

**MEDICAL STAFF BYLAWS, POLICIES, AND
RULES AND REGULATIONS
OF
UPMC PINNACLE HOSPITALS (Harrisburg, West
Shore and Community Osteopathic)**

MEDICAL STAFF CREDENTIALS POLICY

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ARTICLE 1

GENERAL

1.A. DEFINITIONS

The following definitions shall apply to terms used in this Policy:

- (1) "ALLIED HEALTH PROFESSIONALS" ("AHPs") means individuals other than Medical Staff members who are authorized by law and by the Hospital to provide patient care services within the Hospital.
- (2) "BOARD" means the Board of Trustees of the Hospital, which has the overall authority for the Hospital, or its designated committee.
- (3) "CHIEF EXECUTIVE OFFICER" means the individual appointed by the Board to act on its behalf in the overall management of the Hospital.
- (4) "CLINICAL PRIVILEGES" or "PRIVILEGES" means the authorization granted by the Board to render specific patient care services, for which the Medical Staff Leaders and Board have developed eligibility and other credentialing criteria and focused and ongoing professional practice evaluation standards.
- (5) "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.
- (6) "DAYS" means calendar days.
- (7) "DENTIST" means a doctor of dental surgery ("D.D.S."), doctor of dental medicine ("D.M.D.") or oral and maxillofacial surgeon.
- (8) "HOSPITAL" means the UPMC Pinnacle Hospitals - Harrisburg, West Shore and Community Osteopathic Hospitals.
- (9) "MEDICAL EXECUTIVE COMMITTEE" means the Executive Committee of the Medical Staff.
- (10) "MEDICAL STAFF" means all physicians, dentists, and podiatrists who have been appointed to the Medical Staff by the Board.

- (11) "MEDICAL STAFF LEADER" means any Medical Staff Officer, department chair, or committee chair.
- (12) "MEMBER" means any physician, dentist and podiatrist who has been granted Medical Staff appointment by the Board.
- (13) "NOTICE" means written communication by regular U.S. mail, e-mail, facsimile, website, Hospital mail, hand delivery, or other electronic method.
- (14) "ORAL AND MAXILLOFACIAL SURGEON" means an individual with a D.D.S. or a D.M.D. degree, who has completed an accredited residency in oral and maxillofacial surgery and is fully licensed in the Commonwealth of Pennsylvania to practice oral and maxillofacial surgery in all its phases.
- (15) "ORGANIZED HEALTH CARE ARRANGEMENT" ("OHCA") means the term used by the HIPAA Privacy Rule which permits the Hospital and Medical Staff to use joint notice of privacy practices information when patients are admitted to the Hospital. Practically speaking, being part of an OHCA allows the members of the Medical Staff to rely upon the Hospital notice of privacy practices and therefore relieves Medical Staff members of their responsibility to provide a separate notice when members consult or otherwise treat Hospital inpatients.
- (16) "PATIENT CONTACTS" includes any admission, 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 x-rays.
- (17) "PERMISSION TO PRACTICE" means the authorization granted to Allied Health Professionals to exercise clinical privileges or a scope of practice.
- (18) "PHYSICIAN" includes both doctors of medicine ("M.D.s") and doctors of osteopathy ("D.O.s").
- (19) "PODIATRIST" means a doctor of podiatric medicine ("D.P.M.").
- (20) "SCOPE OF PRACTICE" means the authorization granted to an Allied Health Professional to perform certain clinical activities and functions under the supervision of, or in collaboration with, a Supervising Physician.
- (21) "VICE PRESIDENT OF MEDICAL AFFAIRS" means the individual who has been appointed to act as the chief administrative officer of the Medical Staff.
- (22) "SPECIAL NOTICE" means hand delivery, certified mail (return receipt requested), or overnight delivery service providing receipt.

- (23) "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.
- (24) "SUPERVISING PHYSICIAN" means a member of the Medical Staff with clinical privileges, who has agreed in writing to supervise or collaborate with an AHP and to accept full responsibility for the actions of the AHP while he or she is practicing.
- (25) "SUPERVISION" means the supervision of (or collaboration with) an AHP 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, direct, or personal) shall be determined at the time each AHP is credentialed and shall be consistent with any applicable written supervision or collaboration agreement that may exist. ("General" supervision means that the physician is immediately available by phone, "direct" supervision means that the physician is on the Hospital's campus, and "personal" supervision means that the physician is in the same room.)
- (26) "TELEMEDICINE" means the exchange of medical information from one site to another via electronic communications for the purpose of providing patient care, treatment, and services.
- (27) "UNASSIGNED PATIENT" means any individual who comes to the Hospital for care and treatment 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) When a function is to be carried out by a member of Hospital management, by a Medical Staff member, or by a Medical Staff committee, the individual, or the committee through its chair, may delegate performance of the function to one (1) or more designees.

- (2) When a Medical Staff member is unavailable or unable to perform an assigned function, one (1) or more of the Medical Staff Leaders may perform the function personally or delegate it to another appropriate individual.

ARTICLE 2

QUALIFICATIONS, CONDITIONS, AND RESPONSIBILITIES

2.A. QUALIFICATIONS

2.A.1. Threshold Eligibility Criteria:

To be eligible to apply for initial appointment or reappointment to the Medical Staff, physicians, dentists, and podiatrists must:

- (a) have a current, unrestricted license to practice in Pennsylvania;
- (b) where applicable to their practice, have a current, unrestricted DEA registration, or a DEA Waiver;
- (c) be located (office and residence) close enough to fulfill their Medical Staff responsibilities and to provide timely and continuous care for their patients in the Hospital;
- (d) be available on a continuous basis, either personally or by arranging appropriate coverage, to respond to the needs of inpatients and Emergency Department patients in a prompt, efficient, and conscientious manner. (“Appropriate coverage” means coverage by another member of the Medical Staff with appropriate specialty-specific privileges as determined by the Credentials Committee.) Compliance with this eligibility requirement means that the practitioner must document that he or she is willing and able to:
 - (1) respond within fifteen (15) minutes, via phone, to an initial STAT page from the Hospital and respond within thirty (30) minutes, via phone, to all other initial pages; and
 - (2) appear in person to attend to a patient within forty-five (45) minutes of being requested to do so (or more quickly based upon (i) the acute nature of the patient’s condition or (ii) as required for a particular specialty as recommended by the Medical Executive Committee and approved by the Board);
- (e) have current, valid professional liability insurance coverage in a form and in amounts satisfactory to the Hospital;
- (f) 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, nor have been required to pay civil monetary penalties for the same;

- (g) have never been, and are not currently, excluded, precluded, or debarred from participation in Medicare, Medicaid, or other federal or state governmental health care program;
- (h) have never had Medical Staff appointment or clinical privileges denied, revoked, or terminated by any health care facility or health plan for reasons related to clinical competence or professional conduct;
- (i) have never resigned Medical Staff appointment or relinquished privileges during a Medical Staff investigation or in exchange for not conducting such an investigation;
- (j) have never been convicted of, or entered a plea of guilty or no contest, to any felony; or to any misdemeanor relating to controlled substances, illegal drugs, insurance or health care fraud or abuse, child abuse, elder abuse, or violence;
- (k) if applying for Active, Active Community or Allied Health privileges, demonstrate compliance with the Pennsylvania Child Protective Services Law criminal and child abuse history certifications (the Hospital will facilitate initial compliance for all Active or Active Community Staff or Allied Health members as of October 2015 but it shall be the responsibility of the applicant for initial appointment or reappointment thereafter);
- (l) agree to personally fulfill all responsibilities regarding emergency service call coverage for their specialty or to obtain appropriate coverage by another member of the Medical Staff;
- (m) have or agree to make appropriate coverage arrangements (as determined by the Credentials Committee) with other members of the Medical Staff for those times when the individual will be unavailable;
- (n) demonstrate recent clinical activity in their primary area of practice during the last two (2) years;
- (o) meet any current or future eligibility requirements that are applicable to the clinical privileges being sought;
- (p) if applying for privileges in an area that is covered by an exclusive contract, meet the specific requirements set forth in that contract;
- (q) document compliance with all applicable training and/or educational protocols that may be adopted by the Medical Executive Committee and/or required by the Hospital, including, but not limited to, those involving electronic medical records, patient safety, and infection control;

- (r) any practitioner that is seventy (70) years of age or older at both initial and reappointment complete a clinical skills assessment per the Late Career Practitioner Policy
- (s) have successfully completed:*
 - (1) a residency or fellowship training program approved by the Accreditation Counsel for Graduate Medical Education (“ACGME”) or the American Osteopathic Association (“AOA”) in the specialty in which the applicant seeks clinical privileges;
 - (2) a dental or an oral and maxillofacial surgery training program accredited by the Commission on Dental Accreditation of the American Dental Association (“ADA”); or
 - (3) a podiatric surgical residency program accredited by the Council on Podiatric Medical Education of the American Podiatric Medical Association;
- (s) be certified in their primary area of practice at the Hospital by the appropriate specialty/subspecialty board of the American Board of Medical Specialties (“ABMS”), the AOA, the American Board of Oral and Maxillofacial Surgery, the ADA, American Board of Podiatric Medicine, American Board of Podiatric Orthopedics and Primary Podiatric Medicine (ABPOPPM) or the American Board of Foot and Ankle Surgery, as applicable. Those applicants who are not board certified at the time of application but who have completed their residency or fellowship training within the last five years shall be eligible for Medical Staff appointment. However, in order to remain eligible, those applicants must achieve board certification in their primary area of practice within five years from the date of completion of their residency or fellowship training;* and
- (t) maintain board certification and, to the extent required by the applicable specialty/subspecialty board, satisfy recertification requirements. Recertification shall be assessed at reappointment.*

* These requirements are applicable to those individuals who apply for initial staff appointment after January 1, 2010. These requirements are not applicable to Medical Staff members who were appointed prior to that date provided that Medical Staff members who were board certified as of January 1, 2010 shall be required to maintain board certification. Those Medical Staff members shall be grandfathered and shall be governed by the residency and board certification requirements in effect at the time of their initial appointments.

- (u) any provider who does not pass their board recertification or allows it to lapse may be granted an extension of membership and/or privileges. The practitioner must submit a formal request that includes; the date the boards will be retaken and why the boards lapsed or were not passed. A recommendation from the department chair supporting why the request is required, then the Credentialing Committee will review and provide a

recommendation to the Medical Executive Committee, and the Medical Executive Committee will review and provide a recommendation to the Board. Formal approval and acceptance by the Board is required to grant the extension. The physician must submit documentation noting the next scheduled board certification date and their intent to sit for the exam. The extension will be granted through the next board certification exam date with an additional ninety (90) days after the exam to allow for reverification of board certification. Failure to recertify will result in automatic relinquishment of membership and/or privileges for failure to meet certification criteria.

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

- (a) Any applicant who does not satisfy one or more of the threshold eligibility criteria outlined above may request that it be waived. The applicant requesting the waiver bears the burden of demonstrating **exceptional** circumstances, and that his or her qualifications are equivalent to, or exceed, the criterion in question.
- (b) A request for a waiver shall be submitted to the Credentials Committee for consideration. In reviewing the request for a waiver, the Credentials Committee may consider the specific qualifications of the applicant in question, input from the relevant department chair, and the best interests of the Hospital and the communities it serves. Additionally, the Credentials Committee may, in its discretion, consider the application form and other information supplied by the applicant. The Credentials Committee's recommendation will be forwarded to the Medical Executive Committee. Any recommendation to grant a waiver must include the specific basis for the recommendation.
- (c) The Medical Executive Committee shall review the recommendation of the Credentials Committee and make a recommendation to the Board regarding whether to grant or deny the request for a waiver. Any recommendation to grant a waiver must include the specific basis for the recommendation.
- (d) No applicant is entitled to a waiver or to a hearing if the Board determines not to grant a waiver. A determination that an applicant is not entitled to a waiver is not a "denial" of appointment or clinical privileges. Rather, that individual is ineligible to request appointment or clinical privileges. A determination of ineligibility is not a matter that is reportable to the Pennsylvania licensure board or the National Practitioner Data Bank.
- (e) The granting of a waiver in a particular case is not intended to set a precedent for any other applicant or group of applicants.
- (f) An application for appointment that does not satisfy an eligibility criterion will not be processed until the Board has determined that a waiver should be granted.

2.A.3. Factors for Evaluation:

The six ACGME general competencies (patient care, medical knowledge, professionalism, system-based practice, practice-based learning, and interpersonal communications) will be evaluated as part of the appointment and reappointment processes, as reflected in the following factors:

- (a) relevant training, experience, and demonstrated current competence, including medical/clinical knowledge, technical and clinical skills, and 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 and their profession;
- (c) good reputation and character;
- (d) ability to safely and competently perform the clinical privileges requested;
- (e) ability to work harmoniously with others, including, but not limited to, interpersonal and communication skills sufficient to enable them to maintain professional relationships with patients, families, and other members of health care teams; and
- (f) recognition of the importance of, and willingness to support, the Hospital's and Medical Staff's commitment to quality care and a recognition that interpersonal skills and collegiality are essential to the provision of quality patient care.

2.A.4. No Entitlement to Appointment:

No individual is entitled to receive an application or to be appointed or reappointed to the Medical Staff or to be granted particular clinical privileges merely because he or she:

- (a) is employed by the Hospital or its subsidiaries or has a contract with the Hospital;
- (b) is or is not a member or employee of any particular physician group;
- (c) is licensed to practice a profession in this or any other state;
- (d) is a member of any particular professional organization;
- (e) has had in the past, or currently has, Medical Staff appointment or privileges at any hospital or health care facility;
- (f) resides in the geographic service area of the Hospital; or
- (g) is affiliated with, or under contract to, any managed care plan, insurance plan, HMO, PPO, or other entity.

2.A.5. Nondiscrimination:

No individual shall be denied appointment or reappointment on the basis of age, sex, race, creed, or national origin.

2.B. GENERAL CONDITIONS OF APPOINTMENT AND REAPPOINTMENT

2.B.1. Basic Responsibilities and Requirements:

As a condition of being granted appointment or reappointment, and as a condition of ongoing membership, every member specifically agrees to the following:

- (a) to provide continuous and timely quality care to all patients for whom the individual has responsibility, which shall include rounding daily on all inpatients for whom an individual Medical Staff member is the designated attending physician;
- (b) to abide by all Bylaws, policies, and Rules and Regulations of the Hospital and Medical;
- (c) to participate in Medical Staff affairs through committee service, participation in quality improvement and professional practice evaluation activities, and by performing such other reasonable duties and responsibilities as may be assigned;
- (d) within the scope of his or her privileges, to provide emergency service call coverage, consultations, and care for unassigned patients (a member must complete all scheduled emergency service call obligations or arrange appropriate coverage);
- (e) to comply with clinical practice or evidence-based protocols and pathways that are established by, and must be reported to, regulatory or accrediting agencies or patient safety organizations, including those related to national patient safety initiatives and core measures, or clearly document the clinical reasons for variance;
- (f) to comply with clinical practice or evidence-based protocols and pathways pertinent to his or her medical specialty, as may be adopted by the Medical Staff or the Medical Staff leadership, or to clearly document the clinical reasons for variance;
- (g) notify the Vice President Medical Affairs, Department Chair or the President of the Medical Staff, in writing, of any change in the practitioner's status or any change in the information provided on the individual's application form. This information shall be provided with or without request, at the time the change occurs, and shall include, but not be limited to:
 - (1) any and all complaints regarding, or changes in, licensure status or DEA controlled substance authorization;

- (2) loss of professional liability insurance coverage;
 - (3) changes in the practitioner's Medical Staff status (appointment and/or privileges) at any other hospital or health care entity as a result of peer review activities or in order to avoid initiation of peer review activities;
 - (4) arrest, charge, indictment, conviction, or a plea of guilty or no contest in any criminal matter other than a misdemeanor traffic citation;
 - (5) exclusion or preclusion from participation in Medicare/Medicaid or any sanctions imposed;
 - (6) any changes in the practitioner's ability to safely and competently exercise clinical privileges or perform the duties and responsibilities of appointment because of health status issues, including, but not limited to, impairment due to addiction, alcohol use, or other similar issue (all of which shall be referred for review under Appendix F); and
 - (7) any charge of, or arrest for, driving under the influence ("DUI") (Any DUI incident will be reviewed by the President of the Medical Staff and the Vice President Medical Affairs so that they may understand the circumstances surrounding it. If they have any concerns after doing so, they will forward the matter for further review under this Credentials Policy.);
- (h) to immediately submit to an appropriate evaluation, which may include diagnostic testing (such as a blood and/or urine test) and/or a complete physical, mental, and/or behavioral evaluation, if at least two Medical Staff Leaders (or one Medical Staff Leader and one member of the Administrative team) are concerned with the individual's ability to safely and competently care for patients. The health care professional(s) to perform the testing and/or evaluations shall be determined by the Medical Staff Leaders and the Medical Staff member must execute all appropriate releases to permit the sharing of information with the Medical Staff Leaders
 - (i) to appear for personal or phone interviews in regard to an application for initial appointment or reappointment, if requested;
 - (j) to maintain a current e-mail address with Physician & Practitioner Services, which will be the official mechanism used to communicate all Medical Staff information to the member other than peer review information pertaining to the member and/or protected health information of patients (this e-mail address will not be shared by the Hospital; also, this provision (j) shall not be interpreted to limit the ability of Medical Staff Leaders to utilize confidential e-mail to communicate about ongoing peer review matters among and between themselves);

- (k) to refrain from illegal fee splitting or other illegal inducements relating to patient referral;
- (l) to refrain from delegating responsibility for hospitalized patients to any individual who is not qualified or adequately supervised;
- (m) to refrain from deceiving patients as to the identity of any individual providing treatment or services;
- (n) to seek consultation whenever required or necessary;
- (o) to complete in a timely and legible manner all medical and other required records, containing all information required by the Hospital;
- (p) to cooperate with all utilization oversight activities;
- (q) to perform all services and conduct himself/herself at all times in a cooperative and professional manner;
- (r) to promptly pay any applicable dues, assessments, and/or fines;
- (s) to comply with all applicable training and/or educational protocols that may be adopted by the Medical Executive Committee and/or required by the Hospital, including, but not limited to, those involving electronic medical records, patient safety, and infection control;
- (t) to satisfy continuing medical education requirements; and
- (u) that, if there is any misstatement in, or omission from, the application, the Hospital may stop processing the application (or, if appointment has been granted prior to the discovery of a misstatement or omission, appointment and privileges may be deemed to be automatically relinquished). In either situation, there shall be no entitlement to a hearing or appeal. The individual will be informed in writing of the nature of the misstatement or omission and permitted to provide a written response for the Credentials Committee's consideration.

2.B.2. Burden of Providing Information:

- (a) Individuals seeking appointment and reappointment 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 an individual's qualifications. The information to be produced includes such quality data and other information as may be needed to assist in an appropriate assessment of overall qualifications for appointment, reappointment, and current clinical competence for any requested clinical privileges, including, but not limited to, information from other hospitals, information from the individual's office practice,

information from insurers or managed care organizations in which the individual participates, and/or receipt of confidential evaluation forms completed by referring/referred to physicians.

- (b) Individuals seeking appointment and reappointment have the burden of providing evidence that all the statements made and information given on the application are accurate and complete.
- (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 need arises for new, additional, or clarifying information at any time during the credentialing process. Any application that continues to be incomplete one hundred and twenty (120) days after the individual has been notified of the additional information required shall be deemed to be withdrawn.
- (d) The individual seeking appointment or reappointment is responsible for providing a complete application, including adequate responses from references. An incomplete application shall not be processed.

