Medical Staff Credentials Policy

University Hospitals East Market Unified Medical Staff

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ARTICLE I DEFINITIONS & DESIGNEES

1.1 DEFINITIONS

1.1-1 The definitions set forth in the Medical Staff Bylaws shall apply to this Medical Staff Credentials Policy unless otherwise provided herein.

1.2 DESIGNEES

1.2-1 Whenever an individual is authorized in the Medical Staff governing documents to perform a duty by virtue of his/her position, then reference to the individual shall also include the individual's authorized designee.

1.3 ADOPTION/AMENDMENT & APPROVAL OF MEDICAL STAFF POLICY

1.3-1 This Medical Staff Credentials Policy may be adopted or amended and approved in accordance with the applicable procedure set forth in the Medical Staff Bylaws.

ARTICLE II APPLICATION FOR MEDICAL STAFF APPOINTMENT AND/OR PRIVILEGES

2.1 GENERAL CONSIDERATIONS

2.1-1 NO ENTITLEMENT

(a) No Practitioner shall be entitled to Medical Staff appointment and/or 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, a medical staff appointment and/or privileges at another hospital or healthcare entity; or is employed by or contracts with the Hospital.

2.1-2 CONSIDERATION OF NEEDS & RESOURCES

(a) Requests for Medical Staff appointment and/or 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 or group of Practitioners other than the applicant.

2.1-3 NON-DISCRIMINATION

(a) No Practitioner shall be denied Medical Staff appointment and/or 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.

2.2 REQUEST FOR APPLICATION FOR MEDICAL STAFF APPOINTMENT AND/OR PRIVILEGES

2.2-1 A request by a Practitioner for an application for Medical Staff appointment and/or Privileges at the Hospital shall be directed to the CVO.

2.2-2 The CVO shall provide the Practitioner with electronic access to the application packet for completion and to the Medical Staff governing documents for reference.

2.3 CONTENT OF APPLICATION FOR MEDICAL STAFF APPOINTMENT AND/OR PRIVILEGES

2.3-1 Unless otherwise provided in the Medical Staff governing documents, an application for Medical Staff appointment and/or 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 (*e.g.,* residency, fellowship, *etc.*) 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 specialty or subspecialty board certification and recertification in accordance with the requirements set forth in Section 2.4 of this Credentials Policy.

(g) Documentation of current valid Professional Liability Insurance:

(1) At the time of request for initial Medical Staff appointment and/or 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 Medical Staff appointment and/or Privileges: Information on professional liability suits filed, pending, or settled during the preceding Medical Staff appointment and/or 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) specialty or sub-specialty board certification or eligibility;

(5) faculty appointment at any professional school;

(6) medical staff appointment and/or 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) Medical Staff appointment category and/or 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 2.5 of this Credentials Policy

(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) 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 Practitioner requesting Medical Staff appointment and/or Privileges is the same individual as identified in the credentialing documents.

(v) The applicant's signature with date.

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

2.4 BOARD CERTIFICATION

2.4-1 Unless otherwise provided herein, all Physicians, Podiatrists, and Dental Specialists shall be board certified (or board eligible) in the specialty in which the Practitioner seeks Privileges at the time of application for Medical Staff appointment and/or Privileges as follows:

(a) **Physicians**: By the American Board of Medical Specialties board applicable to the Physician's specialty/sub-specialty; or, by the applicable American Osteopathic Association board; or, by the Royal College of Physicians and Surgeons of Canada.

(1) A Physician who is board certified in a subspecialty is not required to also maintain certification with the primary board unless otherwise required by the applicable certifying board or Delineation of Privileges (*e.g.,* a Physician who is board certified in gastroenterology is not also required to maintain internal medicine board certification).

(b) **Podiatrists**: By the American Board of Podiatric Medicine or the American Board of Foot and Ankle Surgery.

(c) **Dental Specialists**: By the American Board of Oral and Maxillofacial Pathology, the American Board of Oral and Maxillofacial Surgery, the American Board of Orthodontics, the American Board of Pediatric Dentistry, or the American Board of Periodontology.

2.4-2 A Physician, Podiatrist, or Dental Specialist who is a qualified candidate for board certification at the time of initial application for Medical Staff appointment and/or Privileges shall have the time period, as set by the applicable certifying board, following the date of completion of residency or fellowship training to become board certified.

