

**MEDICAL STAFF BYLAWS, POLICIES, AND
RULES AND REGULATIONS
OF
RANDOLPH HOSPITAL**

**ALLIED HEALTH
PROFESSIONALS POLICY**

Effective October 1, 2009

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ARTICLE 1

GENERAL

1.A. DEFINITIONS

The following definitions apply to terms used in this Policy:

- (1) "ALLIED HEALTH PROFESSIONAL" means a health care practitioner other than a physician, dentist, podiatrist, or oral surgeon who is authorized to provide patient care services in the Hospital.
- (2) "BOARD" means the Board of Directors of the Hospital, which has the overall responsibility for the Hospital, or its designated committee.
- (3) "CATEGORY I PRACTITIONER" means a Licensed Independent Practitioner, an Allied Health Professional who is permitted by law and by the Hospital to provide patient care services without direction or supervision, within the scope of his or her license and consistent with the clinical privileges granted.
- (4) "CATEGORY II PRACTITIONER" means an Advanced Dependent Practitioner, an Allied Health Professional who provides a medical level of care or performs surgical tasks (i.e., Advanced Practice Registered Nurse ("APRN"), Physician Assistant ("PA")) consistent with the clinical privileges granted, but who is required by law and/or the Hospital to exercise those clinical privileges under the direction of, or in collaboration with, a Supervising Physician, pursuant to a written supervision or collaborative agreement. Category II practitioners also include those physicians not appointed to the Medical Staff who seek to exercise certain limited clinical privileges at the Hospital under the conditions set forth in this Policy (e.g., moonlighting residents).
- (5) "CATEGORY III PRACTITIONER" means a Dependent Practitioner, an Allied Health Professional who is permitted by law or the Hospital to function only under the direction of, or in collaboration with, a Supervising Physician, pursuant to a written supervision agreement and consistent with the scope of practice granted. All aspects of the clinical practice of Category III practitioners at the Hospital shall be handled by the Hospital's Human Resources Department in accordance with applicable human resources policies and procedures, and the provisions of this Policy shall specifically not apply. Hereinafter, as used in this Policy, the term "Allied Health Professional" shall mean Category I and Category II practitioners only.
- (6) "CLINICAL PRIVILEGES" or "PRIVILEGES" means the authorization granted by the Board to a practitioner to render specific patient care services, for which the Medical Staff leaders and Board have developed (i) eligibility and other

credentialing criteria, (ii) ongoing professional practice evaluation review criteria, and (iii) focused professional practice evaluation review criteria.

- (7) "CORE PRIVILEGES" means a defined grouping of privileges for a specialty or subspecialty that includes the fundamental patient care services that are routinely taught in residency and/or fellowship training for that specialty or subspecialty and which have been determined by the Medical Staff leaders and Board to require closely related skills and experience.
- (8) "CREDENTIALS POLICY" means the Hospital's Medical Staff Policy on Appointment, Reappointment and Clinical Privileges.
- (9) "DAYS" means calendar days.
- (10) "DENTIST" means a doctor of dental surgery ("D.D.S.") or doctor of dental medicine ("D.M.D.").
- (11) "EXECUTIVE SESSION" is a meeting of a Medical Staff committee or department which only the voting Medical Staff members may attend, along with senior Hospital management. Executive Sessions may be called by the presiding officer, and are intended to be utilized to discuss peer review issues, personnel issues, or any other issue requiring confidentiality.
- (12) "HOSPITAL" means Randolph Hospital.
- (13) "MEDICAL EXECUTIVE COMMITTEE" ("MEC") means the Executive Committee of the Medical Staff.
- (14) "MEDICAL STAFF" means all physicians, dentists, oral surgeons, and podiatrists who have been appointed to the Medical Staff by the Board.
- (15) "MEDICAL STAFF LEADER" means any Medical Staff officer, service line chair, and committee chair.
- (16) "MEMBER" means any physician, dentist, oral surgeon, and podiatrist who has been granted Medical Staff appointment and clinical privileges by the Board to practice at the Hospital.
- (17) "NOTICE" means written communication by regular U.S. mail, e-mail, facsimile, Hospital mail, or hand delivery.
- (18) "ORAL OR MAXILLOFACIAL SURGEON" means an individual with a D.D.S. or a D.M.D. degree, who has successfully completed an accredited post-graduate training program in oral and maxillofacial surgery.

- (19) "ORGANIZED HEALTH CARE ARRANGEMENT" means the term used by the HIPAA Privacy Rule to describe a clinically-integrated care setting in which patients typically receive health care from more than one provider (such as a hospital and its Medical Staff) and which benefits from regulatory provisions designed to facilitate compliance with the HIPAA Privacy Rule.
- (20) "PATIENT CONTACT" includes any admission, assumption of care, consultation, procedure (inpatient or outpatient), or response to emergency call performed in the Hospital. It shall not include referrals for diagnostic or laboratory tests, or for non-diagnostic treatments or procedures.
- (21) "PERMISSION TO PRACTICE" means the authorization granted to Allied Health Professionals by the Board or President/CEO, as applicable, to exercise clinical privileges.
- (22) "PHYSICIAN" includes both doctors of medicine ("M.D.s") and doctors of osteopathy ("D.O.s").
- (23) "PODIATRIST" means a doctor of podiatric medicine ("D.P.M.").
- (24) "PRESIDENT/CEO" means the individual appointed by the Board to act on its behalf in the overall management of the Hospital.
- (25) "SPECIAL NOTICE" means hand delivery, certified mail (return receipt requested), or overnight delivery service providing receipt.
- (26) "SPECIAL PRIVILEGES" means privileges that fall outside of the core privileges for a given specialty, which require additional education, training, and/or experience beyond that required for core privileges in order to demonstrate competence.
- (27) "SUPERVISING PHYSICIAN" means a member of the Medical Staff with clinical privileges, who has agreed in writing to supervise or collaborate with a Category II practitioner and to accept full responsibility for the actions of the Category II practitioner while he or she is practicing in the Hospital.
- (28) "SUPERVISION" means the supervision of (or collaboration with) a Category II practitioner by a Supervising Physician, that may or may not require the actual presence of the Supervising Physician, but that does require, at a minimum, that the Supervising Physician be readily available for consultation. The requisite level of supervision (general – Supervising Physician is available by telephone; direct – Supervising Physician is physically on the Hospital campus; or personal – Supervising Physician is present in the room) shall be determined at the time each Category II practitioner is credentialed and shall be consistent with any applicable written supervision or collaboration agreement that may exist.

