Advanced Practice Clinician Policy

University Hospitals East Market Unified Medical Staff

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DEFINITIONS

Advanced Practice Clinician or **APC** means those physician assistants, advanced practice registered nurses, and eligible allied health professionals, as designated in Appendix A, who have applied for, or who have applied for and been granted, Privileges to practice at the Hospital either independently (as applicable) or in collaboration with, or under the supervision of, a Physician, Dentist, or Podiatrist with Privileges at the Hospital.

Adverse means a recommendation or action of the Medical Executive Committee or Board that denies, limits (*e.g.*, suspension, restriction, *etc.*) for a period in excess of thirty (30) days (or in excess of fourteen (14) days with respect to a summary suspension) or terminates an APC's Privileges on the basis of clinical competency or professional conduct.

Affiliate Hospital means the System hospitals other than the Hospital.

Board means the governing body of the Hospital that has overall responsibility for the conduct of the Hospital, including the Medical Staff. Reference to the Board shall include any Board committee/subcommittee or individual authorized by the Board to act on its behalf in designated matters.

Chief Medical Officer or **CMO** means the Physicians appointed to serve as the chief medical executive for a Hospital or the East Market, as applicable, and as a liaison to the Medical Staff

Chief of Staff means the chief administrative officer of the Medical Staff.

Clinical Privileges or **Privileges** means the permission granted by the Board to a Practitioner or APC to provide patient care, treatment, and/or clinical services, pursuant to an applicable Delineation of Privileges, at/for the Hospital based upon the individual's professional license, education, training, experience, competence, ability, and judgment.

Credentials Verification Organization or **CVO** means the System credentials verification organization.

Dentist means an individual who has received a Doctor of Dental Surgery ("D.D.S.") or Doctor of Dental Medicine ("D.M.D.") degree and who is currently licensed to practice dentistry in Ohio.

Federal/State Health Program means Medicare, Medicaid, TriCare, or any other federal or state program providing health care benefits that is funded directly or indirectly by the United States government.

Hospital means the University Hospitals Ahuja Medical Center (Ahuja), University Hospitals Geneva Medical Center (Geneva), University Hospitals Conneaut Medical Center (Conneaut), University Hospitals Regionals Medical Center dba University Hospitals Geauga Medical Center (Geauga), and each such Hospital's provider-based locations, if any, all of which comprise the University Hospitals Health System East Market. A reference to "Hospital" may be read as an individual Hospital(s) or the Hospitals collectively, as applicable to the context in which the term is used in the Medical Staff governing documents for purposes of a unified Medical Staff.

Hospital President means the person appointed by the Board to act on its behalf in the overall operation and management of the Hospital. A reference to the Hospital President shall include his/her authorized designee.

Joint Conference Committee means an *ad hoc* Board advisory committee composed of an equal number of Board representatives selected by the Hospital Board and Medical Staff representatives selected by the Medical Executive Committee. Should the Board revise the Hospital's governing documents to provide for a standing Joint Conference Committee then this definition will be deemed likewise automatically amended as well.

Medical Executive Committee or **MEC** means the executive committee of the Medical Staff.

Medical Staff Bylaws or **Bylaws** means the Medical Staff Bylaws as such Bylaws may be amended from time to time.

Medical Staff means those Practitioners who have been granted appointment to the Hospital's Medical Staff with such responsibilities and Prerogatives as defined in the Medical Staff category to which each has been appointed. The Ahuja, Geneva, Conneaut, and Geauga Medical Staffs have elected to create a unified Medical Staff. References to "Medical Staff" in the Medical Staff governing documents shall mean the East Market unified Medical Staff.

Medical Staff Department or **Department** means a grouping or division of Medical Staff clinical services as set forth in the Bylaws or the Medical Staff Organization Policy.

- The head of each Medical Staff Department shall be designated as the Medical Staff Department Chair (Department Chair).
- Medical Staff Departments may be further divided into Medical Staff clinical Divisions each led by a Medical Staff Division Chief (Division Chief).

Medical Staff Member or **Member** means a Practitioner who has been granted appointment to the Medical Staff. A Medical Staff Member must also have applied for and been granted Privileges unless the appointment is to a Medical Staff category without Privileges, or unless otherwise provided in the Bylaws. References to Medical Staff appointee or Medical Staff appointment shall mean the same thing as Medical Staff Member or Medical Staff membership for purposes of the Medical Staff governing documents.

Medical Staff Policy or **Policies** means those Medical Staff policies, adopted/amended and approved in the manner set forth in the Medical Staff Bylaws, that serve to implement the Medical Staff Bylaws including this APC Policy and the Credentials Policy, Organization Policy, Fair Hearing Policy, Professional Conduct Policy, Impairment/Wellness Policy, Peer Review Policy, and Professional Practice Evaluation Policies.

Medical Staff Rules & Regulations or **Rules & Regulations** means the rules and regulations of the Medical Staff, adopted/amended and approved in the manner set forth in the Medical Staff Bylaws, that address issues related to clinical care, treatment, and services provided by Practitioners and APCs with Privileges at the Hospital.

Oral & Maxillofacial Surgeon or **Oral Surgeon** means a Dentist who has successfully completed an accredited postgraduate/residency program in oral/maxillofacial surgery.

Patient Encounter means, for purposes of this APC Policy, a professional contact between an APC and a patient at the Hospital or a provider-based location thereof.

Physician means an individual who holds a Doctor of Medicine ("M.D.") or Doctor of Osteopathic Medicine ("D.O.") degree and who is currently licensed to practice medicine in Ohio.

Podiatrist means an individual who holds the degree of Doctor of Podiatric Medicine (D.P.M.) and who is currently licensed to practice podiatry in Ohio.

Practitioner means, unless otherwise expressly provided, a Physician, Dentist, Podiatrist, or Psychologist.

Prerogative means the right to participate, by virtue of Medical Staff category, granted to a Medical Staff Member and subject to the ultimate authority of the Board and the conditions and limitations imposed in the Medical Staff governing documents.

Professional Liability Insurance means professional liability insurance coverage of such kind, in such amount (but not less than $1,000,000.00 per occurrence/$3,000,000.00 annual aggregate), and underwritten by such insurers as required and approved by the Hospital Board.

Psychologist means an individual with a doctoral degree in psychology or school psychology, or a doctoral degree deemed equivalent by the Ohio Board of Psychology, who is currently licensed to practice psychology in Ohio.

Qualified Medical Person or **QMP** means those qualified individuals who are authorized to perform a medical screening examination as set forth in the Medical Staff Rules & Regulations.

Special Notice means written notice sent by (a) certified mail, return receipt requested; or (b) by personal delivery service with signed acknowledgment of receipt.

System means University Hospitals Health System.

ARTICLE I OVERVIEW

1.1 APPLICABILITY OF APC POLICY

1.1-1 This APC Policy is only applicable to APCs who have requested, or who have requested and been granted, Privileges at the Hospital through the Medical Staff process.

1.1-2 All eligible APCs who request Privileges at the Hospital must be credentialed through the Medical Staff consistent with this Policy and granted Privileges prior to providing care, treatment, and/or services to patients at the Hospital.

1.1-3 Attached hereto, and incorporated by reference herein, is Appendix A which sets forth the types of APCs that are credentialed, eligible for Privileges at the Hospital, and managed through the Medical Staff pursuant to this Policy.

1.1-4 The Medical Executive Committee shall make recommendations to the Board, upon request, with respect to: (1) the types of APCs that are eligible to request Privileges at the Hospital; (2) the scope of practice and applicable Delineation of Privileges for each; and (3) whether any changes should be made, from time to time, to existing APC requirements (*e.g.*, qualifications, duties, Delineations of Privileges, *etc.*).

1.1-5 Each APC shall be assigned to the Medical Staff Department and Division that most clearly reflects his/her professional training and experience in the clinical area in which his/her practice is concentrated.

1.2 DUTIES OF PRACTITIONERS WHO SUPERVISE OR COLLABORATE WITH AN APC

1.2-1 Practitioners with Privileges at the Hospital who supervise or collaborate with an APC shall agree to:

(a) Acquaint the APC with the APC Policy and other applicable policies of the Medical Staff/Hospital as well as the other APCs, Practitioners, and personnel with whom the APC will have contact.

(b) Adhere, as applicable, to the requirements of any supervision agreement, standard care arrangement, or other document required by state law for the APC to practice and provide appropriate supervision or collaboration consistent with this Policy, the APC's Delineation of Privileges, and applicable laws, rules, and regulations.

(1) It shall be the responsibility of each supervising Physician or Podiatrist and his/her Physician Assistant (PA) to have and maintain a current, valid supervision agreement in accordance with applicable Ohio laws and State Medical Board of Ohio rules.

(2) It shall be the responsibility of each Certified Nurse Practitioner (CNP), Clinical Nurse Specialist (CNS), and Certified Nurse-Midwife (CNM) and his/her collaborating Physician or Podiatrist to have and maintain a current, valid, standard care arrangement in accordance with applicable Ohio laws and Ohio Board of Nursing rules.

(3) It shall be the responsibility of each supervising anesthesiologist to have and maintain a current, valid written practice protocol with his/her anesthesiologist assistant in accordance with applicable Ohio laws and State Medical Board of Ohio rules.

(c) Provide immediate notice to the Medical Staff Office when the collaborating or supervising Practitioner receives notice of (i) any grounds for summary suspension or automatic suspension/automatic termination of the APC's Privileges; or (ii) the occurrence of any action that establishes grounds for corrective action against the APC.

(d) Provide immediate notice to the Medical Staff Office when the APC's standard care arrangement, supervision agreement, or other document required by state law to practice, as applicable, expires or is terminated.

1.2-2 Failure to properly supervise or collaborate with an APC shall be grounds for corrective action against a Practitioner pursuant to the Medical Staff Bylaws.

1.3 LIMITATIONS

1.3-1 APCs are not granted appointment to the Medical Staff, may not hold Medical Staff office or serve as a Medical Staff Department Chair/Associate Medical Staff Department Chair or Division Chief, and are not entitled to the fair hearing and appeal rights afforded to Medical Staff Members.

1.3-2 APCs shall have such procedural rights, to the extent applicable, as set forth in Article VIII of this Policy.

1.3-3 APCs may attend Medical Staff meetings and meetings of their Medical Staff Department/Division but may not vote on Medical Staff or Department/Division matters.

1.3-4 APCs may serve on Medical Staff committees if so noted in the committee composition with or without the right to vote, as designated.

1.3-5 APCs must comply, as applicable, with their respective license, certificate, certification, the terms of their standard care arrangement(s), supervision agreement(s), or other credentials/document(s) required by state law to practice, and may only provide care, treatment, and services in accordance with this Policy, other applicable System/Hospital/Medical Staff policies, the Privileges granted to them, and applicable laws, rules, and regulations.

1.4 USE OF AN AUTHORIZED DESIGNEE

1.4-1 Whenever an individual is authorized in the Medical Staff governing documents to perform a duty by virtue of his/her position (*e.g.*, the Hospital President, CMO, Chief of Staff, Medical Staff Department Chair, *etc.*), then reference to the individual shall include the individual's authorized designee.

1.5 NOT A CONTRACT

1.5-1 The Medical Staff Bylaws, Policies, and Rules & Regulations are not intended to and shall not create any contractual rights between the Hospital and any individual APC or the APC's supervising or collaborating Practitioner or group of APCs/Practitioners. Any and all contracts of association or employment shall control contractual and financial relationships between the Hospital, APCs, and the APCs' supervising or collaborating Practitioners.

ARTICLE II QUALIFICATIONS FOR CLINICAL PRIVILEGES & APC RESPONSIBILITIES

2.1 IN GENERAL

2.1-1 Privileges shall be extended only to professionally competent APCs who continuously meet the qualifications and obligations set forth in this Policy.

2.1-2 No APC, including those employed by or contracted with the Hospital, shall provide care, treatment, and/or services to patients in the Hospital unless the APC has been granted Privileges to do so in accordance with the applicable procedures set forth in this Policy.

2.1-3 An APC who is granted Privileges is entitled to exercise such Privileges and is responsible for fulfilling such obligations as set forth in this Policy and the applicable Delineation of Privileges.