(a) In the event that the applicable certifying board does not specify an eligibility time period in which to attain board certification, the Physician, Podiatrist, or Dental Specialist shall have five (5) years following the date of completion of residency or fellowship training to become certified.

2.4-3 Physicians, Podiatrists, and Dental Specialists who were granted Medical Staff appointment and Privileges at Conneaut on or before October 31, 2003; at Geauga on or before January 1, 2002; or at Geneva on or before November 1, 2006; who were not board certified at the time Medical Staff appointment and Privileges were initially granted; and who have continuously held Medical Staff appointment and Privileges at the Hospital (without board certification) since the time such Medical Staff appointment and Privileges were initially granted, are not required to be board certified.

2.4-4 Physicians, Podiatrists, and Dental Specialists for whom board certification is required shall continuously maintain board certification in accordance with the requirements of the applicable certification board unless a waiver is otherwise granted by the Hospital Board. The waiver process is set forth in Section 2.2.3 of the Medical Staff Bylaws.

2.4-5 Board certification is not required for:

(a) Practitioners granted Medical Staff appointment only (no Privileges).

(b) Practitioners grandfathered pursuant to Section 2.4-3.

(c) Dentists (other than Dental Specialists).

(d) Psychologists.

2.4-6 A foreign-trained Practitioner who is not eligible to obtain board certification but who desires to apply for Medical Staff appointment and Privileges at the Hospital, must request a waiver of the board certification requirement pursuant to the waiver process set forth in Section 2.2.3 of the Medical Staff Bylaws. If the waiver is granted, the Practitioner’s application may proceed.

2.5 MEDICARE AND MEDICAID PARTICIPATION

2.5-1 Currently Practicing Ohio Practitioners

(a) Absent the exception set forth in Section 2.5-2 or Section 2.5-3, a currently practicing Ohio Practitioner 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 Practitioner is a participating provider in Medicare and Medicaid and has not elected to opt out of Medicare and/or Medicaid.

2.5-2 Practitioners New to Practice or Relocating to Ohio

(a) A Practitioner new to practice or relocating to Ohio 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 Practitioner 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.

2.5-3 Practitioners Who Elect to Opt Out of Medicare and/or Medicaid Participation

(a) Practitioners 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 Practitioner and granted pursuant to the procedure set forth in Section 2.2.3 of the Medical Staff Bylaws.

2.6 EFFECT OF APPLICATION

2.6-1 By signing and submitting an application for Medical Staff appointment and/or 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 Medical Staff appointment and Privileges.

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

(c) Agrees to the applicable provisions set forth in the Medical Staff Bylaws 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 Medical Staff appointment and/or 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 Medical Staff appointment and/or 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 Practitioner and releases the Board, the Hospital, its Medical Staff, and their representatives from liability for so doing.

(d) Agrees to fulfill Medical Staff responsibilities if Medical Staff appointment and/or Privileges are granted.

(e) Acknowledges receiving access to the Medical Staff governing documents.

(1) Agrees to be bound by the terms of and to comply in all respects with the Medical Staff governing documents in all matters related to consideration of the applicant's application whether or not Medical Staff appointment and/or Privileges are granted.

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

(f) Agrees that if an Adverse recommendation or action is made/taken with respect to Medical Staff appointment and/or Privileges, the applicant will exhaust the administrative remedies afforded by the Bylaws and Fair Hearing 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, Medical Staff appointment and/or Privileges, the Practitioner 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 Medical Staff application. The foregoing obligation shall be a continuing obligation of the applicant so long as he/she has an application pending for Medical Staff appointment and/or Privileges or holds Medical Staff appointment and/or 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 Medical Staff appointment and/or 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.

2.7 APPLICANT'S BURDEN

2.7-1 A completed application for Medical Staff appointment and/or 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.

2.7-2 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.

2.7-3 The applicant shall have the burden of producing adequate information for a proper evaluation of his/her qualifications for Medical Staff appointment and/or Privileges and for resolving any doubts about such qualifications.

2.7-4 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.

2.7-5 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 Medical Staff appointment and/or 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.

2.7-6 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 the Medical Staff Bylaws or Fair Hearing Policy. For any future consideration for Medical Staff appointment and/or Privileges, the applicant must request and submit a new initial application including application fee.

