CREDENTIALS POLICY

Deer Valley Medical Center
John C. Lincoln Medical Center
Scottsdale Osborn Medical Center
Scottsdale Shea Medical Center
Scottsdale Thompson Peak Medical Center

Proposed
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Horty, Springer & Mattern, P.C.

CREDENTIALS POLICY

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APPENDIX A

ARTICLE 1

GENERAL

1.A. TIME LIMITS

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

1.B. DELEGATION OF FUNCTIONS

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

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

1.C. CONFIDENTIALITY AND PEER REVIEW PROTECTION

1.C.1. Confidentiality:

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

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

(b) as authorized by a policy; or

(c) as authorized by the Chief Physician Executive or by legal counsel to the Hospital.

Any breach of confidentiality may result in appropriate sanctions, including but not limited to a professional review action or appropriate legal action. Breaches of confidentiality will not constitute a waiver of any privilege. Any member of the Medical Staff or the Allied Health Staff who becomes aware of a breach of confidentiality is encouraged to inform the Chief Physician Executive, the Chief Medical Officer, the Division Chief of Staff (or the Division Vice Chief of Staff if the Division Chief of Staff is the person committing the claimed breach), or the Chair of the Network Executive Committee (or the Vice Chair if the Chair of the Network Executive Committee is the person committing the claimed breach).

1.C.2. Peer Review Protection:

All professional review activity will be performed by the peer review committees. Peer review committees include, but are not limited to:

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

(b) all departments and service lines;

(c) hearing and appellate review panels;

(d) the Board and its committees; and

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

All oral and written communications, reports, recommendations, actions, materials considered by, and minutes made or taken by peer review committees are confidential and covered by the provisions of applicable law, including but not limited to Ariz. Rev. Stat. Ann. §§ 36-445.01 & 36-2403, and are deemed to be "professional review bodies" as that term is defined in the Health Care Quality Improvement Act of 1986 ("HCQIA"), 42 U.S.C. §11101 et seq.

1.D. INDEMNIFICATION

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

1.E. DEFINITIONS

The following definitions apply to terms used in this Policy:

(1) "ALLIED HEALTH PROFESSIONALS" means individuals other than members of the Medical Staff who are authorized by law and by the Hospital to provide patient care services. A listing of the categories of allied health professionals practicing at the Hospital is included at Appendix A.

(2) "ALLIED HEALTH STAFF" means those allied health professionals who have been appointed to the Allied Health Staff by the Board.

(3) "BOARD" means the Board of Directors of HonorHealth.

(4) "BOARD CERTIFICATION" is the designation conferred by one of the affiliated specialties of the American Board of Medical Specialties, the American

Osteopathic Association, the American Board of Oral and Maxillofacial Surgery, the American Board of Foot and Ankle Surgery, upon an individual, as applicable.

(5) "CHIEF MEDICAL OFFICER" means the Division Chief Medical Officer unless otherwise specified.

(6) "CHIEF PHYSICIAN EXECUTIVE" means the individual appointed by the Board to act as the Chief Medical Officer of HonorHealth, in cooperation with the Chair of the Network Executive Committee and the Division Chiefs of Staff.

(7) "CLINICAL PRIVILEGES" or "PRIVILEGES" means the authorization granted by the Board to render specific clinical procedures and patient care services, subject to the provisions of this Policy.

(8) "COMPLETED APPLICATION" means that all questions on the application form have been answered, all supporting documentation has been supplied, and all information has been verified from primary sources. An application will become incomplete if the need arises for new, additional, or clarifying information at any time. Any application that continues to be incomplete 30 days after the applicant has been notified of the additional information required will be deemed to be withdrawn.

(9) "CORE PRIVILEGES" means a defined grouping of clinical privileges for a specialty or subspecialty that includes the fundamental patient care services that are routinely taught in residency or fellowship training for that specialty or subspecialty and that have been determined by the Medical Staff Leaders and Board to require closely related skills and experience.

(10) "CREDENTIALS POLICY" means HonorHealth's Medical Staff Credentials Policy.

(11) "DAYS" means calendar days.

(12) "DENTIST" means a doctor of dental medicine.

(13) "DIRECT ECONOMIC COMPETITION" means practicing in the same clinical specialty and the same geographic area.