2.2 QUALIFICATIONS FOR PRIVILEGES

Unless otherwise provided in this Policy, to be eligible for Privileges an APC must:

2.2-1 BASELINE QUALIFICATIONS

(a) Have a current license to practice his/her profession in the State of Ohio. APCs shall meet the continuing education requirements necessary to maintain such professional license as determined by the applicable state licensing entity.

(b) Have and maintain, if required for the Privileges requested, a current valid Drug Enforcement Administration (DEA) registration.

(c) Document successful completion of professional education and training requirements as applicable to the Privileges requested.

(d) Possess current, valid Professional Liability Insurance coverage.

(e) Be able to participate in Federal/State Health Programs.

(f) Satisfy the board certification requirements applicable to his/her profession (*e.g.*, national nursing specialty certification for an APRN, *etc.*) and maintain certification in his/her area of practice by the appropriate board.

(g) Be able to read and understand the English language, to write and communicate verbally in the English language in an intelligible manner, and to prepare medical record entries and other required documentation in a legible and professional manner.

(h) Comply with state and/or federal vaccination requirements and implementing System/Hospital policies or obtain an approved exemption therefrom.

(i) Designate, if required for the Privileges requested, an appropriate Practitioner with Privileges at the Hospital to supervise or collaborate with the APC.

(j) Have and maintain, as applicable, a current, valid supervision agreement (for a PA), standard care arrangement (for a CNP, CNS, or CNM), or other document required by state law for the APC to practice with each of his/her supervising or collaborating Practitioners and provide a current copy of such agreement, arrangement, or document (and amendments thereto or designated representative legal authorizations, if any) to the Hospital.

2.2-2 ADDITIONAL QUALIFICATIONS

(a) Provide evidence of the APC's ability to work with others in a positive, professional, cooperative, and collegial manner.

(b) Document and demonstrate the current ability to competently perform the Privileges requested or held with or without a reasonable accommodation.

(c) Document prior and current experience demonstrating a continuing ability to provide patient care, treatment, and/or services at an acceptable level of quality and efficiency and consistent with available resources and applicable standards of care.

(d) Document and demonstrate adherence to the applicable code of professional ethics, good character/judgment, and willingness to fulfill/fulfillment of applicable APC duties.

(e) Obtain and maintain a provider number for Medicare issued by the Centers for Medicare and Medicaid Services and a provider number for Medicaid issued by the Ohio Department of Medicaid and be a Medicare and Medicaid participating provider as set forth in Section 3.6.

(f) Comply with the applicable conflict of interest policies, if any.

(g) Comply with Medical Staff requirements regarding criminal background checks.

(h) Satisfy such other qualifications as set forth in the applicable Delineation of Privileges and as may be otherwise recommended by the Medical Executive Committee and approved by the Board.

2.2-3 WAIVER PROCESS

(a) A qualification for Privileges that is required for state licensure is not eligible for waiver (*i.e.*, cannot be waived).

(b) A written request for a waiver of a qualification (not otherwise required for state licensure – *i.e.*, that can be considered for waiver) may be submitted by the APC for consideration by the MEC and Board.

(1) Such qualification may be waived, at the sole discretion of the Board, based upon the APC's demonstrated exceptional circumstances and a Board determination that such waiver will serve the best interests of patient care.

(2) The MEC will review the waiver request and make a recommendation to the Board regarding whether to grant or deny the request for a waiver.

(3) Upon receipt of the MEC's recommendation, the Board shall either grant or deny the waiver request.

(c) Once a waiver is granted, it shall remain in effect from the time it is granted until the APC's resignation or termination of Privileges unless a shorter time period is otherwise recommended by the MEC and approved by the Board. The APC must thereafter reapply for the waiver.

(d) No APC is entitled to a waiver. A determination by the Board not to grant an APC's request for a waiver; or, the Hospital's inability to process an application; or, termination of an APC's Privileges based upon failure to satisfy the qualifications for Privileges does not give rise to any procedural due process rights pursuant to this APC Policy nor does it create a reportable event for purposes of federal or state law.

(e) Unless a waiver is requested and subsequently granted, an APC's failure to:

(1) Satisfy the applicable qualification(s) at the time of initial application shall result in the Hospital's inability to process the application because the APC fails to meet baseline qualifications.

(2) Continuously satisfy the applicable qualification(s) following attainment of Privileges shall be addressed, as applicable, in the manner set forth in Section 7.4 and/or Section 7.5 or as otherwise appropriate pursuant to this APC Policy.

2.3 APC OBLIGATIONS

2.3-1 Unless otherwise provided in this Policy, each APC granted Privileges at the Hospital shall, as applicable to the Privileges granted to each such APC:

(a) Provide, or arrange for, continuous care of his/her patients at a professional level of quality and efficiency.

(b) Comply with this Policy, other applicable Medical Staff Policies, the Rules & Regulations, the Hospital's governing documents, System and Hospital policies (including, but not limited to, policies related to HIPAA privacy/confidentiality, corporate compliance, conflicts of interest, *etc.*), and applicable laws, rules, regulations, and accreditation standards.

(c) Perform assigned duties.

(d) Successfully complete required education/training on use of the Hospital's electronic health record prior to exercise of Privileges at the Hospital; and, thereafter, timely complete such other technology related education/training as may be directed by the MEC.

(e) Appropriately utilize the Hospital's electronic health record system for order entry and for all other appropriate functionalities.

(f) Prepare and complete medical/electronic health records and other required documentation within the time period(s) required by the Hospital for all Hospital patients the APC provides care, treatment, and/or services to.

(g) Participate in providing care, treatment, and services consistent with the Hospital's mission.

(h) Assist with Medical Staff approved clinical education training programs for APC students, as applicable.

(i) Provide education (within the APC's specialty expertise) for other APCs and Hospital staff as requested.

(j) Refuse to engage in improper inducements for patient referrals or in division of fees.

(k) Provide consultations, as requested, within the APC's scope of practice and subject to the APC's Privileges, standard care arrangement/supervision agreement/other document required by state law to practice (as applicable), the Medical Staff Rules and Regulations, and applicable System/Hospital clinical policies.

(l) Abide by generally recognized standards of professional ethics.

(m) Work in a cooperative and professional manner with others so as not to adversely affect the delivery of quality patient care.

(n) Timely complete required Hospital education and training as directed by the MEC.

(o) Participate in quality assurance, peer review, professional practice evaluation, and utilization review activities whether related to oneself or others.

(p) Cooperate with review of an APC's (including his/her own) conduct, clinical competence, or other qualifications for Privileges and refrain from directly or indirectly interfering, obstructing, or hindering any such review, whether by threat of harm or liability, by withholding information, or by refusing to perform or participate in assigned responsibilities related thereto.

(q) Comply with such notice requirements as are set forth in this Policy.

(r) Comply with mandatory training requirements as set forth in applicable Medical Staff and/or System/Hospital policies.

(s) Satisfy such additional responsibilities as set forth in this Policy, other applicable Medical Staff Policies, the Rules and Regulations, and/or as may be otherwise recommended by the MEC and approved by the Board.

2.3-2 Failure to satisfy any of the aforementioned responsibilities may be grounds for ineligibility for or denial of regrant of Privileges or corrective action pursuant to this Policy.

ARTICLE III PROCEDURE FOR INITIAL GRANT OF PRIVILEGES

3.1 NON-DISCRIMINATION

No APC shall be denied Privileges on the basis of: race; color; sex (including pregnancy); sexual orientation; gender identity; gender expression; transgender status; age (40 and older); religion; marital, familial, or health status; national origin; ancestry; disability (provided that the applicant can competently exercise the Privileges requested with or without a reasonable accommodation); genetic information; veteran or military status; or any other characteristic(s) or class protected by applicable law.

3.2 NO ENTITLEMENT

No APC shall be entitled to Privileges at the Hospital merely by virtue of the fact that he or she holds a certain degree; is duly licensed to practice in this or any other state; is certified by any clinical board; is a member of any professional organization; had in the past, or presently has, privileges at another hospital or healthcare entity; or is employed by or contracts with the Hospital.

3.3 DURATION OF PRIVILEGES

3.3-1 Granting of Privileges/regrant of Privileges shall be for a period of not more than three (3) years.

3.3-2 A grant/regrant of Privileges of less than three (3) years shall not be deemed Adverse for purposes of this Policy.

3.4 CONSIDERATION OF NEEDS & RESOURCES

Requests for Privileges must be compatible with the policies, plans, and objectives formulated by the Board concerning: the Hospital's patient care needs (including current and projected needs) and the care, treatment, and/or services provided by the Hospital; the Hospital's facilities, equipment, personnel, and financial resources; and the Hospital's decision to contract exclusively for the provision of certain medical/professional services with a Practitioner/APC or group of Practitioners/APCs other than the applicant.

3.5 REQUEST FOR & CONTENT OF APPLICATION FOR PRIVILEGES

3.5-1 A request by an APC for an application for Privileges at the Hospital shall be directed to the CVO. The CVO shall provide the APC with electronic access to the application packet for completion and to this Policy, other applicable Medical Staff Policies, and the Rules & Regulations.

3.5-2 Unless otherwise provided in this Policy, an application for Privileges shall include, but not be limited to:

(a) Documentation of professional school/postgraduate education including the name(s) of the institution(s) and the dates attended, the course of study or program completed, and any degree(s) granted.

(b) Documentation of such training as required for the Privileges requested.

(c) Documentation of a current valid Ohio license to practice his/her profession including the date of issuance, expiration date, and license number.

(d) Attestation of participation in continuing education activities at the level required by the applicant's licensing board. The Hospital, in its discretion, has the right to audit and verify the applicant's satisfaction of continuing education requirements at any time.

(e) Documentation of a current valid Drug Enforcement Administration (DEA) registration (if required for the Privileges requested) including the date of issuance, expiration date, registration number, and schedules.

(f) Documentation of board certification and recertification requirements applicable to the APC's profession (*e.g.*, national nursing specialty certification for APRNs, *etc.*).

(g) Documentation of current valid Professional Liability Insurance:

(1) At the time of request for initial Privileges: Information on professional liability claims history and experience (suits filed, pending, or settled and the names/addresses of present and past insurance carriers) for the past five (5) years.

(2) At the time of request for regrant of Privileges: Information on professional liability suits filed, pending, or settled during the preceding Privilege period.

(h) Documentation of hospital affiliations as required by the application.

(i) Documentation of chronological work history as required by the application.

(j) The nature and specifics of any proposed, pending, or completed action involving voluntary (while under investigation or to avoid investigation for conduct or clinical competency concerns) or involuntary denial, revocation, termination, suspension, probation, reduction, limitation, withdrawal, non-renewal, or relinquishment (by resignation or expiration) of:

(1) a professional license in Ohio or in any other state or country;

(2) a controlled substance registration;

(3) membership or fellowship in local, state, or national organizations;

(4) board certification or eligibility;

(5) faculty appointment at any professional school;

(6) privileges at any other health care entity including, but not limited to, a hospital, clinic, surgery center, skilled nursing facility, or managed care organization in this or any other state;

(7) Professional Liability Insurance;

(8) participation in any Federal/State Health Program;

or, as may be otherwise specified in the application.

(k) The Privileges requested.

(l) Any past or current criminal charges of which the applicant was convicted or to which the applicant plead guilty or no contest (other than minor traffic/motor vehicle violations).

(m) Peer references as required by the application.

(n) Documentation with respect to military service/status, as applicable.

(o) Documentation of the applicant's ability to fully and competently exercise the Privileges requested, with or without a reasonable accommodation.

(p) Information as to whether the applicant has been sanctioned by, excluded/precluded from, or the subject of investigation by a Federal/State Health Program and, if so, the outcome of such investigation.

(q) Documentation of Medicare and Medicaid information in accordance with the requirements set forth in Section 3.6.

(r) Information required by applicable conflict of interest policies.

(s) A signed release form authorizing a criminal background check and such other information as is necessary to complete same.

(t) Documentation of compliance with state and/or federal vaccination requirements and implementing System/Hospital policies or an approved exemption.

(u) The name(s) of the APC's supervising or collaborating Practitioner(s), if applicable.

(v) A copy, if applicable, of the APC's current valid standard care arrangement(s), supervision agreement(s), or other document(s) required by state law to practice, amendments thereto, and designated representative legal authorizations, if any.

