committee, or an ad hoc committee.

6.I.3. Investigative Procedure:

(a) Once a determination has been made to begin an investigation, the MEC will investigate the matter itself or appoint an individual or committee ("Investigating Committee") to do so. The Investigating Committee may include individuals on the medical staff of other Covenant facilities when appropriate. The Investigating Committee will not include any individual who:

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

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

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

(b) Whenever the questions raised concern the clinical competence of the individual under review, the ad hoc committee will include a peer of the individual (e.g., physician, dentist, oral surgeon, or podiatrist), but not necessarily a peer of the same specialty.

(c) The individual will be notified of the composition of the Investigating Committee. Within five days of receipt of this notice, the individual must submit to the CAO, Chief of Staff, or the CMO any reasonable objections to the service of any Investigating Committee member. The objections must be in writing. The CAO, Chief of Staff, or the CMO will review the objection and determine whether another member should be selected to serve on the Investigating Committee.

(d) The Investigating Committee may:

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

(2) conduct interviews;

(3) use outside consultants, as needed, for timeliness, expertise, thoroughness and objectivity; or

(4) require an examination or assessment of the individual by a health care professional(s) acceptable to it. The individual being investigated will execute a release allowing the Investigating Committee to discuss with the health care professional(s) the reasons for the examination or assessment and allowing the health care professional to discuss and report the results to the Investigating Committee.

(e) As part of the investigation, the individual will have an opportunity to meet with the Investigating Committee. Prior to this meeting, the individual will be informed of the questions being investigated and will be invited to discuss, explain, or refute the questions. A summary of the interview will be made and included with the Investigating Committee's report. This meeting is not a hearing, and none of the procedural rules for hearings will apply. Lawyers will not be present at this meeting.

(f) The Investigating Committee will make a reasonable effort to complete the investigation and issue its report within 30 days, provided that an outside review is not necessary. When an outside review is involved, 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 as guidelines and, as such, will not be deemed to create any right for an individual to have an investigation completed within such time periods.

(g) At the conclusion of the investigation, the Investigating Committee will prepare a report to the MEC with its findings, conclusions, and recommendations.

6.I.4. Recommendation:

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

(1) determine that no action is justified;

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

(3) impose conditions for continued appointment;

(4) require monitoring, proctoring or consultation;

(5) require additional training or education;

(6) recommend reduction or restriction of clinical privileges;

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

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

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

(b) A recommendation by the MEC that does not entitle the individual to request a hearing will take effect immediately and will remain in effect unless modified by the System Credentials and Clinical Standards Committee.

(c) A recommendation by the MEC that would entitle the individual to request a hearing will be forwarded to the CAO, who will promptly inform the individual by special notice. The recommendation will not be forwarded to the System Credentials and Clinical Standards Committee until after the individual has completed or waived a hearing.

(d) If the System Credentials and Clinical Standards Committee makes a modification to the recommendation of the MEC that would entitle the individual to request a hearing, the CAO will inform the individual by special notice. No final action will occur until the individual has completed or waived a hearing.

6.J ACTIONS OCCURRING AT OTHER ENTITIES WITHIN THE SYSTEM

Any suspension, restriction, limitation or condition imposed upon an individual in one System hospital shall automatically and immediately be effective in all System hospitals in which the individual holds appointment and privileges, without recourse to any additional hearing or appeal.

Any action taken that adversely affects the clinical privileges of a member of the medical staff for more than 30 days, or the acceptance of a relinquishment of privileges, or any restriction of such privileges by the provider while he or she is under investigation related to quality concerns or improper professional conduct, or in return for not conducting such an investigation or proceeding, must be reported to the National Practitioner Data Bank. Any relinquishment of privileges or resignation that is reportable to the National Practitioner Data Bank in one System hospital shall automatically and immediately be

effective in all System hospitals in which the individual holds appointment and privileges, without recourse to any additional hearing or appeal.

A leave of absence effective at any Covenant Health Hospital will automatically and immediately take effect at all other Covenant Health entities where the provider holds privileges. The CAO of each affected facility may consider the provider's request for an exception to the leave of absence by show of good cause.

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, reappointment or requested clinical privileges;

(2) revocation of appointment or clinical privileges;

(3) suspension of clinical privileges for more than 30 days (other than precautionary suspension);

(4) restriction of clinical privileges for greater than 30 days; or

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

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

(c) The System Credentials and Clinical Standards Committee may take these actions in (a) above without an adverse recommendation by the MEC. In this event, an individual is 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 proposed action of the System Credentials and Clinical Standards Committee, any reference in this Article to the "MEC" will be interpreted as a reference to the System Credentials and Clinical Standards Committee.