2.C. APPLICATION

2.C.1. Information:

- (a) Applications for appointment and reappointment shall contain a request for specific clinical privileges and shall require detailed information concerning the individual's professional qualifications. The applications for initial appointment and reappointment existing now and as may be revised are incorporated by reference and made a part of this Policy.
- (b) In addition to other information, the applications shall seek the following:
 - (1) information as to whether the applicant's medical staff appointment or clinical privileges have been voluntarily or involuntarily relinquished, withdrawn, denied, revoked, suspended, subjected to probationary or other conditions, reduced, limited, terminated, or not renewed at any other hospital, health care facility, or other organization, or are currently being investigated or challenged;
 - (2) information as to whether the applicant's license to practice any relevant profession in any state, DEA registration, or any state's controlled substance license has been voluntarily or involuntarily suspended, modified, terminated, restricted, or relinquished 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; the substance of the allegations as well as the findings and the ultimate disposition; and any additional information concerning such proceedings or actions included in the information from the National Practitioner Data Bank as the Credentials Committee, the Medical Executive Committee, or the Board may request;
- (4) current information regarding the applicant's ability to safely and competently exercise the clinical privileges requested; and
- (5) a copy of a government-issued photo identification.
- (6) verification of current and prior affiliations for the past ten (10) years, or longer, if deemed necessary.
- (7) copies of FBI fingerprint clearance, Pennsylvania State Police Background Check and the Child Abuse Clearance. Clearances performed within the last one (1) year will be accepted. Employed providers will have their clearances completed in conjunction with the Human Resource employment policy. Independent providers will complete the clearances independently. Renewal of clearances must be completed within the last five (5) years. All providers are required to have the FBI fingerprint clearance, Pennsylvania State Police Background Check and the Child Abuse Clearances completed every five (5) years and submit results to either Human Resources or the Medical Staff Office. Failure to comply will result in automatic suspension until the clearances and results are submitted.
- (8) All individuals applying for initial clinical privileges at a UPMC facility must show evidence of TB screening (e.g. negative TB skin testing, IGRA and/or chest x-ray if indicated). If the applicant is currently on staff at another UPMC facility without any break in service history, additional TB screenings will not be required unless evidence of initial TB screening is not on file.

Failure to complete the initial PPD testing requirement shall result in an incomplete application. Subsequent PPD screening and ongoing surveillance will be carried out in accordance with the UPMC System Policy (HS-IC0611-Tuberculosis Exposure Control Plan, XII Healthcare Worked TB Screening).

- (c) The applicant shall sign the application and certify that he or she is able to perform the privileges requested and the responsibilities of appointment.

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

By requesting an application and/or applying for appointment, reappointment, or clinical privileges, the individual expressly accepts the conditions set forth in this Section

(a) Immunity:

To the fullest extent permitted by law, the individual releases from any and all liability, extends immunity to, and agrees not to sue the Hospital 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 appointment, reappointment, clinical privileges, or the individual's qualifications for the same. This immunity covers any actions, recommendations, reports, statements, communications, and/or disclosures involving the individual that are made, taken, or received by the Hospital, its authorized agents, or third parties in the course of credentialing and peer review activities.

(b) Authorization to Obtain Information from Third Parties:

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

(c) Authorization to Release Information to Third Parties:

The individual also authorizes Hospital representatives to release information to other hospitals, health care facilities, managed care organizations, government regulatory and licensure boards or agencies, and their agents when information is requested in order to evaluate his or her professional qualifications for appointment, privileges, and/or participation at the requesting organization/facility, and any licensure or regulatory matter.

(d) Authorization to Share Information within UPMC Pinnacle Hospitals:

The individual specifically authorizes all of the Hospitals within UPMC Pinnacle Hospitals or a successor health system to share credentialing and peer review information pertaining to the individual's clinical competence and/or professional conduct. This

information may be shared at initial appointment, reappointment, and/or any other time during the individual's appointment.

(e) Hearing and Appeal Procedures:

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

(f) Scope of Section:

All of the provisions in this Section 2.C.2 are applicable in the following situations:

- (1) whether or not appointment or clinical privileges are granted;
- (2) throughout the term of any appointment or reappointment period and thereafter;
- (3) should appointment, reappointment, or clinical privileges be revoked, reduced, restricted, suspended, and/or otherwise affected as part of the Hospital's professional review activities; and
- (4) as applicable, to any third-party inquiries received after the individual leaves the Medical Staff about his/her tenure as a member of the Medical Staff.

ARTICLE 3

PROCEDURE FOR INITIAL APPOINTMENT

3.A. PROCEDURE FOR INITIAL APPOINTMENT

3.A.1. Request for Application:

- (a) Applications for appointment shall be submitted on forms approved by the Board, upon recommendation by the Medical Executive Committee and Credentials Committee.
- (b) An individual seeking initial appointment will be sent a letter that:
 - (i) outlines the threshold eligibility criteria for appointment outlined earlier in this Policy,
 - (ii) outlines the applicable criteria for the clinical privileges being sought, and
 - (iii) a checklist of required items including but not limited to; copies of current or most recent professional liability face sheet, supervising/collaborating agreement and prescriptive authority application.
- (c) Applications may be provided to residents or fellows who are in the final six (6) months of their training. Such applications may be processed, but final action shall not be taken until all applicable threshold eligibility criteria are satisfied.

3.A.2. Initial Review of Application:

- (a) A completed application form with copies of all required documents must be returned to Physician and Practitioner Services Departments. The application must be accompanied by the application fee.

- (b) As a preliminary step, the application shall be reviewed by Physician and Practitioner Services Departments and Department Chair (and Vice President Medical Affairs, if necessary) to determine that all questions have been answered and that the individual satisfies all threshold eligibility criteria. Incomplete applications shall not be processed. Individuals who fail to return completed applications or fail to meet the threshold eligibility criteria shall be notified that their applications shall not be processed. A determination of ineligibility does not entitle the individual to the hearing and appeal rights outlined in this Policy.
- (c) Physician and Practitioner Services Department shall oversee the process of gathering and verifying relevant information and confirming that all references and other information or materials deemed pertinent have been received. Internet searches may be performed to include but not limited to, Google, Social Media, etc.

3.A.3. Steps to Be Followed for All Initial Applicants:

- (a) Evidence of the applicant's character, professional competence, qualifications, behavior, and ethical standing shall be examined. This information may be contained in the application and obtained from peer references (from the same discipline where practicable) and from other available sources, including the applicant's past or current department chairs at other health care entities, residency training director, and others who may have knowledge about the applicant's education, training, experience, and ability to work with others.
- (b) An interview(s) with the applicant may be conducted. The purpose of the interview is to discuss and review any aspect of the applicant's application, qualifications, and requested clinical privileges. This interview may be conducted by a combination of any of the following: the department chair, the Credentials Committee, a Credentials Committee representative, the Medical Executive Committee, the President of the Medical Staff, Vice President Medical Affairs and/or the Chief Executive Officer.

3.A.4. Department Chair Procedure:

- (a) Physician and Practitioner Services Departments shall provide the complete application and all supporting materials to the chair of each department in which the applicant seeks clinical privileges. The department chair shall prepare a written report regarding whether the applicant has satisfied all of the qualifications for appointment and the clinical privileges requested on a form provided by Physician and Practitioner Services Department.
- (b) The department chair shall be available to the Credentials Committee, the Medical Executive Committee, and the Board to answer any questions that may be raised with respect to the report and findings of that individual.

3.A.5. Credentials Committee Procedure:

- (a) The Credentials Committee shall review and consider the report prepared by the relevant department chair and shall make a recommendation.
- (b) The Credentials Committee may use the expertise of the department chair or any member of the department, or an outside consultant, if additional information is required regarding the applicant's qualifications.
- (c) After determining that an applicant is otherwise qualified for appointment and privileges, 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 perform the privileges requested and the responsibilities of appointment. If so, the Credentials Committee may require the applicant to undergo a physical, mental, and/or behavioral examination by a physician(s) satisfactory to the Credentials Committee. The results of this examination shall be made available to the Committee for its consideration. Failure of an applicant to undergo an examination within a reasonable time after being requested to do so in writing by the Credentials Committee shall be considered a voluntary withdrawal of the application and all processing of the application shall cease. The cost of the health assessment will be borne by the applicant.
- (d) Initial appointment for all physicians shall be for a period of not to exceed two (2) years. The Credentials Committee may recommend the imposition of specific conditions. These conditions may relate to behavior (e.g., personal code of conduct) or to clinical issues (e.g., general consultation requirements, appropriate documentation requirements, proctoring, completion of CME requirements). The Credentials Committee may also recommend that appointment be granted for a period of less than twelve (12) months in order to permit closer monitoring of an individual's compliance with any conditions. Unless these matters involve the specific recommendations set forth in Section 7.A.1(a) of this Policy, such conditions do not entitle an individual to request the procedural rights set forth in Article 7 of this Policy. All Physicians upon initial appointment are subject to Provisional Status/Focused Professional Practice Evaluation as set forth in Appendix B.

3.A.6. Medical Executive Committee Recommendation:

- (a) At its next regular meeting after receipt of the written findings and recommendation of the Credentials Committee, the Medical Executive Committee shall:
 - (1) adopt the findings and recommendation of the Credentials Committee, as its own; or

- (2) refer the matter back to the Credentials Committee for further consideration and responses to specific questions raised by the Medical Executive Committee 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 Medical Executive Committee is to appoint, the recommendation shall be forwarded to the Board.
 - (c) If the recommendation of the Medical Executive Committee is unfavorable and would entitle the applicant to request a hearing in accordance with Section 7.A.1(a) of this Policy, the Medical Executive Committee shall forward its recommendation to the Vice President of Medical Affairs, who shall promptly send special notice to the applicant. The Vice President of Medical Affairs shall then hold the application until after the applicant has completed or waived a hearing and appeal.

3.A.7. Board Action:

- (a) The Board may delegate to a committee, consisting of at least two Board members, action on appointment, reappointment, and clinical privileges if there has been a favorable recommendation from the Credentials Committee and the Medical Executive Committee 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 appoint 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 appointment and clinical privileges, the Board may:
 - (1) appoint the applicant and grant clinical privileges as recommended; or
 - (2) refer the matter back to the Credentials Committee or Medical Executive Committee or to another source inside or outside the Hospital for additional research or information; or

- (3) reject or modify the recommendation.
- (c) If the Board determines to reject a favorable recommendation, it should first discuss the matter with the Chair of the Credentials Committee and the President of the Medical Staff. If the Board's determination remains unfavorable to the applicant, the Vice President of Medical Affairs shall promptly send special notice to the applicant that the applicant is entitled to request a hearing.
- (d) Any final decision by the Board to grant, deny, revise or revoke appointment and/or clinical privileges will be disseminated to appropriate individuals and, as required, reported to appropriate entities.

3.A.8. Time Periods for Processing:

Once an application is deemed complete, it is expected to be processed within ninety (90) business days, unless it becomes incomplete. This time period is intended to be a guideline only and shall not create any right for the applicant to have the application processed within this precise time period.

3.B. ONGOING PROFESSIONAL PRACTICE EVALUATION (OPPE) AND FOCUSED PROFESSIONAL PRACTICE EVALUATION (FPPE) TO CONFIRM COMPETENCE

Clinical privileges will be subject to ongoing professional practice evaluation ("OPPE") or focused professional practice evaluation ("FPPE") in order to confirm competence. The FPPE AND OPPE process is outlined in the Ongoing Professional Practice Evaluation Policy attached as Appendix C and the Focused Professional Practice Evaluation attached as Appendix B.

ARTICLE 4

CLINICAL PRIVILEGES

4.A. CLINICAL PRIVILEGES

4.A.1. General:

- (a) Appointment or reappointment shall not confer any clinical privileges or right to admit or treat patients at the Hospital. Each individual who has been appointed to the Medical Staff is entitled to exercise only those clinical privileges specifically granted by the Board.
- (b) For privilege requests to be processed, the applicant must satisfy any applicable threshold eligibility criteria.
- (c) Requests for clinical privileges that are subject to an exclusive contract will not be processed except as consistent with the contract.
- (d) Requests for clinical privileges that have been grouped into core privileges will not be processed unless the individual has applied for the full core and satisfied all threshold eligibility criteria (or has obtained a waiver in accordance with Section 4.A.2).
- (e) The clinical privileges recommended to the Board shall be based upon consideration of the following factors:

- (1) 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 these criteria;
 - (2) appropriateness of utilization patterns;
 - (3) ability to perform the privileges requested competently and safely;
 - (4) information resulting from ongoing and focused professional practice evaluation and other performance improvement activities, as applicable;
 - (5) availability of other qualified staff members with appropriate privileges (as determined by the Credentials Committee) to provide coverage in case of the applicant's illness or unavailability;
 - (6) adequate professional liability insurance coverage for the clinical privileges requested;
 - (7) the Hospital's available resources and personnel;
 - (8) any previously successful or currently pending challenges to any licensure or registration, or the voluntary or involuntary relinquishment of such licensure or registration;
 - (9) any information concerning professional review actions or voluntary or involuntary termination, limitation, reduction, or loss of appointment or clinical privileges at another hospital;
 - (10) practitioner-specific data as compared to aggregate data, when available;
 - (11) morbidity and mortality data related to the specific individual, and when statistically and qualitatively significant and meaningful, when available; and
 - (12) professional liability actions, especially any such actions that reflect an unusual pattern or excessive number of actions.
- (f) The applicant has the burden of establishing his or her qualifications and current competence for all clinical privileges requested.
- (g) The report of the chair of the clinical department in which privileges are sought shall be forwarded to the Chair of the Credentials Committee and processed as a part of the initial application for staff appointment.

4.A.2. Privilege Modifications and Waivers:

(a) Scope

This Section applies to all requests for modification of clinical privileges during the term of appointment (increases and relinquishments), resignation from the Medical Staff, and waivers related to eligibility criteria for privileges or the scope of those privileges.

(b) Submitting a Request

Requests for privilege modifications, waivers, and resignations must be submitted in writing to Physician and Practitioner Services Department.

(c) Increased Privileges

- (1) Requests for increased privileges must state the specific additional clinical privileges requested and provide information sufficient to establish eligibility, as specified in applicable criteria, and current clinical competence.
- (2) If the individual is eligible and the application is complete, it will be processed in the same manner as an application for initial clinical privileges unless the department chair and the Credentials Committee determine that the privileges being requested are for a “new procedure” as defined in Section 4.A.3. In such cases, the matter will be referred for review in accordance with that Section.

(d) Waivers

- (1) Any individual who does not satisfy one or more eligibility criteria for clinical privileges may request that it be waived. The individual requesting the waiver bears the burden of demonstrating exceptional circumstances, and that his or her qualifications are equivalent to, or exceed, the criterion in question.
- (2) If the individual is requesting a waiver of the requirement that each member apply for the full core of privileges in his or her specialty, the request must indicate the specific patient care services within the core that the member does not wish to provide, state a good cause basis for the request, and include evidence that the individual does not provide the patient care services at issue in any health care facility.
- (3) By applying for a waiver related to limiting the scope of core privileges, the individual nevertheless agrees to participate in the general on-call schedule for the relevant specialty and to maintain sufficient competency to assist other physicians on the Medical Staff in assessing and stabilizing patients who require services within that specialty, if this call responsibility is required by the Medical Staff leadership after review of the specific circumstances involved. If, upon assessment, a patient needs a service that is no longer provided by the individual pursuant to the waiver, the individual shall work cooperatively with

the other physicians in arranging for another individual with appropriate clinical privileges to care for the patient or, if such an individual is not available, in arranging for the patient's transfer.

- (4) A request for a waiver shall be submitted to the Credentials Committee for consideration. In reviewing the request for a waiver, the Credentials Committee shall specifically consider the factors outlined in Paragraph (f) below and may obtain input from the relevant department chair. The Credentials Committee's recommendation will be forwarded to the Medical Executive Committee, which shall review the recommendation of the Credentials Committee to and make a recommendation to the Board regarding whether to grant or deny the request for a waiver. Any recommendation to grant a waiver must include the specific basis for the recommendation.

(e) Relinquishment and Resignation of Privileges

(1) Relinquishment of Individual Privileges

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

(2) Resignation of Appointment and Privileges

A request to resign Medical Staff appointment and relinquish all clinical privileges must specify the desired date of resignation, which must be at least thirty (30) days from the date of the request, and be accompanied by evidence that the individual:

- (i) has completed all medical records;
- (ii) will be able to appropriately discharge or transfer responsibility for the care of any hospitalized patient who is under the individual's care at the time of resignation; and
- (iii) has completed scheduled emergency service call or has arranged for appropriate coverage to satisfy this responsibility.

(f) Factors for Consideration

The Medical Staff Leaders and Board may consider the following factors, among others, when deciding whether to recommend or grant a modification (increases and/or relinquishments) or waiver related to privileges:

- (1) the Hospital's mission and ability to serve the health care needs of the community by providing timely, appropriate care within its facilities;
- (2) whether sufficient notice has been given to provide a smooth transition of patient care services;
- (3) fairness to the individual requesting the modification or waiver, including past service and the other demands placed upon the individual;
- (4) fairness to other Medical Staff members who serve on the call roster in the relevant specialty, including the effect that the modification would have on them;
- (5) the expectations of other members of the Medical Staff who are in different specialties but who rely on the specialty in question in the care of patients who present to the Hospital;
- (6) any perceived inequities in modifications or waivers being provided to some, but not others;
- (7) any gaps in call coverage that might/would result from an individual's removal from the call roster for the relevant privilege and the feasibility and safety of transferring patients to other facilities in that situation; and
- (8) how the request may affect the Hospital's ability to comply with applicable regulatory requirements, including the Emergency Medical Treatment and Active Labor Act.

(g) Effective Date

If the Board grants a modification or waiver related to privileges, it shall specify the date that the modification or waiver will be effective. Failure of a member to request privilege modifications or waivers in accordance with this section shall, as applicable, result in the member retaining Medical Staff appointment and clinical privileges and all associated responsibilities.

(h) Procedural Rights

No individual is entitled to a modification or waiver related to privileges. Individuals are also not entitled to a hearing or appeal or other process if a waiver or a modification related to a relinquishment of privileges is not granted.

4.A.3. Clinical Privileges for New Procedures:

- (a) Requests for clinical privileges to perform either a procedure not currently being performed at the Hospital or a new technique to perform an existing procedure (hereafter, “new procedure”) shall not be processed until
 - (1) a determination has been made that the procedure shall be offered by the Hospital and
 - (2) criteria to be eligible to request/grant those clinical privileges have been established.
- (b) As an initial step in the process, the individual seeking to perform the new procedure will prepare and submit a report to the department chair:
 - (1) minimum education, training, and experience necessary to perform the new procedure safely and competently;
 - (2) clinical indications for when the new procedure is appropriate;
 - (3) whether there is empirical evidence of improved patient outcomes with the new procedure or other clinical benefits to patients;
 - (4) whether proficiency for the new procedure is volume-sensitive and if the requisite volume would be available;
 - (5) whether the new procedure is being performed at other similar hospitals and the experiences of those institutions; and
 - (6) whether the Hospital currently has the resources, including space, equipment, personnel, and other support services, to safely and effectively perform the new procedure.

The department chair will review this report, conduct additional research as necessary, and make a preliminary recommendation as to whether the new procedure should be offered to the community.

- (c) If the preliminary recommendation is favorable, recommendations will be presented to the Credentials Committee.
- (d) The Credentials Committee will forward its approval to the Medical Executive Committee as information only.
- (e) Once the foregoing steps are completed, specific requests from eligible Medical Staff members who wish to perform the procedure or service may be processed.