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

1.B. TIME LIMITS

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

1.C. DELEGATION OF FUNCTIONS

- (1) Unless otherwise provided, when a function is to be carried out by a person in a particular office or by a committee, the person, or the committee through its chair, may delegate performance of the function to one or more qualified designees.
- (2) When a medical staff member is unavailable to perform a necessary function, one or more of the Medical Staff Leaders shall perform the function personally or delegate it to another appropriate individual.

1.D. GOVERNING LAWS

The Medical Staff Bylaws, Policies, Rules and Regulations and related documents have been drafted in accordance with relevant Federal and North Carolina laws and shall be interpreted in accordance with those laws.

ARTICLE 2

SCOPE AND OVERVIEW OF POLICY

2.A. SCOPE OF POLICY

- (1) This Policy addresses those Allied Health Professionals who are permitted to provide patient care services in the Hospital and are listed in the Appendices to this Policy. It also addresses those physicians who are not appointed to the Medical Staff, but who seek to exercise certain limited privileges at the Hospital as Category II practitioners, under the conditions set forth in this Policy (e.g., moonlighting residents).
- (2) This Policy sets forth the credentialing process and the general practice parameters for these individuals, as well as guidelines for determining the need for additional categories of Allied Health Professionals at the Hospital.

2.B. CATEGORIES OF ALLIED HEALTH PROFESSIONALS

- (1) Only those specific categories of Allied Health Professionals that have been approved by the Board of Directors shall be permitted to practice at the Hospital. All Allied Health Professionals who are addressed in this Policy shall be classified as either Category I, Category II, or Category III practitioners.
- (2) Current listings of the specific categories of Allied Health Professionals functioning in the Hospital as Category I, Category II, and Category III practitioners are attached to this Policy as Appendices A, B, and C, respectively. The Appendices may be modified or supplemented by action of the Board, after receiving the recommendation of the MEC, without the necessity of further amendment of this Policy.

2.C. PROCESS FOR DETERMINING NEED FOR A NEW CATEGORY OF ALLIED HEALTH PROFESSIONALS

2.C.1. Review of Need:

- (a) Whenever an Allied Health Professional requests to practice at the Hospital, and the Board has not already approved the category of practitioner for practice at the Hospital, the President/CEO shall appoint an ad hoc committee to evaluate the need for that category of Allied Health Professional. The ad hoc committee shall report to the MEC, which shall make a recommendation to the Board for final action.
- (b) As part of the process of determining need, the Allied Health Professional shall be invited to submit information about the nature of the proposed practice, the reason

access to the Hospital is sought, and the potential benefits to the community of having such services available at the Hospital.

- (c) The ad hoc committee may consider the following factors when making a recommendation as to the need for the services of a specific category of Allied Health Professional:
 - (1) the nature of the services that would be offered;
 - (2) any state license or regulation which outlines the specific patient care services and/or activities that the Allied Health Professional is authorized by law to perform;
 - (3) any state "nondiscrimination" or "any willing provider" laws that would apply to the Allied Health Professional;
 - (4) the patient care objectives of the Hospital, including patient convenience;
 - (5) the community's needs and whether those needs are currently being met or could be better met if the services offered by the Allied Health Professional were provided at the Hospital;
 - (6) the type of training that is necessary to perform the services that would be offered and whether there are individuals with more training currently providing those services;
 - (7) the availability of supplies, equipment, and other necessary Hospital resources;
 - (8) the need for, and availability of, trained staff to support the services that would be offered; and
 - (9) the ability to appropriately supervise performance and monitor quality of care.

2.C.2. Additional Recommendations:

- (a) If the ad hoc committee makes a recommendation that there is a need for the particular category of Allied Health Professional at the Hospital, it shall also recommend:
 - (1) any specific qualifications and/or training that must be possessed beyond those set forth in this Policy;
 - (2) a detailed description of clinical privileges;

- (3) any specific conditions that apply to practice within the Hospital; and
 - (4) any supervision requirements, if applicable.
- (b) In developing such recommendations, the ad hoc committee shall consult the appropriate service line chair(s) and consider relevant state law and may contact professional societies or associations. The ad hoc committee may also recommend the number of Allied Health Professionals that are needed.

ARTICLE 3

QUALIFICATIONS, CONDITIONS AND RESPONSIBILITIES

3.A. QUALIFICATIONS

3.A.1. Eligibility Criteria:

To be eligible to apply for initial and continued permission to practice, Allied Health Professionals must, where applicable:

- (a) have a current, unrestricted license, certification, or registration to practice in North Carolina and have never had a license, certification or registration to practice revoked or suspended by any state licensing agency;
- (b) where applicable to their practice, have a current, unrestricted DEA registration;
- (c) demonstrate that they understand, and can satisfy, the specific response time requirements for their specialty as may be recommended by the MEC and approved by the Board;
- (d) have (or can provide formal documentation evidencing the process of obtaining) current, valid professional liability insurance coverage in a form and in amounts satisfactory to the Hospital, which shall be a minimum of \$1 million per incident and \$3 million aggregate;
- (e) have never been convicted of, or entered a plea of guilty or no contest to, Medicare, Medicaid, or other federal or state governmental or private third-party payer fraud or program abuse or have been required to pay civil monetary penalties for the same;
- (f) have never been and are not currently excluded or precluded from participation in Medicare, Medicaid or other federal or state governmental health care program;
- (g) have never had clinical privileges denied, revoked, or terminated by any health care facility or health plan for reasons related to clinical competence or professional conduct, and have never resigned or relinquished affiliation or clinical privileges during an investigation or in exchange for not conducting an investigation;
- (h) have never been convicted of, or entered a plea of guilty or no contest to, any felony or any misdemeanor relating to controlled substances, illegal drugs, insurance or health care fraud or abuse, or violence;

- (i) satisfy all additional eligibility qualifications relating to their specific area of practice that may be established by the Hospital; and
- (j) if seeking to practice as a Category II practitioner, have a written agreement with a Supervising Physician, which agreement must meet all applicable requirements of state law and Hospital policy (any request for clinical privileges must be consistent with and permitted by this written agreement).