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

None of the following actions constitute grounds for a hearing. These actions take effect without hearing or appeal. The individual is entitled to submit a written statement regarding these actions for inclusion in his or her file:

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

(b) conditions, monitoring, proctoring, or a general consultation requirement;

(c) a lapse, withdrawal of or decision not to grant or not to renew temporary privileges;

(d) automatic relinquishment of appointment or privileges;

(e) a requirement for additional training or continuing education;

(f) precautionary suspension;

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

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

(i) the voluntary acceptance of a performance improvement plan option;

(j) determination that an application is incomplete;

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

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

7.A.3. Notice of Recommendation:

The CAO will promptly give special notice of a recommendation which entitles an individual to request a hearing. This notice will 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.A.4. Request for Hearing:

An individual has 30 days following receipt of the notice to request a hearing, in writing, to the CAO, including the name, address, and telephone number of the individual's counsel, if any. Failure to request a hearing will constitute waiver of the right to a hearing, and the recommendation will be transmitted to the System Credentials and Clinical Standards Committee for final action.

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

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

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

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

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

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

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

7.A.6. Witness List:

(a) At least 15 days before the pre-hearing conference, the individual requesting the hearing will provide a written list of the names of witnesses expected to offer testimony on his or her behalf.

(b) The witness list will 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.A.7. Hearing Panel, Presiding Officer, and Hearing Officer:

(a) Hearing Panel:

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

(1) The Hearing Panel will consist of at least three members, one of whom will be designated as chair.

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

(i) any member of the Medical Staff; or

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

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

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

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

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

(ii) is professionally associated with, a relative of, or involved in a referral relationship with, the individual requesting the hearing;

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

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

(b) Presiding Officer:

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

(2) The Presiding Officer will:

(i) schedule and conduct a pre-hearing conference at least 14 days prior to the hearing;

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

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

(iv) maintain decorum throughout the hearing;

(v) determine the order of procedure;

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

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

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

(c) Hearing Officer:

(1) As an alternative to a Hearing Panel, in matters in which the underlying recommendation is based upon concerns involving behavior, sexual harassment, or failure to comply with rules, regulations or policies and not issues of clinical competence, knowledge, or technical skill, the CAO, after consulting with and obtaining the agreement of the Chief of Staff, may appoint a Hearing Officer. The Hearing Officer, who should preferably be an attorney, will perform the functions of a Hearing Panel. The Hearing Officer may not be, or represent clients, in direct economic competition with the individual requesting the hearing.

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

(d) Objections:

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

7.A.8. Counsel:

The Presiding Officer, Hearing Officer, and counsel for either party may be attorneys at law licensed to practice, in good standing, in Tennessee.

7.B. PRE-HEARING PROCEDURES

7.B.1. General Procedures:

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

7.B.2. Time Frames:

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

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

(b) the parties will exchange witness lists including specially retained independent experts and proposed exhibits at least 15 days prior to the pre-hearing conference; and

(c) any objections to witnesses and/or proposed exhibits must be provided in writing at least five days prior to the pre-hearing conference and will be ruled upon by the presiding officer.

7.B.3. Provision of Relevant Information:

(a) Prior to receiving any confidential documents, the individual requesting the hearing must agree that all documents and information will be maintained as confidential and will not be disclosed or used for any purpose outside of the hearing. The individual must also provide a written representation that his or her counsel and any expert(s) have executed a Health Insurance Portability and Accountability Act (HIPAA) compliant Business Associate agreement.

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

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

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

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

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

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

(c) The individual will have no right to discovery beyond the above information. No information will be provided regarding other practitioners on the Medical Staff or APPs. In addition, there is no right to depose, interrogate, or interview witnesses or other individuals prior to the hearing.

(d) Fifteen days prior to the pre-hearing conference, or on dates set by the Presiding Officer or agreed upon by both sides, each party will provide the other party with its proposed exhibits.

7.B.4. Pre-Hearing Conference:

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

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

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

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

(e) The Presiding Officer will establish the time to be allotted to each witness's testimony and cross-examination, and will serve as the gatekeeper to prevent abuse and cumulative, repetitive and irrelevant testimony.

7.B.5. Stipulations:

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

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

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

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

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

(c) stipulations agreed to by the parties.

7.C. THE HEARING

7.C.1. Time Allotted for Hearing:

It is expected that the hearing will last no more than 10 hours, with each side being afforded approximately 5 hours to present its case, in terms of both direct and cross-examination of witnesses. Both parties are required to prepare their case so that a hearing will be concluded after a maximum of 10 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.

7.C.2. Record of Hearing:

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

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

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

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

(2) to introduce exhibits;

(3) to cross-examine any witness;

(4) to have representation by counsel who may be present but not call, examine, and cross-examine witnesses and present the case;

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

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

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

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

7.C.4. Order of Presentation:

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

7.C.5. Admissibility of Evidence:

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

7.C.6. Persons to Be Present:

The hearing will be restricted to those individuals involved in the proceeding. Administrative personnel may be present as requested by the CAO the Chief of Staff, or the CMO.