(w) A current valid hospital identification card with photo, name, and professional designation; or a current, valid photo identification issued by a state or federal agency (*e.g.*, a driver's license or passport). An authorized Hospital representative verifies that the APC requesting Privileges is the same individual as identified in the credentialing documents.

(x) The applicant's signature with date.

(y) Such additional information as may be required by the application.

3.6 MEDICARE AND MEDICAID PARTICIPATION

3.6-1 Currently Practicing Ohio APCs

(a) Absent the exception set forth in Section 3.6-2 or Section 3.6-3, a currently practicing Ohio APC who is eligible to be a Medicare and Medicaid participating provider must provide documentation of the following in order for an application/request for Privileges to be processed:

(1) An active Medicare provider number issued by the Centers for Medicare and Medicaid Services (CMS).

(2) An active Medicaid provider number issued by the Ohio Department of Medicaid.

(3) That the APC is a participating provider in Medicare and Medicaid and has not elected to opt out of Medicare and/or Medicaid.

3.6-2 APCs New to Practice or Relocating to Ohio

(a) An APC new to practice or relocating to Ohio who is eligible to be a Medicare and Medicaid participating provider must provide documentation of the following in order for an application/request for Privileges to be processed:

(1) An active Medicare provider number issued by the Centers for Medicare and Medicaid Services (CMS) or evidence that a complete Medicare provider enrollment application has been submitted and is pending action by CMS.

(2) An active Medicaid provider number issued by the Ohio Department of Medicaid or evidence that a complete Ohio Medicaid provider enrollment application has been submitted and is pending action by the Ohio Department of Medicaid.

(3) That the APC is a participating provider (or has applied to become a participating provider) in Medicare and Medicaid and has not elected to opt out of Medicare and/or Medicaid.

3.6-3 APCs Who Elect to Opt Out of Medicare and/or Medicaid Participation

(a) APCs who are eligible to be a Medicare and Medicaid participating provider but who elect to opt out of Medicare and/or Medicaid participation are not eligible for Privileges at the Hospital unless a waiver is requested by the APC and granted pursuant to the procedure set forth in Section 2.2-3.

3.7 EFFECT OF APPLICATION

3.7-1 By signing and submitting an application for Privileges, the applicant:

(a) Attests that the application is correct and complete and acknowledges that any material misrepresentation, misstatement, or omission is grounds to stop processing the application or for termination of Privileges.

(b) Agrees to appear for interviews in support of his/her application.

(c) Agrees to the applicable provisions set forth in this Policy regarding confidentiality, immunity, and release of liability.

(1) Authorizes the Board, the Hospital, its Medical Staff, and their authorized representatives to consult with others who have been associated with the applicant and who may have information bearing on his/her qualifications for Privileges and releases the Board, the Hospital, its Medical Staff, and their representatives from liability for so doing.

(2) Authorizes the Board, the Hospital, its Medical Staff, and their authorized representatives to review all records and documents that may be material to an evaluation of the applicant's qualifications for Privileges and releases the Board, the Hospital, its Medical Staff, and their representatives from liability for so doing.

(3) Authorizes the Board, the Hospital, its Medical Staff, and their authorized representatives to provide to other hospitals, licensing boards, and organizations concerned with provider performance and the quality and safety of patient care with information relevant to such matters that the Hospital may have concerning the APC and releases the Board, the Hospital, its Medical Staff, and their representatives from liability for so doing.

(d) Agrees to fulfill APC responsibilities if Privileges are granted.

(e) Acknowledges receiving access to this Policy, other applicable Medical Staff Policies, and the Rules & Regulations.

(1) Agrees to be bound by the terms of and to comply in all respects with this Policy in all matters related to consideration of the applicant's application whether or not Privileges are granted.

(2) Agrees to be bound by the terms of and to comply in all respects with this Policy, other applicable Medical Staff Policies, the Rules & Regulations, as well as applicable System/Hospital policies (*e.g.*, corporate compliance plan, notice of privacy practices, conflict of interest policies, *etc.*) if granted Privileges at the Hospital.

(f) Agrees that if an Adverse recommendation or action is made/taken with respect to Privileges, the applicant will exhaust the administrative remedies afforded by this Policy before resorting to formal legal action.

(g) Understands and agrees that if a final Adverse decision is made by the Board with respect to a request for, or existing, Privileges, the APC may be subject to reporting to the National Practitioner Data Bank and/or state authorities.

(h) Agrees to promptly notify the CVO and Medical Staff Office, in writing, of any changes to the information set forth in the applicant's APC application. The foregoing obligation shall be a continuing obligation of the applicant so long as he/she has an application pending for Privileges or holds Privileges at the Hospital.

(i) Acknowledges that the Hospital is part of a healthcare system with other Affiliate Hospitals and that information is shared among the Hospital and Affiliate Hospitals. The applicant recognizes and understands that any and all information (including peer review information) relative to his/her request for and/or grant of Privileges that is maintained, received, and/or generated by the Hospital or Affiliate Hospitals may be shared among the Hospital and Affiliate Hospitals. The applicant further understands that this information may be used as part of the respective Hospital's or an Affiliate Hospital's quality assessment and improvement activities and can form the basis for corrective action.

3.8 APPLICANT'S BURDEN

3.8-1 A completed application for Privileges must be submitted to the CVO by the applicant electronically on the Hospital-approved form, signed by the applicant, and accompanied by the full amount of the non-refundable application fee.

3.8-2 Upon receipt of the application and required non-refundable application fee, a credentials file will be created and maintained for each applicant by the Hospital.

3.8-3 The applicant shall have the burden of producing adequate information for a proper evaluation of his/her qualifications for Privileges and for resolving any doubts about such qualifications.

3.8-4 If a completed application is not returned to the CVO by the requesting applicant within thirty (30) days after the application was made available to such applicant, the application may be deemed to have been voluntarily withdrawn.

3.8-5 The applicant shall be responsible for providing a complete application. An application shall be considered incomplete if the need arises at any time for new, additional, or clarifying information.

(a) Until the applicant has provided all information requested, the application for Privileges will be deemed incomplete and will not be processed.

(b) Failure, without good cause, by an applicant to respond to a request for additional information regarding his/her pending application, within thirty (30) days after written request for such additional information, may be deemed a voluntary withdrawal of the application and the applicant's file will be closed.

3.8-6 The applicant shall be notified, in writing, when his/her application is deemed to have been voluntarily withdrawn and that such withdrawal does not give rise to any procedural due process rights pursuant to this Policy. For any future consideration for Privileges, the applicant must request and submit a new initial application including application fee.

3.9 CREDENTIALING COLLECTION AND VERIFICATION PROCESS

3.9-1 The CVO is responsible for collection and verification of APC applications, and accompanying materials, for Privileges. The CVO shall:

(a) Review the application to determine that all questions have been answered and that all requested information and documentation has been provided.

(b) Verify the information provided in the application with the primary sources, as applicable.

(c) Conduct a National Practitioner Data Bank (NPDB) query on all applicants in accordance with NPDB requirements, which may be satisfied by use of the NPDB's continuous query process.

(d) Query the appropriate sources (*e.g.*, Office of Inspector General's Cumulative Sanction report, General Services Administration List of Parties Excluded from Federal Procurement and Non-Procurement Programs, *etc*.) to determine whether the applicant has been convicted of a health care related offense, or debarred, precluded, excluded, or otherwise made ineligible for participation in a Federal/State Health Program.

3.9-2 The CVO shall gather Privilege related data (*e.g.*, case logs, *etc*.) specific to the Privileges requested by each applicant

3.9-3 When the CVO collection and verification process is finished, the CVO shall notify the Medical Staff Office.

3.9-4 When the application packet is complete, the Medical Staff Office shall notify the applicable Medical Staff Department Chair, Associate Medical Staff Department Chair, and/or Division Chief that the application packet is available for review.

3.9-5 The application for Privileges shall thereafter be processed in accordance with Section 3.10.

3.10 PRIVILEGING PROCESS

3.10-1 REVIEW BY A MEDICAL STAFF DEPARTMENT CHAIR, ASSOCIATE MEDICAL STAFF DEPARTMENT CHAIR, AND/OR DIVISION CHIEF

(b) The applicable Medical Staff Department Chair, Associate Medical Staff Department Chair, and/or Division Chief will review the application packet to assess the applicant's qualifications for Privileges.

(c) The Medical Staff Department Chair, Associate Medical Staff Department Chair, and/or Division Chief may, at his/her discretion, interview the applicant.

(a) Following such review and interview, if any, the Medical Staff Department Chair, Associate Medical Staff Department Chair, and/or Division Chief will provide his/her written recommendation as to approval or denial of the applicant's request for Privileges to the Credentials Committee.

3.10-2 REVIEW BY THE CREDENTIALS COMMITTEE

(a) At its next regular meeting after receipt of the Medical Staff Department Chair's, Associate Medical Staff Department Chair's, and/or Division Chief's recommendation(s), the Credentials Committee shall consider such recommendation(s) and review the application packet to determine whether the applicant meets the qualifications for Privileges.

(b) If the Credentials Committee requires clarification or additional information, it may table making a recommendation and note in the Credentials Committee minutes the deferral and the reason(s) therefore. The Credentials Committee shall act on the deferred application at its next regular meeting unless otherwise unable to do so for good cause.

(c) The Credentials Committee may, at its discretion, interview the applicant.

(d) If, during the processing of an application, it becomes apparent to the Credentials Committee that the committee is considering a recommendation for denial of Privileges, the chair of the Credentials Committee may notify the applicant of the general tenor of the possible recommendation and ask if the applicant desires to meet with the committee prior to a recommendation by the committee. At such meeting, if any, the applicant may be informed of the general nature of the facts supporting the action contemplated and invited to discuss, explain, or refute such facts. The Credentials Committee shall indicate in the Credentials Committee minutes whether such a meeting occurred; and, if so, will include a summary of such meeting for the MEC.

(e) Following such review and interview, if any, the Credentials Committee shall provide its written recommendation (which recommendation will be documented in the Credentials Committee minutes) as to approval or denial of the applicant's request for Privileges to the MEC.

3.10-3 RECOMMENDATION BY THE MEDICAL EXECUTIVE COMMITTEE

(a) At its next regular meeting after receipt of recommendations from the Medical Staff Department Chair, Associate Medical Staff Department Chair, and/or Division Chief and the Credentials Committee, the MEC shall consider such recommendations, review the application packet, as necessary, and may take any of the following actions (which action will be documented in the MEC meeting minutes):

(1) Deferral. The MEC may table making a recommendation on the application and note in the MEC minutes the deferral and the reason(s) therefore. A decision by the MEC to defer the application for further consideration must be revisited at the next regularly scheduled meeting, except for good cause, at which point the MEC shall issue its recommendation as to approval or denial of Privileges.

(2) Favorable Recommendation. If the recommendation of the MEC is favorable to the applicant, the MEC shall forward its recommendation to the Board (in accordance with Section 3.10-4 or Section 3.10-5) for action.

(3) Adverse Recommendation. If the recommendation of the MEC is Adverse to the applicant, the Chief of Staff shall notify the applicant of the Adverse recommendation, by Special Notice, and of the applicant's right, as applicable, to request the procedural due process rights set forth in Section 8.2. No such Adverse recommendation shall be forwarded to the Board until after the applicant has exercised or has been deemed to have waived his or her right, as applicable, to the procedural due process rights provided for in this Policy.

3.10-4 BOARD ACTION – CLEAN APPLICATIONS

(a) Fully clean applications that qualify for expedited approval with a favorable recommendation from the Medical Staff Department Chair, Associate Medical Staff Department Chair, and/or Division Chief (depending upon which Medical Staff leader(s) reviewed the application packet); a favorable recommendation from the Credentials Committee; and a favorable recommendation from the MEC, will be acted upon by a designated committee of the Board (comprised of at least two (2) voting Board members).

(b) If approved, the applicant shall be granted the Privileges for which he/she applied effective as of the date the designated Board committee takes action. No further Board action is required.

3.10-5 BOARD ACTION – ALL OTHER APPLICATIONS

(a) Applications that do not qualify for expedited approval pursuant to Section 3.10-4 will be acted upon by the Board following a recommendation from the Board Quality & Professional Affairs Committee (QPAC) in accordance with the procedure set forth in subsection (b).