ARTICLE III PROCEDURE FOR INITIAL GRANT OF MEDICAL STAFF APPOINTMENT AND/OR PRIVILEGES

3.1 CREDENTIALING COLLECTION AND VERIFICATION PROCESS

3.1-1 The CVO is responsible for collection and verification of applications, and accompanying materials, for Medical Staff appointment and/or 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.

3.1-2 The CVO shall gather Privilege related data (*e.g.,* case logs, *etc.*) specific to the Privileges requested, if any, by each applicant.

3.1-3 When the CVO collection and verification process is finished, the CVO shall notify the Medical Staff Office.

3.1-4 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.

3.1-5 The application for Medical Staff appointment and/or Privileges shall thereafter be processed in accordance with Section 3.2.

3.2 MEDICAL STAFF APPOINTMENT AND/OR PRIVILEGING PROCESS

3.2-1 REVIEW BY A MEDICAL STAFF DEPARTMENT CHAIR, ASSOCIATE MEDICAL STAFF DEPARTMENT CHAIR, AND/OR DIVISION CHIEF

(a) 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 Medical Staff appointment and/or Privileges.

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

(c) 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 Medical Staff appointment and/or Privileges to the Credentials Committee.

3.2-2 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 Medical Staff appointment and/or 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 Medical Staff appointment and/or 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. This meeting shall not constitute a hearing and none of the procedural due process rights provided in the Fair Hearing Policy with respect to hearings and appeals shall apply. 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 Medical Staff appointment and/or Privileges to the MEC.

3.2-3 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 Medical Staff appointment and/or 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 3.2-4 or Section 3.2-5) 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 a hearing. 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 a hearing as provided for in the Fair Hearing Policy.

3.2-4 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 Medical Staff appointment and/or Privileges for which he/she applied effective as of the date the designated Board committee takes action. No further Board action is required.

3.2-5 BOARD ACTION – ALL OTHER APPLICATIONS

(a) Applications that do not qualify for expedited approval pursuant to Section 3.2-4 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 Medical Staff appointment and/or 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 3.2-6 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 the Fair Hearing Policy 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, under the Fair Hearing Policy. The fact that the Adverse decision is held

in abeyance shall not be deemed to confer Medical Staff appointment and/or 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 the Fair Hearing Policy.

(2) The Board shall thereafter take final action in the matter as provided for in the Fair Hearing Policy.

3.2-6 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.

3.2-7 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 Medical Staff appointment and/or Privileges shall include, as applicable: the Medical Staff category to which the applicant is appointed; the Department and Division to which the Practitioner is assigned; the Privileges he/she may exercise; and any special conditions attached to the Medical Staff appointment and/or Privileges.

3.3 TIME PERIOD GUIDELINES FOR APPLICATION PROCESSING

3.3-1 All individuals and groups required to act on an application for Medical Staff appointment and/or Privileges must do so in a timely and good faith manner.

3.3-2 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.

3.3-3 Section 3.3-2 is a guideline and shall not create any rights for the applicant to have an application processed within these time periods.

3.3-4 If additional information is needed from the applicant, the time awaiting a response from the applicant shall not count towards the applicable time guideline.

3.3-5 If the provisions of the Fair Hearing Policy are activated, the time requirements provided therein govern the continued processing of the application.

3.4 DURATION OF MEDICAL STAFF APPOINTMENT AND/OR PRIVILEGES

3.4-1 Granting of Medical Staff appointment, reappointment, and/or Privileges/regrant of Privileges shall be for a period of not more than three (3) years.

3.4-2 A Medical Staff appointment, reappointment, and/or grant/regrant of Privileges of less than three (3) years shall not be deemed Adverse for purposes of the Medical Staff governing documents.

3.5 RESIGNATION

3.5-1 A Practitioner who desires to resign his/her Medical Staff appointment and/or 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.

3.5-2 Notification of the resignation will be communicated by the Medical Staff Office as appropriate.

3.5-3 A resignation should be submitted sufficiently in advance to assure that there is continuity of patient care and no disruption in services. A Practitioner who resigns his/her Medical Staff appointment and/or 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 a Practitioner fails to do so, consideration may be given

by the Hospital/Medical Staff to contacting the applicable state licensing board regarding the Practitioner's actions.