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

- (a) Any individual who does not satisfy a threshold eligibility criterion may request that it be waived. The individual requesting the waiver bears the burden of demonstrating that his or her qualifications are equivalent to, or exceed, the criterion in question.
- (b) The Board may grant waivers in exceptional cases after considering the findings of the Credentials Committee, the MEC, or other committee designated by the Board, the specific qualifications of the individual in question, and the best interests of the Hospital and the community it serves. The granting of a waiver in a particular case is not intended to set a precedent for any other individual or group of individuals.
- (c) No individual is entitled to a waiver or to a hearing if the Board determines not to grant a waiver.
- (d) A determination that an individual is not entitled to a waiver is not a "denial" of clinical privileges.

3.A.3. Factors for Evaluation:

The following factors will be evaluated as applicable, as part of a request for permission to practice:

- (a) relevant training, experience, and demonstrated current competence, including medical/clinical knowledge, technical and clinical skills, clinical judgment, and an understanding of the contexts and systems within which care is provided;
- (b) adherence to the ethics of their profession, continuous professional development, an understanding of and sensitivity to diversity, and responsible attitude toward patients, families, and their profession;
- (c) ability and willingness to safely and competently perform the clinical privileges requested;
- (d) good reputation and character;

- (e) ability to work harmoniously with others, including, but not limited to, interpersonal and communication skills sufficient to enable them to maintain professional relationships with patients, families and other members of health care teams; and
- (f) recognition of the importance of, and willingness to support, the Hospital's commitment to quality care and a recognition that interpersonal skills and collegiality are essential to the provision of quality patient care.

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

Allied Health Professionals shall not be appointed to the Medical Staff or entitled to the rights, privileges, and/or prerogatives of Medical Staff appointment unless otherwise provided for under this Policy.

3.A.5. Nondiscrimination Policy:

No individual shall be denied clinical privileges at the Hospital on the basis of gender, race, creed, sexual orientation, or national origin.

3.B. GENERAL CONDITIONS OF PRACTICE

3.B.1. Assumption of Duties and Responsibilities:

As a condition of being granted permission to practice and as a condition for continued permission to practice, Allied Health Professionals specifically agree to the following:

- (a) to provide continuous and timely care to all patients for whom the individual has responsibility;
- (b) to abide by all bylaws, policies and rules and regulations of the Hospital and Medical Staff;
- (c) to accept committee assignments, participation in quality improvement and peer review activities, and such other reasonable duties and responsibilities as assigned by the Medical Staff Leaders;
- (d) to constructively participate in the development, review, and revision of clinical protocols and pathways pertinent to his or her specialty, including those related to national patient safety initiatives and core measures;
- (e) to comply with adopted protocols and pathways or document reasons for variance;
- (f) to maintain a current e-mail address with the Medical Staff Office;

- (g) to provide, with or without request, new or updated information to the President/CEO as it occurs, pertinent to any question on the application form;
- (h) to immediately submit to a complete physical and/or mental evaluation, if at least two Medical Staff leaders (or one Medical Staff leader and one member of administration) are concerned with the individual's ability to safely and competently care for patients and request such testing and/or evaluation. The health care professional(s) to perform the testing and/or evaluations shall be determined by the Medical Staff leadership;
- (i) to acknowledge that the individual has had an opportunity to read a copy of this Policy and any other applicable bylaws, policies, rules and regulations and agrees to be bound by them;
- (j) to appear for personal interviews as may be requested;
- (k) to refrain from illegal fee splitting or other illegal inducements relating to patient referral;
- (l) to refrain from assuming responsibility for diagnosis or care of hospitalized patients for which he or she is not qualified or without adequate supervision;
- (m) to refrain from deceiving patients as to his or her status as an Allied Health Professional;
- (n) to seek consultation when appropriate;
- (o) to participate in monitoring and evaluation activities;
- (p) to complete, in a timely manner, all medical and other required records containing all information required by the Hospital;
- (q) to perform all services and conduct himself or herself at all times in a cooperative and professional manner;
- (r) to satisfy applicable continuing education requirements;
- (s) to promptly pay any applicable dues and assessments; and
- (t) that any misstatement in or omission from the application, as determined by the Chief of Staff and the President/CEO, shall cause the credentialing process for an application to be stopped. If permission to practice has been granted prior to the discovery of a misstatement or omission, clinical privileges shall be automatically relinquished. In either situation, there shall be no entitlement to the procedural rights in Article 7 of this Policy. Applicants shall be informed in writing of the nature of the misstatement or omission and permitted to provide a written

response. The Credentials Committee shall review the individual's response and provide a recommendation to the MEC. The MEC shall recommend to the Board whether the application should be processed further, whereupon the Board shall make the final decision. The possible reinstatement of an existing Allied Health Professional who automatically relinquished privileges shall be reviewed in accordance with Section 6.D of this Policy.

3.B.2. Burden of Providing Information:

- (a) Allied Health Professionals seeking permission to practice shall have the burden of producing information deemed adequate by the Hospital for a proper evaluation of current competence, character, ethics, and other qualifications and for resolving any doubts about such qualifications.
- (b) Allied Health Professionals seeking permission to practice at the Hospital have the burden of providing evidence that all the statements made and information given on the application are accurate.
- (c) An application shall be complete when all questions on the application form have been answered, all supporting documentation has been supplied, and all information has been verified from primary sources. An application shall become incomplete if the service line chair, Credentials Committee, MEC, and/or Board request any new, additional, or clarifying information at any time. Any application that continues to be incomplete 30 days after the individual has been notified of the additional information required shall be deemed to be withdrawn.
- (d) It is the responsibility of the individual seeking permission to practice at the Hospital to provide a complete application, including adequate responses from references. An incomplete application shall not be processed.

3.C. APPLICATION

3.C.1. Information:

- (a) The application forms for Allied Health Professionals shall be approved by the MEC and the Board. The applications existing now, and as may be revised, are incorporated by reference and made a part of this Policy.
- (b) The application forms shall require detailed information concerning the applicant's professional qualifications. In addition to other information, the applications shall seek the following:
 - (1) information as to whether the applicant's scope of practice or clinical privileges and/or affiliation has ever been voluntarily or involuntarily relinquished, withdrawn, denied, revoked, suspended, subject to probationary or other conditions, reduced, limited, terminated, or not

renewed at any hospital or health care facility or is currently being investigated or challenged;

- (2) information as to whether the applicant's license or certification to practice any profession in any state or DEA registration or any state controlled substance license is, or has ever been, voluntarily or involuntarily relinquished, suspended, modified, terminated, or restricted or is currently being investigated or challenged;
 - (3) information concerning the applicant's professional liability litigation experience, including past and pending claims, final judgments or settlements, and the substance of the allegations, as well as the findings and the ultimate disposition;
 - (4) current information regarding the applicant's ability to safely and competently exercise the scope of practice or clinical privileges he or she has requested; and
 - (5) a copy of government-issued photo identification.
- (c) The applicant shall sign the application and certify that he or she is able to perform the scope of practice or clinical privileges requested and the responsibilities of Allied Health Professionals.