(b) At its next regular meeting after receipt of a recommendation from the MEC, the Board may take any of the following actions:

(1) Deferral. The Board may table a decision on the application and note in the Board minutes the deferral and the reason(s) therefore.

(2) Favorable MEC Recommendation. The Board may:

(i) Grant Privileges as recommended by the MEC. If the Board's decision is favorable to the applicant, the action shall be effective as the Board's final decision.

(ii) Refer the matter back to the MEC for additional consideration. In such event, the Board must state the reason(s) for the requested reconsideration and set a time limit within which a subsequent MEC recommendation to the Board must be made.

(iii) Reject or modify the MEC's favorable recommendation in whole or in part. If the Board's proposed decision is contrary to the MEC's favorable recommendation, the matter shall be referred to the Joint Conference Committee pursuant to Section 3.10-6

below. If the Board's determination is Adverse to the applicant following such referral to the Joint Conference Committee, the Hospital President shall notify the applicant, by Special Notice, and the applicant shall be entitled, if applicable, to the procedural due process rights provided for in Section 8.2 upon proper and timely request therefore. Such Adverse decision shall be held in abeyance until the applicant has exercised or been deemed to have waived his/her procedural due process rights, if any, in Section 8.2. The fact that the Adverse decision is held in abeyance shall not be deemed to confer Privileges where none existed before.

(c) Adverse MEC Recommendation

(1) If the Board is to receive an Adverse MEC recommendation, the Chief of Staff shall withhold the recommendation and not forward it to the Board until after the applicant either exercises or waives his/her right, if any, to the procedural due process rights set forth in Section 8.2.

(2) The Board shall thereafter take final action in the matter as provided for in Article VIII.

3.10-6 REFERRAL TO JOINT CONFERENCE COMMITTEE

(a) Whenever the Board's proposed decision is contrary to the recommendation of the MEC, there shall be a further review of the recommendation by the Joint Conference Committee.

(b) The Joint Conference Committee shall, after due consideration, make its written recommendation to the Board within seven (7) days after referral to the committee. Thereafter, the Board may act. Such action by the Board may include accepting, rejecting, or modifying, in whole or in part, the recommendation of the Joint Conference Committee.

3.10-7 FINAL DECISION

(a) The Board, through the Hospital President, shall give notice of the Board's final decision to the applicant. The Medical Staff and Hospital personnel shall be notified, as appropriate.

(b) A notice of Privileges shall include, as applicable: the Department and Division, if applicable, to which the APC is assigned; the Privileges he/she may exercise; and any special conditions attached to the Privileges.

3.11 TIME PERIOD GUIDELINES FOR APPLICATION PROCESSING

3.11-1 All individuals and groups required to act on an application for Privileges must do so in a timely and good faith manner.

3.11-2 The following time periods will be used as a guideline:

(a) Medical Staff Department Chair, Associate Medical Staff Department Chair, and/or Division Chief. Within 30 days following notification from the Medical Staff Office that the complete application packet is available for review.

(b) Credentials Committee. Next regular meeting after receipt of a recommendation from the Medical Staff Department Chair, Associate Medical Staff Department Chair and/or Division Chief.

(c) Medical Executive Committee. Next regular meeting after receipt of a recommendation from the Credentials Committee.

(d) Board: Next regular meeting after receipt of a recommendation from the Medical Executive Committee.

3.11-3 Section 3.11-2 is a guideline and shall not create any rights for the applicant to have an application processed within these time periods.

3.11-4 If additional information is needed from the applicant, the time awaiting a response from the applicant shall not count towards the applicable time guideline.

3.11-5 If the provisions of Article VIII are activated, the time requirements provided therein govern the continued processing of the application.

3.12 RESIGNATION

3.12-1 An APC who desires to resign his/her Privileges shall submit a written resignation (which may be provided by e-mail) to the Medical Staff Office. Such resignation shall take effect on the date specified in the resignation notice.

3.12-2 Notification of the resignation will be communicated by the Medical Staff Office as appropriate.

3.12-3 A resignation should be submitted sufficiently in advance to assure that there is continuity of patient care and no disruption in services. An APC who resigns his/her Privileges is obligated to complete all medical records for which he/she is responsible prior to the effective date of the resignation. In the event an APC fails to do so, consideration may be given by the Hospital/Medical Staff to contacting the applicable state licensing board regarding the APC's actions.

3.13 REAPPLICATION

3.13-1 Except as otherwise provided in this Policy, or as otherwise determined by the Board, upon recommendation of the Medical Executive Committee, in light of exceptional circumstances:

(a) An APC whose Privileges are automatically terminated pursuant to Section 7.5-1 (a)/(License Revocation/Expiration), (b)/(Controlled Substance Authorization), (d)/(Federal/State Health Program), or (f)/(Designated Offense) of this Policy shall not be eligible to reapply for Privileges for a period of at least two (2) years following the effective date of the automatic termination.

(b) An APC who has received a final Adverse decision regarding Privileges/regrant of Privileges shall not be eligible to reapply for Privileges for a period of at least two (2) years following the latter of the date of the notice of the final Adverse decision or final court decision.

(c) An APC who has resigned his/her Privileges or who fails to seek regrant of Privileges while under investigation or to avoid an investigation for professional conduct or clinical competency concerns shall not be eligible to reapply for Privileges for a period of at least two (2) years following the effective date of the resignation.

(d) An APC who has withdrawn an initial application for Privileges for professional conduct or clinical competency concerns shall not be eligible to reapply for Privileges for a period of at least two (2) years following the date of the withdrawal.

3.13-2 Any such reapplication shall be processed as an initial application, in accordance with the privileging process set forth in Section 3.10, and the APC must submit such additional information as may be reasonably required to demonstrate that the basis for the automatic termination, Adverse decision, resignation, or withdrawal has been resolved or no longer exists. If such information is not provided, the reapplication will be considered incomplete and voluntarily withdrawn and will not be further processed.

ARTICLE IV PROCEDURE FOR REGRANT OF PRIVILEGES

4.1 APPLICATION FOR REGRANT OF PRIVILEGES

4.1-1 Prior to the expiration date of an APC's current Privilege period, the APC will be provided with a Hospital approved application for regrant of Privileges.

4.1-2 Each current APC who is eligible to be regranted Privileges shall be responsible for returning a completed application form to the CVO within the time period specified. The APC must sign the application for regrant of Privileges and in so doing accepts the same conditions as set forth in Section 3.7.

4.1-3 The APC has the burden of producing adequate information for a proper evaluation of his/her qualifications for regrant of Privileges, of resolving any doubts about such qualifications, and of satisfying requests for additional information or clarification made by authorized Medical Staff or Hospital representatives as set forth in Section 3-8.

4.1-4 Failure to return an application for regrant of Privileges results in termination of the APC's Privileges at the expiration of his/her current Privilege term. For any future consideration for Privileges, the APC will need to submit a new initial application, including application fees.

4.1-5 Each recommendation concerning regrant of Privileges shall be based upon review and consideration of an APC's:

(a) Continued satisfaction of the qualifications for Privileges as set forth in Section 2.2 and the applicable Delineation of Privileges.

(b) Updated information provided by the APC with respect to Section 3.5 as necessary to bring the APC's credentials file current.

(c) Satisfaction of the APC responsibilities set forth in the Section 2.3.

(1) An APC who fails to comply with mandatory training requirements, as set forth in applicable Medical Staff and/or System/Hospital policies, is not eligible to apply for regrant of Privileges until all such mandatory training requirements are satisfied.

(d) Attestation of completion of continuing education requirements, as applicable. The Hospital/Medical Staff, through the CVO and/or the Medical Staff Office, reserve(s) the right to request proof of completion of continuing professional education requirements.

(e) Results of the Medical Staff's peer review and professional practice evaluation process and relevant findings from other quality assessment/performance improvement activities.

(f) Request for changes, if any, in Privileges.

(g) Such other information as the MEC and Board deem applicable to a request for regrant of Privileges.

4.1-6 To be eligible to apply for a regrant of Privileges, an APC must have had a sufficient number of Patient Encounters in the previous Privilege period to enable assessment of the APC's current clinical competence for the Privileges requested. An APC seeking regrant of Privileges who has had minimal activity at the Hospital must submit supplemental information regarding current professional practice/performance from the APC's primary hospital (*e.g.*, additional peer reference from the applicant's primary hospital department chair, *etc.*) as may be requested, before the APC's application for regrant of Privileges shall be considered complete and processed further.

4.2 PROCESSING APPLICATIONS FOR REGRANT OF PRIVILEGES

4.2-1 An application for regrant of Privileges shall be processed as follows:

(a) The CVO verifies the information provided on the application for regrant of Privileges working with the same authorities and generally in the same manner, to the extent applicable, as provided for in the initial application process set forth in Section 3.9.

(b) Applications for regrant of Privileges shall be reviewed and acted upon in accordance with the procedure set forth in Section 3.10.

(c) For purposes of regrant of Privileges, the terms "applicant" and "Privileges" as used in Articles II and III shall be read, as "APC" and "regrant of Privileges," respectively.

(d) All individuals and groups required to act on an application for regrant of Privileges must do so in a timely and good faith manner.

4.2-2 If an application for regrant of Privileges has not been fully processed by the expiration date of the APC's current Privilege period, the APC's Privileges shall terminate at the end of the last day of his/her current Privilege period. An APC whose Privileges are so terminated shall not be entitled to the procedural due process rights provided in Article VIII. If the APC qualifies, he/she may be granted temporary Privileges pursuant to Section 5.1.

4.3 MODIFICATION OF PRIVILEGES

4.3-1 A request for **new/additional Privileges** during a current Privilege period by an APC with Privileges at the Hospital requires completion of the applicable Delineation of Privileges and documentation supportive of the request. Following collection and verification of the required information, such request will be processed in the manner set forth in Section 3.10.

4.3-2 A request to **exercise currently granted Privileges at an additional location(s) within the System's East Market** requires that the APC complete an updated Delineation of Privileges to designate and document the additional location(s) requested. Such request will be acted upon (*e.g.*, approved) by the Hospital President or CMO and subsequently

reported to the applicable Medical Staff Department Chair and Division Chief, the Credentials Committee, the MEC, and the Board.

ARTICLE V TEMPORARY PRIVILEGES, DISASTER PRIVILEGES & TELEMEDICINE PRIVILEGES

5.1 TEMPORARY PRIVILEGES

5.1-1 CONDITIONS

(a) Temporary Privileges may be granted to eligible APCs only in the circumstances and under the conditions set forth in this Section.

(b) Special requirements of consultation and reporting may be imposed by the applicable Medical Staff Department Chair, Associate Medical Staff Department Chair, and/or Division Chief or the Chief of Staff.

(c) The APC requesting temporary Privileges must agree, in writing, to abide by this Policy, other applicable Medical Staff Policies, the Rules & Regulations, and applicable System/Hospital policies.

5.1-2 CIRCUMSTANCES

(a) When dictated by (i) urgent patient care need; or (ii) when an application is complete, without any negative or adverse information, and before action by the Medical Executive Committee or Board, the Hospital President (or CMO, as the Hospital President's authorized designee) may, on a case-by-case basis, grant temporary Privileges upon recommendation of the Chief of Staff or, in the Chief of Staff's absence, another member of the MEC.

(d) Criteria for granting temporary Privileges:

(1) Primary verification of education.

(2) Demonstration of current competence.

(3) Primary verification of state professional license(s) and DEA registration if required for the Privileges requested.

(4) Receipt of professional references (including information regarding current competence).

(5) Receipt of database profiles from AMA (as applicable to a Physician Assistant), NPDB, and OIG Medicare/Medicaid Exclusions.

(6) Confirmation of Professional Liability Insurance.

(7) Confirmation of supervising or collaborating Practitioner (if required) with Privileges at the Hospital.

(8) Receipt, if applicable, of a copy of the APC's current valid standard care arrangement(s), supervision agreement(s), or other document(s) required by state law to practice, amendments thereto, and designated representative legal authorizations, if any.

(e) Temporary Privileges may be granted for a period of time not to exceed 120 days.