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

- (a) Requests for clinical privileges that previously at the Hospital have been exercised only by individuals from another specialty shall not be processed until the steps outlined in this Section have been completed and a determination has been made regarding the individual's eligibility to request the clinical privileges in question.
- (b) As an initial step in the process, the individual seeking the privilege will prepare and submit a report to the Credentials Committee that specifies the minimum qualifications needed to perform the procedure safely and competently, whether the individual's specialty is performing the privilege at other similar hospitals, and the experiences of those other hospitals in terms of patient care outcomes and quality of care.
- (c) The Credentials Committee shall then conduct additional research and consult with experts, as necessary, including those on the Medical Staff (e.g., department chairs, individuals on the Medical Staff with special interest and/or expertise) and those outside the Hospital (e.g., other hospitals, residency training programs, specialty societies).
- (d) The Credentials Committee may or may not recommend that individuals from different specialties be permitted to request the privileges at issue. If it does, the Committee may develop recommendations regarding:
 - (1) the minimum education, training, and experience necessary to perform the clinical privileges in question;
 - (2) the clinical indications for when the procedure is appropriate;
 - (3) the manner of addressing the most common complications that arise which may be outside of the scope of the clinical privileges that have been granted to the requesting individual;
 - (4) the extent (time frame and mechanism) of focused monitoring and supervision that should occur if the privileges are granted in order to confirm competence;
 - (5) the manner in which the procedure would be reviewed as part of the Hospital's ongoing and focused professional practice evaluation activities (which may include assessment of both long-term and short-term outcomes for all relevant specialties); and
 - (6) the impact, if any, on emergency call responsibilities.
- (e) The Credentials Committee shall forward its recommendations to the Medical Executive Committee, which shall review the matter and forward its recommendations to the Board for final action. The Board shall make a reasonable effort to render the final decision within 60 days of receipt of the Medical Executive Committee's recommendation.

- (f) Once the foregoing steps are completed, specific requests from eligible Medical Staff members who wish to exercise the privileges in question may be processed.

4.A.5. Clinical Privileges for Dentists and Oral and Maxillofacial Surgeons:

- (a) For any patient who meets the classification of ASA 1 (normal, healthy patients) or ASA 2 (patients with mild systemic disease with no functional limitations), dentists and oral and maxillofacial surgeons may admit such patients, perform a complete admission history and physical examination, and assess the medical risks of any surgical procedure to be performed or the medical management of the patient's condition, if they are deemed qualified to do so by the Credentials Committee and Medical Executive Committee. They must, nevertheless, have a relationship with a physician on the Medical Staff (established and declared in advance) who is available to respond and become involved with that individual's care should any medical issue arise with the patient.
- (b) For any patient who meets ASA 3 or 4 classifications, a medical history and physical examination of the patient shall be made and recorded by a physician who is a member of the Medical Staff before dental or oral surgery may be performed. In addition, a designated physician shall be responsible for the medical care of the patient throughout the period of hospitalization.
- (c) The dentist or oral and maxillofacial surgeon shall be responsible for the oral surgery care of the patient, including the appropriate history and physical examination, as well as all other appropriate elements of the patient's record. Dentists and oral and maxillofacial surgeons may write orders within the scope of their licenses and consistent with relevant Hospital policies and rules and regulations.

4.A.6. Clinical Privileges for Podiatrists:

- (a) For any patient who meets the classification of ASA 1 (normal, healthy patients) or ASA 2 (patients with mild systemic disease with no functional limitations), podiatrists may admit such patients, perform a complete admission history and physical examination, and assess the medical risks of any surgical procedure to be performed or the medical management of the patient's condition, if they are deemed qualified to do so by the Credentials Committee and Medical Executive Committee. They must, nevertheless, have a relationship with a physician on the Medical Staff (established and declared in advance) who is available to respond and become involved with that individual's care should any medical issue arise with the patient.
- (b) For any patient who meets ASA 3 or 4 classifications, a medical history and physical examination of the patient shall be made and recorded by a physician who is a member of the Medical Staff before podiatric surgery shall be performed. In addition, a

designated physician shall be responsible for the medical care of the patient throughout the period of hospitalization.

- (c) The podiatrist shall be responsible for the podiatric care of the patient, including the podiatric history and the podiatric physical examination, as well as all appropriate elements of the patient's record. Podiatrists may write orders which are within the scope of their license and consistent with relevant Hospital policies and rules and regulations.

4.A.7. Physicians in Training:

Physicians in training (residents) shall not hold appointments to the Medical Staff and shall not be granted specific privileges. The program director, clinical faculty, and/or attending staff member shall be responsible for the direction and supervision of the on-site and/or day-to-day patient care activities of each trainee, who shall be permitted to perform only those clinical functions set out in curriculum requirements, affiliation agreements, and/or training protocols approved by the Hospital and the Medical Executive Committee or their designee(s). The applicable program director shall be responsible for verifying and evaluating the qualifications of each physician in training.

4.A.8. Telemedicine Privileges:

- (a) A qualified individual may be granted telemedicine privileges regardless of whether the individual is appointed to the Medical Staff.
- (b) Requests for initial or renewed telemedicine privileges shall be processed through one of the following options, as determined by the Vice President of Medical Affairs in consultation with the President of the Medical Staff:
 - (1) A request for telemedicine privileges may be processed through the same process for Medical Staff applications, as set forth in this Policy, with the exception that affiliation verifications is a selected review of at minimum five (5) affiliation verifications from the prior ten (10) years, to include affiliations from the last two (2) organizations. In such case, the individual must satisfy all qualifications and requirements set forth in this Policy, except those relating to geographic location, coverage arrangements, and emergency call responsibilities.
 - (2) If the individual requesting telemedicine privileges is practicing at a distant hospital that participates in Medicare or a telemedicine entity (as that term is defined by Medicare), a request for telemedicine privileges may be processed using an abbreviated process that relies on the credentialing and privileging decisions made by the distant hospital or telemedicine entity. In such cases, the Hospital must ensure, through a written agreement, that the distant hospital or

telemedicine entity will comply with all applicable Medicare regulations and accreditation standards. The distant hospital or telemedicine entity must provide:

- (i) confirmation that the practitioner is licensed in Pennsylvania;
- (ii) a current list of privileges granted to the practitioner;
- (iii) information indicating that the applicant has actively exercised the relevant privileges during the previous twelve (12) months (or in the case of recent appointees to the Distant Site Hospital medical staff, during the period of such appointment) and has done so in a competent manner;
- (iv) any other information required by the agreement or requested by the Hospital.

This information shall be provided to the Medical Executive Committee for review and recommendation to the Board for final action. Notwithstanding the process set forth in this subsection, the Hospital may determine that an applicant for telemedicine privileges is ineligible for appointment or clinical privileges if the applicant fails to satisfy the threshold eligibility criteria set forth in this Policy.

- (c) Telemedicine privileges, if granted, shall be for a period of not more than two years.
- (d) Individuals granted telemedicine privileges shall be subject to the Hospital's peer review activities. The results of the peer review activities, including any adverse events and complaints filed about the practitioner providing telemedicine services from patients, other practitioners or staff, will be shared with the hospital or entity providing telemedicine services.
- (e) Telemedicine privileges granted in conjunction with a contractual agreement shall be incident to and coterminous with the agreement.

4.B. TEMPORARY CLINICAL PRIVILEGES

4.B.1. Eligibility to Request Temporary Clinical Privileges:

(a) Applicants

Temporary privileges for an applicant for initial appointment are granted by the CEO or his designee, such as the Vice President of Medical Affairs, upon recommendation of the President of the Medical Staff, under the following conditions:

- (1) the applicant has submitted a complete application, along with the application fee;
- (2) the verification process is complete, including verification of current licensure, relevant training or experience, current competence, (verification of good standing in current hospital(s), to include number of cases performed and outcomes for cases), peer references, ability to exercise the privileges requested, and current professional liability coverage acceptable to UPMC Pinnacle Hospitals; compliance with privileges criteria; results of a query from the National Practitioner Data Bank, FBI Clearance, Pennsylvania Child Abuse Clearance, Pennsylvania Criminal background check, and OIG queries;
- (3) the applicant demonstrates that (i) there are no current or previously successful challenges to his or her licensure or registration, and (ii) he or she has not been subject to involuntary termination of Medical Staff membership or involuntary limitation, reduction, denial, or loss of clinical privileges, at another health care facility;
- (4) the application is pending review by the Medical Executive Committee and the Board, following a favorable recommendation by the Credentials Committee, after considering the evaluation of the department chair; and
- (5) temporary privileges for a Medical Staff applicant will be granted for a maximum period of one hundred and twenty (120) consecutive days.

(b) Locum Tenens

The CEO or his designee, upon recommendation of the President of the Medical Staff, may grant temporary privileges (both admitting and treatment) to an individual serving as a locum tenens, to meet an important patient care need, for a member of the Medical Staff who is on vacation, attending an educational seminar, or ill, and/or otherwise needs coverage assistance for a period of time, under the following conditions:

- (1) the applicant has submitted an appropriate application;
- (2) the verification process is complete, including verification of current licensure, relevant training or experience, current competence (verification of good standing in all hospitals where the individual practiced for at least the previous two years), ability to exercise the privileges requested, and current professional liability coverage; compliance with privileges criteria; and consideration of information from the National Practitioner Data Bank, from a criminal background check, and from OIG queries;

- (3) the applicant demonstrates that (i) there are no current or previously successful challenges to his or her licensure or registration, and (ii) he or she has not been subject to involuntary termination of Medical Staff membership or involuntary limitation, reduction, denial, or loss of clinical privileges, at another health care facility;
- (4) the applicant has received a favorable recommendation from the Credentials Committee Chair, after considering the evaluation of the department chair;
- (5) the applicant will be subject to any focused professional practice requirements established by the Hospital.

(c) Visiting

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

- (1) the care of a specific patient;
- (2) when a proctoring or consulting physician is needed, but is otherwise unavailable; or
- (3) when necessary to prevent a lack or lapse of services in a needed specialty area.

The following factors will be considered and verified prior to the granting of temporary privileges in these situations: current licensure, relevant training or experience, current competence (verification of good standing in hospitals where the individual practiced for at least the previous two years, to include number of cases performed and outcomes for cases they shall be proctoring), and peer references, current professional liability coverage acceptable to the Hospital, and results of a query to the National Practitioner Data Bank, FBI Clearance, Pennsylvania Child Abuse Clearance, Pennsylvania Criminal background check, and from OIG queries. The grant of clinical privileges in these situations will not exceed sixty (60) days. In exceptional situations, this period of time may be extended in the discretion of the Vice President of Medical Affairs and the President of the Medical Staff.

- (d) Compliance with Bylaws and Policies. Prior to any temporary privileges being granted, the individual must agree in writing to be bound by the bylaws, rules and regulations, policies, procedures, and protocols of the Medical Staff and the Hospital.
- (e) FPPE. Individuals who are granted temporary privileges will be subject to the Hospital policy regarding focused professional practice evaluation.

4.B.2. Supervision Requirements:

Special requirements of supervision and reporting may be imposed on any individual granted temporary clinical privileges.

4.B.3. Termination of Temporary Clinical Privileges:

- (a) The Chief Executive Officer, at any time after consulting with the President of the Medical Staff, the Chair of the Credentials Committee, the department chair, or the Vice President Medical Affairs, may terminate temporary admitting privileges. Clinical privileges shall be terminated when the individual's inpatients are discharged.
- (b) If the care or safety of patients might be endangered by continued treatment by the individual granted temporary privileges, the Chief Executive Officer, the department chair, the President of the Medical Staff, or the Vice President Medical Affairs may immediately terminate all temporary privileges. The department chair or the President of the Medical Staff shall assign to another member of the Medical Staff responsibility for the care of such individual's patients until they are discharged or an appropriate transfer arranged. Whenever possible, consideration shall be given to the wishes of the patient in the selection of a substitute physician.

4.C. EMERGENCY TEMPORARY PRIVILEGES

4.C.1. Eligibility to Request Emergency Temporary Clinical Privileges:

(a) Applicants

Emergency Temporary privileges may be granted by the CEO or his designee, such as the Vice President of Medical Affairs or President of the Medical Staff, upon recommendation of the Department Chair, under the following conditions; in a situation where there is an emergent care need (e.g. medical staff member or allied health provider becomes suddenly ill) that cannot be provided by present staff.

- (1) the applicant has submitted a complete application, along with the application fee;
- (2) the verification process is complete, including verification of current licensure, relevant training or experience, current competence, (verification of good standing in current hospital(s), to include number of cases performed and outcomes for cases), peer references, ability to exercise the privileges requested, and current professional liability coverage acceptable to UPMC Pinnacle Hospitals; compliance with privileges criteria; results of a query from

the National Practitioner Data Bank, FBI Clearance, Pennsylvania Child Abuse Clearance, Pennsylvania Criminal background check, and OIG queries;

- (3) the applicant demonstrates that (i) there are no current or previously successful challenges to his or her licensure or registration, and (ii) he or she has not been subject to involuntary termination of Medical Staff membership or involuntary limitation, reduction, denial, or loss of clinical privileges, at another health care facility;
- (4) the chair of the affected department will request this process with detail of the need. The medical staff office will obtain as much information on the provider as possible in the time allotted. The chair will review the application and make a recommendation. The Vice President of Medical Affairs or the President of the Medical Staff will review the application and determine if emergency temporary privileges should be granted. If granted, the provider may care for patients at that time. The applicants file will be reviewed at the next regularly scheduled credentials committee.
- (5) temporary privileges for a Medical Staff applicant will be granted for a maximum period of one hundred and twenty (120) consecutive days.

4.D. YELLOW FLAGS

Potential concerns about an applicant, often called yellow flags, that are identified and verified, could result in additional information gathering and a full Board review and approval process.

Thus not permitting the applicant to qualify for an expedited and/or temporary privilege approval process. Examples of yellow flags include but are not limited to;

- (a) Frequent practice changes and moves, unexplained time gaps, references that raise concerns, disciplinary actions during training and affiliations and/or employment, involuntary change in hospital staff category, disciplinary actions on licensures, board certification and DEA, claims of fraud, an unusual number of malpractice claims or lawsuits for the specialty, requests for privileges not consistent with training, discrepancies between information provided by the applicant and what's received from references and verifications.

When reasonable explanations provided and verified whenever possible don't necessarily indicate a problem, however, they do require additional information be obtained.

The Department Chair in consultation with Vice President Medical Affairs, may determine that the yellow flag will not preclude an applicant for the expedited and/or temporary privilege process. This recommendation will be clearly documented in the applicants

4.E. EMERGENCY SITUATIONS

- (1) For the purpose of this section, an “emergency” is defined as a condition which could result in serious or permanent harm to a patient(s) and in which any delay in administering treatment would add to that harm.
- (2) In an emergency situation, a member of the Medical Staff may administer treatment to the extent permitted by his or her license, regardless of department status or specific grant of clinical privileges.
- (3) When the emergency situation no longer exists, the patient shall be assigned by the department chair or the President of the Medical Staff to a member with appropriate clinical privileges, considering the wishes of the patient.

4.F. DISASTER PRIVILEGES & CREDENTIALING IN THE EVENT OF A MAJOR EMERGENCY OR MASS DISASTER

In the event of a major emergency or mass disaster (determined by the activation of the facilities Emergency Operations Plan) the appointment and privileging of professional staff who volunteer to provide patient care and assistance shall be managed as follows: 1) the CEO or designee shall grant temporary privileges to physicians, dentists, and allied health practitioners to treat patients at the corresponding facility 2) if such professionals are staff members at another facility affiliated with the UPMC, this fact shall be authenticated by way of verbal and/or electronic confirmation of license and privileges by the Medical Staff Office Director or other person responsible for credential management at the relevant facility;

- (1) Before a volunteer practitioner is considered eligible to function as a volunteer licensed independent practitioner, the hospital obtains his or her valid government-issued photo identification (for example, a driver’s license or passport) and at least one (1) of the following:
 - (a) A current picture identification card from a healthcare organization that clearly identifies professional designation
 - (b) A current licensure to practice
 - (c) Primary source verification of licensure
 - (d) Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT), the Medical Reserve Corps (MRC), the Emergency System

for Advance Registration of Volunteer Health Professionals (ESAR-VHP) or other recognized state or federal response organization or group

- (e) Identification indicating that the individual has been granted authority by a government entity to provide patient care, treatment or services in disaster circumstances
 - (f) Confirmation by a licensed independent practitioner currently privileged by the hospital or by a staff member with personal knowledge of the volunteer practitioner's ability to act as a licensed independent practitioner during a disaster
- (2) Primary source verification of licensure occurs as soon as the disaster is under control or within seventy-two (72) hours from the time the volunteer licensed independent practitioner presents him or herself to the hospital, whichever comes first. If primary source verification of a volunteer licensed independent practitioner's licensure cannot be completed within seventy-two (72) hours of the practitioner's arrival due to extraordinary circumstances, the hospital documents all of the following:
- (a) Reason(s) it could not be performed within seventy-two (72) hours of the practitioner's arrival.
 - (b) Evidence of the licensed independent practitioner's demonstrated ability to continue to provide adequate care, treatment and services
 - (c) Evidence of the hospital's attempt to perform primary source verification as soon as possible
- (3) Notwithstanding any existing delineation of privileges or scope of authority, medical staff members, associates, and volunteers are authorized to take whatever steps they reasonably believe are necessary to save or preserve life in such declared extreme situations.

4.G. CONTRACTS FOR SERVICES

- (1) From time to time, the Hospital may enter into contracts with practitioners and/or groups of practitioners for the performance of clinical and administrative services at the Hospital. All individuals providing clinical services pursuant to such contracts will obtain and maintain clinical privileges at the Hospital, in accordance with the terms of this Policy.
- (2) To the extent that:

- (a) any such contract confers the exclusive right to perform specified services to one or more practitioners or groups of practitioners, or
 - (b) the Board by resolution limits the practitioners who may exercise privileges in any clinical specialty to employees of the Hospital or its affiliates, no other practitioner except those authorized by or pursuant to the contract or resolution may exercise clinical privileges to perform the specified services while the contract or resolution is in effect. This means that only authorized practitioners are eligible to apply for appointment or reappointment to the Medical Staff and for the clinical privileges in question. No other applications will be processed.
- (3) Prior to the Hospital signing any exclusive contract and/or passing any Board resolution described in paragraph (2) in a specialty area that has not previously been subject to such a contract or resolution, the Board will request the Medical Executive Committee's review of the matter. The Medical Executive Committee (or a subcommittee of its members appointed by the President of the Medical Staff) will review the quality of care and service implications of the proposed exclusive contract or Board resolution, and provide a report of its findings and recommendations to the Board within thirty (30) days of the Board's request. As part of its review, the Medical Executive Committee (or subcommittee) may obtain relevant information concerning quality of care and service matters from (i) members of the applicable specialty involved, (ii) members of other specialties who directly utilize or rely on the specialty in question, and (iii) Hospital administration. However, the actual terms of any such exclusive arrangement or employment contract, and any financial information related to them, including but not limited to the remuneration to be paid to Medical Staff members who may be a party to the arrangement, are not relevant and shall neither be disclosed to the Medical Executive Committee nor discussed as part of the Medical Executive Committee's review.
- (4) After receiving the Medical Executive Committee's report, the Board shall determine whether or not to proceed with the exclusive contract or Board resolution. If the Board determines to do so, and if that determination would have the effect of preventing an existing Medical Staff member from exercising clinical privileges that had previously been granted, the affected member is entitled to the following notice and review procedures:
 - (a) The affected member shall be given at least thirty (30) days' advance notice of the exclusive contract or Board resolution and have the right to meet with the Board or a committee designated by the Board to discuss the matter prior to the contract in question being signed by the Hospital or the Board resolution becoming effective.