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

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

- (a) whether or not permission to practice and clinical privileges or scope of practice are granted;
 - (b) throughout the term of any affiliation with the Hospital and thereafter;
 - (c) should permission to practice or clinical privileges or scope of practice be denied, revoked, reduced, restricted, suspended, and/or otherwise affected as part of the Hospital's professional review activities; and
 - (d) to any third-party inquiries received after the individual leaves the Hospital about his/her tenure at the Hospital.
- (1) Immunity:

To the fullest extent permitted by law, the individual releases from any and all liability, extends absolute immunity to, and agrees not to sue the Hospital or the Board, any member of the Medical Staff or the Board, their

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

(2) Authorization to Obtain Information from Third Parties:

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

(3) Authorization to Release Information to Third Parties:

The individual also authorizes Hospital representatives to release information to other hospitals, health care facilities, managed care organizations, government regulatory and licensure boards or agencies, and their agents when information is requested in order to evaluate his or her professional qualifications for permission to practice, clinical privileges or scope of practice, and/or participation at the requesting organization/facility, and any licensure or regulatory matter. The specific process for release of information shall be coordinated by the Medical Staff Office.

(4) Procedural Rights:

The Allied Health Professional agrees that the procedural rights set forth in this Policy shall be the sole and exclusive remedy with respect to any professional review action taken by the Hospital.

(5) Legal Actions:

If, notwithstanding the provisions in this Section, an individual institutes legal action and does not prevail, he or she shall reimburse the Hospital, any member of the Medical Staff or Board involved in the action for all costs incurred in defending such legal action, including reasonable attorney's fees and lost revenues.

ARTICLE 4

CREDENTIALING PROCEDURE

4.A. PROCESSING OF INITIAL APPLICATION TO PRACTICE

4.A.1. Request for Application:

- (a) Any individual requesting an application for permission to practice as an Allied Health Professional shall be sent a letter that outlines the eligibility criteria for permission to practice and the application form.
- (b) An Allied Health Professional who is in a category of practitioners that has not been approved by the Board to practice at the Hospital shall be ineligible to receive an application. A determination of ineligibility does not entitle an Allied Health Professional to the procedural rights outlined in Article 7 of this Policy.

4.A.2. Submission of Application:

- (a) A completed application, with copies of all required documents, must be returned to the Medical Staff Office within 30 days after receipt of the application if the Allied Health Professional desires further consideration. The application must be accompanied by the application processing fee, if one is required.
- (b) An application shall be deemed to be complete when all questions on the application form have been answered, all supporting documentation has been supplied, and all information has been verified. An application shall become incomplete if the service line chair, Credentials Committee, MEC, or Board requests new, additional, or clarifying information at any time.
- (c) Any application that continues to be incomplete 30 days after the applicant has been notified of the additional information required shall be deemed to be withdrawn. It is the responsibility of the applicant to provide a complete application, including adequate responses from references. An incomplete application shall not be processed.

4.A.3. Initial Review of Application:

- (a) As a preliminary step, the Medical Staff Office shall review the application to determine that the individual satisfies all threshold criteria. An individual who fails to meet the eligibility criteria set forth in Section 3.A.1 of this Policy shall be notified that his or her application shall not be processed.
- (b) The Medical Staff Office shall also review the application to determine if all questions have been answered, all references and other information or materials

have been received, and pertinent information provided on the application has been verified with primary sources. If an application is complete, it shall be transmitted, along with all supporting documentation, to the applicable service line chair.

4.A.4. Review by Service Line Chair:

- (a) The Medical Staff Office shall transmit the complete application and all supporting materials to the appropriate service line chair. Each chair shall prepare a written report as recorded on initial applicant evaluation forms maintained by the Medical Staff Office regarding whether the applicant has satisfied all of the qualifications for the scope of practice or clinical privileges requested.
- (b) In preparing this report, the service line chair has the right to meet with the applicant, and the Supervising Physician (if applicable), to discuss any aspect of the application, qualifications, and requested scope of practice or clinical privileges. The service line chair may also confer with experts within the service line and outside of the service line in preparing the report (e.g., other physicians, appropriate supervisor within the service line, nurse managers).
- (c) The service line chair shall be available to answer any questions that may be raised with respect to that chairman's report and findings.

4.A.5. Credentials Committee Procedure:

- (a) The Credentials Committee shall review and consider the report prepared by the service line chair and may interview the applicant. Thereafter, the Credentials Committee shall make a recommendation.
- (b) After determining that an applicant is otherwise qualified for permission to practice, the Credentials Committee shall review the applicant's Health Status Confirmation Form to determine if there is any question about the applicant's ability to practice. If so, the Credentials Committee may require the applicant to undergo a physical and/or mental health examination by a physician(s) satisfactory to the Committee. The results of this examination shall be made available to the Credentials Committee for its consideration. Failure of an applicant to undergo an examination within a reasonable time after being requested to do so in writing by the Credentials Committee shall be considered a voluntary withdrawal of the application and all processing of the application shall cease.
- (c) The Credentials Committee's recommendation shall be forwarded to the MEC or the Chief of Staff, as applicable.

4.A.6. MEC Procedure:

- (a) At its next regular meeting, after receipt of the written findings and recommendations of the Credentials Committee, the MEC shall:
 - (1) adopt the findings and recommendations of the Credentials Committee; or
 - (2) refer the matter back to the Credentials Committee for further consideration and responses to specific questions raised by the MEC prior to its final recommendation; or
 - (3) state its reasons in its report and recommendation, along with supporting information, for its disagreement with the Credentials Committee's recommendation.
- (b) If the recommendation of the MEC is favorable, it shall be forwarded to the Board through the Chief of Staff.
- (c) If the recommendation of the MEC would entitle the applicant to the procedural rights set forth in Article 7, the President/CEO shall send the applicant special notice. The President/CEO shall then hold the application until after the applicant has completed or waived the procedural process outlined in this Policy.