(14) "DIVISION" means the group comprised of those members of the Medical Staff and Allied Health Staff who have clinical privileges to practice at any one Hospital within HonorHealth. As of the adoption of this Policy, the Divisions are as follows: Deer Valley Division; John C. Lincoln Division, Osborn Division, Shea Division, and Thompson Peak Division.

(15) "DIVISION EXECUTIVE COMMITTEE" or "EXECUTIVE COMMITTEE" means the Medical Executive Committee at one of the HonorHealth Hospitals. As

of the adoption of this Policy, the Division Executive Committees are as follows: Deer Valley Executive Committee, John C. Lincoln Executive Committee, Osborn Executive Committee, Shea Executive Committee, and Thompson Peak Executive Committee.

(16) "EX-OFFICIO" means a member of a body by virtue of an office or position held and, unless otherwise expressly provided, means without voting rights.

(17) "HOSPITAL" or "HOSPITALS" means any one or all, as applicable, of the following: Deer Valley Medical Center, John C. Lincoln Medical Center, Scottsdale Osborn Medical Center, Scottsdale Shea Medical Center, and Scottsdale Thompson Peak Medical Center.

(18) "HOSPITAL ADMINISTRATION" or "ADMINISTRATOR" means the Chief Executive Officer of the Network, or his or her designee, or, as appropriate, the Chief Executive Officer of the Hospital, or his or her designee.

(19) "HOSPITAL CHIEF EXECUTIVE OFFICER" means the individual appointed by the Board to act on its behalf in the overall management of the Hospital.

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

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

(22) "MEDICAL STAFF YEAR" means the period from January 1 to December 31.

(23) "MEMBER" means a physician, dentist, oral surgeon, psychologist, or podiatrist who has been granted Medical Staff appointment, or an individual who has been granted Allied Health Staff appointment, by the Board to practice at the Hospital.

(24) "MEMBER OF A DIVISION" or "MEMBERS OF A DIVISION" means a member, or members, of the Medical Staff or the Allied Health Staff who have clinical privileges to practice at a Division. An individual may be a member of more than one Division.

(25) "NETWORK CHIEF EXECUTIVE OFFICER" means the individual appointed by the Board to act on its behalf in the overall management of the Network.

(26) "NOTICE" means written communication by regular U.S. mail, e-mail, facsimile, or Hospital mail.

(27) "ORAL SURGEON" means a doctor of dental surgery who has received additional training.

(28) "PATIENT CONTACTS" includes any admission, consultation, procedure, response to emergency call, evaluation, treatment, or service performed in any facility operated by the Hospital or affiliate, including outpatient facilities.

(29) "PERFORMANCE IMPROVEMENT" activities means structured processes by which members and allied health professionals can learn about and apply performance measures over a useful interval and evaluate their performance.

(30) "PHYSICIAN" includes both doctors of medicine and doctors of osteopathy.

(31) "PHYSICIAN ASSISTANT" means a person who is a graduate of an approved program or its equivalent or meets standards approved by the state board and is licensed to perform medical services delegated by the Supervising Physician and is acceptable to the Board of the Hospital.

(32) "PODIATRIST" means a doctor of podiatric medicine.

(33) "PRACTITIONER HEALTH ISSUE" or "HEALTH ISSUE" means any physical, mental, or emotional condition that could adversely affect an individual's ability to practice safely.

(34) "PROFESSIONAL REVIEW ACTION" has the meaning defined in the Health Care Quality Improvement Act.

(35) "PROFESSIONAL REVIEW ACTIVITY" has the meaning defined in the Health Care Quality Improvement Act.

(36) "PSYCHOLOGIST" means an individual with a Ph.D. in clinical psychology.

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

(38) "SERVICE LINE" means members of the Medical Staff, Allied Health Staff and Hospital personnel organized to collaboratively address the medical, mental/emotional, nutritional, social, and other needs of patients suffering from a particular condition or group of conditions. Service lines will be guided by the principles applicable to departments and will be entitled to the same confidentiality, privilege, indemnification, and immunity protections that apply to departments and their leaders. Once a service line is established, functions performed by the service line pertaining to clinical care standards will be reported to and acted on by the Division Executive Committee and the Network Executive Committee.

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

(40) "SUPERVISING PHYSICIAN" means a member of the Medical Staff who has agreed in writing to supervise or collaborate with an allied health professional and to accept full responsibility for the actions of the allied health professional while he or she is practicing in the Hospital.