- (b) At the meeting, the affected member shall be entitled to present any information that he or she deems relevant to the decision to enter into the exclusive contract or enact the Board resolution.
 - (c) If, following this meeting, the Board confirms its initial determination to enter into the exclusive contract or enact the Board resolution, the affected member shall be notified that he or she is ineligible to continue to exercise the clinical privileges covered by the exclusive contract or Board resolution. In that circumstance, the ineligibility begins as of the effective date of the exclusive contract or Board resolution and continues for as long as the contract or Board resolution is in effect.
 - (d) The affected member shall not be entitled to any procedural rights beyond those outlined above with respect to the Board's decision or the effect of the decision on his or her clinical privileges, notwithstanding the provisions in Article 7 of this Policy.
 - (e) The inability of a physician to exercise clinical privileges because of an exclusive contract or resolution is not a matter that requires a report to the Pennsylvania licensure board or to the National Practitioner Data Bank.
- (5) Except as provided in paragraph (1), in the event of any conflict between this Policy or the Medical Staff Bylaws and the terms of any contract, the terms of the contract shall control.

ARTICLE 5

PROCEDURE FOR REAPPOINTMENT

5.A. PROCEDURE FOR REAPPOINTMENT

All terms, conditions, requirements, and procedures relating to initial appointment shall apply to continued appointment and clinical privileges and to reappointment.

5.A.1. Eligibility for Reappointment:

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

- (a) completed all medical records and be current at time of reappointment;
- (b) completed all continuing medical education requirements;
- (c) satisfied all Medical Staff responsibilities, including payment of dues, fines, and assessments;
- (d) continued to meet all qualifications and criteria for appointment and the clinical privileges requested, including those set forth in the threshold eligibility criteria outlined in this Policy;
- (e) if applying for clinical privileges, had sufficient patient contacts to enable the assessment of current clinical judgment and competence for the privileges requested.

Any individual seeking reappointment who has minimal activity at the Hospital must submit such information as may be requested (such as a copy of his/her confidential quality profile from his/her primary hospital, clinical information from the individual's private office practice, and/or a quality profile from a managed care organization or insurer), before the application shall be considered complete and processed further.

5.A.2. Factors for Evaluation:

In considering an individual's application for reappointment, the factors listed in Section 2.A.3 of this Policy will be considered. Additionally, the following factors will be evaluated as part of the reappointment process:

- (a) compliance with the Bylaws, rules and regulations, and policies of the Medical Staff and the Hospital;
- (b) participation in Medical Staff duties, including committee assignments, emergency call, consultation requests, participation in quality improvement, utilization activities, and professional practice evaluation activities, and such other reasonable duties and responsibilities as assigned;
- (c) the results of the Hospital's performance improvement and professional practice evaluation activities, taking into consideration practitioner-specific information compared to aggregate information concerning other individuals in the same or similar specialty (provided that, other practitioners will not be identified);
- (d) any focused professional practice evaluations;
- (e) verified complaints received from patients, families, and/or staff; and
- (f) other reasonable indicators of continuing qualifications.

5.A.3. Reappointment Application:

- (a) An application for reappointment shall be furnished to members at least sixty (60) days prior to the expiration of their current appointment term. A completed reappointment application must be returned to Physician and Practitioner Services Department within fifteen (15) days. Supporting documents to include but not limited to; copies of current professional liability face sheet, supervising/collaborating agreement and prescriptive authority application.
- (b) Failure to return a completed application within fifteen (15) days may result in the assessment of a reappointment late fee, which must be paid prior to the application being processed. In addition, failure to submit a complete application at least one month prior to the expiration of the member's current term may result in the automatic expiration of appointment and clinical privileges at the end of the then current term of

appointment unless the application can still be processed in the normal course, without extraordinary effort on the part of Physician and Practitioner Services Department and the Medical Staff Leaders.

- (c) Reappointment shall be for a period of not more than two (2) years.
- (d) If an application for reappointment is submitted timely, but the Medical Staff and/or Board has not acted on it prior to the end of the current term, the individual's appointment and clinical privileges shall expire at the end of the then current term of appointment. Subsequent Board action may be to grant reappointment and renewal of clinical privileges using the filed application.
- (e) The application shall be reviewed by Physician and Practitioner Services Department to determine that all questions have been answered and that the individual satisfies all threshold eligibility criteria for reappointment and for the clinical privileges requested.
- (f) Physician and Practitioner Services Departments shall oversee the process of gathering and verifying relevant information and shall also be responsible for confirming that all relevant information has been received. Internet searches may be performed to include but not limited to, Google, Social Media, etc.

5.A.4. Processing Applications for Reappointment:

- (a) Physician and Practitioner Services Departments shall forward the application to the relevant department chair and the application for reappointment shall be processed in a manner consistent with applications for initial appointment.
- (b) Additional information may be requested from the applicant if any questions or concerns are raised with the application or if new privileges are requested.
- (c) If it becomes apparent to the Credentials Committee or the Medical Executive Committee that it is considering a recommendation to deny reappointment or to reduce clinical privileges, the chair of the committee may notify the individual of the general tenor of the possible recommendation and invite the individual to meet prior to any final recommendation being made. At the meeting, the individual should be informed of the general nature of the information supporting the recommendation contemplated and shall be invited to discuss, explain, or refute it. This meeting is not a hearing, and none of the procedural rules for hearings shall apply. The individual requesting reappointment shall not have the right to be represented by legal counsel at this meeting. The committee shall indicate as part of its report whether such a meeting occurred and shall include a summary of the meeting with its minutes.

5.A.5. Conditional Reappointments:

- (a) Recommendations for reappointment and renewed privileges may be contingent upon an individual's compliance with certain specific conditions. These conditions may relate to behavior (e.g., personal code of conduct) or to clinical issues (e.g., general consultation requirements, appropriate documentation requirements, proctoring, completion of CME requirements). Unless the conditions involve the matters set forth in Section 7.A.1(a) of this Policy, the imposition of such conditions does not entitle an individual to request the procedural rights set forth in Article 7 of this Policy.
- (b) Reappointments may be recommended for periods of less than two years in order to permit closer monitoring of an individual's compliance with any conditions that may be imposed. A recommendation for reappointment for a period of less than two years does not, in and of itself, entitle an individual to the procedural rights set forth in Article 7.
- (c) In addition, in the event the applicant for reappointment is the subject of an unresolved professional practice evaluation concern, a formal investigation, or a hearing at the time reappointment is being considered, a conditional reappointment for a period of less than two years may be granted pending the completion of that process.

5.A.6. Time Periods for Processing:

Once an application is deemed complete and verified, it is expected to be processed within sixty (60) days, unless it becomes incomplete. This time period is intended to be a guideline only and shall not create any right for the applicant to have the application processed within this precise time period.

ARTICLE 6

PEER REVIEW PROCEDURES FOR QUESTIONS INVOLVING MEDICAL STAFF MEMBERS

6.A. COLLEGIAL INTERVENTION

- (1) This Policy encourages the use of progressive steps by Medical Staff Leaders and Hospital management, beginning with collegial and educational efforts, to address questions relating to an individual's clinical practice and/or professional conduct. The goal of these efforts is to arrive at voluntary, responsive actions by the individual to resolve questions that have been raised.
- (2) Collegial intervention efforts are a part of the Hospital's ongoing and focused professional practice evaluation activities.
- (3) "Collegial Intervention" means a discussion between a Medical Staff member and one (1) or more Medical Staff Leaders, the Vice President Medical Affairs, and/or the Chief Executive Officer, along with a follow-up letter that summarizes the discussion and, when applicable, the expectations regarding the practitioner's future practice and/or conduct in the Hospital. No legal counsel for the Medical Staff member, the Medical Staff Leaders, or the Hospital shall be present during any collegial intervention efforts, and no recording (audio, video, or transcript) shall be permitted or made.
- (4) Collegial intervention efforts involve reviewing and following up on questions raised about the clinical practice and/or conduct of Medical Staff members and pursuing counseling, education, and related steps, such as the following:

- (a) advising colleagues of all applicable policies, such as policies regarding appropriate behavior, communication issues, emergency call obligations, and the timely and adequate completion of medical records; and
 - (b) sharing comparative quality, utilization, and other relevant information, including any variations from clinical practice or evidence-based protocols, in order to assist individuals to conform their practices to appropriate norms.
- (5) The relevant Medical Staff Leader(s) shall document collegial intervention efforts in an individual's confidential file. The individual shall have an opportunity to review any formal documentation prepared by the Medical Staff Leader(s) and respond in writing. The response shall be maintained in that individual's file along with the original documentation.
- (6) Collegial intervention efforts are encouraged, but are not mandatory, and shall be within the discretion of the appropriate Medical Staff Leaders and Hospital management.
- (7) The relevant Medical Staff Leader(s), in conjunction with the Chief Executive Officer or Vice President Medical Affairs, shall determine whether to direct that a matter be handled in accordance with another policy (e.g., code of conduct policy; professional practice evaluation policy), or to direct it to the Medical Executive Committee for further review.

6.B. INVESTIGATIONS

6.B.1. Initial Review:

- (a) Whenever a serious question has been raised, or where collegial efforts or actions under the professional practice evaluation policy have not resolved an issue, regarding:
 - (1) the clinical competence or clinical practice of any member of the Medical Staff, including the care, treatment or management of a patient or patients;
 - (2) the safety or proper care being provided to patients;
 - (3) the known or suspected violation by any member of the Medical Staff of applicable ethical standards or the Bylaws, rules and regulations, and policies of the Hospital or the Medical Staff; and/or
 - (4) conduct by any member of the Medical Staff that is considered lower than the standards of the Hospital or disruptive to the orderly operation of the Hospital or its Medical Staff, including the inability of the member to work harmoniously with others, the matter may be referred to the President of the Medical Staff,

the chair of the department, the chair of a standing committee, the Vice President Medical Affairs or the Chief Executive Officer.

- (b) In addition, if the Board becomes aware of information that raises concerns about any Medical Staff member, the matter shall be referred to the President of the Medical Staff, the chair of the department, the chair of a standing committee, the Vice President Medical Affairs, or the Chief Executive Officer for review and appropriate action in accordance with this Policy.
- (c) The person to whom the matter is referred shall conduct or arrange for an inquiry to determine whether the question raised has sufficient credibility to warrant further review and, if so, shall forward it in writing to the Medical Executive Committee.
- (d) No action taken pursuant to this Section shall constitute an investigation.

6.B.2. Initiation of Investigation:

- (a) When a question involving clinical competence or professional conduct is referred to, or raised by, the Medical Executive Committee, the Medical Executive Committee shall review the matter and determine whether to conduct an investigation, to direct the matter to be handled pursuant to another policy (e.g., code of conduct policy; professional practice evaluation policy), or to proceed in another manner. The Medical Executive Committee may determine to refer matters involving disruptive behavior or sexual harassment to the Board for further action. Prior to making its determination, the Medical Executive Committee may discuss the matter with the individual. An investigation shall begin only after a formal determination by the Medical Executive Committee to do so.
- (b) The Medical Executive Committee shall inform the individual that an investigation has begun. Notification may be delayed if, in the Medical Executive Committee's judgment, informing the individual immediately would compromise the investigation or disrupt the operation of the Hospital or Medical Staff.

6.B.3. Investigative Procedure:

- (a) Once a determination has been made to begin an investigation, the President of the Medical Staff shall appoint committee members in consultation with the Vice President of Medical Affairs, keeping in mind the conflict of interest guidelines outlined in Article 8. Any ad hoc committee may include individuals not on the Medical Staff. The committee shall include the President of the Medical Staff, Vice President of Medical Affairs, Medical Staff President-Elect, Secretary/Treasurer, Department Chair and at minimum four (4) active members of the Medical Staff and appointment of additional representatives as recommended by the President of the Medical Staff. Whenever the questions raised concern the clinical competence of the individual under review, the ad

hoc committee shall include a peer of the individual (e.g., physician, dentist, oral surgeon, or podiatrist). Legal Counsel must be consulted by the “investigating committee.”

- (b) The committee conducting the investigation (“investigating committee”) shall have the authority to review relevant documents and interview individuals. It shall also have available to it the full resources of the Medical Staff and the Hospital, as well as the authority to use outside consultants, if needed. An outside consultant or agency may be used whenever a determination is made by the Hospital and investigating committee that
 - (1) the clinical expertise needed to conduct the review is not available on the Medical Staff;
 - (2) the individual under review is likely to raise, or has raised, questions about the objectivity of other practitioners on the Medical Staff;
 - (3) the individuals with the necessary clinical expertise on the Medical Staff would not be able to conduct a review without risk of allegations of bias, even if such allegations are unfounded; or
 - (4) the thoroughness and objectivity of the investigation would be aided by such an external review.
- (c) The investigating committee may require a physical, mental, and/or behavioral examination of the individual by health care professional(s) acceptable to it. The individual being investigated shall execute a release (in a form approved or provided by the investigating committee) allowing (i) the investigating committee (or its representative) to discuss with the health care professional(s) conducting the examination the reasons for the examination; and (ii) the health care professional(s) conducting the examination to discuss and provide documentation of the results of such examination directly to the investigating committee. The cost of such health examination shall be borne by the individual.
- (d) The individual shall have an opportunity to meet with the investigating committee before it makes its report. Prior to this meeting, the individual shall be informed of the general questions being investigated. At the meeting, the individual shall be invited to discuss, explain, or refute the questions that gave rise to the investigation. No recording (audio or video) or transcript of the meeting shall be permitted or made. A summary of the interview shall be prepared by the investigating committee and included with its report. This meeting is not a hearing, and none of the procedural rules for hearings shall apply. The individual being investigated shall not have the right to be represented by legal counsel at this meeting.

- (e) The investigating committee shall make a reasonable effort to complete the investigation and issue its report within thirty (30) days of the commencement of the investigation, provided that an outside review is not necessary. When an outside review is necessary, the investigating committee shall make a reasonable effort to complete the investigation and issue its report within thirty (30) days of receiving the results of the outside review. These time frames are intended to serve as guidelines and, as such, shall not be deemed to create any right for an individual to have an investigation completed within such time periods.
- (f) At the conclusion of the investigation, the investigating committee shall prepare a report with its findings, conclusions, and recommendations.
- (g) In making its recommendations, the investigating committee shall strive to achieve a consensus as to what is in the best interests of patient care and the smooth operation of the Hospital, while balancing fairness to the individual, recognizing that fairness does not require that the individual agree with the recommendation. Specifically, the committee may consider:
 - (1) relevant literature and clinical practice guidelines, as appropriate;
 - (2) all of the opinions and views that were expressed throughout the review, including report(s) from any outside review(s);
 - (3) any information or explanations provided by the individual under review; and
 - (4) other information as deemed relevant, reasonable, and necessary by the investigating committee.

6.B.4. Recommendation:

- (a) The Medical Executive Committee may accept, modify, or reject any recommendation it receives from an investigating committee. Specifically, the Medical Executive Committee may:
 - (1) determine that no action is justified;
 - (2) issue a letter of guidance, counsel, warning, or reprimand;
 - (3) impose conditions for continued appointment;
 - (4) impose a requirement for monitoring, proctoring, or consultation;
 - (5) impose a requirement for additional training or education;
 - (6) recommend reduction of clinical privileges;
 - (7) recommend suspension of clinical privileges for a term;

- (8) recommend revocation of appointment and/or clinical privileges; or
 - (9) make any other recommendation that it deems necessary or appropriate.
- (b) A recommendation by the Medical Executive Committee that would entitle the individual to request a hearing shall be forwarded to the Chief Executive Officer, who shall promptly inform the individual by special notice. The Chief Executive Officer shall hold the recommendation until after the individual has completed or waived a hearing and appeal.
 - (c) If the Medical Executive Committee makes a recommendation that does not entitle the individual to request a hearing, it shall take effect immediately and shall remain in effect unless modified by the Board.
 - (d) In the event the Board considers a modification to the recommendation of the Medical Executive Committee that would entitle the individual to request a hearing, the Chief Executive Officer shall inform the individual by special notice. No final action shall occur until the individual has completed or waived a hearing and appeal.
 - (e) When applicable, any recommendations or actions that are the result of an investigation or hearing and appeal shall 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. PRECAUTIONARY SUSPENSION OR RESTRICTION OF CLINICAL PRIVILEGES

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

- (a) Whenever, in their sole discretion, failure to take such action may result in imminent danger to the health and/or safety of any individual, the Medical Executive Committee, the President of the Medical Staff, the President-Elect, the department chair, or the Vice President Medical Affairs shall each have the authority to (1) afford an individual an opportunity to voluntarily refrain from exercising privileges pending an investigation; or (2) suspend or restrict all or any portion of an individual's clinical privileges as a precaution.
- (b) A precautionary suspension or restriction can be imposed at any time, including, but not limited to, immediately after the occurrence of an event that causes concern, following a pattern of occurrences that raises concern, or following a recommendation of the Medical Executive Committee that would entitle the individual to request a hearing.
- (c) Precautionary suspension or restriction is an interim step in the professional review activity, but it is not a complete professional review action in and of itself. It shall not

imply any final finding of responsibility for the situation that caused the suspension or restriction.

- (d) A precautionary suspension or restriction shall become effective immediately upon imposition, shall immediately be reported in writing to the Vice President Medical Affairs and the President of the Medical Staff, and shall remain in effect unless it is modified by the Chief Executive Officer or Medical Executive Committee.
- (e) The individual in question shall be provided a brief written description of the reason(s) for the precautionary suspension, including the names and medical record numbers of the patient(s) involved (if any), within three days of the imposition of the suspension.

6.C.2. Medical Executive Committee Procedure:

- (a) The Medical Executive Committee shall review the matter resulting in a precautionary suspension or restriction (or the individual's agreement to voluntarily refrain from exercising clinical privileges) within a reasonable time under the circumstances, not to exceed 14 days. Prior to, or as part of, this review, the individual shall be given an opportunity to meet with the Medical Executive Committee. The individual may propose ways other than precautionary suspension or restriction to protect patients and/or employees, depending on the circumstances. Neither the Medical Executive Committee nor the individual shall be represented by legal counsel at this meeting, and no recording (audio or video) or transcript of the meeting shall be permitted or made.
- (b) After considering the matters resulting in the suspension or restriction and the individual's response, if any, the Medical Executive Committee shall determine whether there is sufficient information to warrant a final recommendation, or whether it is necessary to commence an investigation. The Medical Executive Committee shall also determine whether the precautionary suspension or restriction should be continued, modified, or terminated pending the completion of the investigation (and hearing and appeal, if applicable).
- (c) There is no right to a hearing based on the imposition or continuation of a precautionary suspension or restriction.

6.C.3. Care of Patients:

- (a) Immediately upon the imposition of a precautionary suspension or restriction, the President of the Medical Staff or Vice President Medical Affairs shall assign to another individual with appropriate clinical privileges responsibility for care of the suspended individual's hospitalized patients, or to otherwise aid in implementing the precautionary restriction, as appropriate. The assignment shall be effective until the patients are

discharged. The wishes of the patient shall be considered in the selection of a covering physician.

- (b) All members of the Medical Staff have a duty to cooperate with the President of the Medical Staff, the department chair, the Medical Executive Committee, the Vice President Medical Affairs, and the Chief Executive Officer in enforcing precautionary suspensions or restrictions.

6.D. AUTOMATIC RELINQUISHMENT/ACTIONS

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

Failure to complete medical records, after notification by the medical records department of delinquency, shall result in automatic relinquishment of all clinical privileges (except that the individual must complete all scheduled emergency service obligations or arrange appropriate coverage). Relinquishment shall continue until all delinquent records are completed and reinstatement accomplished in accordance with applicable policies and rules and regulations. Failure to complete the medical records that caused relinquishment within the time required by applicable policies and rules and regulations shall result in automatic resignation from the Medical Staff.