4.A.7. Board Action:

- (a) The Board may delegate to a committee, consisting of at least two Board members, action on the clinical privileges requested if there has been a favorable recommendation from the Credentials Committee and the MEC and there is no evidence of any of the following:
 - (1) a current or previously successful challenge to any license or registration;
 - (2) an involuntary termination, limitation, reduction, denial, or loss of appointment or privileges at any other hospital or other entity; or
 - (3) an unusual pattern of, or an excessive number of, professional liability actions resulting in a final judgment against the applicant.

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

- (b) When there has been no delegation to the Board Committee, upon receipt of a recommendation that the applicant be granted clinical privileges requested, the Board may:
 - (1) grant the applicant the clinical privileges as recommended; or
 - (2) refer the matter back to the Credentials Committee or MEC or to another source inside or outside the Hospital for additional research or information; or
 - (3) reject or modify the recommendation.
- (c) If the Board determines to reject a favorable recommendation, it should first discuss the matter with the Chair of the Credentials Committee and the Chair of the MEC. If the Board's determination remains unfavorable to the applicant, the President/CEO shall promptly send special notice to the applicant that the applicant is entitled to request a hearing.

4.B. CLINICAL PRIVILEGES

4.B.1. General:

The clinical privileges recommended to the Board will be based upon consideration of the following:

- (a) education, relevant training, experience, and demonstrated current competence, including medical/clinical knowledge, technical and clinical skills, clinical judgment, interpersonal and communication skills, and professionalism with patients, families and other members of the health care team and peer evaluations relating to the same;
- (b) ability to perform the privileges requested competently and safely;
- (c) information resulting from ongoing and focused professional practice evaluation, performance improvement and other peer review activities, if applicable;
- (d) adequate professional liability insurance coverage for the clinical privileges requested;
- (e) the Hospital's available resources and personnel;
- (f) any previously successful or currently pending challenges to any licensure or registration, or the voluntary or involuntary relinquishment of such licensure or registration;

- (g) any information concerning professional review actions or voluntary or involuntary termination, limitation, reduction, or loss of appointment or clinical privileges at another hospital;
- (h) practitioner-specific data as compared to aggregate data, when available;
- (i) morbidity and mortality data, when available; and
- (j) professional liability actions, especially any such actions that reflect an unusual pattern or excessive number of actions.

4.B.2. Provisional Clinical Privileges:

- (a) All initial clinical privileges, regardless of when granted, will be provisional for a period of 12 months or longer, up to a maximum of 24 months, if recommended by the Credentials Committee.
- (b) During the provisional period, the individual's exercise of the provisional clinical privileges will be evaluated by the chair of the service line in which the individual has clinical privileges. The evaluation may include chart review, monitoring of the individual's practice patterns, proctoring, external review and information obtained from other practitioners.
- (c) During the provisional period, the individual must participate in the care of a sufficient number of patients so as to permit the Credentials Committee to evaluate the individual's competence to exercise the newly granted privilege(s), or those clinical privileges will be automatically relinquished.

4.C. TEMPORARY CLINICAL PRIVILEGES

4.C.1. Request for Temporary Clinical Privileges:

- (a) Temporary privileges may be granted by the President/CEO, upon recommendation of the Chief of Staff, when an Allied Health Professional has submitted a completed application and the application is pending review by the MEC and the Board, following a favorable recommendation of the Credentials Committee. Prior to temporary privileges being granted in this situation, the credentialing process must be complete, including, where applicable, verification of current licensure, relevant training or experience, current competence, ability to exercise the privileges requested, and compliance with criteria, and consideration of information from the National Practitioner Data Bank. In order to be eligible for temporary privileges, an individual must demonstrate that there are no current or previously successful challenges to his or her licensure or registration and that he or she has not been subject to involuntary termination of membership, or involuntary limitation, reduction, denial, or loss of scope of practice or clinical privileges, at another health care facility.

- (b) Prior to temporary privileges being granted, the individual must agree in writing to be bound by all applicable bylaws, rules and regulations, policies, procedures and protocols.
- (c) Temporary privileges shall be granted for a specific period of time, not to exceed 120 days, and shall expire at the end of the time period for which they are granted.

4.C.2. Termination of Temporary Clinical Privileges:

- (a) The President/CEO may, at any time after consulting with the Chief of Staff, the Chair of the Credentials Committee or the service line chair, terminate temporary privileges for any reason.
- (b) The granting of temporary privileges is a courtesy. Neither the denial nor termination of temporary privileges shall entitle the individual to the procedural rights set forth in Article 7.

4.D. PROCESSING APPLICATIONS FOR RENEWAL TO PRACTICE

4.D.1. Submission of Application:

- (a) The grant of a scope of practice or clinical privileges is a courtesy and, if granted, shall be for a period not to exceed two years. A request to renew a scope of practice or clinical privileges shall be considered only upon submission of a completed renewal application.
- (b) At least three months prior to the date of expiration of an Allied Health Professional's scope of practice or clinical privileges, the Medical Staff Office shall notify the individual of the date of expiration and provide the individual with a renewal application.
- (c) Failure to return a completed application at least two months prior to the expiration of the individual's scope of practice or clinical privileges shall result in automatic expiration of such scope of practice or clinical privileges at the end of the then current term.
- (d) Once an application for renewal of scope of practice or clinical privileges has been completed and submitted to the Medical Staff Office, it shall be evaluated following the same procedures outlined in this Policy regarding initial applications.

4.D.2. Renewal Process:

- (a) The procedures pertaining to an initial request for clinical privileges, including assessment of threshold eligibility criteria and factors for evaluation, as well as

the overall credentialing process set forth in Section 4.A shall be applicable in processing requests for renewal.

- (b) As part of the process for renewal of clinical privileges, the following factors shall be considered:
 - (1) an assessment prepared by the applicable service line chair;
 - (2) an assessment prepared by a peer or by a physician in the same overall discipline;
 - (3) results of the Hospital's performance improvement and peer review activities, taking into consideration, when applicable, practitioner-specific information concerning other individuals in the same or similar specialty (provided that, other practitioners shall not be identified);
 - (4) resolution of any verified complaints received from patients or staff; and
 - (5) any focused professional practice evaluations.
- (c) In addition to the above, for Category II Practitioners, the following information shall be considered:
 - (1) an assessment prepared by the Supervising Physician(s); and
 - (2) an assessment prepared by the applicable Hospital supervisor (i.e., OR Supervisor, Nursing Supervisor).