(41) "SUPERVISION" means the supervision of (or collaboration with) an allied health professional 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) will be determined at the time each allied health professional is credentialed or employed and will be consistent with any applicable written supervision or collaboration agreement.

(42) "UNASSIGNED PATIENT" means any individual who comes to the Hospital for care and treatment who does not have an attending physician with clinical privileges, 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 or her care while a patient at the Hospital.

ARTICLE 2

QUALIFICATIONS, CONDITIONS, AND RESPONSIBILITIES

2.A. QUALIFICATIONS

2.A.1. Threshold Eligibility Criteria:

To be eligible to apply for initial appointment, reappointment or clinical privileges, an applicant must, as applicable:

(a) have a current, unrestricted license to practice in Arizona that is not subject to any restrictions, probationary terms, or conditions, including a decree of censure not generally applicable to all licensees, and have not had, within the last five years, a license to practice in any jurisdiction revoked, restricted or suspended by any state licensing agency;

(b) have a current, unrestricted DEA registration and state controlled substance license;

(c) while providing services, be located (office and residence) close enough to fulfill Medical Staff responsibilities and to provide timely and continuous care for his or her patients in the Hospital;

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

(e) have not been, within the last five years, and are not currently, excluded or precluded from participation in Medicare, Medicaid, or other federal or state governmental health care program;

(f) have not had, within the last five years, medical staff or allied health staff appointment or clinical privileges, or status as a participating provider denied, revoked, or terminated by any health care facility, including this Hospital, or health plan for reasons related to clinical competence or professional conduct;

(g) have not, within the last five years, resigned medical staff or allied health staff appointment or relinquished privileges during an investigation or in exchange for not conducting such an investigation at any health care facility, including this Hospital;

(h) not currently be under any criminal investigation or indictment and have not, within the last five years, been required to pay a civil money penalty for governmental fraud or program abuse or been convicted of, or entered a plea of guilty or no contest to, any felony or misdemeanor related to: (i) controlled substances; (ii) illegal drugs; (iii) insurance or health care fraud (including Medicare, Medicaid

or other federal or state governmental or private third-party payer fraud or program abuse); (iv) violent acts; (v) sexual misconduct; (vi) moral turpitude; or (vii) child or elder abuse;

(i) not currently be under investigation by any federal or state agency or healthcare facility for reasons related to clinical competence or professional conduct;

(j) agree to fulfill all responsibilities regarding emergency call as designated by their department;

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

(l) document compliance with all applicable training and educational protocols that may be adopted by the Division Executive Committee, or the Network Executive Committee, and required by the Board, including, but not limited to, those involving electronic medical records or patient safety;

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

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

(o) demonstrate recent clinical activity in their primary area of practice during the last two years;

(p) document compliance with any applicable health screening requirements (e.g., health examinations, TB testing, mandatory flu vaccines, and infectious agent exposures);

(q) have successfully completed[1]:

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

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

[1] The residency training requirement will be applicable only to those individuals who apply for initial appointment after the date of adoption of this Policy. Existing members will be governed by the residency training requirement in effect at the time of their initial appointment.

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

(4) for allied health professionals, have satisfied the applicable training requirements as established by the Hospital;

(r) be or have been certified in their primary area of practice at the Hospital by the appropriate specialty/subspecialty board of the American Board of Medical Specialties, the American Osteopathic Association, the American Board of Oral and Maxillofacial Surgery, the American Dental Association, or the American Board of Foot and Ankle Surgery, as applicable. Applicants who are not board certified at the time of application but who have completed their residency or fellowship training within the last seven years will be eligible for Medical Staff appointment. However, in order to remain eligible, those applicants must achieve board certification in their primary area of practice within seven years from the date of completion of their residency or fellowship training;[2]

(s) maintain board certification in their primary area of practice at the Hospital and, to the extent required by the applicable specialty/subspecialty board, satisfy recertification requirements (recertification will be assessed at reappointment);[3] and

(t) if seeking to practice as an allied health professional, must have a written agreement with a Supervising Physician, which agreement must meet all applicable requirements of Arizona law and Hospital policy.