(b) Temporary Privileges may be terminated pursuant to Section 5.4.

5.2 DISASTER PRIVILEGES

5.2-1 In circumstances of disaster when the Emergency Operations Plan ("EOP") has been activated and the Hospital is unable to meet immediate patient needs, the Hospital may choose to rely on volunteer APCs to help meet these needs subject to applicable state licensure laws, rules, and regulations.

5.2-2 Under such circumstances, if the routine credentialing and privileging process (or temporary Privileges process) cannot be followed, the Hospital President, CMO, or Chief of Staff may grant such disaster Privileges on a case-by-case basis after the Hospital obtains from the volunteer APC a valid government-issued photo identification (*e.g.*, a driver's license or passport) and at least one of the following:

(a) Evidence of a current license to practice, primary source verified as soon as the Hospital is able to do so.

(b) Identification indicating the individual is a member of a Disaster Medical Assistance Team ("DMAT"), the Medical Reserve Corp ("MRC"), the Emergency System for Advance Registration of Volunteer Health Professionals ("ESAR-VHP"), or other recognized state or federal disaster response organization or group.

(c) Authorization from a government entity granting the volunteer APC (*e.g.*, a retired APC) the authority to provide patient care, treatment, or services during the disaster.

(d) A current picture identification card from a hospital/health care entity where the APC currently practices that clearly identifies the volunteer APC's professional designation.

(e) Confirmation by current Medical Staff Members with Privileges at the Hospital who know the volunteer APC and have personal knowledge regarding the volunteer APC's clinical ability.

5.2-3 Unless otherwise provided by applicable Ohio licensure laws, rules, and/or regulations, a volunteer APC requesting disaster Privileges shall also provide:

(a) The name of his/her collaborating or supervising Practitioner(s) (if applicable) who must also apply for and be granted disaster Privileges at the Hospital in order for the volunteer APC to be granted disaster Privileges.

(b) A copy, if applicable, of a current valid supervision agreement, standard care arrangement, or other document required by state law to practice with each such supervising or collaborating Practitioner including any amendments thereto and designated legal authorizations, if any.

5.2-4 It is anticipated that disaster Privileges may be granted to both Ohio and out-of-state volunteer APCs subject to applicable Ohio licensure laws, rules, and regulations.

5.2-5 The activities of volunteer APCs who receive disaster Privileges shall be managed by and under the supervision of the applicable Medical Staff Department Chair, Associate Medical Staff Department Chair, Division Chief, or an appropriate designee.

5.2-6 All volunteer APCs who receive disaster Privileges must wear a photo identification badge designating the APC as a volunteer disaster privileged provider.

5.2-7 Disaster Privileges may be terminated pursuant to Section 5.4 and shall cease upon alleviation of the circumstances of disaster as determined by the Hospital President.

5.3 TELEMEDICINE PRIVILEGES

5.3-1 Section 5.3 applies to distant-site telemedicine APCs who do not practice on-site at the Hospital.

5.3-2 Distant-site APCs who are responsible for the patient's care, treatment, and/or services via a telemedicine link shall be credentialed (which may be by proxy) and privileged to do so by the Hospital in accordance with this Policy, accreditation standards, and applicable laws, rules, and regulations.

5.3-3 Prior to a distant-site APC providing telemedicine services to patients at the Hospital, the APC must be appropriately credentialed (which may be by proxy) and granted Privileges by the Hospital. A distant-site APC providing services via a telemedicine link shall be credentialed and privileged in one of the following ways:

(a) The Hospital may fully credential and grant Privileges to each distant-site APC using the routine credentialing and privileging process set forth in Articles II – IV of this Policy

OR

(b) The credentialing information and privileging decision from the distant-site may be relied upon by the Hospital Medical Staff and Board in making its telemedicine privileging recommendations/decisions regarding each distant-site APC provided that the Hospital has entered into a written agreement with the distant-site and all of the following requirements are met:

(1) The distant-site is a Medicare-participating hospital **OR** a facility that qualifies as a distant-site telemedicine entity. A "distant-site telemedicine entity" is defined as an entity that (1) provides telemedicine services, (2) is not a Medicare-participating hospital, and (3) provides contracted services in a manner that enables hospitals using its services to meet all applicable conditions of participation, particularly those requirements related to the credentialing and privileging of APCs providing telemedicine services to the patients of the hospital.

(i) When the distant-site is a Medicare-participating hospital the written agreement shall specify that it is the responsibility of the

distant-site hospital to meet the credentialing requirements of 42 C.F.R. 482.12 (a)(1)-(a)(7) [and 42 CFR 485.616 (c)(1)(i) through (c)(1)(vii) with respect to services provided to critical access hospitals], as such provisions may be amended from time to time, with regard to the distant-site hospital APCs providing telemedicine services.

(ii) When the distant-site is a distant-site telemedicine entity the written agreement shall specify that the distant-site telemedicine entity is a contractor of services to the Hospital and, as such, furnishes the contracted services in a manner that permits the Hospital to comply with all applicable conditions of participation for the contracted services including, but not limited to, 42 C.F.R. 482.12 (a)(1)-(a)(7) [and 42 CFR 485.616 (c)(1)(i) through (c)(1)(vii) with respect to services provided to critical access hospitals], with regard to the distant-site telemedicine entity APCs providing telemedicine services. The written agreement shall further specify that the distant-site telemedicine entity's medical staff credentialing and privileging process and standards will, at minimum, meet the standards at 42 C.F.R. 482.12 (a)(1)-(a)(7) and at 42 C.F.R. 482.22 (a)(1)-(a)(2) [and 42 CFR 485.616 (c)(1)(i) through (c)(1)(vii) with respect to services provided to critical access hospitals], as those provisions may be amended from time to time.

(2) Each distant-site APC is privileged at the distant-site for those services to be provided at the Hospital and the distant-site provides the Hospital with a current list of each distant-site APC's privileges at the distant-site.

(3) Each distant-site APC holds an appropriate license issued by the applicable licensing entity in the state in which the Hospital whose patients are receiving the telemedicine services is located (*i.e.*, the state in which the patients are located) in addition to meeting the licensing standards, as applicable, in the state in which the APC is located.

(4) The Hospital maintains documentation of its internal review of the performance of each distant-site APC and sends the distant-site such performance information for use in the distant-site's periodic appraisal of the distant-site APC. At a minimum, this information must include:

(i) All adverse events that result from the telemedicine services provided by the distant-site APC to Hospital patients.

(ii) All complaints the Hospital receives about the distant-site APC.

(c) If the Hospital relies upon the telemedicine credentialing by proxy option pursuant to subsection (b), the distant-site shall additionally confirm:

(1) That the distant-site APC has a supervising or collaborating Practitioner (if required) with Privileges at the Hospital.

(2) Receipt, if applicable, of a copy of the distant-site APC's current valid standard care arrangement(s), supervision agreement(s), or other document(s) required by state law to practice, amendments thereto, and designated representative legal authorizations, if any.

(d) A critical access hospital must also satisfy 42 CFR 485.631(d)(2)(iv) or (v) and 42 CFR 485.641(b)(4)(iv) or (v).

(e) Telemedicine Privileges may be terminated pursuant to Section 5.4.

5.4 TERMINATION OF TEMPORARY PRIVILEGES, DISASTER PRIVILEGES, OR TELEMEDICINE PRIVILEGES

5.4-1 The Hospital President, CMO, or Chief of Staff may terminate an APC's temporary, disaster, or telemedicine Privileges at any time.

5.4-2 Where the life or well-being of a patient is determined to be endangered, the APC's temporary, disaster, or telemedicine Privileges may be terminated by any person entitled to impose a summary suspension pursuant to this Policy.

5.4-3 An APC is not entitled to the procedural due process rights set forth in Article VIII because the APC's request for temporary, disaster, or telemedicine Privileges is refused, in whole or in part, or because all or any portion of such Privileges are terminated, not renewed, restricted, suspended, or otherwise limited, modified, or monitored in any way.

5.5 RECOGNITION OF A NEW SERVICE OR PROCEDURE; AMENDMENT OF EXISTING DELINEATIONS OF PRIVILEGES

5.5-1 The Board shall determine the Hospital's scope of patient care services based upon recommendations from the Medical Executive Committee. Overall considerations for establishing new services and procedures include, but are not limited to:

(a) The Hospital's available resources and staff.

(b) The Hospital's ability to appropriately monitor and review the competence of the performing APC(s)/Practitioner(s).

(c) The availability of other qualified APCs/Practitioners with Privileges at the Hospital to provide coverage for the new service or procedure when needed.

(d) The quality and availability of training programs.

(e) Whether such service or procedure currently, or in the future, would be more appropriately provided through a contractual arrangement with the Hospital.

(f) Whether there is a community need for the service or procedure.

5.5-2 Requests for Privileges for a new service or procedure at the Hospital that has not yet been recognized by the Board shall be processed as follows:

(a) The APC must submit a written Privilege request for a new service or procedure to the CVO who shall notify the Medical Staff Office. The Medical Staff Office shall, in turn, notify the applicable Medical Staff Department Chair. The request should include a description of the Privileges requested, the reason why the APC believes the Hospital should recognize such Privileges, and any additional information that the APC believes may be of assistance in evaluating the request.

(b) Following discussion with the Hospital President and CMO:

(1) If the Medical Staff Department Chair (who may consult with the Associate Medical Staff Department Chair and/or Division Chief as necessary) determines that the new service or procedure should not be recognized at the Hospital, the Department Chair will provide his/her recommendation to the Credentials Committee for consideration.

(2) If the Medical Staff Department Chair (who may consult with the Associate Medical Staff Department Chair and/or Division Chief as necessary) determines that the new service or procedure should be recognized at the Hospital and included in an existing Delineation of Privileges, the Department Chair will provide the basis for his/her recommendation to the Credentials Committee.

(3) If the Medical Staff Department Chair (who may consult with the Associate Medical Staff Department Chair and/or Division Chief as necessary) determines that the new service or procedure should be recognized at the Hospital and that a new Delineation of Privileges is required, the Department Chair (who may consult with the Associate Medical Staff Department Chair and/or Division Chief as necessary) shall develop and submit to the Credentials Committee a new Delineation of Privileges based upon:

(i) A determination as to what specialties are likely to request the Privileges.

(ii) The positions of specialty societies, certifying boards, *etc.*

(iii) The available training programs.

(iv) Recommended standards to be met with respect to the following: education; training; board certification; experience; and performance data to confirm and monitor current clinical competency.

(v) Criteria required by other hospitals with similar resources.

(c) Upon receipt of a recommendation from the Medical Staff Department Chair (who may consult with the Associate Medical Staff Department Chair and/or Division Chief as necessary), the Credentials Committee shall review the matter and forward its recommendation to the Medical Executive Committee.

(d) Upon receipt of a recommendation from the Credentials Committee, the Medical Executive Committee shall review the matter and forward its recommendation to the Board:

(1) If the Board approves the new service or procedure (and new or amended Delineation of Privileges), the requesting APC(s) may apply for such Privilege(s) consistent with the credentialing and privileging process set forth in Articles II and III.

(2) If the Board does not approve the new service or procedure, the requesting APC(s) shall be so notified. A decision by the Board not to recognize a new service or procedure does not give rise to the procedural due process rights provided in Article VIII.

5.5-3 Adoption and amendment of Delineations of Privileges (*i.e.*, Privilege sets) for care, treatment, and/or services provided at the Hospital requires review by the Medical Staff Department Chair (who may consult with the Associate Medical Staff Department Chair and/or Division Chief) and Credentials Committee, a recommendation from the MEC (who may request input from the Medical Staff Leadership Councils), and approval of the Board.

5.6 EMERGENCY SITUATION

5.6-1 In an emergency, an APC with Privileges at the Hospital is permitted to provide patient care, treatment, and/or services necessary as a life-saving measure or to prevent serious harm provided that the care, treatment, and/or services rendered during the emergency are within the scope of the APC's license.

ARTICLE VI LEAVE OF ABSENCE PROCEDURE

6.1 NOTICE OF LEAVE OF ABSENCE

6.1-1 An APC may, for good cause (which may include, but is not limited to, illness, injury, military duty, or educational sabbatical), take a voluntary leave of absence by giving written notice to the Medical Staff Office who shall communicate receipt of such notification as appropriate. The notice must state the reason for the leave and the approximate period of time of the leave which may not exceed one (1) year.