ARTICLE 5

CONDITIONS OF PRACTICE APPLICABLE TO CATEGORY II PRACTITIONERS

5.A. OVERSIGHT BY SUPERVISING PHYSICIAN

- (1) Category II practitioners may function in the Hospital only so long as they have a Supervising Physician.
- (2) Any activities permitted to be performed at the Hospital by a Category II practitioner shall be performed only under the supervision or direction of the Supervising Physician.
- (3) It shall be the responsibility of the Supervising Physician to countersign all medical record entries made by his or her Category II practitioner in accordance with applicable policies and rules and regulations.
- (4) If the Medical Staff appointment or clinical privileges of a Supervising Physician are resigned, revoked or terminated, the Category II practitioner's clinical privileges shall automatically terminate. The Credentials Committee may, however, recommend that the Category II practitioner be permitted to arrange for another Supervising Physician.
- (5) As a condition of clinical privileges, a Category II practitioner and the Supervising Physician must provide the Hospital with notice of any revisions or modifications that are made to the supervision agreement. This notice must be provided to the Credentials Committee at least one month prior to the effective date of the revision or modification.

5.B. QUESTIONS REGARDING THE AUTHORITY OF CATEGORY II PRACTITIONERS

- (1) Should any member of the Medical Staff, or any employee of the Hospital who is licensed or certified by the state, have a reasonable question regarding the clinical competence or authority of a Category II practitioner to act or issue instructions outside the presence of the Supervising Physician, such individual shall have the right to request that the Supervising Physician validate, either at the time or later, the instructions of the Category II practitioner. Any act or instruction of the Category II practitioner shall be delayed until such time as the individual with the question has ascertained that the act is clearly within the scope of practice granted to the individual.
- (2) Any question regarding the conduct of a Category II practitioner shall be reported to the Chief of Staff, the Chair of the Credentials Committee, the relevant service line chair, or the President/CEO for appropriate action. The individual to whom

the concern has been reported shall also discuss the matter with the Supervising Physician.

5.C. RESPONSIBILITIES OF SUPERVISING PHYSICIAN

- (1) The Supervising Physician shall remain responsible for all care provided by the Category II practitioner in the Hospital.
- (2) The number of Category II practitioners acting under the supervision of one Medical Staff member, as well as the care they may provide, shall be consistent with applicable state statutes and regulations and any other policies adopted by the Hospital. The Supervising Physician shall make all appropriate filings with the State Board of Medicine regarding the supervision and responsibilities of the Category II practitioner, to the extent that such filings are required.
- (3) It shall be the responsibility of the Supervising Physician to provide, or to arrange for, professional liability insurance coverage for the Category II practitioner in amounts required by the Board. The insurance must cover any and all activities of the Category II practitioner in the Hospital. The Supervising Physician shall furnish evidence of such coverage to the Hospital. The Category II practitioner shall act in the Hospital only while such coverage is in effect.

ARTICLE 6

PEER REVIEW PROCEDURES FOR QUESTIONS INVOLVING ALLIED HEALTH PROFESSIONALS

6.A. COLLEGIAL INTERVENTION

- (1) As part of the Hospital's performance improvement and professional and peer review activities, this Policy encourages the use of progressive steps by Medical Staff leaders and administration to arrive at voluntary, responsive actions by individuals to resolve questions that have been raised. Collegial intervention efforts are not mandatory and shall be within the discretion of the appropriate Medical Staff leaders.
- (2) Collegial efforts may include, but are not limited to, counseling, sharing of comparative data, monitoring, and additional training or education.
- (3) Collegial intervention is a part of ongoing and focused professional practice evaluation, performance improvement and peer review.
- (4) The Chief of Staff, in conjunction with the President/CEO, shall determine whether to direct that a matter be handled in accordance with another policy (e.g., policy on practitioner health, code of conduct policy, peer review policy) or to direct the matter to the Credentials Committee or the MEC for further review and/or investigation.

6.B. INVESTIGATIONS

6.B.1. Initiation of Investigation:

- (a) When a question involving clinical competence or professional conduct of an Allied Health Professional is referred to, or raised by, the MEC, the MEC will review the matter and determine whether to conduct an investigation or to direct the matter to be handled pursuant to another policy, or to proceed in another manner.
- (b) The Chief of Staff will keep the President/CEO fully informed of all action taken in connection with an investigation.

6.B.2. Investigative Procedure:

- (a) The MEC shall either investigate the matter itself or request that it be conducted by the Credentials Committee or appoint an individual or ad hoc committee to conduct the investigation ("investigating committee"). The investigating committee will not include relatives or financial partners of the Allied Health

Professional or the Allied Health Professional's Supervising Physician (where applicable).

- (b) The investigating committee will have the authority to review relevant documents and interview individuals. It will also have available to it the full resources of the Medical Staff and the Hospital.
- (c) The investigating committee will also have the authority to use outside consultants, if needed.
- (d) The investigating committee may require a physical and/or mental examination of the individual by a health care professional(s) acceptable to it.
- (e) The individual will have an opportunity to meet with the investigating committee before it makes its report. Prior to this meeting, the individual will be informed of the general questions being investigated. At the meeting, the individual will be invited to discuss, explain, or refute the questions that gave rise to the investigation. A summary of the interview will be prepared. This meeting is not a hearing, and none of the procedural rules for hearings will apply. The individual being investigated shall not have the right to be represented by legal counsel at this meeting.
- (f) The investigating committee will make a reasonable effort to complete the investigation and issue its report within 45 days of the commencement of the investigation, provided that an outside review is not necessary. When an outside review is necessary, the investigating committee will make a reasonable effort to complete the investigation and issue its report within 30 days of receiving the results of the outside review. These time frames are intended to serve only as guidelines.
- (g) At the conclusion of the investigation, the investigating committee will prepare a report with its findings, conclusions, and recommendations.