3.6 REAPPLICATION

3.6-1 Except as otherwise provided in the Medical Staff governing documents, or as otherwise determined by the Board, upon recommendation of the Medical Executive Committee, in light of exceptional circumstances:

(a) A Practitioner whose Medical Staff appointment and Privileges are automatically terminated pursuant to Section 7.5-1 (a) (License Revocation/Expiration), (b) (Controlled Substance Authorization), (d) (Federal/State Health Program), or (e) (Designated Offense) of the Medical Staff Bylaws shall not be eligible to reapply for Medical Staff appointment and/or Privileges for a period of at least two (2) years following the effective date of the automatic termination.

(b) A Practitioner who has received a final Adverse decision regarding Medical Staff appointment/reappointment and/or Privileges/regrant of Privileges shall not be eligible to reapply for Medical Staff appointment and/or 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) A Practitioner who has resigned his/her Medical Staff appointment and/or Privileges or who fails to seek Medical Staff reappointment and/or 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 Medical Staff appointment and/or Privileges for a period of at least two (2) years following the effective date of the resignation.

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

3.6-2 Any such reapplication shall be processed as an initial application, in accordance with the Medical Staff appointment/privileging process set forth in Section 3.2 and the Practitioner 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 MEDICAL STAFF REAPPOINTMENT/REGRANT OF PRIVILEGES

4.1 APPLICATION FOR MEDICAL STAFF REAPPOINTMENT/REGRANT OF PRIVILEGES

4.1-1 Prior to the expiration date of a Practitioner's current Medical Staff appointment and/or Privilege period, the Practitioner will be provided with a Hospital approved application for Medical Staff reappointment and/or regrant of Privileges.

4.1-2 Each current Practitioner who is eligible to be reappointed to the Medical Staff and/or regranted Privileges shall be responsible for returning a completed application form to the CVO within the time period specified. The Practitioner must sign the application for Medical Staff reappointment and/or regrant of Privileges and in so doing accepts the same conditions as set forth in Section 2.6.

4.1-3 The Practitioner has the burden of producing adequate information for a proper evaluation of his/her qualifications for Medical Staff reappointment and/or 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 2.7.

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

4.1-5 Each recommendation concerning Medical Staff reappointment and/or regrant of Privileges shall be based upon review and consideration of a Practitioner's:

(a) Continued satisfaction of the qualifications for Medical Staff appointment and/or Privileges as set forth in Section 2.2 of the Medical Staff Bylaws and the applicable Medical Staff category and/or Delineation of Privileges.

(b) Updated information provided by the Practitioner with respect to Section 2.3 as necessary to bring the Practitioner's credentials file current.

(c) Satisfaction of the Medical Staff responsibilities set forth in the Section 2.3 of the Medical Staff Bylaws and the applicable Medical Staff category.

(1) A Practitioner 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 Medical Staff reappointment and/or 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 medical/other 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 Medical Staff appointment category and/or Privileges.

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

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

4.1-7 Practitioners appointed to the honorary/emeritus Medical Staff category are not required to complete an application for Medical Staff reappointment but shall confirm their desire to maintain their Medical Staff appointment in such manner as requested by the CVO and/or Medical Staff Office.

4.2 PROCESSING APPLICATIONS FOR MEDICAL STAFF REAPPOINTMENT AND/OR REGRANT OF PRIVILEGES

4.2-1 Practitioners appointed to the honorary/emeritus Medical Staff category shall be reappointed to the honorary Medical Staff category upon recommendation of the MEC and approval of the Board.

4.2-2 With the exception set forth in Section 4.2-1, an application for Medical Staff reappointment and/or regrant of Privileges shall be processed as follows:

(a) The CVO verifies the information provided on the application for Medical Staff reappointment and/or 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 3.1.

(b) Applications for Medical Staff reappointment and/or regrant of Privileges shall be reviewed and acted upon in accordance with the procedure set forth in Section 3.2.

(c) For purposes of Medical Staff reappointment and/or regrant of Privileges, the terms "applicant" and "Medical Staff appointment" or "appointment" and "Privileges" as used in Articles II and III shall be read, as "Practitioner" and "Medical Staff reappointment" or "reappointment" and "regrant of Privileges," respectively.