6.D.2. Action by Government Agency or Insurer and Failure to Satisfy Threshold Eligibility Criteria:

- (a) Any action taken by any licensing board, professional liability insurance company, court or government agency regarding any of the matters set forth below, or any failure to satisfy any of the threshold eligibility criteria set forth in this Policy, must be promptly reported by the Medical Staff member to the Chief Executive Officer, Vice President Medical Affairs or the President of the Medical Staff.
- (b) An individual's appointment and clinical privileges shall be automatically relinquished, without the right to a hearing and appeal, if any of the following occur:
 - (1) Licensure:
Revocation, expiration, suspension, or the placement of restrictions on an individual's license.
 - (2) Controlled Substance Authorization:

Revocation, expiration, suspension or the placement of restrictions on an individual's DEA controlled substance authorization.

(3) Insurance Coverage:

Termination or lapse of an individual's professional liability insurance coverage, or other action causing the coverage to fall below the minimum required by the Hospital or cease to be in effect, in whole or in part.

(4) Medicare and Medicaid Participation:

Debarment, proposed debarment, termination, exclusion, or preclusion by government action from participation in the Medicare/Medicaid or other federal or state health care programs.

(5) Criminal Activity:

Arrest, charge, indictment, conviction, or a plea of guilty or no contest pertaining to any felony; or to any misdemeanor involving (i) controlled substances; (ii) illegal drugs; (iii) Medicare, Medicaid, or insurance or health care fraud or abuse; (iv) child abuse; (v) elder abuse; or (vi) violence against another. (DUIs will be addressed in the manner outlined in this document)

- (c) An individual's appointment and clinical privileges shall also be automatically relinquished, without entitlement to the procedural rights outlined in this Policy, if the individual fails to satisfy any of the other threshold eligibility criteria set forth in this Policy, including those set forth in document.
- (d) Automatic relinquishment shall take effect immediately upon notice to the Hospital and continue until the matter is resolved and the individual is reinstated, if applicable.
- (e) If the underlying matter leads to automatic relinquishment, the individual may immediately request reinstatement. Failure to resolve the matter or failure to obtain reinstatement within 60 days of the date of relinquishment shall result in an automatic resignation from the Medical Staff.
- (f) Request for Reinstatement
 - (1) Requests for reinstatement following the expiration or lapse of a license, controlled substance authorization, and/or insurance coverage will be processed by Physician and Practitioner Services Departments. If any questions or concerns are noted, Physician and Practitioner Services Departments will refer the matter for further review in accordance with this document.

- (2) All other requests for reinstatement shall be reviewed by the relevant department chair, the Chair of the Credentials Committee, the President of the Medical Staff, the Vice President Medical Affairs, and the Chief Executive Officer. If all these individuals make a favorable recommendation on reinstatement, the Medical Staff member may immediately resume clinical practice at the Hospital. This determination shall then be forwarded to the Credentials Committee, Medical Executive Committee, and the Board for ratification. If, however, any of the individuals reviewing the request have any questions or concerns, those questions shall be noted and the reinstatement request shall be forwarded to the full Credentials Committee, Medical Executive Committee, and Board for review and recommendation.

6.D.3. Failure to Complete or Comply with Training or Educational Requirements:

Failure to complete and/or comply with training or educational requirements that are adopted by the Medical Executive Committee and/or required by the Hospital, including, but not limited to, those pertinent to electronic medical records, patient safety, and infection control, shall result in the automatic relinquishment of all clinical privileges. Any relinquishment will continue to effect until documentation of compliance is provided to the satisfaction of the requesting party. If the requested information is not provided within 60 days of the date of relinquishment, it shall result in automatic resignation from the Medical Staff.

6.D.4. Failure to Provide Requested Information:

Failure to provide information pertaining to an individual's qualifications for appointment, reappointment, or clinical privileges, in response to a written request from the Credentials Committee, the Medical Executive Committee, the Professional Practice Evaluation Committee, the Vice President Medical Affairs, the Chief Executive Officer, or any other committee authorized to request such information, shall result in the automatic relinquishment of all clinical privileges. The information must be provided within the time frame established by the requesting party. Any relinquishment will continue in effect until the information is provided to the satisfaction of the requesting party. If the requested information is not provided within 60 days of the date of relinquishment, it shall result in automatic resignation from the Medical Staff.

6.D.5. Failure to Attend Special Meeting:

- (a) Whenever there is a concern regarding the clinical practice or professional conduct involving any individual, a Medical Staff Leader may require the individual to attend a special meeting with one (1) or more of the Medical Staff Leaders and/or with a standing or ad hoc committee of the Medical Staff.
- (b) No legal counsel shall be present at this meeting, and no recording (audio or video) or transcript shall be permitted or made.

- (c) The notice to the individual regarding this meeting shall be given by special notice at least three days prior to the meeting and shall inform the individual that attendance at the meeting is mandatory.
- (d) Failure of the individual to attend the meeting shall be reported to the Medical Executive Committee. Unless excused by the Medical Executive Committee upon a showing of good cause, such failure shall result in automatic relinquishment of all or such portion of the individual's clinical privileges as the Medical Executive Committee may direct. Such relinquishment shall remain in effect until the matter is resolved.

6.E. LEAVES OF ABSENCE (LOA)

- (a) An individual appointed to the Medical Staff may request a LOA by submitting a written request to Physician and Practitioner Services Departments. Except in extraordinary circumstances, this request will be submitted at least thirty (30) days prior to the anticipated start of the leave in order to permit adjustment of the call roster and assure adequate coverage of clinical and/or administrative activities. The request must state the beginning and ending dates of the leave, which shall not exceed one (1) year, and the reasons for the leave.
- (b) Except for maternity/paternity/adoption leaves of twelve (12) weeks or less, members of the Medical Staff must notify the Physician and Practitioner Services Departments any time they are going to be away from Medical Staff and/or patient care responsibilities for longer than thirty (30) days. This notification must include the reason for their absence (e.g. sabbatical, health reasons, etc.). The Vice President Medical Affairs shall determine whether a request for a LOA shall be granted. In determining whether to grant a request, the Vice President Medical Affairs shall consult with the relevant department chair.
- (c) The granting of a LOA, or reinstatement, as appropriate, may be conditioned upon the individual's completion of all medical records.
- (d) During the LOA, the individual shall not exercise any clinical privileges. In addition, the individual shall be excused from all Medical Staff responsibilities (e.g., meeting attendance, committee service, emergency service call obligations) during this period.
- (e) Individuals requesting reinstatement shall submit a written request for such. The request should include a summary of any medical professional activities performed during the leave (e.g. providing medical care in another state or country). The department chair and/or Vice President Medical Affairs may request more information from the individual. If the leave of absence was for health reasons (except for maternity leave), the request for reinstatement must be accompanied by a report from the

individual's physician indicating that the individual is physically and/or mentally capable of resuming a hospital practice and safely exercising the clinical privileges requested.

- (f) Requests for reinstatement shall then be reviewed by the relevant department chair, the President of the Medical Staff, the Vice President Medical Affairs. If they make a favorable recommendation on reinstatement, the Medical Staff member may immediately resume clinical practice at the Hospital. If a request for reinstatement is not granted, for reasons related to clinical competence or professional conduct, the individual shall be entitled to request a hearing and appeal.
- (g) Depending on the reason for and/or the length the LOA, an FPPE may be instituted when the individual is approved to resume clinical care.
- (h) Absence for longer than one (1) year shall result in automatic relinquishment of Medical Staff appointment and clinical privileges unless an extension is granted by the Department Chair and Vice President Medical Affairs. Extensions shall be considered only in extraordinary cases where the extension of a leave is in the best interest of the Hospital.
- (i) If an individual's current appointment is due to expire during the leave, the individual must apply for reappointment, or appointment and clinical privileges shall lapse at the end of the appointment period.
- (j) Leaves of absence are matters of courtesy, not of right. In the event that it is determined that an individual has not demonstrated good cause for a leave, or where a request for extension is not granted, the determination shall be final, with no recourse to a hearing and appeal.

ARTICLE 7

PROCESS TO DETERMINE IF CORRECTIVE ACTION IS WARRANTED

7.A. PRELIMINARY REVIEW

Whenever any person has cause to question a Practitioner's continued satisfaction of the qualifications and responsibilities of Medical Staff membership and Clinical Privileges as set forth in the Bylaws, then such person may bring the matter to the attention of the applicable UPMC Pinnacle Hospitals, Department Chair, Vice President Medical Affairs or President of the Medical Staff.

Whenever a Practitioner's continued satisfaction of the qualifications and responsibilities of Medical Staff Membership or Clinical Privileges have been brought into question, the UPMC Pinnacle Hospitals, the Department Chair, the Vice President Medical Affairs, or the President of the Medical Staff shall review and discuss the allegations and supporting documentation with the affected Practitioner.

7.B. REQUEST FOR INVESTIGATION TO DETERMINE IF CORRECTIVE ACTION IF WARRANTED

Whenever the Department Chair, the Vice President Medical Affairs, or the President of the Medical Staff has reasonable cause after Preliminary Review pursuant to Section 7.A to question a Practitioner's continued satisfaction of the qualifications and responsibilities of Medical Staff membership and Clinical Privileges as set forth in the Bylaws, then such person may request an investigation as described in Section 7.C.1.

All requests for an investigation to determine if corrective action is warranted must be in writing to the Medical Executive Committee (MEC) and must be copied to the affected Practitioner. The request must

be supported by reference to the specific activity or conduct which constitutes the grounds for the investigation. This written request commences an “investigation” for the purpose of reporting adverse actions pursuant to the Health Care Quality Improvement Act and 28 Pa. Code §107.

7.C. INVESTIGATION

7.C.1. Appointment of Ad Hoc Investigating Committee

The President of the Medical Staff within five (5) business days of receipt of a request for investigation shall appoint an ad hoc Investigating Committee comprised of at least three (3) Active Medical Staff members, and the Chair of the Quality Department for the applicable department/section acting as a Professional Competence Committee, to investigate the matter. The President of the Medical Staff shall appoint one (1) of the members of the committee to serve as chair. If the President of the Medical Staff is the subject of the investigation, then the Vice President Medical Affairs will chair the committee.

7.C.2. Fact Finding of Ad Hoc Investigating Committee

The ad hoc Investigating Committee shall review all relevant evidence and interview individuals who have been identified to have information pertinent to the concerns that constitute the grounds for the request to investigate. The Practitioner who is the subject of the investigation shall have an opportunity for an interview by the ad hoc Investigating Committee and may furnish any relevant materials to the Committee. At such interview, the specific nature of the charges against him/her shall be reviewed along with supporting documentation and he/she shall be invited to discuss, explain or refute them. This interview shall not constitute a hearing and shall be preliminary in nature. None of the procedural rules provided in the Bylaws with respect to hearings shall apply thereto.

7.C.3. Report of the Ad Hoc Investigating Committee

Within fifteen (15) business days after the President’s or applicable physician leader appointment of the ad hoc Investigating Committee, the chair of the ad hoc Investigating Committee shall make a report of the investigation to the President of the Medical Staff or the applicable physician leader as to investigations involving the President of the Medical Staff with a copy to the affected Practitioner.

7.D. MEDICAL EXECUTIVE COMMITTEE RECOMMENDATION

7.D.1. Recommendations and Actions

Within ten (10) business days following receipt of a report from the ad hoc Investigating Committee, the President or the applicable physician leader as to investigations involving the President of the Medical Staff shall present the report to the MEC. The MEC will review the report and determine what action(s) to take. Before taking action, the MEC may in its discretion require additional information and may

require the Practitioner to appear before it. The action of the MEC on the reported concerns may include one (1) or more of the following:

- (a) determine the concern warrants no further action,
- (b) issue a warning letter,
- (c) require a focused professional practice evaluation (FPPE),
- (d) require time-limited precepting of all patient care by the Practitioner,
- (e) recommend terms of probation or a requirement for consultation,
- (f) recommend that the Practitioner's staff membership and/or Clinical Privileges should be suspended or revoked, or
- (g) other actions deemed appropriate by the MEC

(Items d, e, and f are all reportable to the National Practitioner Data Bank, additionally if a practitioner resigns in the midst of an investigation that is a reportable event as well)

7.D.2. Notice to the Practitioner

The President of the Medical Staff shall notify the affected Practitioner of the actions of the MEC within three (3) business days following the MEC meeting at which the recommendation occurred. Notice of any recommendation by the MEC for adverse action that would constitute grounds for a hearing shall be given by written notice.

7.D.3. Appearance before Medical Executive Committee

If the MEC takes adverse action other than to recommend corrective action that would constitute grounds for a hearing, the affected Practitioner is permitted and/or the MEC may require the Practitioner to appear before the MEC after the meeting at which the MEC took action. This appearance shall not constitute a hearing. None of the procedural rules provided in the Bylaws with respect to hearings shall apply thereto. The MEC must thereafter affirm, modify or revoke the original action. A summary record of such appearances must be made by the MEC and provided to the Practitioner

ARTICLE 8

HEARING AND APPEAL PROCEDURES

8.A. INITIATION OF HEARING

8.A.1. Grounds for Hearing:

- (a) An individual is entitled to request a hearing whenever the Medical Executive Committee makes one (1) of the following recommendations:
 - (1) denial of initial appointment to the Medical Staff;
 - (2) denial of reappointment to the Medical Staff;
 - (3) revocation of appointment to the Medical Staff;
 - (4) denial of requested clinical privileges;
 - (5) revocation of clinical privileges;
 - (6) suspension of clinical privileges for more than thirty (30) days;
 - (7) mandatory concurring consultation requirement (i.e., the consultant must approve the course of treatment in advance); or
 - (8) denial of reinstatement from a leave of absence if the reasons relate to clinical competence or professional conduct.

- (b) No other recommendations shall entitle the individual to a hearing.
- (c) If the Board makes any of these determinations without an adverse recommendation by the Medical Executive Committee, an individual would also be entitled to request a hearing. For ease of use, this Article refers to adverse recommendations of the Medical Executive Committee. When a hearing is triggered by an adverse recommendation of the Board, any reference in this Article to the “Medical Executive Committee” shall be interpreted as a reference to the “Board.”

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

None of the following actions shall constitute grounds for a hearing, and they shall take effect without hearing or appeal, provided that the individual shall be entitled to submit a written explanation to be placed into his or her file:

- (a) issuance of a letter of guidance, counsel, warning, or reprimand;
- (b) imposition of conditions, monitoring, proctoring, or a general consultation requirement (i.e., the individual must obtain a consult but need not get prior approval for the treatment);
- (c) termination of temporary privileges;
- (d) automatic relinquishment of appointment or privileges;
- (e) imposition of a requirement for additional training or continuing education;
- (f) precautionary suspension for thirty (30) days or less;
- (g) denial of a request for leave of absence, for an extension of a leave or for reinstatement from a leave if the reasons do not relate to clinical competence or professional conduct;
- (h) determination that an application is incomplete;
- (i) determination that an application shall not be processed due to a misstatement or omission; or
- (j) determination of ineligibility based on a failure to meet threshold eligibility criteria, a lack of need or resources, or because of an exclusive contract.

8.B. THE HEARING

8.B.1. Notice of Recommendation:

The Chief Executive Officer or his designee shall promptly give special notice of a recommendation which entitles an individual to request a hearing. This notice shall contain:

- (a) a statement of the recommendation and the general reasons for it;
- (b) a statement that the individual has the right to request a hearing on the recommendation within thirty (30) days of receipt of this notice;
- (c) a copy of this Article;
- (d) an explanation that failure to request a hearing within the thirty (30) day time period and in the proper manner constitutes a waiver of all rights under Article 7; and
- (e) a statement indicating that the adverse action is reportable to the National Practitioner Data Bank if the action becomes final.

8.B.2. Request for Hearing:

An individual has thirty (30) days following receipt of the notice to request a hearing. The request shall be in writing to the Chief Executive Officer or the person designated by the Chief Executive Officer in the notice of hearing and shall include the name, address, and telephone number of the individual's counsel, if any. The Chief Executive Officer or his designee shall forward the request to the President of the Medical Staff. Failure to request a hearing shall constitute waiver of the right to a hearing, and the recommendation shall be transmitted to the Board for final action.

8.B.3. Notice of Hearing and Statement of Reasons:

- (a) The President of the Medical Staff shall schedule the hearing and provide, by special notice to the individual requesting the hearing, the following:
 - (1) the time, place, and date of the hearing;
 - (2) a proposed list of witnesses who shall give testimony at the hearing and a brief summary of the anticipated testimony;
 - (3) the names of the Hearing Panel members and Presiding Officer, if known; and
 - (4) a statement of the reasons for the recommendation, including a list of patient records (if applicable), and a general description of the information supporting the recommendation. This statement does not bar presentation of additional evidence or information at the hearing, so long as the additional material is relevant to the recommendation or the individual's qualifications and the individual has a sufficient opportunity to review and rebut the additional information.

- (b) The hearing shall begin no sooner than thirty (30) days nor more than sixty (60) days after the notice of the hearing, unless an earlier hearing date has been specifically agreed to in writing by the parties.
- (c) The notice of hearing shall further indicate that failure to appear at the hearing shall constitute a waiver of all rights under Article 7.

8.B.4. Hearing Panel and Presiding Officer:

(a) Hearing Panel:

The President of the Medical Staff, shall appoint a Hearing Panel in accordance with the following guidelines:

- (1) The Hearing Panel shall consist of at least five members and may include any combination of:
 - (i) any member of the Medical Staff, provided the member has not actively participated in the matter at any previous level; and/or
 - (ii) physicians or laypersons not connected with the Hospital (i.e., physicians not on the Medical Staff or laypersons not affiliated with the Hospital).
- (2) Knowledge of the underlying peer review matter, in and of itself, shall not preclude the individual from serving on the Panel.
- (3) Employment by, or other contractual arrangement with, the Hospital or an affiliate shall not preclude an individual from serving on the Panel.
- (4) The Panel shall not include any individual who is in direct economic competition with the individual requesting the hearing.
- (5) The Panel shall not include any individual who is professionally associated with, related to, or involved in a referral relationship with, the individual requesting the hearing.
- (6) The Panel shall not include any individual who is demonstrated to have an actual bias, prejudice, or conflict of interest that would prevent the individual from fairly and impartially considering the matter.

(b) Presiding Officer:

- (1) The President of the Medical Staff, shall appoint a Presiding Officer. The Presiding Officer shall not act as an advocate for either side at the hearing. The Presiding Officer and hearing panel shall be compensated by the Hospital, but

the individual requesting the hearing may participate in that compensation should the individual wish to do so.

- (2) The Presiding Officer shall:
 - (i) 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;
 - (ii) prohibit conduct or presentation of evidence that is cumulative, excessive, irrelevant or abusive or that causes undue delay;
 - (iii) maintain decorum throughout the hearing;
 - (iv) determine the order of procedure;
 - (v) rule on all matters of procedure and the admissibility of evidence; and
 - (vi) conduct argument by counsel on procedural points within or outside the presence of the Hearing Panel at the Presiding Officer's discretion.
- (3) The Presiding Officer may be advised by legal counsel to the Hospital with regard to the hearing procedure.

(c) Objections:

Any objection to any member of the Hearing Panel shall be made in writing, within 10 days of receipt of notice, to the President of the Medical Staff. The President of the Medical Staff shall rule on the objection and give notice to the parties.

8.B.5. Counsel:

Counsel for either party may be an attorney at law who is licensed to practice, in good standing, in any state.