6.B.3. Recommendation:

- (a) The MEC may accept, modify, or reject any recommendation it receives from an investigating committee. Specifically, the MEC may:
 - (1) determine that no action is justified;
 - (2) issue a letter of guidance, counsel, warning, or reprimand;
 - (3) impose a requirement for monitoring or consultation;
 - (4) recommend additional training or education;

- (5) recommend reduction of clinical privileges or scope of practice;
 - (6) recommend suspension of clinical privileges or scope of practice for a term;
 - (7) recommend revocation of clinical privileges or scope of practice; or
 - (8) make any other recommendation that it deems necessary or appropriate.
- (b) A recommendation by the MEC or Board that would entitle the individual to request a hearing will be forwarded to the President/CEO, who will promptly inform the individual by special notice. The President/CEO will hold the recommendation until after the individual has completed or waived a hearing and appeal.
 - (c) If the MEC makes a recommendation that does not entitle the individual to request a hearing, it will take effect immediately and will remain in effect unless modified by the Board.
 - (d) When applicable, any recommendations or actions that are the result of an investigation or hearing and appeal will be monitored by Medical Staff leaders on an ongoing basis through the Hospital's performance improvement activities or pursuant to the applicable policies regarding conduct, as appropriate.

6.C. ADMINISTRATIVE SUSPENSION

- (1) The President/CEO, the Chief of Staff, and/or the appropriate service line chair shall each have the authority to impose an administrative suspension of all or any portion of the scope of practice or clinical privileges of any Allied Health Professional whenever a question has been raised about such individual's clinical care or professional conduct.
- (2) An administrative suspension shall become effective immediately upon imposition, shall immediately be reported in writing to the President/CEO and the Chief of Staff, and shall remain in effect unless or until modified by the President/CEO or MEC. The imposition of an administrative suspension does not entitle an Allied Health Professional to the procedural rights set forth in Article 7 of this Policy.
- (3) Upon receipt of notice of the imposition of an administrative suspension, the President/CEO and Chief of Staff shall forward the matter to the MEC which shall review and consider the question(s) raised and thereafter make a recommendation to the Board.

6.D. AUTOMATIC RELINQUISHMENT OF CLINICAL PRIVILEGES

- (1) The clinical privileges of an Allied Health Professional shall be automatically relinquished, without entitlement to the procedural rights outlined in this Policy, in the following circumstances:
 - (a) the Allied Health Professional no longer satisfies any of the threshold eligibility criteria set forth in Section 3.A.1 or any additional threshold credentialing qualifications set forth in the specific Hospital policy relating to his or her discipline;
 - (b) the Allied Health Professional is indicted for any felony, or any misdemeanor involving (i) controlled substances; (ii) illegal drugs; (iii) Medicare, Medicaid, or insurance or health care fraud or abuse; or (iv) violence against another;
 - (c) the Allied Health Professional fails to provide information pertaining to his or her qualifications for the scope of practice or clinical privileges, in response to a written request from the Credentials Committee, the MEC, the President/CEO, or any other committee authorized to request such information;
 - (d) a determination is made that there is no longer a need for the services of a particular discipline or category of Allied Health Professional; or
 - (e) the Category II practitioner fails, for any reason, to maintain an appropriate supervision relationship with a Supervising Physician as defined in this Policy.
- (2) Requests for reinstatement shall be reviewed by the relevant service line chair, the Chair of the Credentials Committee, the Chief of Staff, and the President/CEO. If all these individuals make a favorable recommendation on reinstatement, the Allied Health Professional may immediately resume clinical practice at the Hospital. This determination shall then be forwarded to the Credentials Committee, MEC, and the Board for ratification. If, however, any of the individuals reviewing the request have any questions or concerns, those questions shall be noted and the reinstatement request shall be forwarded to the full Credentials Committee, MEC, and Board for review and recommendation.

6.E. LEAVE OF ABSENCE

- (1) An Allied Health Professional may request a leave of absence, for a period not to exceed a year, by submitting a written request to the MEC which shall forward the request and any recommendations to the President/CEO. After consulting with the Chief of Staff, the President/CEO shall determine whether to grant a

request for a leave of absence. Requests for reinstatement must be made at least 30 days prior to the conclusion of the leave of absence.

- (2) If the leave of absence was for health reasons (except for maternity leaves), the request for reinstatement must be accompanied by a report from the individual's physician indicating that the individual is physically and/or mentally capable of resuming a hospital practice and safely exercising the scope of practice or clinical privileges requested.
- (3) Absence for longer than one year shall result in automatic relinquishment of scope of practice or clinical privileges unless an extension is granted by the President/CEO, in consultation with the Chief of Staff. Extensions shall be considered only in extraordinary cases where the extension of a leave is in the best interest of the Hospital.
- (4) Individuals requesting reinstatement shall submit a written summary of their professional activities during the leave, and any other information that may be requested by the Hospital. Requests for reinstatement shall then be reviewed by the relevant service line chair, the Chair of the Credentials Committee, the Chief of Staff, and the President/CEO. If all these individuals make a favorable recommendation on reinstatement, the Allied Health Professional may immediately resume practice. This determination shall then be forwarded to the Credentials Committee, the MEC, and the Board for ratification. If, however, any of the individuals reviewing the request have any questions or concerns, those questions shall be noted and the reinstatement request shall be forwarded to the full Credentials Committee, MEC, and Board for review and recommendation. In the event the MEC determines to take action that would entitle the individual to the procedural rights set forth in Article 7, the individual shall be given special notice.

ARTICLE 7

PROCEDURAL RIGHTS OF ALLIED HEALTH PROFESSIONALS

Allied Health Professionals shall not be entitled to the hearing and appeals procedures set forth in the Medical Staff Credentials Policy. Any and all rights to which Allied Health Professionals are entitled are set forth in this Policy.

7.A. NOTICE OF RECOMMENDATION AND HEARING RIGHTS

- (1) In the event a recommendation is made by the MEC that an Allied Health Professional not be granted clinical privileges or that the privileges previously granted be restricted for a period of more than 30 days, terminated or not renewed, the individual shall receive special notice of the recommendation. The special notice shall include a general statement of the reasons for the recommendation and shall advise the individual that he or she may request a hearing.
- (2) The rights and procedures in this Section shall also apply if the Board, without a prior adverse recommendation from the MEC, makes a recommendation not to grant clinical privileges or that the privileges previously granted be restricted, terminated or not renewed. In this instance, all references in this Article to the MEC shall be interpreted as a reference to the Board.
- (3) If the Allied Health Professional wants to request a hearing, the request must be in writing, directed to the President/CEO, within 30 days after receipt of written notice of the adverse recommendation.
- (4) The hearing shall be convened as soon as is practical, but no sooner than 30 days after the notice of the hearing, unless an earlier hearing date has been specifically agreed to by the parties.