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

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

7.C.8. Failure to Appear:

Failure, without good cause for the individual, to appear and proceed at the hearing will constitute a waiver of the right to a hearing and the matter will be forwarded to the System Credentials and Clinical Standards Committee for final action.

7.C.9. Postponements and Extensions:

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

7.D. HEARING CONCLUSION, DELIBERATIONS, AND RECOMMENDATIONS

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

Consistent with the burden 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 a preponderance of the evidence, that the recommendation that prompted the hearing was arbitrary, capricious, or not supported by credible evidence.

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

Within 20 days after final adjournment of the hearing (which may be designated as the time the Hearing Panel receives the hearing transcript or any post-hearing statements, whichever is later), the Hearing Panel will conduct its deliberations outside the presence of any other person except the Presiding Officer. Within 30 days after conclusion of its deliberation, the Hearing Panel will render a recommendation, accompanied by a report, which will contain a statement of the basis for its recommendation.

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

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

7.E. APPEAL PROCEDURE

7.E.1. Time for Appeal:

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

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

7.E.2. Grounds for Appeal:

The grounds for appeal will be limited to the following:

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

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

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

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

7.E.4. Nature of Appellate Review:

(a) The System Quality Committee shall appoint a Review Panel composed of members of the Board.

(b) The Review Panel may consider the record upon which the recommendation was made, including the hearing transcripts and exhibits, post-hearing statements, the findings and recommendations of the MEC and Hearing Panel, and any other information that it deems relevant. The Review Panel's decision shall be final and reported to the System Quality Committee.

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

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

7.F. FINAL DECISION

7.F.1. Final Decision of Review Panel:

(a) The Review Panel will take final action within 30 days after it (i) considers the appeal as a Review Panel, or (ii) receives the Hearing Panel's report when no appeal has been requested.

(b) The Review Panel may review any information that it deems relevant, including, but not limited to, the findings and recommendations of the MEC and the Hearing Panel.

(c) The Review Panel may adopt, modify, or reverse any recommendation that it receives or refer the matter back to the MEC for further review.

(d) The Review Panel will render its final decision in writing including the basis for its decision, and will send special notice to the individual and Chief of Staff.

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

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

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

ARTICLE 8

ADVANCED PRACTICE PROFESSIONALS

8.A. CONDITIONS OF PRACTICE APPLICABLE TO APPs

8.A.1. Utilization of APPs in the Inpatient Setting:

(a) Advanced Practice Professionals are not permitted to function independently in the inpatient Hospital setting and are bound by all Covenant Health policies and procedures pertaining to performance and supervision. As a condition of being granted permission to practice at the Hospital, all APPs specifically agree to abide by the conditions 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 Supervising Physicians to such individuals also specifically agree to abide by the standards set forth in this Section.

(b) The following conditions of practice apply to the functioning of Advanced Practice Professionals in the inpatient Hospital setting:

(1) Admitting Privileges. APPs are not granted inpatient admitting privileges and therefore may not admit patients independent of the Supervising Physician.

(2) Consultations. APPs may not independently provide patient consultations in lieu of the practitioners' Supervising Physicians. APPs may gather data and order tests; however, the Supervising Physician must personally review and approve care plan within 24 hours (or more timely in the case of any emergency consultation request).

(3) Emergency On-Call Coverage. It will be within the discretion of the Emergency Department physician requesting assistance whether it is appropriate to contact an APP prior to the Supervising Physician. APPs may not independently participate in the emergency on-call roster (formally, or informally by agreement with their Supervising Physicians), in lieu of the Supervising Physician. The Supervising Physician (or his or her covering physician) must personally respond in a timely manner to all calls directed to him or her. Following discussion with the Emergency Department physician, the Supervising Physician may direct an APP to see the patient, gather data, and order tests for further review by the Supervising Physician. However, the Supervising Physician must still personally see the patient when requested by the Emergency Department physician.

(4) Calls Regarding Supervising Physician's Hospitalized Inpatients. It will be within the discretion of the Hospital personnel requesting assistance to determine whether it is appropriate to contact an APP prior to the Supervising Physician. However, the Supervising Physician must personally respond in a timely manner to all calls directed to him or her.

(5) Daily Inpatient Rounds. APPs may assist their Supervising Physician in fulfilling his or her responsibility to round daily on all inpatients for whom the Supervising Physician is the designated attending physician, as deemed clinically appropriate at the time of initial evaluation by the attending physician.