8.C. PRE-HEARING PROCEDURES

8.C.1. General Procedures:

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

8.C.2. Time Frames:

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

- (a) the pre-hearing conference shall be scheduled at least 14 days prior to the hearing;
- (b) the parties shall exchange witness lists and proposed documentary exhibits at least 10 days prior to the pre-hearing conference; and
- (c) any objections to witnesses and/or proposed documentary exhibits must be provided at least five days prior to the pre-hearing conference.

8.C.3. Witness List:

- (a) At least 10 days before the pre-hearing conference, the individual requesting the hearing shall provide a written list of the names of witnesses expected to offer testimony on his or her behalf.
- (b) The witness list shall include a brief summary of the anticipated testimony.
- (c) The witness list of either party may, in the discretion of the Presiding Officer, be amended at any time during the course of the hearing, provided that notice of the change is given to the other party.

8.C.4. Provision of Relevant Information:

- (a) Prior to receiving any confidential documents, the individual requesting the hearing must agree that all documents and information shall be maintained as confidential and shall not be disclosed or used for any purpose outside of the hearing. The individual must also provide a written representation that his/her counsel and any expert(s) have executed Business Associate agreements in connection with any patient Protected Health Information contained in any documents provided.
- (b) Upon receipt of the above agreement and representation, the individual requesting the hearing shall be provided with a copy of the following:
 - (1) copies of, or reasonable access to, all patient medical records referred to in the statement of reasons, at the individual's expense;
 - (2) reports of experts relied upon by the Medical Executive Committee;
 - (3) copies of relevant minutes (with portions regarding other physicians and unrelated matters deleted); and
 - (4) copies of any other documents relied upon by the Medical Executive Committee.

The provision of this information is not intended to waive any privilege under the Pennsylvania peer review protection statutes.

- (c) The individual shall have no right to discovery beyond the above information. No information shall be provided regarding other practitioners on the Medical Staff. In addition, there is no right to depose, interrogate, or interview witnesses or other individuals prior to the hearing.
- (d) At least 10 days prior to the pre-hearing conference (or as otherwise agreed upon by both sides), each party shall provide the other party with its proposed exhibits. All objections to documents or witnesses shall be submitted in writing at least five days in advance of the pre-hearing conference. The Presiding Officer shall not entertain subsequent objections unless the party offering the objection demonstrates good cause.
- (e) Evidence unrelated to the reasons for the recommendation or to the individual's qualifications for appointment or the relevant clinical privileges shall be excluded.
- (f) Neither the individual, nor any other person acting on behalf of the individual, may contact Hospital employees or Medical Staff members whose names appear on the Medical Executive Committee's witness list or in documents provided pursuant to this section concerning the subject matter of the hearing, until the Hospital has been notified and has contacted the individuals about their willingness to be interviewed. The Hospital will advise the individual who has requested the hearing once it has contacted such employees or Medical Staff members and confirmed their willingness to meet. Any employee or Medical Staff member may agree or decline to be interviewed by or on behalf of the individual who requested a hearing.

8.C.5. Pre-Hearing Conference:

The Presiding Officer shall require the individual and the Medical Executive Committee or their representatives (who may be counsel) to participate in a pre-hearing conference, which shall be held no later than 14 days prior to the hearing. At the pre-hearing conference, the Presiding Officer shall resolve all procedural questions, including any objections to exhibits or witnesses. The Presiding Officer shall establish the time to be allotted to each witness's testimony and cross-examination. It is expected that the hearing shall last no more than 15 hours, with each side being afforded approximately seven and a half hours to present its case, in terms of both direct and cross-examination of witnesses. Both parties are required to prepare their case so that a hearing shall be concluded after a maximum of 15 hours. The Presiding Officer may, after considering any objections, grant limited extensions upon a demonstration of good cause and to the extent compelled by fundamental fairness.

8.C.6. Stipulations:

The parties and their counsel, if applicable, shall use their best efforts to develop and agree upon stipulations, so as to provide for a more orderly and efficient hearing by narrowing the issues on which live testimony is reasonably required.

8.C.7. Provision of Information to the Hearing Panel:

The following documents shall be provided to the Hearing Panel in advance of the hearing: (a) a pre-hearing statement that either party may choose to submit; (b) exhibits offered by the parties following the pre-hearing conference (without the need for authentication); and (c) any stipulations agreed to by the parties.

8.D. HEARING PROCEDURES

8.D.1. Rights of Both Sides and the Hearing Panel at the Hearing:

- (a) At a hearing, both sides shall have the following rights, subject to reasonable limits determined by the Presiding Officer:
 - (1) to call and examine witnesses, to the extent they are available and willing to testify;
 - (2) to introduce exhibits;
 - (3) to cross-examine any witness on any matter relevant to the issues;
 - (4) to have representation by counsel who may call, examine, and cross-examine witnesses and present the case; and
 - (5) to submit proposed findings, conclusions, and recommendations to the Hearing Panel after the conclusion of the hearing session(s).
- (b) If the individual who requested the hearing does not testify, he or she may be called and questioned.
- (c) The Hearing Panel may question witnesses, request the presence of additional witnesses, and/or request documentary evidence.

8.D.2. Record of Hearing:

A stenographic reporter shall be present to make a record of the hearing. The cost of the reporter shall be borne by the Hospital. Copies of the transcript shall be available at the individual's expense. Oral evidence shall be taken only on oath or affirmation administered by any person entitled to notarize documents in this state.

8.D.3. Failure to Appear:

Failure, without good cause, to appear and proceed at the hearing shall constitute a waiver of the right to a hearing and the matter shall be transmitted to the Board for final action.

8.D.4. Presence of Hearing Panel Members:

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

8.D.5. Persons to be Present:

The hearing shall be restricted to those individuals involved in the proceeding, the President of the Medical Staff, and the Chief Executive Officer. In addition, administrative personnel may be present as requested by the Chief Executive Officer or the President of the Medical Staff.

8.D.6. Order of Presentation:

The Medical Executive Committee shall first present evidence in support of its recommendation. Thereafter, the burden shall shift to the individual who requested the hearing to present evidence.

8.D.7. Admissibility of Evidence:

The hearing shall not be conducted according to rules of evidence. Evidence shall not be excluded merely because it is hearsay. Any relevant evidence shall be admitted if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law. The guiding principle shall be that the record contains information sufficient to allow the Board to decide whether the individual is qualified for appointment and clinical privileges.

8.D.8. Post-Hearing Statement:

Each party shall have the right to submit a written statement, and the Hearing Panel may request that statements be filed, following the close of the hearing.

8.D.9. Postponements and Extensions:

Postponements and extensions of time may be requested by anyone, but shall be permitted only by the Presiding Officer or the President of the Medical Staff on a showing of good cause.

8.E. HEARING CONCLUSION, DELIBERATIONS, AND RECOMMENDATIONS

8.E.1. Basis of Hearing Panel Recommendation:

Consistent with the burden on the individual to demonstrate that he or she satisfies, on a continuing basis, all criteria for initial appointment, reappointment, and clinical privileges, the Hearing Panel shall recommend in favor of the Medical Executive Committee unless it finds that the individual who

requested the hearing has proved, by clear and convincing evidence, that the recommendation that prompted the hearing was arbitrary, capricious, or not supported by credible evidence.

8.E.2. Deliberations and Recommendation of the Hearing Panel:

Within thirty (30) days after final adjournment of the hearing (which may be designated as the time the Hearing Panel receives the hearing transcript or any post-hearing statements, whichever is later), the Hearing Panel shall conduct its deliberations outside the presence of any other person except the Presiding Officer. Thereafter, the Hearing Panel shall render a recommendation reflecting the majority of the Hearing Panel, accompanied by a report, which shall contain a concise statement of the basis for its recommendation. The report may recommend confirmation, modification or rejection of the adverse recommendation.

8.E.3. Disposition of Hearing Panel Report:

The Hearing Panel shall deliver its report to the Chief Executive Officer. The Chief Executive Officer shall send by special notice a copy of the report to the individual who requested the hearing and to legal counsel for the parties. The Chief Executive Officer shall also provide a copy of the report to the Medical Executive Committee.

8.F. APPEAL PROCEDURE

8.F.1. Time for Appeal:

- (a) Within 10 days after notice of the Hearing Panel's recommendation, either party may request an appeal. The request shall be in writing, delivered to the Chief Executive Officer either in person or by certified mail, return receipt requested, and shall include a statement of the reasons for appeal and the specific facts or circumstances which justify further review.
- (b) If an appeal is not requested within 10 days, an appeal is deemed to be waived and the Hearing Panel's report and recommendation shall be forwarded to the Board for final action.

8.F.2. Grounds for Appeal:

The grounds for appeal shall be limited to the following:

- (a) there was substantial failure by the Hearing Panel to comply with this Policy and/or the Medical Staff Bylaws during the hearing, so as to deny a fair hearing; and/or
- (b) the recommendations of the Hearing Panel were made arbitrarily or capriciously and/or were not supported by credible evidence.

8.F.3. Time, Place and Notice:

Whenever an appeal is requested as set forth in the preceding Sections, the Chair of the Board (or the Chief Executive Officer on behalf of the Chair) shall schedule and arrange for an appeal. The individual shall be given special notice of the time, place, and date of the appeal. The appeal shall be held as soon as arrangements can reasonably be made, taking into account the schedules of all the individuals involved.

8.F.4. Nature of Appellate Review:

- (a) The Board may serve as the Review Panel or the Chair of the Board may appoint a Review Panel composed of not less than three persons, either members of the Board or others, including but not limited to reputable persons outside the Hospital, to consider the record upon which the recommendation before it was made and recommend final action to the Board.
- (b) Each party shall have the right to present a written statement in support of its position on appeal. The party requesting the appeal shall submit a statement first and the other party shall then have ten days to respond. In its sole discretion, the Review Panel may allow each party or its representative to appear personally and make oral argument not to exceed thirty (30) minutes.
- (c) When requested by either party, the Review Panel may, in its discretion, accept additional oral or written evidence subject to the same rights of cross-examination provided at the Hearing Panel proceedings. Such additional evidence shall be accepted only if the Review Panel determines that the party seeking to admit it has demonstrated that it is relevant, new evidence that could not have been presented at the hearing, or that any opportunity to admit it at the hearing was improperly denied.

8.G. BOARD ACTION

8.G.1. Final Decision of the Board:

- (a) Within thirty (30) days after the Board (i) considers the appeal as a Review Panel, (ii) receives a recommendation from a separate Review Panel, or (iii) receives the Hearing Panel's report and recommendation when no appeal has been requested, the Board shall consider the matter and take final action.
- (b) The Board may review any information that it deems relevant, including, but not limited to, the findings and recommendations of the Medical Executive Committee, Hearing Panel, and Review Panel (if applicable). The Board may adopt, modify, or reverse any recommendation that it receives or, in its discretion, refer the matter to any individual or committee for further review and recommendation, or make its own decision based upon the Board's ultimate legal authority for the operation of the Hospital and the quality of care provided.

- (c) The Board shall render its final decision in writing, including specific reasons, and shall send special notice to the individual. A copy shall also be provided to the Medical Executive Committee for its information.

8.G.2. Further Review:

Except where the matter is referred by the Board for further action and recommendation by any individual or committee, the final decision of the Board shall be effective immediately and shall not be subject to further review. If the matter is referred for further action and recommendation, such recommendation shall be promptly made to the Board in accordance with the instructions given by the Board.

8.G.3. Right to One Hearing and One Appeal Only:

No member of the Medical Staff shall be entitled to more than one (1) hearing and one (1) appellate review on any matter. If the Board denies initial appointment to the Medical Staff or reappointment or revokes the appointment and/or clinical privileges of a current member of the Medical Staff, that individual may not apply for staff appointment or for those clinical privileges for a period of five years unless the Board provides otherwise.

ARTICLE 9

CONFLICT OF INTEREST GUIDELINES

(A chart summarizing the following guidelines can be found in Appendix A to this Policy.)

9.A.1. General Principles:

- (a) All those involved in credentialing and professional practice evaluation activities must be sensitive to potential conflicts of interest in order to be fair to the individual whose qualifications are under review, to protect the individual with the potential conflict, and to protect the integrity of the review process.
- (b) It is also essential that peers participate in credentialing and professional practice evaluation review activities in order for these activities to be meaningful and effective. Therefore, whether and how an individual can participate must be evaluated reasonably, taking into consideration common sense and objective principles of fairness.

9.A.2. Immediate Family Members:

No immediate family member (spouse, parent, child, sibling, or in-law) of a practitioner whose application or care is being reviewed shall participate in any aspect of the review process, except to provide information.

9.A.3. Employment or Contractual Relationship with the Hospital:

Employment by, or other contractual arrangement with, the Hospital or an affiliate shall not, in and of itself, preclude an individual from participating in credentialing and professional practice evaluation

activities. Rather, participation by such individuals shall be evaluated as outlined in the paragraphs below.

9.A.4. Actual or Potential Conflict Situations:

With respect to a practitioner whose application or care is under review, actual or potential conflict situations involving other members of the Medical Staff include, but are not limited to, the following:

- (a) membership in the same group practice;
- (b) having a direct or indirect financial relationship;
- (c) being a direct competitor;
- (d) close friendship;
- (e) a history of personal conflict;

- (f) personal involvement in the care of a patient which is subject to review;
- (g) raising the concern that triggered the review; or
- (h) prior participation in review of the matter at a previous level.

Any such individual shall be referred to as an “Interested Member” in the remainder of this Article for ease of reference.

9.A.5. Guidelines for Participation in Credentialing and Professional Practice Evaluation Activities:

An Interested Member shall have the obligation to disclose any actual or potential conflict of interest. When an actual or potential conflict situation exists as outlined in the paragraph above, the following guidelines shall be used.

(a) Initial Reviewers

An Interested Member may participate as an initial reviewer as long as there is a check and balance provided by subsequent review by a Medical Staff committee. This applies, but is not limited to, the following situations:

- (1) participation in the review of applications for appointment, reappointment, and clinical privileges because of the Credentials Committee’s and Medical Executive Committee’s subsequent review of credentialing matters; and
- (2) participation as case reviewers in professional practice evaluation activities because of the Professional Practice Evaluation Committee’s (Peer Review Committee’s) subsequent review of peer review matters.

(b) Credentials Committee or Professional Practice Evaluation Committee Member

An Interested Member may fully participate as a member of these committees because these committees do not make any final recommendation that could adversely affect the clinical privileges of a practitioner, which is only within the authority of the Medical Executive Committee. However, the chairs of these committees always have the discretion to recuse an Interested Member if they determine that the Interested Member's presence would inhibit full and fair discussion of the issue or would skew the recommendation or determination of the committee.

(c) Ad Hoc Investigating Committee

Once a formal investigation has been initiated, additional precautions are required. Therefore, an Interested Member may not be appointed as a member of an ad hoc investigating committee, but may be interviewed and provide information to the ad hoc investigating committee if necessary, for the committee to conduct a full and thorough investigation.

(d) Medical Executive Committee

An Interested Member will be recused and may not participate as a member of the Medical Executive Committee when the Medical Executive Committee is considering a recommendation that could adversely affect the clinical privileges of a practitioner, subject to the rules for recusal outlined below.

(e) Board

An Interested Member will be recused and may not participate as a member of the Board when the Board is considering a recommendation that could adversely affect the clinical privileges of a practitioner, subject to the rules for recusal outlined below.

9.A.6. Guidelines for Participation in Development of Privileging Criteria:

Recognizing that the development of privileging criteria can have a direct or indirect financial impact on particular physicians, the following guidelines apply. Any individual who has a personal interest in privileging criteria, including criteria for privileges that cross specialty lines or criteria for new procedures, may:

- (a) provide information and input to the Credentials Committee or an ad hoc committee charged with development of such criteria;
- (b) participate in the discussion or action of the Credentials Committee or an ad hoc committee charged with development of such criteria because these committees do not make the final recommendation regarding the criteria (however, the Chair of the Credentials Committee or ad hoc committee always has the discretion to recuse an

Interested Member in a particular situation, in accordance with the rules for recusal outlined below); but

- (c) not participate in the discussion or action of the Medical Executive Committee when it is considering its final recommendation to the Board regarding the criteria or participate in the final discussions or action of the Board related to the criteria.

9.A.7. Rules for Recusal:

- (a) Any Interested Member who is recused from participating in a committee or Board meeting must leave the meeting room prior to the committee's or Board's final deliberation and determination but may answer questions and provide input before leaving.
- (b) Any recusal will be documented in the committee's or Board's minutes.
- (c) Whenever possible, an actual or potential conflict should be brought to the attention of the President of the Medical Staff or committee/Board chair, a recusal determination made, and the Interested Member informed of the recusal determination prior to the meeting.

9.A.8. Other Considerations:

- (a) Any member of the Medical Staff who is concerned about a potential conflict of interest on the part of any other member, including but not limited to the situations noted in the paragraphs above, must call the conflict of interest to the attention of the President of the Medical Staff (or to the President-Elect if the President of the Medical Staff is the person with the potential conflict), or the applicable committee/Board chair. The member's failure to notify will constitute a waiver of the claimed conflict. The President of the Medical Staff or the applicable committee/Board chair has the authority to make a final determination as to how best to manage the situation, guided by this Article, including recusal of the Interested Member, if necessary.
- (b) No staff member has a right to compel the disqualification of another staff member based on an allegation of conflict of interest. Rather, that determination is within the discretion of the Medical Staff Leaders or Board chair, guided by this Article.
- (c) The fact that an individual chooses to refrain from participation or is excused from participation in any credentialing or peer review activity, shall not be interpreted as a finding of actual conflict that inappropriately influenced the review process.

ARTICLE 10

CONFIDENTIALITY AND PEER REVIEW PROTECTION

10.A. CONFIDENTIALITY

Actions taken and recommendations made pursuant to this Policy shall be strictly confidential. Individuals participating in, or subject to, credentialing and professional practice evaluation activities shall make no disclosures of any such information (discussions or documentation) outside of committee meetings, except:

- (a) when the disclosures are to another authorized member of the Medical Staff or authorized Hospital employee including, without limitation, respective Department Chairs, Vice President Medical Affairs, chair and members of the Credentials Committee, Hospital Legal Counsel and the CEO, and are for the purpose of researching, investigating, or otherwise conducting legitimate credentialing and professional practice evaluation activities;
- (b) when the disclosures are authorized by a Medical Staff or Hospital policy; or
- (c) when the disclosures are authorized, in writing, by the Chief Executive Officer or by legal counsel to the Hospital.

Any breach of confidentiality may result in a professional review action and/or appropriate legal action. Such breaches are unauthorized and do not waive the peer review privilege. Any member of the Medical Staff who becomes aware of a breach of confidentiality must immediately inform the Chief Executive Officer, Vice President Medical Affairs, or the President of the Medical Staff (or the President-Elect if the President of the Medical Staff is the person committing the claimed breach).

10.B. PEER REVIEW PROTECTION

- (a) All professional review activity will be performed by peer review committees.

Peer review committees include, but are not limited to:

- (1) all standing and ad hoc Medical Staff and Hospital committees;
- (2) all departments and sections;
- (3) hearing and appellate review panels;
- (4) the Board and its committees; and
- (5) any individual acting for or on behalf of any such entity, including but not limited to department chairs, section chiefs, committee chairs and members, officers of the Medical Staff, all Hospital personnel, and experts or consultants retained to assist in peer review activities.

All oral or written communications, reports, recommendations, actions, and minutes made or taken by peer review committees are confidential and covered by the applicable provisions of state or federal law providing protection for credentialing and peer review activities.