7.B. HEARING COMMITTEE

- (1) If a request for a hearing is timely made, the President/CEO, in consultation with the Chief of Staff, shall appoint a Hearing Committee composed of up to three individuals (including, but not limited to, members of the Medical Staff, Allied Health Professionals, Hospital management, individuals not connected with the Hospital, or any combination of these individuals). The Hearing Committee shall not include anyone who previously participated in the recommendation, any relatives or practice partners of the Allied Health Professional, or any competitors of the affected individual.
- (2) The President/CEO, in consultation with the Chief of Staff, shall appoint a Presiding Officer ("Presiding Officer"), who may be legal counsel to the Hospital.

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

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

7.C. HEARING PROCESS

- (1) A record of the hearing shall be maintained by a stenographic reporter or by a recording of the proceedings. Copies of the transcript shall be available at the individual's expense.
- (2) The hearing shall last no more than six hours, with each side being afforded approximately three hours to present its case, in terms of both direct and cross-examination of witnesses.
- (3) At the hearing, a representative of the MEC shall first present the reasons for the recommendation. The Allied Health Professional shall be invited to present information to refute the reasons for the recommendation.
- (4) Both parties shall have the right to present witnesses. The Presiding Officer shall permit reasonable questioning of such witnesses.
- (5) The Allied Health Professional and the MEC may be represented at the hearing by legal counsel. However, while counsel may be present at the hearing, counsel shall not call, examine, or cross-examine witnesses or present the case.
- (6) The Allied Health Professional shall have the burden of demonstrating, by clear and convincing evidence, that the recommendation of the MEC was arbitrary, capricious or not supported by substantial evidence. The quality of care provided to patients and the smooth operation of the Hospital shall be the paramount considerations.
- (7) The Allied Health Professional and the MEC shall have the right to prepare a post-hearing memorandum for consideration by the Hearing Committee. The

Presiding Officer shall establish a reasonable schedule for the submission of such memoranda.

7.D. HEARING COMMITTEE REPORT

- (1) Within 20 days after the conclusion of the proceeding or submission of the post-hearing memoranda, whichever date is later, the Hearing Committee shall prepare a written report and recommendation. The Hearing Committee shall forward the report and recommendation, along with all supporting information, to the President/CEO. The President/CEO shall send a copy of the written report and recommendation by special notice to the Allied Health Professional and the MEC for information.
- (2) Within ten days after notice of such recommendation, the Allied Health Professional and/or the MEC may make a written request for an appeal. The request must include a statement of the reasons, including specific facts, which justify an appeal.
- (3) The grounds for appeal shall be limited to an assertion that there was substantial failure to comply with this Policy and/or other applicable bylaws or policies of the Hospital and/or that the recommendation was arbitrary, capricious or not supported by substantial evidence.
- (4) The request for an appeal shall be delivered to the President/CEO by special notice.
- (5) If a written request for appeal is not timely submitted, the appeal is deemed to be waived and the recommendation and supporting information shall be forwarded to the Board for final action. If a timely request for appeal is submitted, the President/CEO shall forward the report and recommendation, the supporting information and the request for appeal to the Board. The Chair of the Board shall arrange for an appeal.

7.E. APPELLATE REVIEW

- (1) An Appellate Review Committee appointed by the Chair of the Board shall consider the record upon which the adverse recommendation was made. New or additional written information that is relevant and could not have been made available to the Hearing Committee may be considered at the discretion of the Appellate Review Committee. This review shall be conducted within 30 days after receiving the request for appeal.
- (2) The Allied Health Professional and the MEC shall each have the right to present a written statement on appeal.

- (3) At the sole discretion of the Appellate Review Committee, the Allied Health Professional and a representative of the MEC may also appear personally to discuss their position.
- (4) Upon completion of the review, the Appellate Review Committee shall provide a report and recommendation to the full Board for action. The Board shall then make its final decision based upon the Board's ultimate legal responsibility to grant privileges and to authorize the performance of clinical activities at the Hospital.
- (5) The Allied Health Professional shall receive special notice of the Board's action. A copy of the Board's final action shall also be sent to the MEC for information.

ARTICLE 8

HOSPITAL EMPLOYEES

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

- B. A request for clinical privileges, on an initial basis or for renewal, submitted by a Category I or Category II practitioner who is seeking employment or who is employed by the Hospital, shall be processed in accordance with the credentialing process set forth in Article 4 of this Policy. At the conclusion of the credentialing process, a report regarding each practitioner's qualifications shall be made to Administration or Human Resources (as appropriate) to assist the Hospital in making employment decisions.

- C. If a concern about an employed Allied Health Professional's clinical conduct or competence originates with the Medical Staff, the concern will be reviewed and addressed in accordance with Articles 6 and 7 of this Policy, after which a report will be provided to Human Resources.

ARTICLE 9

AMENDMENTS

This Policy may be amended by a majority vote of the members of the MEC present and voting at any meeting of that committee where a quorum exists, provided that the written recommendations of the Credentials Committee concerning the proposed amendments shall have first been received and reviewed by the MEC. Notice of all proposed amendments shall also be provided to all members of the Medical Staff at least 14 days prior to the MEC meeting and any member of the Medical Staff may submit written comments to the MEC. No amendment shall be effective unless and until it has been approved by the Board.

ADOPTION

This Allied Health Professionals Policy is adopted, and made effective as of October 1, 2009, upon approval of the Board, superseding and replacing any and all other bylaws, rules, regulations, policies, or manuals pertaining to the subject matter thereof.

Adopted by the Medical Staff on July 16, 2009:

Chief of Staff

Approved by the Board on July 28, 2009:

Chair, Board of Directors

Revision Dates:

APPENDIX A

Those Allied Health Professionals currently practicing as Category I Practitioners at Randolph Hospital are as follows:

Audiologists

Clinical Counselors (PhD)

Clinical Psychologists (PhD)

Speech Therapists

APPENDIX B

Those Allied Health Professionals currently practicing as Category II Practitioners at Randolph Hospital are as follows:

Certified Registered Nurse Anesthetists

Certified Registered Nurse Practitioners

Physician Assistants

Physicians Providing Limited Services (i.e., moonlighting residents)

APPENDIX C

Those Allied Health Professionals currently practicing as Category III Practitioners at Randolph Hospital are employed by members of the Medical Staff and are as follows:

Medical Assistants

Physician Employed LPNs

Physician Employed RNs

Psychologists

Scrub Techs

Surgical First Assistants