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

4.2-3 If an application for Medical Staff reappointment and/or regrant of Privileges has not been fully processed by the expiration date of the Practitioner's current Medical Staff appointment and/or Privilege period, the Practitioner's Medical Staff appointment and/or Privileges shall terminate at the end of the last day of his/her current Medical Staff appointment and/or Privilege period. A Practitioner whose Medical Staff appointment and/or Privileges are so terminated shall not be entitled to the procedural due process rights provided in the Fair Hearing Policy. If the Practitioner qualifies, he/she may be granted temporary Privileges pursuant to Section 6.1.

4.3 MODIFICATION OF MEDICAL STAFF APPOINTMENT AND/OR PRIVILEGES

4.3-1 A Practitioner may, either in connection with Medical Staff reappointment and/or regrant of Privileges or at any other time, request a **change of Medical Staff appointment category** (*i.e.,* a transfer from one Medical Staff category to another) and/or Privileges by submitting a written request to the CVO or Medical Staff Office. A request for transfer from one Medical Staff category to another by a Practitioner with current Medical Staff appointment at the Hospital shall be acted in the manner set forth in Section 3.2.

4.3-2 A request for **new/additional Privileges** during a current Medical Staff appointment and/or Privilege period by a Practitioner with Medical Staff appointment and/or 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 3.2.

4.3-3 A request to **exercise currently granted Privileges at an additional location(s) within the System's East Market** requires that the Practitioner 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 LEAVE OF ABSENCE

5.1 NOTICE OF LEAVE OF ABSENCE

5.1-1 A Practitioner 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.

5.1-2 A Practitioner may not take a leave of absence to avoid fulfilling any Medical Staff obligation, such as taking call.

5.1-3 The MEC may decline a leave of absence in the event that such leave does not satisfy the criteria set forth in Sections 5.1-1 and 5.1-2. The decision of the MEC is final without right to appeal.

5.1-4 With the exception of an emergency leave, the Practitioner 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.

5.2 DURING A LEAVE OF ABSENCE

5.2-1 During a leave of absence, the Practitioner is not entitled to exercise Privileges at the Hospital and has no Medical Staff appointment Prerogatives or responsibilities with the exception that he/she must continue to pay Medical Staff dues unless otherwise waived by the MEC.

5.2-2 In the event that a leave of absence (which may not exceed twelve (12) consecutive months) extends beyond the final date of the Practitioner's current Medical Staff appointment and/or Privilege period the Practitioner may apply, during the leave, for Medical Staff reappointment and/or regrant of Privileges:

(a) If the Practitioner applies and is granted Medical Staff reappointment and/or regrant of Privileges during the leave, the Practitioner's Medical Staff appointment and/or Privileges (along with the leave) will continue subject to the conditions set forth in Section 5.2-1.

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

5.3 REINSTATEMENT FOLLOWING A LEAVE OF ABSENCE

5.3-1 Eligibility for Reinstatement. Practitioners who maintain Medical Staff appointment and/or Privileges at the Hospital during a leave (*i.e.,* because the leave occurs within a Practitioner's current Medical Staff appointment and/or Privilege period or pursuant to Section 5.2-2 (a) above), may request reinstatement of Medical Staff appointment and/or Privileges at the end of the leave period.

5.3-2 Request for Reinstatement. A Practitioner must submit to the Medical Staff Office a written request for reinstatement of his/her Medical Staff appointment and/or Privileges as well as such additional information as is reasonably necessary to reflect that the Practitioner is qualified for reinstatement.

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

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

5.3-3 Professional Liability Insurance Requirements During Leave. In order to qualify for reinstatement following a leave of absence, the Practitioner must maintain Professional Liability Insurance coverage during the leave or purchase tail coverage for all periods during which the Practitioner held Privileges at the Hospital. The Practitioner shall provide information to demonstrate satisfaction of continuing Professional Liability Insurance coverage or tail coverage as required by this provision upon request for reinstatement.

5.3-4 Processing a Request for Reinstatement. Once the Practitioner's request for reinstatement is deemed complete, the request shall be reviewed and acted on in the manner set forth in Section 3.2.