6.1-2 An APC may not take a leave of absence to avoid fulfilling the APC's obligations.

6.1-3 The MEC may decline a leave of absence in the event that such leave does not satisfy the criteria set forth in Sections 6.1-1 and 6.1-2. The decision of the MEC is final without right to appeal.

6.1-4 With the exception of an emergency leave, the APC shall complete his/her patients' medical records and shall have made arrangements, acceptable to the MEC, prior to leave for the care of his/her patients, if any, during the leave.

6.2 DURING A LEAVE OF ABSENCE

6.2-1 During a leave of absence, the APC is not entitled to exercise Privileges at the Hospital and has no APC responsibilities.

6.2-2 In the event that a leave of absence (which may not exceed twelve (12) consecutive months) extends beyond the final date of the APC's current Privilege period the APC may apply, during the leave, for a regrant of Privileges:

(a) If the APC applies and is regranted Privileges during the leave, the APC's Privileges (along with the leave) will continue subject to the conditions set forth in Section 6.2-1.

(b) If the APC does not apply for a regrant of Privileges during the leave, the APC's Privileges (along with the leave) will terminate at the end of the APC's current Privilege period. The APC may thereafter apply for initial Privileges if/when the APC is able to return to practice.

6.3 REINSTATEMENT FOLLOWING A LEAVE OF ABSENCE

6.3-1 Eligibility for Reinstatement. APCs who maintain Privileges at the Hospital during a leave (*i.e.,* because the leave occurs within the APC's current Privilege period or pursuant to Section 6.2-2 (a) above), may request reinstatement of Privileges at the end of the leave period.

6.3-2 Request for Reinstatement. An APC must submit to the Medical Staff Office a written request for reinstatement of his/her Privileges as well as such additional information as is reasonably necessary to reflect that the APC is qualified for reinstatement.

(a) If the leave of absence was for medical reasons, the APC may be asked to obtain a physical examination and/or mental evaluation addressing the APC's capability to resume clinical practice.

(b) If the leave of absence was for educational reasons, the APC may be asked to submit information regarding the educational activities undertaken during the leave.

(c) If the leave of absence was for military reasons, the APC may be asked to submit documentation of military status.

6.3-3 Professional Liability Insurance Requirements During Leave. In order to qualify for reinstatement following a leave of absence, the APC must maintain Professional Liability Insurance coverage during the leave or purchase tail coverage for all periods during which the APC held Privileges at the Hospital. The APC shall provide information to demonstrate satisfaction of continuing Professional Liability Insurance coverage or tail coverage as required by this provision upon request for reinstatement.

6.3-4 Processing a Request for Reinstatement. Once the APC's request for reinstatement is deemed complete, the request shall be reviewed and acted on in the manner set forth in Section 3.10.

ARTICLE VII COLLEGIAL INTERVENTION/REMEDIATION, CORRECTIVE ACTION, SUMMARY SUSPENSION & AUTOMATIC SUSPENSION/AUTOMATIC TERMINATION

7.1 COLLEGIAL INTERVENTION & REMEDIATION

7.1-1 Prior to initiating corrective action against an APC for professional conduct or clinical competency concerns, the Medical Staff leadership or Board (through the Hospital President or CMO as its administrative agent) may elect to attempt to resolve the concerns in a collegial manner as it determines appropriate.

7.1-2 An appropriately designated Medical Staff peer review committee may enter into a voluntary remediation agreement with an APC, consistent with the applicable Medical Staff Policy (*e.g.*, conduct, peer review), to resolve potential clinical competency or conduct issues.

7.1-3 If the affected APC fails to abide by the terms of an agreed to remedial agreement, the APC may be subject to the corrective action procedure set forth in Section 7.2.

7.1-4 Nothing in this Section shall be construed as obligating the Hospital or Medical Staff leadership to engage in collegial intervention or remediation prior to implementing corrective action on the basis of a single incident.

7.1-5 A written record of any collegial intervention and/or remediation efforts will be prepared and maintained in the APC's confidential peer review file.

7.2 CORRECTIVE ACTION PROCESS

7.2-1 Grounds for Corrective Action

(a) Corrective action may be taken whenever an APC engages in activities or exhibits actions, statements, demeanor, or conduct within or outside of the Hospital that is/are, or is/are reasonably likely to be:

(1) Contrary to this APC Policy, the Medical Staff Rules & Regulations, or applicable System, Hospital, or Medical Staff policies or procedures.

(2) Detrimental to patient safety or to the quality or efficiency of patient care in the Hospital.

(3) Disruptive to Hospital operations.

(4) Damaging to the Medical Staff's or the Hospital's reputation.

(5) Below the applicable standard of care.

7.2-2 Request for Initiation of Corrective Action

(a) Any of the following may request that corrective action be initiated:

(1) An officer of the Medical Staff

(2) The Department Chair or Associate Department Chair of any Medical Staff Department in which the APC exercises Privileges

(3) Any standing committee or subcommittee of the Medical Staff (including the MEC or a Medical Staff Leadership Council) or chair thereof

(4) The CMO

(5) The Hospital President

(6) The Board or Board chair

(b) All requests for corrective action shall be submitted to the MEC in writing, which writing may be reflected in minutes. Such request must be supported by reference to the specific activities or conduct that constitute(s) the grounds for the request. In the event the request for corrective action is initiated by the MEC, it shall reflect the basis therefore in its minutes.

(c) The chair of the MEC shall promptly notify the Hospital President, in writing, of all requests for corrective action and shall continue to keep him/her fully informed of all action taken in conjunction therewith.

7.2-3 MEC Action Upon Receipt of Request for Initiation of Corrective Action

(a) Upon receipt of a request for corrective action, the MEC shall act on the request.

(b) The MEC may:

(1) Determine that no corrective action is warranted and close the matter.

(2) Determine that no corrective action is warranted but remand the matter for collegial intervention or remediation consistent with the applicable Medical Staff governing documents.

(3) Initiate a corrective action investigation.

7.2-4 Commencement of Corrective Action

(a) A matter shall be deemed to be under investigation as of the start of an MEC meeting at which a request for corrective action is being presented.

(b) For the sole purpose of determining whether there is a potential reportable event, the matter will be deemed to be under corrective action until the end of the MEC meeting at which the issue is presented; provided, however, that if the MEC determines to proceed with a corrective action investigation, the matter shall remain under corrective action until such time as the MEC rejects the request for corrective action, closes the investigation, or a final decision is rendered by the Board.

(c) The affected APC shall be provided with written notice of a determination by the MEC to initiate a corrective action investigation.

7.2-5 Conducting a Corrective Action Investigation

(a) The MEC may conduct such investigation itself; assign this task to a Medical Staff officer, Medical Staff Department Chair/Associate Medical Staff Department Chair, Division Chief, CMO, or a standing or *ad hoc* Medical Staff committee; or may refer the matter to the Board for investigation and resolution.

(b) The MEC may reasonably rely upon the findings of all prior Hospital or Medical Staff committees without conducting further inquiry.

(c) This investigation process does not entitle the APC to the procedural due process rights provided in Article VIII.

(d) The investigating individual/group will proceed with its investigation in a prompt manner. The investigative process may include, without limitation: a meeting with the APC involved who may be given an opportunity to provide information in a manner and upon such terms as the investigating individual/group deems appropriate; with the individual or group who made the request; and/or with other individuals who may have knowledge of, or information relevant to, the events involved.

(e) If the investigation is conducted by a group or individual other than the MEC or the Board, that group or individual shall submit a written report of its investigation, which may be reflected by minutes, to the MEC as soon as is practicable after its receipt of the assignment to investigate. The report should contain such detail as is necessary for the MEC to rely upon it including recommendations for appropriate corrective action, or no action at all, and the basis for such recommendations.

(f) The MEC may at any time in its discretion, and shall at the request of the Board, terminate the investigative process and proceed with action as provided below.

7.2-6 MEC Action Following Completion/Receipt of Report

(a) As soon as is practicable following completion of its report (which may be reflected by minutes), or receipt of a report from the investigating individual or group, the MEC shall act upon the request for corrective action.

(b) The MEC's actions may include, without limitation, the following:

(1) A determination that no corrective action be taken.

(2) Issuance of a verbal or written warning or a letter of reprimand.

(3) Imposition of a focused professional practice evaluation period with retrospective review of cases and/or other review of professional practice or conduct but without requirement of prior or concurrent consultation or direct supervision.

(4) Imposition of prior or concurrent consultation or direct supervision or other form of focused professional practice evaluation that limits the

APC's ability to continue to exercise previously exercised Privileges for a period of up to thirty (30) days.

(5) Imposition of a suspension of all, or any part, of the APC's Privileges for a period of up to thirty (30) days.

(6) Other actions deemed appropriate under the circumstances that will result in a limitation or reduction of the APC's Privileges for a period of up to thirty (30) days.

(7) Recommendation of imposition of prior or concurrent consultation or direct supervision or other form of focused professional practice evaluation that limits the APC's ability to continue to exercise previously exercised Privileges for a period in excess of thirty (30) days.

(8) Recommendation of a suspension of all, or any part, of an APC's Privileges for a period in excess of thirty (30) days.

(9) Recommendation of other actions deemed appropriate under the circumstances that will result in a limitation or reduction of the APC's Privileges for a period in excess of thirty (30) days.

(10) Recommendation of revocation of all, or any part, of the APC's Privileges.

7.2-7 Adverse Recommendation. When the MEC's recommendation is Adverse (as defined in this Policy) to the APC, the Chief of Staff shall inform the APC, by Special Notice, and the APC shall be entitled, upon timely and proper request, to the procedural due process rights contained in Section 8.3. The Chief of Staff shall then hold the Adverse recommendation in abeyance until the APC has exercised or waived the procedural due process rights set forth in Section 8.3 after which the final MEC recommendation, together with all accompanying information, shall be forwarded to the Board.

7.2-8 Referral/Failure by MEC to Act. If the MEC (a) refers the matter to the Board; or (b) fails to act on a request for corrective action within an appropriate time, as determined by the Board, the Board may proceed with its own investigation or determination as applicable to the circumstances. In the case of (b), the Board shall make such determination after notifying the MEC of the Board's intent and allowing a reasonable period of time for response by the MEC.

(a) If the Board's decision is not Adverse to the APC the action shall be effective as its final decision and the Hospital President shall inform the APC of the Board's decision by Special Notice.

(b) If the Board's action is Adverse to the APC, the Hospital President shall inform the APC, by Special Notice, and the APC shall be entitled, upon timely and proper request, to the procedural due process rights set forth in Section 8.3.

7.2-9 The commencement of corrective action procedures against an APC shall not preclude the summary suspension or automatic suspension or automatic termination of all, or any portion, of the APC's Privileges in accordance with the applicable procedures set forth in this Article.

7.3 SUMMARY SUSPENSION

7.3-1 Grounds and Authority to Impose

(a) Whenever an APC's conduct is of such a nature as to require immediate action to protect, or to reduce the substantial likelihood of injury or imminent danger to the life, health, or safety of any individual at the Hospital *(e.g.*, patient, employee, visitor, *etc.),* any of the following have the authority to summarily suspend all, or any portion, of the Privileges of such APC:

(1) Chief of Staff

(2) Medical Staff Department Chair with approval of the Chief of Staff

(3) Medical Executive Committee

(4) Medical Staff Leadership Council

(5) Hospital President or CMO

(6) Board or its chair

7.3-2 A summary suspension is effective immediately. The person(s) or group imposing the summary suspension (if other than the Hospital President) shall immediately inform the Hospital President of the summary suspension and the Hospital President or the Chief of Staff shall promptly give Special Notice thereof to the APC.

7.3-3 The Chief of Staff or applicable Medical Staff Department Chair/Associate Medical Staff Department Chair or Division Chief shall assign a suspended APC's patients then in the Hospital to another APC or Practitioner with appropriate Privileges considering the wishes of the patient where feasible.

7.3-4 As soon as possible, but in no event later than five (5) days after a summary suspension is imposed, the MEC (if it did not impose the summary suspension) shall convene to review the matter and consider the need, if any, for a professional review action (*i.e.,* corrective action) pursuant to Section 7.2.