- (b) All peer review committees shall also be deemed to be “professional review bodies” as that term is defined in the Health Care Quality Improvement Act of 1986, 42 U.S.C. §11101 et seq.

ARTICLE 11

AMENDMENTS

This Policy may be amended by a majority vote of the members of the Medical Executive Committee 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 Medical Executive Committee. Notice of all proposed amendments shall be provided to all voting members of the Medical Staff at least 14 days prior to the Medical Executive Committee meeting and any Medical Staff member may submit written comments to the Medical Executive Committee. No amendment shall be effective unless and until it has been approved by the Board.

ARTICLE 12

ADOPTION

This Policy is adopted and made effective upon approval of the Board, superseding and replacing any and all other Bylaws, Rules and Regulations of the Medical Staff or Hospital policies pertaining to the subject matter thereof.

Adopted by the Medical Staff: _____

Approved by the Board: _____

APPENDIX A

CONFLICT OF INTEREST GUIDELINES

Potential Conflicts	Levels of Participation							
	Provide Information	Individual Reviewer Application / Case	Committee Member				Hearing Panel	Board
			Credentials	PPEC	Medical Executive Committee	Ad Hoc Investigating		
Family Member	Y	R	R	R	R	N	N	R
Employment relationship with hospital	Y	Y	Y	Y	Y	Y	Y	Y
Partner	Y	Y	Y	Y	R	N	N	R
Direct or indirect financial impact	Y	Y	Y	Y	R	N	N	R
Competitor	Y	Y	Y	Y	R	N	N	R
History of conflict	Y	Y	Y	Y	R	N	N	R
Close friends	Y	Y	Y	Y	R	N	N	R
Personally involved in care of patient	Y	Y	Y	Y	R	N	N	R
Reviewed at prior level	Y	Y	Y	Y	R	N	N	R
Raised the concern	Y	Y	Y	Y	R	N	N	R

Y – (green “Y”) means the Interested Member may serve in the indicated role, no extra precautions are necessary.

Y – (yellow “Y”) means that the Medical Staff Leaders have discretion to determine whether an Interested Member may serve in the indicated role. It is legally-permissible for such Interested Members to serve in these roles because of the check and balance provided by the multiple levels of review, and the fact that neither the PPEC nor the Credentials Committee have disciplinary authority. In addition, the Credentials/PPEC Chair always has the authority and discretion to recuse a member in particular situation if the Chair determines that the Interested Member’s presence would be unfair to the practitioner under review, inhibit the full and fair discussion of the issue before the committee, or skew the recommendation or determination of the committee. Allowing Interested Members to participate in the credentialing or professional practice evaluation process underscores the importance of establishing (i) objective threshold criteria for appointment and clinical privileges, (ii) objective criteria to review cases against in PPE activities (adopted protocols, etc.), and (iii) objective review and evaluation forms to be used by reviewers.

N – (red “N”) means the individual may not serve in the indicated role.

R – (red “R”) means the individual must be recused in accordance with the rules for recusal on the following page.

Rules for Recusal

- Interested Member must leave the meeting room prior to the committee’s or Board’s final deliberation and determination, but may answer question and provide input before leaving.
- Recusal shall be specifically documented in the minutes.
- Whenever possible, the actual or potential conflict should be raised and resolved prior to meeting by the committee or Board chair and the Interested Member informed of the recusal determination in advance.
- No Medical Staff member has the RIGHT to demand recusal – that determination is within discretion of the Medical Staff Leaders.
- Voluntarily choosing to refrain from participating in a particular situation is not a finding or an admission of an actual conflict or any improper influence on the process.

Appendix B

Focused Professional Practice Evaluation (FPPE) Policy

I. PURPOSE

To establish a system to evaluate the professional competence of all practitioners new to UPMC Pinnacle Hospitals (Harrisburg, West Shore and Community Osteopathic) who have been granted clinical privileges, currently appointed practitioners who request and are granted additional clinical privileges and if a question/concern arises regarding a current privileged practitioner's ability to execute a privilege(s) in a safe, high quality, professional manner.

II. POLICY

Practitioners who are new to UPMC Pinnacle Hospitals will be subject to monitoring and evaluation in accordance with quality management mechanisms that are applied to all practitioners. In addition, for a defined period of time, an FPPE (i.e. prospective proctoring, concurrent proctoring and/or retrospective review) will be employed in order to evaluate competency.

Practitioners who request additional privileges will also be subject to additional monitoring in order to evaluate competency.

If a question/concern arises regarding a current privileged practitioner's ability to execute a privilege(s) in a safe, high quality, professional manner, an FPPE will be implemented.

Whether prospective proctoring, concurrent proctoring or retrospective review is more appropriate depends on the practitioner's specialty, the clinical privileges granted, and questions which may be raised regarding the practitioner's competence to perform specific clinical privileges. Cognitive specialties are usually evaluated retrospectively. Prospective review and concurrent proctoring are the preferred methods of evaluation of practitioners who perform procedural privileges.

The Department Chair, Credentials Committee and/or the Medical Executive Committee may place a practitioner practicing in an outpatient setting on an FPPE if a question/concern arises about the practitioner's ability to deliver care in a safe, high quality, professional manner. This could occur on initial appointment or during medical staff membership.

The Credentials Committee is charged with the responsibility of monitoring compliance with this policy and procedure and will receive regular status reports related to the progress of all practitioners during their FPPEs as well as any issues or problems involved in implementation of this policy and procedure.

III. DEFINITIONS

Prospective Proctoring: Presentation of cases with planned treatment outlined for the reviewer's concurrence or review of case documentation for treatment concurrence prior to care being delivered to the patient.

Concurrent Proctoring: Direct observation of the procedure being performed or medical management either through observation of practitioner interactions with patients and staff members or review of clinical history and physical and review of treatment orders during the patient's hospital stay.

Retrospective Evaluation: Review of case record after care has been completed. May also involve interviews of personnel directly involved in the care of the patient.

IV. PRACTITIONERS SUBJECT TO THIS POLICY AND PROCEDURE

Practitioners subject to this policy and procedure include:

- A. New practitioners appointed to the Medical or Allied Health Staff.
- B. Practitioners who request additional privileges; and
- C. When a question arises regarding a current privileged practitioner's ability to execute a privilege(s) in a safe, high quality, professional manner.

V. DEPARTMENT ASSIGNMENT AND ASSIGNMENT OF EVALUATORS

At the time of initial appointment, all practitioners are assigned to a department of the Medical Staff Organization.

- A. The Chair of the Department to which a practitioner has been assigned shall have primary responsibility for assuring that the practitioner's clinical competency and conduct is evaluated.
- B. The Department Chair will make a recommendation related to the specific types of the FPPE (to include number of cases/reviews required, see Section VIII for required number regarding Retrospective Evaluation). This recommendation will be based on the degree of difficulty and/or technical similarity of the privileges that have been recommended. The Department Chair may delegate this responsibility to a Section Chief when appropriate.
- C. The Department Chair may delegate the responsibility to conduct prospective review, concurrent proctoring and/or retrospective review and evaluations of the practitioner to other members of the department (section) or to practitioners in other departments who have expertise in the clinical privileges granted to the practitioner. In addition, the Department Chair may request (of the Credentials Committee and Medical Executive Committee) that evaluation be accomplished by assistance from a qualified practitioner who is not currently appointed to the Medical or Allied Health Staff of UPMC Pinnacle Hospitals.

D. Requirements of Reviewers/Proctor(s):

1. Reviewers/Proctor(s) shall be assigned by the Department Chair, or designee.
2. It is the responsibility of all members of the Active staff (or when appropriate) Allied Health Staff within each Department to serve as Reviewers/Proctors when asked to do so. Refusal to accept Reviewer/Proctor assignment or to fulfill service as a Reviewer/Proctor may lead to corrective action.
3. Reviewer(s)/Proctor(s) must be members in good standing of the Active Medical Staff (or when appropriate) Allied Health Staff of UPMC Pinnacle Hospitals and must have unrestricted privileges to perform any procedure(s) to be concurrently observed (See #4 for exception).
4. In circumstances where no one on the Medical Staff has the expertise to review/proctor for a privilege(s), qualified practitioners who are not currently appointed to the Medical Staff may be allowed to review/proctor.

VI. CONCURRENT PROCTORING OF SURGICAL OR OTHER INVASIVE PROCEDURES

- A. The concurrent Proctor is at all times acting on behalf of, and with the authority of the Medical Staff Organization and UPMC Pinnacle Hospitals.
- B. The concurrent evaluation of surgical or other invasive procedures shall consist of the following, as applicable:
 1. Discussion with the practitioner about the procedure to be done and the indicators for it. If the Proctor disagrees with the practitioner, the Proctor should explain his or her opinion to the practitioner.
 2. The Proctor will be present during the essential part of the procedure.
 3. A written report of each evaluation (Exhibit A) shall be made to the Department Chair to which the practitioner has been assigned.
- C. The Proctor is encouraged to intervene directly (even to the extent of taking over the case) at any time during the concurrent evaluation if, in the Proctor's opinion, such intervention is in the best interest of the patient. The intervention shall be reported to the Chair of the Department to which the practitioner has been assigned.

VII. REQUIREMENTS OF THE PRACTITIONER BEING PROCTORED

- A. It is the responsibility of the practitioner to contact the assigned Proctor for each case that is to be prospectively or concurrently observed.
- B. It is the responsibility of the practitioner to comply with the requirements related to the number and types of cases to be observed and evaluated.

- C. At the time of a new staff member's appointment to the Medical or Allied Staff, or in the case of existing members requesting additional privileges, such member shall be provided with the names and contact information of assigned Proctors by the Department Chair or Section Chief. It will be the practitioner's responsibility to obtain an Proctor for each case/procedure that requires prospective or concurrent observation/proctoring. If the practitioner is unable to obtain a Proctor, the practitioner should contact the Department Chair.
- D. Proctoring forms (see Exhibits A and B) shall be supplied to the practitioner by Physician and Practitioner Services Department. These forms, when completed by Proctors, shall be forwarded to Physician and Practitioner Services Department by the Proctor(s) within a reasonable timeframe of completion of the evaluation. It shall be the responsibility of Physician and Practitioner Services Department to ensure that observation forms are forwarded to the appropriate Department Chair, or designee, for review and recommendations. Observation forms are considered confidential, peer review documents and, as such, are not subject to discovery.
- E. Observation forms received by Physician and Practitioner Services Department will be filed in that practitioner's credentials file. When the evaluation/observation process is completed (i.e. the required number of observation reports have been submitted), the Department Chair will be contacted to review the evaluation/observation status. Any additional information from the Quality Management Department (i.e., peer review summaries and other quality-related information) will be obtained for review. The Chair will make his/her report and recommendation to the Credentials Committee (see Exhibit C) about release from evaluation/observation status or continuation of the same for a specific period of time and number/types of cases.

VIII. RETROSPECTIVE EVALUATION

Retrospective evaluation of practitioners shall be coordinated by staff from the Performance Improvement Department (PI). PI representatives shall be notified of the required retrospective evaluation and shall coordinate and facilitate review by the assigned Reviewer.

- A. Retrospective evaluations conducted by assigned Reviewers shall consist of the following, as applicable:
 - 1. A minimum of five (5) medical records of patients admitted or treated by the practitioner will be reviewed. The exact number of medical records that will be reviewed (five (5) or greater) will be determined by the Department Chair or his/her designee.
 - 2. Review of a sample of the medical records of patients admitted and/or treated by the practitioner during his/her first day of providing patient care is recommended. The number of medical records reviewed will depend on the practitioner's specialty and clinical assignment for that day.

3. The selected records for review shall be representative of the types of patients admitted or treated by the practitioner. The review shall include evaluation of the following, as applicable:
 - a. History and physical;
 - b. Diagnosis and justification for it;
 - c. Proposed treatment or procedure and indicators for it;
 - d. Appropriateness of tests and medications prescribed;
 - e. Progress notes;
 - f. Consultation reports;
 - g. Operative notes and reports; and
 - h. Discharge summary
 4. Discussions with other individuals involved in the care of each patient including, where appropriate, consulting practitioners, assistants at surgery, anesthesiologists, pharmacists and nurses.
 5. Discussion with the practitioner about the cases.
 6. A written report of each evaluation shall be made to the Department Chair to which the practitioner has been assigned.
- B. If, during the course of the retrospective evaluation, the Reviewer is concerned regarding the practitioner's ability to exercise privileges granted, the Proctor shall immediately contact the Department Chair to which the practitioner has been assigned. The Department Chair shall initiate appropriate action.

IX. FPPE TIMEFRAME FOR COMPLETION

Initially appointed practitioners will have the initial appointment timeframe to complete their FPPE. Depending on the amount and type of clinical activity, the FPPE will be completed as soon as the criteria is met.

Practitioners granted additional privileges are expected to complete their FPPE within ninety (90) days of being granted privileges.

When a question arises regarding a current privileged practitioner's ability to execute a privilege(s) in a safe, high quality, professional manner, the FPPE timeframe will be determined by the Department Chair.

If the practitioner has not completed the FPPE in the timeframe established, he/she will be asked to submit, in writing, a statement of the circumstances that prevented completion of the FPPE, the plan to complete the FPPE and an estimate of the timeframe to complete it. The Department Chair will review this request for an extension of the FPPE and make a recommendation to the Credentials Committee. The Credentials Committee will review and make a recommendation to the Medical Executive Committee who will make the final determination. An example of a situation where this may occur is a practitioner has periodic call coverage responsibilities but they are infrequent and the need to execute a specific privilege is infrequent. The clinical skill to perform the privilege is related to other clinical skills.

The Department Chair, Credentials Committee and Medical Executive Committee may extend the FPPE in order to allow the practitioner to continue to participate in call coverage. If the privilege(s) under FPPE are executed during one of the call coverage assignments, review of that care should occur as soon as possible.

If a practitioner continues to have difficulty completing an FPPE because he/she has not executed the privilege(s) over a long time period, the Department Chair will have a discussion about this situation with the practitioner. One option that should be considered is for the practitioner to voluntarily relinquish the privilege(s).

X. RECOMMENDATIONS

- A. If, at any time during the evaluation period, the Chair of the Department to which the practitioner has been assigned determines that the practitioner is not competent to perform specific clinical privileges and his or her continued exercise of those privileges jeopardizes patient safety, the Department Chair shall report his or her findings and assessment to the Credentials Committee (a summary suspension shall be considered if there is an immediate threat to patient safety). The Credentials Committee shall then review the Reviewer's/Proctor's reports and shall make a recommendation regarding the practitioner's continued appointment and clinical privileges. The Credentials Committee's recommendation shall be forwarded to the Medical Executive Committee. The Medical Executive Committee shall either adopt the Credentials Committee's recommendation, or if it determines to make a recommendation different than the Credentials Committee, outline specific reasons for its disagreement. The Medical Executive Committee's recommendation is forwarded to the Board.

XI. TERMINATION OF APPOINTMENT OR REDUCTION IN CLINICAL PRIVILEGES DUE TO QUESTIONS OF CLINICAL COMPETENCE OR CONDUCT

If there is a recommendation by the MEC to terminate the practitioner's appointment or additional clinical privileges due to questions about qualifications, behavior or clinical competence, the practitioner shall be entitled to the hearing and appeal process outlined in the Medical Staff Credentialing Policy.

XI. ATTACHMENTS TO THIS POLICY

Exhibit A – FPPE Procedure Evaluation Form

Exhibit B – FPPE Clinical Management (non-procedure) Evaluation Form

Exhibit C – Focused Professional Practice Evaluation (FPPE) Form

Exhibits A and B provide templates that may be modified with specific department criteria.

UPMC Pinnacle Hospitals

FPPE Procedure Evaluation Form

CONFIDENTIAL PEER REVIEW DOCUMENT

To: Chair, Department of _____

Confidential for File of: _____
(Practitioner’s Name)

Name of Proctor: _____

Patient Record Identifier: _____

Diagnosis and/or Procedure: _____

PLEASE ANSWER ALL OF THE FOLLOWING: If the answer to any of the following questions is “no”, please attach an explanation on a separate sheet.

Yes	No	N/A	
			1. Was pre-operative justification for surgery documented?
			2. Was all necessary information (i.e., history, physical, consent and operative notes) recorded by the practitioner in a timely manner in the patient’s medical record?
			3. Was the practitioner’s use of diagnostic services (i.e., lab, x-ray and invasive diagnostics procedures) appropriate?
			4. Was the practitioner’s surgical technique appropriate?
			5. Were complications, if any, recognized and managed appropriately?
			6. Was the operative report complete, accurate and timely?
			7. Was there any evidence that the practitioner exhibited any disruptive or inappropriate behavior?

Generally, how would you rate this practitioner’s skill and competence in performing this procedure?

- _____ Acceptable
- _____ Unacceptable

UPMC Pinnacle Hospitals

FPPE Clinical Management (non-procedure) Evaluation Form

CONFIDENTIAL PEER REVIEW DOCUMENT

To: Chair, Department of _____

Date: _____

Confidential for File of: _____
(Practitioner’s Name)

Name of Reviewer: _____

Patient Record Identifier: _____

Final Diagnosis: _____

PLEASE ANSWER ALL OF THE FOLLOWING: If the answer to any of the following questions is “no”, please explain in the additional comment section or attach an explanation on a separate sheet.

DIAGNOSTIC WORKUP

Yes	No	N/A	
			1. Was the practitioner’s problem formulation (i.e., initial impressions rules-outs, assessment, etc.) appropriate?
			2. Was the patient admitted to the appropriate level of care (i.e. Med/Surg, Critical Care)?
			3. Was all necessary information (e.g. history, physical, progress notes) recorded by the practitioner in a timely manner in the patient’s medical record?
			4. Was the practitioner’s use of diagnostic services (i.e., lab, x-ray and invasive diagnostic procedures) appropriate?
			5. Did the practitioner consult other practitioners appropriately?

PATIENT MANAGEMENT

Yes	No	N/A	
			6. Was the practitioner’s medication use appropriate?
			7. Was the practitioner’s use of ancillary services (physical therapy, respiratory therapy, social service, etc.) appropriate?
			8. Were complications anticipated, recognized promptly, dealt with appropriately?

UPMC Pinnacle Hospitals

Department Chair FPPE Report and Recommendation

PRACTITIONER: _____

SPECIALTY: _____

FPPE Time Frame: From _____ To _____

RECOMMENDATION OF DEPARTMENT CHAIR

The Department Chair has reviewed the attached information related to the performance of the staff member, during the FPPE period.

RECOMMENDATION

PLEASE CHECK ONE AND COMPLETE IN FULL

_____ **SUCCESSFUL CONCLUSION OF THE FPPE:**

The practitioner has satisfactorily demonstrated his/her ability to exercise the clinical privileges initially granted.

_____ **EXTENSION OF OBSERVATION/EVALUATION WITH NO CHANGE IN PRIVILEGES:**

Recommend that the practitioner remains on a FPPE without any changes in privileges for an additional _____ days.

Reason: _____

Specific observation/evaluation requirements: _____

_____ **ALTERNATIVE RECOMMENDATION (must explain specific recommendation and rationale):**

Recommend as follows:

Signature, Department Chair

Date

CREDENTIALS COMMITTEE RECOMMENDATION

DATE

_____ Confirm recommendation of the Department Chair
_____ Recommend the following: _____

MEDICAL EXECUTIVE COMMITTEE RECOMMENDATION

DATE

_____ Confirm recommendation of the Credentials Committee
_____ Recommend the following: _____

APPENDIX C

EXCHANGE OF INFORMATION CONCERNING CERTAIN MEDICAL STAFF ADVERSE ACTIONS OR FORMAL PRECCOMENDATIONS POLICY

It is the policy of the Medical Staff Services Offices of the UPMC hospitals to exchange information with each other relating to certain adverse actions or formal recommendations concerning appointment or privileges that result from peer review.