ARTICLE VI

TEMPORARY PRIVILEGES, DISASTER PRIVILEGES, TELEMEDICINE PRIVILEGES & MOONLIGHTING RESIDENT PRIVILEGES

6.1 TEMPORARY PRIVILEGES

6.1-1 CONDITIONS

(a) Temporary Privileges may be granted to eligible Practitioners 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 Practitioner requesting temporary Privileges must agree, in writing, to abide by the Medical Staff Bylaws, Policies, Rules & Regulations, and applicable policies of the System/Hospital.

6.1-2 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.

(b) Criteria for granting temporary Privileges:

(1) Primary verification of education (AMA/AOA Profile is acceptable).

(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, AOA, NPDB, and OIG Medicare/Medicaid Exclusions.

(6) Confirmation of Professional Liability Insurance.

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

(d) Temporary Privileges may be terminated pursuant to Section 6.5.

6.2 DISASTER PRIVILEGES

6.2-1 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 Practitioners to help meet these needs subject to applicable state licensure laws, rules, and regulations.

6.2-2 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 Practitioner 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 Practitioner (*e.g.,* a retired Practitioner) 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 Practitioner currently practices that clearly identifies the volunteer Practitioner's professional designation.

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

6.2-3 It is anticipated that disaster Privileges may be granted to both Ohio and out-of-state volunteer Practitioners subject to applicable Ohio licensure laws, rules, and regulations.

6.2-4 The activities of volunteer Practitioners 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.

6.2-5 All volunteer Practitioners who receive disaster Privileges must wear a photo identification badge designating the Practitioner as a volunteer disaster privileged provider.

6.2-6 Disaster Privileges may be terminated pursuant to Section 6.5 and shall cease upon alleviation of the circumstances of disaster as determined by the Hospital President.

6.3 TELEMEDICINE PRIVILEGES

6.3-1 Section 6.3 applies to distant-site telemedicine Practitioners who do not practice on-site at the Hospital.

6.3-2 Distant-site Practitioners 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 the Medical Staff Bylaws and this Credentials Policy, accreditation standards, and applicable laws, rules, and regulations.

6.3-3 Prior to a distant-site Practitioner providing telemedicine services to patients at the Hospital, the Practitioner must be appropriately credentialed (which may be by proxy) and granted Privileges by the Hospital. A distant-site Practitioner 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 Practitioner 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 Practitioner 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 <u>Medicare-participating hospital</u> **OR** a facility that qualifies as a <u>distant-site telemedicine entity</u>. 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 practitioners providing telemedicine services to the patients of the hospital.

(i) When the distant-site is a <u>Medicare-participating hospital</u> 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 Practitioners providing telemedicine services.

(ii) When the distant-site is a <u>distant-site telemedicine entity</u> 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 Practitioners 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 Practitioner 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 Practitioner's privileges at the distant-site.

(3) Each distant-site Practitioner 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 Practitioner is located.

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

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

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

(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 6.5.

6.4 MOONLIGHTING RESIDENT PRIVILEGES

6.4-1 QUALIFICATIONS

Moonlighting resident Privileges may be granted to Physician residents who:

(a) Have and maintain a current valid license (not a training certificate) to practice medicine in Ohio and meet the continuing education requirements necessary to maintain such medical license as determined by the State Medical Board of Ohio.

(b) Satisfy the other qualifications set forth in Section 2.2 of the Medical Staff Bylaws, to the extent applicable, with the exception that a resident seeking moonlighting resident Privileges will not yet have completed their residency training and will not yet have obtained specialty board certification.

(c) Are requesting Privileges to provide clinical care, treatment, and/or services to patients at the Hospital (or a provider-based location thereof) outside of the time periods that the resident is participating in their residency training education/program.

(d) Obtain prior written approval from the director of the applicable residency program.

(e) Are in good standing in his/her residency program, as confirmed by the program director.

6.4-2 CONDITIONS

(a) PGY-1 residents are not permitted to moonlight.

(b) Residents prohibited by applicable laws, rules, and/or regulations from moonlighting are not eligible for moonlighting resident Privileges.

(c) A moonlighting resident must request and be granted moonlighting resident Privileges prior to providing any clinical care, treatment, and/or services to patients at the Hospital (or a provider-based location thereof) outside of the time periods that the resident is participating in their residency training education/program.

(d) Special requirements of consultation and reporting may be imposed at such time as moonlighting resident Privileges are granted.