7.3-5 The MEC may modify, continue, or terminate a summary suspension provided that the summary suspension was not imposed by the Board.

7.3-6 In the case of a summary suspension imposed by the Board, the MEC shall give its recommendation to the Board as to whether such summary suspension should be modified, continued, or terminated. The Board may accept, modify, or reject the MEC's recommendation.

7.3-7 Not later than fourteen (14) days following the original imposition of the summary suspension, the Hospital President or the Chief of Staff shall notify the APC, by Special Notice, of the MEC's determination; or, in the case of a summary suspension imposed by the Board, of the MEC's recommendation as to whether such summary suspension should be terminated, modified, or continued.

(a) If a summary suspension remains in place for more than fourteen (14) days the APC shall be advised, by Special Notice, of the APC's rights, if any, pursuant to Section 8.3.

(b) A summary suspension that is lifted within fourteen (14) days of its original imposition shall not be deemed an Adverse action for purposes of the procedural due process rights set forth in Article VIII.

7.4 GROUNDS FOR AUTOMATIC SUSPENSION OF PRIVILEGES

7.4-1 The following events shall result in an automatic suspension of the APC's Privileges without recourse to the procedural due process rights set forth in Article VIII.

(a) Licensure

(1) Suspension. Whenever an APC's license is suspended by the applicable licensing entity, the APC's Privileges shall be automatically suspended.

(2) Restriction. Whenever an APC's license is limited/restricted by the applicable licensing entity, the APC's Privileges shall be likewise automatically limited/restricted.

(3) Failure to Renew/Expired. Whenever an APC's license expires solely as a result of the APC's inadvertent failure to renew such license on a timely basis, the APC's Privileges shall be automatically suspended subject to Section 7.5-1 (a)(2).

(b) Controlled Substance Authorization

If a DEA registration (or other authorization to prescribe controlled substances) is required for the Privileges granted:

(1) Suspension. Whenever an APC's DEA registration (or other authorization to prescribe controlled substances) is suspended by the DEA or other applicable federal or state authority, his/her Privileges shall be automatically suspended.

(2) Restriction. Whenever an APC's DEA registration (or other authorization to prescribe controlled substances) is limited/restricted by the DEA or other applicable federal or state authority, his/her Privileges shall be automatically suspended.

(3) Failure to Renew/Expired. Whenever an APC's DEA registration (or other authorization to prescribe controlled substances) expires solely as a result of the APC's inadvertent failure to renew such registration on a timely basis, the APC's Privileges shall be automatically suspended subject to Section 7.5-1 (b)(2).

(c) Professional Liability Insurance

(1) If an APC's Professional Liability Insurance coverage lapses, falls below the required minimum, is terminated, or otherwise ceases to be in effect, in whole or in part, the APC's Privileges shall be automatically suspended until Professional Liability Insurance coverage is restored or the matter is otherwise resolved pursuant to Section 7.5-1 (c) below.

(2) The CVO/Medical Staff Office must be provided with a certified copy of the insurance certificate from the insurance company and a written statement explaining the circumstances of the APC's non-compliance with the Hospital's Professional Liability Insurance requirements, any limitations on the new policy, and a summary of relevant activities during the period of non-compliance.

(3) For purposes of this section, the failure of an APC to provide proof of Professional Liability Insurance shall constitute failure to meet the requirements of this provision.

(d) Federal/State Health Program

(1) Whenever an APC is suspended from participating in a Federal/State Health Program, the APC's Privileges shall be automatically suspended.

(e) Failure to Complete Electronic Health Record Training

(1) An APC's Privileges shall be automatically suspended for failure to successfully complete the Hospital's training with respect to use of the electronic health record.

(f) Required Vaccination(s)

(1) Failure to provide documentation of compliance with state and/or federal vaccination requirements and implementing System/Hospital policies (or an approved exemption therefrom) will result in an automatic suspension of the APC's Privileges subject to Section 7.5-1 (e).

(g) Designated Offense

(1) An APC's Privileges shall be automatically suspended upon a grand jury indictment for a Designated Offense.

(2) Designated Offense means (i) a felony; or (ii) other serious offense that involves: violence or abuse upon a person; conversion, embezzlement, or misappropriation of property; fraud; bribery; evidence tampering; perjury; or drugs.

(h) Supervising or Collaborating Practitioner

(1) For those APCs who are required to have a supervising or collaborating Practitioner: Lapse, suspension, or termination of the APC's supervising or collaborating Practitioner's Medical Staff appointment and/or Privileges at the Hospital, for any reason, shall result in an automatic

suspension of the APC's Privileges unless the APC has more than one (1) supervising or collaborating Practitioners with Privileges at the Hospital.

(i) Standard Care Arrangement/Supervision Agreement, *etc.*

(1) Termination or expiration of a CNP's, CNM's, or CNS's standard care arrangement or a Physician Assistant's supervision agreement or other document required by state law for an APC to practice shall result in an automatic suspension of the APC's Privileges unless the APC has more than one (1) current, valid standard care arrangement or supervision agreement or other applicable document with an appropriate Practitioner with Privileges at the Hospital.

(j) Failure to Maintain Board Certification

(1) Failure to maintain current board certification if required for state licensure (*e.g.*, national nursing specialty certification for Advanced Practice Registered Nurses or certification with the National Commission on Certification of Physician Assistants for Physician Assistants) will result in automatic suspension of the APC's Privileges.

(k) Failure to Complete Medical Records

(1) Whenever an APC fails to complete medical records as provided for in this APC Policy, the Medical Staff Rules & Regulations, and/or applicable Medical Staff or System/Hospital (*i.e.*, Health Information Management) policies, the APC's Privileges shall be automatically suspended consistent with the applicable documents.

7.4-2 Action Following Imposition of an Automatic Suspension

(a) As soon as practicable after the imposition of an automatic suspension, the MEC shall convene, as appropriate, to determine if corrective action is necessary in accordance with Section 7.2.

(b) Appropriate resolution on the part of the APC of the action or inaction that gave rise to an automatic suspension of Privileges shall result in the automatic reinstatement of the APC's Privileges.

(c) The APC shall be obligated to provide such information as the CVO and/or Medical Staff Office shall reasonably request to assure that all information in the APC's credentials file is current upon reinstatement.

7.4-3 Impact of Automatic Suspension

(a) During such period of time when an APC's Privileges are automatically suspended pursuant to Section 7.4-1 (a)-(j) he/she may not, as applicable, exercise any Privileges at the Hospital.

(b) An APC whose Privileges are automatically suspended pursuant to Section 7.4-1 (k) (*i.e.*, for delinquent medical records), is subject to the same limitations except

that such APC may conclude the management of any patient under his/her care in the Hospital at the time of the effective date of the automatic suspension.

7.5 GROUNDS FOR AUTOMATIC TERMINATION OF PRIVILEGES

7.5-1 The following events shall result in an automatic termination of an APC's Privileges without recourse to the procedural due process rights set forth in Article VIII.

(a) License Revocation or Expiration

(1) Whenever an APC's license to practice is revoked by the applicable licensing entity, his/her Privileges shall be automatically terminated.

(2) Whenever an APC (whose Privileges were automatically suspended pursuant to Section 7.4-1 (a)(3) for an expired license) fails to renew his/her license within ninety (90) days after its expiration, the APC's Privileges shall be automatically terminated as of the ninety-first (91st) day.

(b) Controlled Substance Authorization

If a DEA registration (or other authorization to prescribe controlled substances) is required for the Privileges granted:

(1) Whenever an APC's DEA registration (or other authorization to prescribe controlled substances) is revoked, his/her Privileges shall be automatically terminated.

(2) Whenever an APC (whose Privileges were automatically suspended pursuant to Section 7.4-1 (b)(3) for an expired DEA registration or other authorization to prescribe controlled substances) fails to renew his/her registration within ninety (90) days after its expiration, his/her Privileges shall be automatically terminated as of the ninety-first (91st) day.

(c) Professional Liability Insurance

(1) If an APC's Professional Liability Insurance coverage lapses, falls below the required minimum, is terminated, or otherwise ceases to be in effect for a period greater than ninety (90) days (during which time the APC is automatically suspended pursuant to Section 7.4-1 (c)), the APC's Privileges shall automatically terminate as of the ninety-first (91st) day.

(2) For purposes of this provision, the failure of an APC to provide proof of Professional Liability Insurance shall constitute a failure to meet the requirements of this provision.

(d) Federal/State Health Program

(1) Whenever an APC is ineligible to participate in or is excluded or precluded from participating in a Federal/State Health Program, the APC's Privileges shall be automatically terminated.

(e) Required Vaccination(s)

(1) Failure to provide documentation of compliance with state and/or federal vaccination requirements and implementing System/Hospital policies (or an approved exemption therefrom) within thirty (30) days following the date of an automatic suspension pursuant to Section 7.4.1 (f) shall result in an automatic termination of the APC's Privileges as of the thirty-first (31st) day.

(f) Designated Offense

(1) If an APC pleads guilty to, is found guilty of, or pleads no contest to a Designated Offense, as defined in Section 7.4.1 (g), the APC's Privileges shall be automatically terminated.

(g) Supervising/Collaborating Practitioner

(1) If the APC's Privileges are automatically suspended pursuant to Section 7.4-1 (h) and the APC does not make arrangements for supervision by or collaboration with an appropriate Practitioner with Privileges at the Hospital within thirty (30) days after the automatic suspension, the APC's Privileges at the Hospital shall automatically terminate as of the thirty-first (31st) day.

(h) Failure to Submit New Standard Care Arrangement/Supervision Agreement, *etc.*

(1) If the APC's Privileges are automatically suspended pursuant to Section 7.4-1 (i) and the APC does not submit a new, executed standard care arrangement or supervision agreement or other document required by state law to practice with an appropriate Practitioner with Privileges at the Hospital within thirty (30) days after the automatic suspension, the APC's Privileges shall automatically terminate as of the thirty-first (31st) day.

7.5-2 Upon the imposition of an automatic suspension or automatic termination of Privileges, the Chief of Staff, the applicable Medical Staff Department Chair/Associate Medical Staff Department Chair, or Division Chief shall provide for alternative coverage for the affected APC's Hospital patients. The wishes of the patient shall be considered, where feasible, in choosing a substitute APC or Practitioner. The affected APC shall confer with the substitute APC or Practitioner(s) to the extent necessary to safeguard the patients.

7.6 CONSISTENCY OF ACTION

7.6-1 So that there is consistency between the Hospital and Affiliate Hospitals regarding corrective action and the status of privileges considering that the Hospital and the Affiliate Hospitals are part of the same healthcare system and that the Hospital and the Affiliate Hospitals have agreed to share information regarding privileges, the following automatic actions shall occur:

(a) With the exception of an automatic suspension for delinquent medical records and/or non-payment of APC fees (as applicable), if an APC's privileges are automatically suspended or automatically terminated, in whole or in part, at an

Affiliate Hospital(s), the APC's Privileges at this Hospital shall automatically become subject to the same action without recourse to the procedural due process rights set forth in Article VIII.

(b) If an APC's privileges are summarily suspended or if an APC voluntarily agrees not to exercise privileges while undergoing an investigation at an Affiliate Hospital(s), such summary suspension or voluntary agreement not to exercise privileges shall automatically and equally apply to the APC's Privileges at this Hospital and shall remain in effect until such time as the Affiliate Hospital(s) render(s) a final decision or otherwise terminate(s) the process.

(c) If an APC's privileges are limited, suspended, or terminated at an Affiliate Hospital, in whole or in part, based on professional conduct or clinical competency concerns, the APC's Privileges at this Hospital shall automatically and immediately become subject to the same decision without recourse to the procedural due process rights set forth in Article VIII unless otherwise provided in the final decision at the Affiliate Hospital.

(d) If an APC resigns his/her privileges or fails to seek regrant of Privileges at an Affiliate Hospital(s) while under investigation or to avoid investigation for professional conduct or clinical competency concerns, such resignation shall automatically and equally apply to the APC's Privileges at this Hospital without recourse to the procedural due process rights set forth in Article VIII.