PURPOSE

The purpose of exchanging information is to promote quality patient care and patient safety, and the exchange of information is to occur in a confidential privileged peer review environment. The Medical Staff Services Offices perform various credentialing and peer review functions on behalf of the UPMC hospitals. In applying for appointment or reappointment at any UPMC hospital, the applicant must sign a release authorizing the UPMC affiliated hospitals for which he or she is an appointee or applicant for appointment to release to one another information that bears on his or her professional qualifications, credentials, clinical competence, character, ability to perform safely and competently, ethics, and professional conduct. UPMC hospitals have a duty to promote quality patient care and patient safety by exercising reasonable efforts to select and retain only competent practitioners.

UPMC is a commonly controlled system in which practitioners frequently seek and hold privileges at more than one UPMC hospital. Accordingly, to meet its duty to patients, each UPMC hospital is entitled to obtain information with respect to a practitioner on its medical staff or seeking appointment to or privileges on its medical staff who has been the recipient of an adverse privilege action or formal recommendation at another UPMC hospital for reasons bearing on quality, competency or patient safety. This may include sharing of information with any entity that is involved in the employment or supervision of an independent practitioner at a UPMC hospital or hospital –based/affiliated clinic.

PROCEDURES

Initial Notification

The Medical Staff Services Office at each UPMC hospital shall provide notification of adverse actions or formal recommendations made concerning Medical Staff appointees or applicants for Medical Staff appointment at such hospital in the circumstances set forth in the chart below. The notification shall be provided to the Medical Staff Services office of each other UPMC hospital at which such appointee or applicant is also an appointee or an applicant. At the same time, the Medical Staff appointee or applicant shall be informed that such notification has been made. The Medical Staff Services Office of the notifying hospital shall obtain from the UPMC CVO the identity of other UPMC hospitals at which

such person is an appointee or applicant for appointment. The notice shall be provided by written confidential correspondence. The information to be provided in such notice and the timing of such notice is set forth in the chart below. If a Medical Staff Service office questions whether notification should be provided in circumstances that are not described herein, or if there is question about what information to provide, the UPMC Corporate Legal Department should be consulted.

Type of Action or Formal Recommendation	Basis for Action or Formal Recommendation	When is the Information to be Exchanged	What Information is to be Exchanged
1. Immediate or summary suspension of privileges pending investigation or appeal in accordance with the medical staff bylaws	1-3. In all cases, <u>only</u> where the action or formal recommendation is based upon concerns relating to clinical competence, quality of care, patient safety, or professional conduct or behavior creating a patient safety concern	1. At the time the privileges are suspended in accordance with the medical staff bylaws	1-3. A description of the action taken or the formal recommendation made and a description of the basis for such action or formal recommendation is to be made in writing
2. Formal recommendation of the Credentials Committee to the Medical Executive Committee or formal recommendation of the Medical Executive Committee to the Board in accordance with the medical staff bylaws of any of the following: a. Denial of medical staff appointment b. Denial of medical staff reappointment c. Denial of request for initial or increased clinical privilege(s) d. Revocation, reduction or restriction of clinical privilege(s) e. Termination of Medical Staff appointment		2. At the time the action is formally recommended by the Credentials Committee or the Medical Executive Committee in accordance with the medical staff bylaws	

<p>3. Voluntary agreement of the appointee or applicant to forego appointment or reappointment or clinical privileges or to a reduction or restriction of clinical privileges under threat of a formal adverse action as listed in 1 and 2(a)-(e) above</p>		<p>3. At the time the appointee or applicant agrees voluntarily to the limitation</p>	
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Subsequent Notification

The Medical Staff Services Office providing such initial notification shall provide subsequent notification of any changes to any such adverse action and, in the case of a formal adverse recommendation, of the final action of the hospital concerning such recommendation.

Treatment of Information

The Medical Staff Office(s) receiving such information shall treat the information as peer review privileged and confidential. The information may be used in the context of such hospitals' credentialing, privileging and peer review functions; however, the information shall not be re-disclosed by the recipient hospital to any non-UPMC entity without valid authorization by the appointee or applicant.

Bylaw Procedures

The exchange of information provided for herein does not alter medical staff bylaw provisions with respect to hearing and appeal rights and procedures at either the hospital providing the notification or the hospital receiving the notification. Also, the exchange of information does not alter medical staff bylaw provisions obligating medical staff appointees to notify the hospital of final adverse privilege actions taken by other hospitals.

APPENDIX D

ONGOING PROFESSIONAL PRACTICE EVALUATION (OPPE)

The OPPE requires that the medical staff conduct an ongoing evaluation of each practitioner's professional performance. This process allows any potential problems with the practitioner's performance or trends that impact quality of care and patient safety to be identified and resolved in a timely manner. The OPPE also fosters an efficient, evidence-based privilege renewal process. The information resulting from the ongoing professional practice evaluation is used to determine whether to continue, limit, or revoke any existing privilege(s).

PROCEDURE GUIDELINES:

- A. The respective department chair is responsible to coordinate the Ongoing Professional Practice Evaluations (OPPE) review. The OPPE will be performed on all practitioners two (2) times per calendar year.
- B. The type of information and the process for evaluation of each practitioner's ongoing professional practice has been approved by the departments through the Medical Executive Committee. The defined process is below.
- C. At each review, every practitioner will be reviewed by the department Chair or representative. This review will be factored into the decision to maintain existing privilege(s), to revise existing privilege(s), or to revoke an existing privilege prior to or at the time of renewal.
- D. Data reports and information that are included in the OPPE include, the following indicators as applicable:
 1. Complications of Care
 2. Mortality Rate
 3. thirty (30) Day Readmission
 4. Peer Review Outcomes
 5. Customer Concerns
 6. Suspensions
 7. Additional department specific or privilege specific data will be incorporated into the review process as applicable.

- E. Administration Review – The Performance Improvement Department will review all of the above documentation and flag the following elements for specific review by the department chair or representative on each individual practitioner:
- 1 % Complication of Care > 1SD from mean
 - 2 Mortality Rate > 1 SD from mean
 - 3 % 30 Day Readmission > 1 SD from mean
 - 4 Peer Review Outcomes > 1 Level C
 - 5 Customer Concerns > 1 per qtr
 - 6 Suspensions > 1 per qtr
- F. The department chair or representative will document pertinent findings and recommendations on the Ongoing Professional Practice Evaluation report or checklist to include:
- 1 Confirmation that the practitioner has been reviewed and there are no potential problems with performance or trends that would impact the quality of care and patient safety. The individual practitioner will then be reviewed again at their next OPPE.
 - 2 Request for additional review for an individual practitioner based on an identified issue. Information gathered for review may include, but is not limited to:
 - a. Crimson detail report
 - b. Additional performance of a specific procedure
 - c. Additional Monthly Review
 - d. Direct Observation
 - e. Concurrent Monitoring
 - f. Retrospective Chart Review
 - g. Discussion with other individuals involved in the care of the practitioner's patients including consulting physicians, assistants at surgery, nursing and administrative personnel.
 - 3 This review process will continue until the Department Chair or Representative is either:

- a. Satisfied with the information received and reviewed, or
 - b. Recommendations are made to the Credentials Committee or the Clinical Care and Health Support Committee, as applicable, for review and recommendation to the Medical Executive Committee for action including, but not limited to the initiation of Corrective Action
- 4 Request for immediate action according to the Medical Staff Bylaws can be taken at any time during the OPPE process, which may include, but not limited to, forwarding concerns to the following committees:
 - a. Respective Department QA Committee
 - b. Credentials Committee
 - c. Clinical Care and Health Support Committee
 - d. Medical Executive Committee
- G. The information gained by the review of the above information will be documented on the Ongoing Professional Practice Evaluation report or checklist, which will be filed in the credentials file and incorporated into the two-year reappointment process. Single incidents or trending of quality and safety issues that impact the safety of patients will require immediate action by the medical staff.
- H. If behavior is identified as a possible issue, the Medical Staff Code of Conduct will be followed as a component of the OPPE.
- I. Relevant information obtained from the OPPE will be forwarded for inclusion into the performance improvement activities maintaining confidentiality.
- J. All data collected is considered peer review information. Peer Review information is privileged and confidential in accordance with medical staff and hospital bylaws, state and federal laws, and regulations pertaining to confidentiality and non-discoverability.
- K. Low or No Clinical Activity
 - a. Low clinical activity is defined as less than <5 (five) clinical encounters within a two (2) year appointment cycle. A clinical encounter is considered any instance where the practitioner was the attending, consulting, managing or procedure performing practitioner.
 - b. When a practitioner has low or no clinical activity, supplemental data from another organization where the provider holds active privileges may also be used for Ongoing Professional Practice Evaluation (OPPE). Supplemental data will not be used in lieu of local facility level data.

- c. If after using local and supplemental site data the provider is still considered low volume, they will be notified that they will need to provide volume and a clinical competency form completed by the Practitioner's Department Chair or Administrator at their primary hospital or facility.

- d. If the practitioner cannot provide adequate data to verify clinical competency, they will be required to meet with the Department Chair. During that meeting the individual will either be placed on a FPPE and commit to having adequate clinical activity that meets the OPPE requirement or will be asked to voluntarily resign their privileges. If the practitioner refuses to agree to one of these actions, disciplinary action may occur to include the possibility of Corrective Action.

APPENDIX E

PRECEPTING

Precepting is the process through which a practitioner gains experience and/or training of new skills and knowledge or to update skills and knowledge by a monitor or preceptor, who represents the Medical Staff and is responsible to the Staff.

UPMC Pinnacle Hospitals requires that all new appointees to the Medical Staff serve a Provisional/Focused Professional Practice Period during which time precepting may be required for specific procedures/techniques.

Currently credentialed and privileged members of the Medical Staff may require precepting if new privileges/techniques are requested. Precepting may be required by recommendation of the Medical Executive Committee to assess potential quality of care issues or for remedial reasons.

Precepting does not replace basic educational and experience requirements as deemed necessary by the department chair and the Credentials Committee for specific privileges.

PROCEDURE:

- I Approved precepting methods may include direct or indirect observation (both clinical and surgical), and/or review of medical records.
 - A. Methods of Precepting
 1. Prospective precepting includes either a review by the preceptor of the patient's chart and/or of the patient personally before treatment.
 2. Concurrent review occurs when the preceptor actually observes the precepted Medical Staff member's work.
 3. Retrospective review is a review of patient charts and/or recorded material by the precepting Medical Staff member.

II Terms of Precepting

The terms of preceptorship are determined by the department chair and approved by the Credentials Committee. The department chair will submit with the following information:

- A. Define in what instances a staff member or physician must be precepted and the method to be utilized for precepting each specific procedure/technique.
- B. Establish a minimum number of cases/procedures to be precepted and determine when the preceptor must be present.

1. A time frame for completion of the precepting process must also be determined.
- C. Report preceptorship requirements, for specific privileges, to the Credentials Committee.
- D. Identify the Medical Staff members eligible to serve as preceptors.
1. Preceptors should be qualified and privileged to perform the procedures for which he/she is reviewing.
 2. Department chairs should take into consideration a possible conflict of interest when assigning preceptors.
 3. When the situation exists in which no other Medical Staff member is qualified or privileged to serve as a preceptor, an outside consultant may be retained. An outside consultant may be granted temporary privileges to serve in a precepting capacity as set forth in the Temporary Privileges Policy (Medical Staff Credentials Policy). The preceptor shall not charge a fee to UPMC Pinnacle Hospitals for this service.
- E. Any Medical Staff member or physician applying for permanent staff privileges requiring precepting shall be so informed. The communication shall include: (1) the specific procedure/technique that will be precepted; (2) the minimum number of cases to be precepted (if applicable); (3) the requirements for when a preceptor must be present; (4) the time frame for completion of the precepting process; and (5) the names of Medical Staff members eligible to serve as preceptors.
1. A copy of the communication shall be forwarded to Physician and Practitioner Services.
- III It is the responsibility of the Medical Staff member being precepted to schedule surgery/procedures in cooperation with the preceptor(s). The Medical Staff member being precepted shall also inform the preceptor(s) of any unusual incident in any way associated with his/her patients related to the precepted procedures/activities.
- IV Temporary privileges for a newly requested procedure/technique are provided while precepting is ongoing. Such temporary privileges shall identify the necessity for precepting.
- V Credentials Committee Recommendation
- A. Upon completion of the preceptorship requirements, the preceptor shall provide a Precepting Summary to the department chair with a copy to Physician and Practitioner Services Department that shall include, but not be limited to, the following:

1. Whether a sufficient number of cases have or have not been presented for review to properly evaluate the clinical privileges requested and whether, in the preceptor's opinion, the provisional appointment should be extended for an additional period.
 - a. If a sufficient number of cases were not precepted in the time allotted, the Medical Staff member may present any extenuating circumstances to the Credentials Committee for consideration to extend the preceptorship.
 2. If a sufficient number of cases have been completed to properly evaluate the clinical privileges requested, the preceptor shall give his/her opinion concerning the Medical Staff member's qualifications and competence to exercise the privileges.
- B. The department chair shall forward the report with his/her recommendation to the Credentials Committee.
- C. Adverse Recommendation
1. If the recommendation of the Credentials Committee is adverse to granting privileges, the Medical Staff member shall be notified in writing by the Credentials Committee (Adverse Recommendation Letter). The Committee may request that the Medical Staff member appear before the Credentials Committee.
- D. Documentation Requirements
- There shall be recorded in the minutes of the Credentials Committee meeting all information, findings, and recommendations relative to the requirements of precepting and the outcomes of precepting.
- E. Medical Executive Committee Notification
1. When the precepting activities are completed, the Credentials Committee shall present its recommendations relative to the requested privileges to the Medical Executive Committee for its consideration and recommendation to the Quality and Safety Committee which shall take action on behalf of the Board of Directors.

APPENDIX F

ACCESS TO CREDENTIALING DATA

- I Access to credentials files is limited.
 - A. Physician and Practitioner Services Departments staffs are authorized to access credentialing documentation.
 - B. Credentials files may be provided to other individuals including respective department chairs, the Vice President Medical Affairs or his designee, Chairman and members of Credentials Committee, Director of Legal Services, the Chief Nursing Officer, and the Chief Executive Officer.
 - C. A Medical Staff Member may be provided information from his/her credentials file under the following conditions:
 - 1. The information was provided by the Staff member (e.g., copy of CME, licensure).
 - 2. Specific forms such as applications or privilege forms that the Member completed.
- II Any request for access to credentials files other than that listed in above must be presented to a custodian of the records.
- III Requests for access to credentials files not resolved by a custodian of the records will be presented to the Director of Legal Services for disposition or to the Vice President Medical Affairs, as appropriate.
- III Credentials files will be made available to accrediting bodies such as The Joint Commission, the Pennsylvania Department of Health, and others as permitted or required by Federal or State law.
- IV Requests for a credentials file and/or information from a file for legal purposes will be processed through the Vice President for Organizational Quality and Performance Improvement and/or the Director of Legal Services.
- V Credentials files shall always remain intact; nothing is ever removed from a file.
- VI No information from a credentials file shall be photocopied without permission of the custodian of the records.
- VII Information pertaining to Medical Staff Members will not be provided over the telephone other than acknowledging membership, and providing the office addresses and telephone numbers. Professional references may be provided over the telephone by department chairs, the Vice President Medical Affairs, residency program directors or the Vice President of Medical Education.

APPENDIX G

IMPAIRED PRACTITIONER

Policy:

It is the policy of the Hospital and its Medical Staff to address the issue of Physician & Practitioner impairment in such a way as to provide quality patient care while dealing with the impaired clinician in a comprehensive but compassionate and confidential manner. This process and the Clinical Care Committee are designed to maintain the confidentiality of clinicians who are seeking referral or are referred for assistance. This confidentiality is breached only when disclosure is mandated, or if there is an overt danger to patient safety.

Purpose:

To identify and manage matters of individual clinician health and performance through a formal process with the goals of assistance, rehabilitation, and retention or re-attainment of optimal functioning consistent with patient safety. This policy is not intended to supersede or replace the corrective action or credentialing processes.

Definitions:

Clinicians- All members of the Medical Staff including physicians, dentists, podiatrists, and allied health professionals.

Clinical Care and Health Support Committee (CCHSC) - This is a peer review committee of the Medical Staff, composed of members appointed by the President of the Medical Staff. All voting members shall be members of the Medical Staff.

Impaired or Impairment - Unable to perform professional services with the skill necessary to ensure quality patient care; a physical, medical, psychological or emotional illness or condition of a Clinician posing a significant risk of substantial harm to the health or safety of patients, co-workers, or other individuals, including but not limited to loss of cognitive or motor skill, or excessive use or abuse of drugs including alcohol. These illnesses or conditions may be rehabilitated if appropriate treatment is received.

Process:

1. **Identification:** Concerns or suspicions regarding a possible physical or psychological impairment of any provider holding Medical/Allied Health Staff appointment and/or clinical privileges should be reported immediately to the Department Chair, Section Chief, Vice President Medical Affairs, or Medical Staff President. It is further noted that any practitioner can self-refer. If the Department Chair, Section Chief, President of the Medical Staff or Vice President of Medical

Affairs believes there is a reasonable basis to investigate whether a physical or psychological impairment is present, a referral will be made to the Clinical Care & Health Support Committee.

2. **Review:** The CCHSC will use discretion as to how to conduct the review. The inquiry process will include
 - A. Work with the referral source to gather relevant information, including gathering information from primary sources when appropriate regarding specifics of the action or conduct, or alleged nature of the medical condition, whether the actions/conditions affected or involved a patient in any way, and whether any action was taken at the time.
 - B. Determine whether it is necessary to meet with the provider at issue.
 - C. Provide resource information on programs that the provider may access for assistance.
 - D. If the CCHSC determines there is a reasonable basis to believe that a provider may be abusing substances, or that there are behavioral or mental health concerns, the committee may make an external referral for intervention, assessment, and a treatment process as outlined below. The referral may be to the external referral program of a professional board, professional association, or other community based external referral program. (e.g. Pennsylvania Physicians Health Program)

3. **External Evaluation:** The external referral program may be notified by the CCHSC to provide assistance in determining whether intervention is warranted and/or assist the CCHSC in conducting the intervention. All costs for evaluation, treatment, monitoring, and support shall be the responsibility of the affected provider.

4. **Intervention:** During, or as a result of, its investigations and any external consultation or monitoring, the CCHSC has the authority to recommend either:
- A. That chair proceed routinely with performance and exception monitoring consistent with peer review processes; and/or
 - B. That chair initiate formal action (“no right to a hearing”) as specified in the Medical Staff Bylaws/Rules and Regulations; or
 - C. That the Medical Executive Committee consider Corrective Action (“right to a hearing”) in accordance with the Medical Staff Bylaws/Rules and Regulations.

5. **Monitoring:** Ongoing reports of a clinician’s progress and/or contract compliance must be made available from an external referral program to the Chair of the CCHSC; any required consent must be provided by the provider.

- A. The Chair of the CCHSC is responsible for monitoring the identified provider until the rehabilitation process is complete and/or, if applicable, any disciplinary process is complete.
- B. If the Chair of the CCHSC becomes aware that the provider is not participating in the agreed to program or is not able to practice within reasonable skills and safety, he/she will call an ad hoc meeting of the CCHSC to review the situation. The CCHSC will consider all information available, including information obtained from the external referral program and/or information obtained from other

outside experts. If the CCHSC determines that allowing the provider to continue to practice may jeopardize patient safety, they will immediately inform the Vice President Medical Affairs and the President of the Medical Staff.

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