(e) A moonlighting resident must agree, in writing, to abide by the Medical Staff governing documents and the policies of the System/Hospital in all matters relating to his/her moonlighting activities at the Hospital.

(f) Moonlighting is not required and must not interfere with the resident's residency clinical training/education.

(g) All moonlighting hours must be reported and counted towards work duty hour requirements.

(h) Permission to moonlight may be withdrawn if the residency program director determines that the resident's education/training is adversely impacted by such moonlighting activities.

6.4-3 PROCESSING A REQUEST FOR MOONLIGHTING RESIDENT PRIVILEGES

(a) A request for moonlighting resident Privileges shall be processed in accordance with Section 3.2 with the exceptions noted in Sections 6.4-1 and 6.4-2.

(b) Moonlighting resident Privileges may be terminated pursuant to Section 6.5.

6.5 TERMINATION OF TEMPORARY PRIVILEGES, DISASTER PRIVILEGES, TELEMEDICINE PRIVILEGES, OR MOONLIGHTING RESIDENT PRIVILEGES

6.5-1 The Hospital President, CMO, or Chief of Staff may terminate a Practitioner's temporary, disaster, or telemedicine Privileges (or a resident's moonlighting resident Privileges) at any time.

6.5-2 Where the life or well-being of a patient is determined to be endangered, the Practitioner's temporary, disaster, or telemedicine Privileges (or a resident's moonlighting resident Privileges) may be terminated by any person entitled to impose a summary suspension pursuant to the Medical Staff Bylaws.

6.5-3 A Practitioner granted temporary, disaster, or telemedicine Privileges (or a resident granted moonlighting resident Privileges) is not a Medical Staff Member and is not entitled to the procedural due process rights afforded to Medical Staff Members.

6.5-4 A Practitioner (or moonlighting resident) is not be entitled to the procedural due process rights set forth in the Medical Staff Bylaws or Fair Hearing Policy because the Practitioner's request for temporary, disaster, or telemedicine Privileges (or a resident's request for moonlighting resident 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.

6.5-5 In the event a Practitioner's temporary, disaster, or telemedicine Privileges (or a resident's moonlighting Privileges) are revoked, the Practitioner's patients shall be assigned to another Practitioner by the Chief of Staff or applicable Medical Staff Department Chair, Associate Medical Staff Department Chair, or Division Chief. The wishes of the patient will be considered, where feasible, in choosing a substitute Practitioner.

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

6.6-1 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 Practitioner(s).

(c) The availability of other qualified 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.

6.6-2 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 Practitioner 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 Practitioner believes the Hospital should recognize such Privileges, and any additional information that the Practitioner 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 Practitioner(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 Practitioner(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 the Fair Hearing Policy.

6.6-3 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.

6.7 EMERGENCY SITUATION

6.7-1 In an emergency, a Medical Staff Member 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 (regardless of their Medical Staff category or type of Privileges) provided that the care, treatment, and/or services rendered during the emergency are within the scope of the Practitioner's license.

ARTICLE VII

CONFLICTS OF INTEREST & CONTRACTED PROVIDERS

7.1 CONFLICTS OF INTEREST

7.1-1 In any instance where a Practitioner 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 Practitioner 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 Practitioner 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 Practitioner from participating in the pending matter.

7.1-2 For purposes of this Section 7.1, the fact that Practitioners are competitors, partners, or employed in the same group shall not, in and of itself, automatically disqualify such Practitioners from participating in the review of applications or other Medical Staff matters with respect to their colleagues.

7.1-3 All Practitioner nominees for election or appointment to a position on the Board, a Board committee, as a Medical Staff officer, Medical Staff Department Chair, Associate Medical Staff Department Chair, Division Chief, member of the Medical Executive Committee, or such other Medical Staff committee as may be set forth in the applicable conflict of interest policy shall disclose, in writing, any conflicts of interest with the Hospital in accordance with the applicable conflict of interest policy.

7.2 CONTRACTED PRACTITIONERS

7.2-1 A Practitioner 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 Medical Staff appointment/reappointment and/or Privileges/regrant of Privileges and must meet all of the responsibilities of Medical Staff appointment and/or Privileges as set forth in the Medical Staff governing documents for any other Practitioner.