ARTICLE VIII APC PROCEDURAL DUE PROCESS RIGHTS

8.1 APPLICABILITY

8.1-1 The procedural due process rights set forth in this Article are only applicable to APCs requesting or granted Privileges through the Medical Staff process.

8.1-2 The provisions in the Medical Staff Bylaws and Fair Hearing Policy setting forth the procedural rights of Medical Staff applicants and Medical Staff Members do not apply to APCs.

8.2 APC PROCEDURAL DUE PROCESS RIGHTS FOLLOWING RECOMMENDATION OF DENIAL OF APC APPLICATION FOR PRIVILEGES

8.2-1 When the MEC proposes to make a recommendation to deny an APC's application for Privileges based upon professional conduct or clinical competence concerns, the APC shall be provided written notice, by Special Notice, of the MEC's proposed recommendation and the APC's procedural due process rights pursuant to this Section.

8.2-2 The APC shall then have five (5) days in which to submit a written response to the MEC as to why such Adverse recommendation should be withdrawn and a favorable recommendation made. The APC may meet with the MEC (or a subcommittee of the MEC) upon request. After reviewing the APC's written response and meeting with the APC (if applicable), the MEC shall make its final recommendation to the Board. The APC will be advised, by Special Notice, of the MEC's final recommendation, the basis for such recommendation, and, if applicable, the APC's right to appeal.

8.2-3 If the MEC's recommendation continues to be Adverse to the APC, the APC shall have five (5) days in which to submit a written appeal to the Board. At the Board's discretion, it may meet (or have a committee of the Board meet) with the APC. During this meeting, the basis of the Adverse recommendation that gave rise to the appeal will be reviewed with the APC. After considering the Adverse recommendation of the MEC, the APC's written response/appeal, and information from any meeting with the APC, the Board shall take action.

8.2-4 Whenever the Board determines that it will decide a matter contrary to the recommendation of the MEC, and the matter has not previously been submitted to the Joint Conference Committee, the matter will be submitted to such committee for review and recommendation before the Board makes its final decision.

8.2-5 The APC will receive written notice, by Special Notice, of the Board's final decision.

8.3 APC PROCEDURAL DUE PROCESS RIGHTS FOLLOWING SUMMARY SUSPENSION OR CORRECTIVE ACTION ADVERSE RECOMMENDATION

8.3-1 When an Adverse recommendation or action is make/taken against an APC's Privileges as a result of a summary suspension or corrective action, the APC shall be provided written notice, by Special Notice, of the Adverse recommendation or action and the APC's procedural due process rights pursuant to this Section.

8.3-2 The APC shall then have five (5) days in which to submit a written response to the MEC as to why such Adverse recommendation or action should be reconsidered. The APC may meet with the MEC (or a subcommittee of the MEC) upon request. After reviewing the APC's written response and meeting with the APC (as applicable), the MEC shall make its final recommendation to the Board. The APC shall be advised, by Special Notice, of the MEC's final recommendation, the basis for such recommendation, and, if applicable, the APC's right to appeal.

8.3-3 If the MEC's recommendation continues to be Adverse to the APC, the APC shall have five (5) days in which to submit a written appeal to the Board. At the Board's discretion, it may meet (or have a committee of the Board meet) with the affected APC. During this meeting, the basis of the Adverse recommendation or action that gave rise to the appeal will be reviewed with the APC. After considering, as applicable, the recommendation of the person/group that imposed a summary suspension, the recommendation of the MEC, the APC's written response/appeal, and information from any meeting with the APC, the Board shall take action.

8.3-4 Whenever the Board determines that it will decide a matter contrary to the recommendation of the MEC, and the matter has not previously been submitted to the Joint Conference Committee, the matter will be submitted to such committee for review and recommendation before the Board makes its final decision.

8.3-5 The APC will receive written notice, by Special Notice, of the Board's final decision.

ARTICLE IX MISCELLANEOUS

9.1 CONFLICTS OF INTEREST

9.1-1 In any instance where an APC has or reasonably could be perceived to have a conflict of interest in any matter that comes before the Medical Staff, a Medical Staff Department/Division, or a Medical Staff committee, the APC is expected to disclose the conflict to, as applicable, the Chief of Staff, the Medical Staff Department Chair, Associate Medical Staff Department Chair, Division Chief, or committee chair. The APC may be asked and is expected to answer any questions concerning the conflict. The Chief of Staff, Medical Staff Department Chair, Associate Medical Staff Department Chair, Division Chief, or committee chair is responsible for determining whether a conflict exists and, if so, whether the conflict rises to the level of precluding the APC from participating in the pending matter.

9.1-2 For purposes of this Section 9.1, the fact that APCs/Practitioners are competitors, partners, or employed in the same group shall not, in and of itself, automatically disqualify such other APCs/Practitioners from participating in the review of applications or other Medical Staff matters with respect to their colleagues.

9.2 CONTRACTED APCS

9.2-1 An APC who is or who will be providing professional services pursuant to a contract with the Hospital (or for a group holding a contract with the Hospital) is subject to all qualifications for Privileges/regrant of Privileges and must meet all of the APC responsibilities as set forth in this Policy for any other APC.

9.2-2 The effect of the expiration or termination of an APC's contract with the Hospital (or the expiration or termination of an APC's association with the group holding the contract with the Hospital) upon an APC's Privileges at the Hospital will be governed solely by the terms of the APC's contract with the Hospital (or with the group holding the contract with the Hospital). If the contract is silent on the matter, then contract expiration or termination alone (or the expiration or termination of the APC's association with the group holding the contract with the Hospital) will not affect the APC's Privileges at the Hospital with the exception set forth in subsections 9.2-3 and 9.2-4 below.

9.2-3 In the absence of language in the contract to the contrary, if an exclusive contract under which an APC is engaged is terminated or expires (or if the relationship of the APC with the group that has the exclusive contractual relationship with the Hospital is terminated or expires) then the APC's Privileges covered by the exclusive contract shall also be terminated and the procedural due process rights afforded by Article VIII shall not apply; provided, however, that the Board in its sole discretion may waive this automatic termination result.

9.2-4 If the Hospital enters into an exclusive contract for a particular service(s), any APC who previously held Privileges to provide such service(s), but who is not a party to the exclusive contract (or otherwise employed by or contracted with the group that holds the exclusive contract with the Hospital), may not provide such service(s) as of the effective date of the exclusive contract irrespective of any remaining time on the APC's Privilege period.

9.3 ADOPTION/AMENDMENT & APPROVAL OF MEDICAL STAFF POLICY

9.3-1 This APC Policy may be adopted or amended and approved in accordance with the applicable procedure set forth in the Medical Staff Bylaws.

ARTICLE X CONFIDENTIALITY, IMMUNITY, REPORTING, AND RELEASES

10.1 SPECIAL DEFINITIONS

10.1-1 For purposes of this Article, the following definitions shall apply:

(a) Information means documentation of proceedings, minutes, interviews, records, reports, forms, memoranda, statements, investigations, examinations, meetings, recommendations, findings, evaluations, opinions, conclusions, actions, data, and other disclosures or communication, whether in written or oral form, relating to any of the subject matter specified in Section 10.5 of this Article.

(b) Representative means the Board, Hospital, Medical Staff, and any agent (*e.g.*, Board members, Practitioners, APCs, Hospital employees, committee members, *etc.*) authorized to perform specific Information gathering, analysis, use, or disseminating functions.

(c) Third Parties means both individuals and organizations providing Information to any Representative.

10.2 AUTHORIZATIONS AND CONDITIONS

10.2-1 By submitting an application for Privileges, and at all times during which an APC holds Privileges at the Hospital, such APC:

(a) Authorizes Representatives to solicit, provide, and act upon Information regarding the APC's qualifications for Privileges and his/her professional practice.

(b) Authorizes Third Parties to provide Information to Representatives regarding the APC's qualifications for Privileges and his/her professional practice.

(c) Agrees to be bound by the provisions of this Article and to waive all legal claims against any Representative or Third Party who acts in accordance with provisions of this Article.

(d) Acknowledges that the provisions of this Article are express conditions to his/her application for and exercise of Privileges at the Hospital.

10.3 CONFIDENTIALITY OF INFORMATION

10.3-1 Information with respect to any APC submitted, collected, or prepared by any Representative of this Hospital or by any other health care facility or organization of health professionals or medical staff for the purpose of: evaluating, monitoring, or improving the quality, appropriateness, and efficiency of patient care; evaluating the qualifications and performance (*e.g.*, conduct, clinical competence, *etc.*) of an APC; acting upon matters relating to corrective action; reducing morbidity and mortality; contributing to teaching or clinical research; determining that health care services are professionally indicated and performed in accordance with the applicable standards of care; or establishing and enforcing guidelines to help keep health care costs within reasonable bounds shall, to the fullest extent permitted by law, be confidential. Such Information shall not be disclosed or

disseminated to anyone other than a Representative or other health care facility or organization or medical staff engaged in an official, authorized activity for which the Information is needed, nor be used in any way except as authorized by the Medical Staff governing documents, applicable System/Hospital policies, or as otherwise required by law. Such confidentiality shall also extend to Information of like kind that may be provided by Third Parties. This Information shall not become part of any particular patient's record. It is expressly acknowledged by each APC that violation of the confidentiality provisions provided herein is grounds for corrective action pursuant to this Policy.

10.4 IMMUNITY FROM LIABILITY

10.4-1 For Action Taken. No Representative or Third Party shall be liable to an APC for damages or other relief for any action taken or decision, opinion, statement, or recommendation made within the scope of his/her duties as a Representative or Third Party provided that such Representative or Third Party does not act on the basis of false Information knowing such Information to be false.

10.4-2 For Gathering/Providing Information. No Representative or Third Party shall be liable to an APC for damages or other relief by reason of gathering or providing Information, including otherwise privileged or confidential Information, concerning an APC who is or has been an applicant for Privileges or who did or does exercise Privileges at the Hospital provided that such Representative or Third Party acts within the scope of his/her duties as a Representative or Third Party and does not act on the basis of false Information knowing it to be false.

10.5 ACTIVITIES & INFORMATION COVERED

10.5-1 Activities. The confidentiality and immunity provided by this Article shall apply to all Information in connection with the activities of this Hospital or any other health care facility or organization of health professionals or medical staff concerning, but not limited to:

(a) Applications for Privileges

(b) Applications for regrant of Privileges

(c) Corrective action

(d) Procedural due process rights

(e) Performance improvement/quality assessment/peer review activities

(f) Utilization review/management activities

(g) Any other Hospital, Department/Division, committee, or Medical Staff activities related to evaluating, monitoring, and maintaining quality and efficient patient care, clinical competency, and professional conduct.

10.6 RELEASES

10.6-1 Each APC shall, upon request of the Hospital, execute general and specific releases in accordance with this Article, subject to such requirements as may be applicable under state and federal laws. Such releases will operate in addition to the provisions of this Article. Execution of such releases shall not be deemed a prerequisite to the effectiveness of this Article.

10.7 CUMULATIVE EFFECT

10.7-1 Provisions in the Medical Staff governing documents and in the APC application for Privileges or other Hospital or Medical Staff forms relating to authorizations, confidentiality of Information, and release of/immunity from liability shall be in addition to other protections provided by law and not in limitation thereof.

10.7-2 A finding by a court of law or administrative agency with proper jurisdiction that all or any portion of any such provision is not enforceable shall not affect the legality or enforceability of the remainder of such provision or any other provision.

ADOPTION & APPROVAL

Adopted by the UH Ahuja Medical Executive Committee

January 21, 2026

Adopted by the UH Conneaut Medical Executive Committee

January 9, 2026

Adopted by the UH Geauga Medical Executive Committee

January 14, 2026

Adopted by the UH Geneva Medical Executive Committee

January 9, 2026

Approved by the Board

January 23, 2026

APPENDIX A

Advanced Practice Clinicians credentialed by the Medical Staff and eligible to be granted Privileges at the Hospital:

Advanced Practice Registered Nurses

- Certified Nurse-Midwives
- Certified Nurse Practitioners
- Certified Registered Nurse Anesthetists
- Clinical Nurse Specialists

Anesthesiologist Assistants

Licensed Independent Social Workers

Pharmacists (for Medication Therapy Management only)

Physician Assistants

Surgical Assistants (*e.g.*, RNFA, CSFA, CSA)