8.A.2. Oversight by Supervising Physician:

(a) APPs may function in the Hospital only so long as they have a Supervising Physician.

(b) Any activities permitted to be performed at the Hospital by an APP will be performed only under the oversight of the Supervising Physician.

(c) If the Medical Staff appointment or clinical privileges of a Supervising Physician are resigned, revoked or terminated, or the APP fails, for any reason, to maintain an appropriate supervision relationship with a Supervising Physician, the APP's clinical privileges or scope of practice will be automatically relinquished, unless he or she has another Supervising Physician who has been approved as part of the credentialing process.

(d) As a condition of clinical privileges or scope of practice, APPs and Supervising Physicians must provide the Hospital with notice of any revisions or modifications that are made to the agreement between them. This notice must be provided to the Credentials Committee and CNO as appropriate within three days of any such change.

8.A.3. Questions Regarding the Authority of APPs:

(a) Should any member of the Medical Staff, or any employee of the Hospital who is licensed or certified by the state, have a reasonable question regarding the clinical competence or authority of an APP to act or issue instructions outside the presence of the Supervising Physician, such individual will have the right to request that the Supervising/Collaborating Physician validate, either at the time or later, the instructions of the APP. Any act or instruction of the APP will be delayed until such time as the individual with the question has ascertained that the act is clearly within the clinical privileges or scope of practice granted to the individual.

(b) Any question regarding the conduct of an APP will be reported to the Chief of Staff, the chair of the Credentials Committee, the relevant department chair, the CAO, or the CMO for appropriate action. The individual to whom the concern has been reported will also discuss the matter with the Supervising Physician.

8.A.4. Responsibilities of Supervising Physicians:

(a) Physicians who wish to utilize the services of APPs 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 and all other applicable Covenant Health policies and procedures before the APP performs services or engages in any kind of activity in the Hospital.

(b) Supervising Physicians who wish to utilize the services of APPs in the inpatient setting specifically agree to abide by the standards of practice set forth in Article 8.A.1 above.

(c) The number of APPs acting under the supervision of one Medical Staff member, 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.

(d) It will be the responsibility of the Supervising Physician to provide, or to arrange for, professional liability insurance coverage for the APP in amounts required by the Board. The insurance must cover any and all activities of the APP in the Hospital. The 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.

8.B. PROCEDURAL RIGHTS FOR APPs

8.B.1 Due Process for Adverse Actions

(a) The appointment of APPs shall be at the discretion of the System Credentials and Clinical Standards Committee. The Chief Administrative Officer is authorized to suspend or terminate any or all of an advanced practice professional's privileges. Because APPs are not members of the Medical Staff, such appointments shall not be subject to the detailed Hearing and Appeals procedures described in these bylaws. If MEC makes an adverse recommendation regarding the privileging of an APP, the APP may request the following due process:

(b) The APP may appear before an ad hoc committee of MEC consisting of a minimum of three (3) voting members of MEC and at least one (1) impartial, non-voting peer of the APP with privileges similar to those in question to discuss the

adverse recommendation. After hearing the concerns of the APP, the ad hoc committee will report its recommendation to the MEC.

(c) If the ad hoc committee makes an adverse recommendation regarding the privileges of the APP, the APP may appear before MEC to appeal the recommendation of the ad hoc committee. After considering all discussions, MEC will report its final decision to the System Credentials and Clinical Standards Committee for informational purposes only and to assure enforcement of the action across the System. Action taken at one Covenant Health hospital will automatically and immediately take effect at all other Covenant Health entities where the provider holds privileges.

(d) Any APP who chooses to appear before either the ad hoc committee or the MEC for discussion of the proposed adverse action must also be accompanied by his/her supervising physician.

ARTICLE 9

GUIDELINES FOR MANAGING CONFLICTS OF INTEREST AND APPEARANCES

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

(b) Any member with knowledge of the existence of a potential conflict of interest or bias on the part of any other member may call the conflict of interest to the attention of the Chief of Staff (or the Chief of Staff Elect if the Chief of Staff is the person with the potential conflict) or the applicable department or committee chair. The Chief of Staff or the applicable department or committee chair will make a final determination as to whether the provisions in this Article should be triggered.

(c) The fact that a chair or a member is in the same specialty as a member whose performance is being reviewed does not automatically create a conflict. In addition, the assessment of whether a conflict of interest exists will be interpreted reasonably by the persons involved, taking into consideration common sense and objective principles of fairness. No member has a right to compel disqualification of another member based on an allegation of conflict of interest.

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

APPENDIX A

ADVANCED PRACTICE PROFESSIONALS

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

1. Nurse Practitioners (“NPs”)

2. Physician Assistants (“PAs”)

3. Certified Registered Nurse Anesthetists (“CRNAs”)

4. Nurse Midwives