7.2-2 The effect of the expiration or termination of a Practitioner’s contract with the Hospital (or the expiration or termination of a Practitioner’s association with the group holding the contract with the Hospital) upon a Practitioner’s Medical Staff appointment and/or Privileges at the Hospital will be governed solely by the terms of the Practitioner’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

Practitioner's association with the group holding the contract with the Hospital) will not affect the Practitioner's Medical Staff appointment and/or Privileges at the Hospital with the exception set forth in subsections 7.2-3 and 7.2-4 below.

7.2-3 In the absence of language in the contract to the contrary, if an exclusive contract under which a Practitioner is engaged is terminated or expires (or if the relationship of the Practitioner with the group that has the exclusive contractual relationship with the Hospital is terminated or expires) then the Practitioner's Medical Staff appointment and those Privileges covered by the exclusive contract shall also be terminated and the procedural due process rights afforded by the Fair Hearing Policy shall not apply; provided, however, that the Board in its sole discretion may waive this automatic termination result.

7.2-4 If the Hospital enters into an exclusive contract for a particular service(s), any Practitioner 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 Practitioner's Medical Staff appointment, reappointment, and/or Privilege term.

ARTICLE VIII UNIFIED MEDICAL STAFF

8.1 REFLECTION OF UNIQUE NEEDS, CIRCUMSTANCES, PATIENT POPULATIONS AND SERVICES

8.1-1 In order to reflect the unique needs, circumstances, patient populations, and services at Hospitals served by the unified Medical Staff:

(a) Practitioner representatives from each unified Medical Staff Hospital will serve on unified Medical Staff committees and provide input with respect to the unique needs, circumstances, patient populations, and services provided at the unified Medical Staff Hospital at which each such Practitioner representative practices. Documentation of the outcome of a unified Medical Staff committee's review of any concerns and unique needs/circumstances raised with respect to a unified Medical Staff Hospital is set forth in meeting minutes.

(b) Practitioners granted appointment to the unified Medical Staff and/or Privileges at a unified Medical Staff Hospital:

(1) May, at any time, communicate unique needs/circumstances regarding a unified Medical Staff Hospital's patient population and/or services to a Medical Staff officer, a Medical Staff Department Chair, Associate Medical Staff Department Chair, Division Chief, or any member of an appropriate unified Medical Staff committee to be addressed in accordance with the applicable unified Medical Staff governing documents.

(2) Are provided access to the unified Medical Staff governing documents, and amendments thereto, which serve to inform such Practitioners of the process by which unique needs/circumstances regarding a unified Medical Staff Hospital's patient population and/or services may be raised.

8.2 UNIFIED MEDICAL STAFF OPT-OUT PROCEDURE

8.2-1 Should a medical staff initially elect to become part of the unified Medical Staff but at a later date wish to opt out of that relationship, a vote to opt out of the unified Medical Staff may be called consistent with the methodology for opting out set forth below:

(a) For the purpose of opting out of the unified Medical Staff, a Practitioner will only be deemed eligible to vote if the Practitioner is appointed to the active Medical Staff category and has Privileges to practice <u>on-site</u> at the Hospital that is deciding whether to opt out of the unified Medical Staff.

(b) An opt out vote may not be called more often than the two (2) year anniversary of the last date that a vote to opt in or opt out of a unified Medical Staff was taken.

(c) A petition requesting that an opt out vote be called must be signed by not less than twenty-five (25%) of the Practitioners eligible to vote at the Hospital that is deciding whether to opt out of the unified Medical Staff (not the entire unified Medical Staff). Such petition must be submitted to the unified Medical Staff Chief of Staff who shall convene a meeting of the Practitioners eligible to vote at the Hospital that is deciding whether to opt out of the unified Medical Staff (not the entire unified Medical Staff).

(d) Action to opt out of the unified Medical Staff requires a majority vote of the total number of Practitioners entitled to vote at the Hospital that is deciding whether to opt out of the unified Medical Staff.

8.2-2 Members of the unified Medical Staff will be advised, in writing, at the time of initial Medical Staff appointment and/or grant of Privileges and, thereafter, at the time of each Medical Staff reappointment and/or regrant of Privileges, of the right to opt-out of the unified Medical Staff and the process by which to do so.

CERTIFICATION OF ADOPTION AND 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