<u>2.A.2. Extension of Time Frame to Satisfy Board Certification Criterion</u>:

In exceptional circumstances, the seven-year time frame for initial applicants to obtain certification and the time frame for recertification by existing members may be extended for one additional appointment term, in order to permit an individual an opportunity to obtain certification. In order to be eligible to request an extension in these situations, an individual must, at a minimum, satisfy the following criteria:

(a) the individual has been a member of an HonorHealth Medical Staff for at least three consecutive years;

(b) there have been no documented peer review concerns related to the individual's competence or behavior within HonorHealth during the individual's tenure that

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[2] The board certification requirement will be applicable only to those individuals who apply for initial appointment after July 1, 2007; members appointed prior to this date will be governed by the board certification requirement in effect at the time of their initial appointment and at the specific Hospital in which they were initially appointed.

[3] The board certification requirement will be applicable only to those individuals who apply for initial appointment after the date of adoption of this Policy.

have risen to the level of the involvement of the Division Executive Committee or the Network Executive Committee;

(c) the individual provides a letter from the appropriate certifying board confirming that the individual remains eligible to take the certification examination within the next two years; and

(d) the appropriate department chair provides a favorable report concerning the individual's qualifications.

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

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

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

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

(d) The Division Executive Committees will review the recommendation of the Credentials Committee and make a recommendation regarding whether to grant or deny the request for a waiver. The recommendation of the Division Executive Committees will be reviewed by and acted on by the Network Executive Committee. Any recommendation by the Network Executive Committee to grant a waiver must include the specific basis for the recommendation. The recommendation by the Network Executive Committee will be forwarded to the Board.

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

2.A.4. Factors for Evaluation:

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

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

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

(c) good reputation and character;

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

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

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

2.A.5. No Entitlement to Appointment:

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

(a) is employed by HonorHealth or its affiliate;

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

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

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

(e) has had in the past, or currently has, medical staff or allied health staff appointment or privileges at any hospital or health care facility;

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

(g) is affiliated with, or under contract to, any managed care plan, insurance plan, health maintenance organization, preferred physician organization, or other entity.

2.A.6. Nondiscrimination:

No one will be denied appointment or clinical privileges on the basis of gender, race, creed, sexual orientation, national origin, age, or a handicap unrelated to the ability to fulfill patient care and required staff obligations, or any other criterion unrelated to the standards set forth in the Bylaws, policies, manuals, or rules and regulations of the Medical Staff.

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

2.B.1. Basic Responsibilities and Requirements:

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

(a) to provide continuous and timely care;

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

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

(d) to provide emergency call coverage, consultations, and care for unassigned patients as designated by their department;

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

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

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

(h) to use HonorHealth Hospitals sufficiently to allow continuing assessment of current competence;

(i) to seek consultation whenever necessary;

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

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

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

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

(n) to satisfy continuing medical education requirements;

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

(p) to comply with all applicable training and educational protocols that may be adopted by the Network Executive Committee, or other committee as may be designated by the Network Executive Committee, including, but not limited to, those involving electronic medical records, patient safety, and infection control;

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

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

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

2.B.2. Burden of Providing Information:

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

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

(c) An application will be complete when all questions on the application form have been answered, all supporting documentation has been supplied, and all information has been verified from primary sources. An application will become incomplete if the need arises for new, additional, or clarifying information. Any

application that continues to be incomplete 30 days after the applicant has been notified of the additional information required may be deemed to be withdrawn. Any initial application that continues to be incomplete after six months from the date of receipt will be deemed to be withdrawn.

(d) Applicants are responsible for providing a complete application, including adequate responses from references. An incomplete application will not be processed.

(e) Applicants and members are responsible for notifying Medical Staff Office, the Chief of Staff, or the Chief Physician Executive of any change in status or any change in the information provided on the application form within 14 days of the change. This information is required to be provided with or without request, at the time the change occurs, and includes, but not be limited to:

(1) any information on the application form;

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

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

(4) changes in professional liability insurance coverage;

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

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

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

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

2.C. APPLICATION

2.C.1. Information:

(a) Application forms for appointment, reappointment, and clinical privileges will be approved by the Board, upon recommendation by the Credentials Committee.

These applications existing now (and as may be revised) are incorporated by reference and made a part of this Policy.

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

2.C.2. Misstatements and Omissions:

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

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

(c) It shall not be a valid excuse for a misstatement or omission that an applicant or Member's office staff completed the application or submitted the materials in question.

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

2.C.3. Grant of Immunity and Authorization to Obtain/Release Information[4]:

(a) Conditions Prerequisite to Application and Consideration:

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

(b) Scope of Conditions:

The terms set forth in this Section:

(1) commence with the individual's initial contact with the Hospital, whether an application is furnished or appointment or clinical privileges are granted;

(2) apply throughout the credentialing process and the term of any appointment, reappointment, or clinical privileges; and

[4] Review application form for consistency.

(3) survive for all time, even if appointment, reappointment, or clinical privileges are denied, revoked, reduced, restricted, suspended, or otherwise affected as part of the Hospital's professional review activities and even if the individual no longer maintains appointment or clinical privileges at the Hospital.

(c) Use and Disclosure of Information about Individuals:

(1) Information Defined:

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

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

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

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

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

(2) Authorization for Criminal Background Check:

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

(3) Authorization to Share Information within the Network:

The individual authorizes the Hospital and its affiliates to share information with one another.

(4) Authorization to Obtain Information from Third Parties:

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

(5) Authorization to Disclose Information to Third Parties:

The individual authorizes the Hospital, Medical Staff Leaders, and their representatives to disclose information to other hospitals, health care facilities, managed care organizations, government regulatory and licensure boards or agencies, and their representatives to assist them in evaluating the individual's qualifications. Nothing in this Section prohibits the Hospital, Medical Staff Leaders, and their representatives from requesting or requiring a specific release from an individual before responding to a request for information about the individual.

(6) Access to Information by Individuals:

(i) Upon request, applicants will be informed of the status of their applications for appointment or clinical privileges.

(ii) Except during the hearing and appeal processes, which are governed by Article 7 of this Policy, an individual may review information obtained or maintained by the Hospital only upon request and only if the identity of the individual who provided the information will not be revealed.

(iii) If an individual disputes any information obtained or maintained by the Hospital, the individual may submit, in writing, a correction or clarification of the relevant information which will be maintained in the individual's file.

(d) Hearing and Appeal Procedures:

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

(e) Immunity:

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

This immunity covers any actions, recommendations, reports, statements, communications, or disclosures that are made, taken, or received by the Hospital,

its representatives, or third parties in the course of credentialing or ongoing peer review or when using or disclosing information as described in this Section. Nothing herein will be deemed to waive any other immunity or privilege provided by federal or Arizona law.

(f) Legal Actions:

If, despite this Section, an individual institutes legal action challenging any credentialing, privileging, peer review, or other professional review action or activity and does not prevail, he or she will reimburse HonorHealth, the Hospital, the Board, and the Medical Staff, their authorized representatives, any members of the Medical Staff, or Allied Health Staff, or Board, and any third party who provides information involved in the action for all costs incurred in defending such legal action, including costs and attorneys' fees, expert witness fees, and any lost wages or income associated with defending or participating in the legal action (e.g., attending depositions, providing witness testimony, etc.).

ARTICLE 3

PROCEDURE FOR INITIAL APPOINTMENT AND PRIVILEGES

3.A. PROCEDURE FOR INITIAL APPOINTMENT AND PRIVILEGES

3.A.1. Application:

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

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

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

3.A.2. Initial Review of Application:

(a) As a preliminary step, the application will be reviewed by the CVO to determine, to the extent possible, that all threshold eligibility criteria have been met and that all questions have been answered. Applicants who fail to return completed applications will be notified that their applications will not be processed. A determination of ineligibility does not entitle the individual to a hearing and appeal.

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

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

(d) An interview(s) with the applicant may be conducted. The purpose of the interview is to discuss and review any aspect of the applicant's application, qualifications, and requested clinical privileges. This interview will be conducted at the Division or Network level and may involve any of the following: department chair, Credentials Committee, Credentials Committee representative, Network Executive Committee, Chair of the Network Executive Committee, or the Chief Physician Executive.

(e) Each applicant will be assigned to an appropriate Category I, II, or III based upon predetermined, Board-approved criteria. The criteria for designation of Category I, II, or III for initial appointment are outlined in Appendix B.

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

(a) The Medical Staff Office will transmit the complete application and all supporting materials to the chair of each department in which the applicant seeks clinical privileges. The department chair will prepare a written report regarding whether the applicant has satisfied all of the qualifications for appointment and the clinical privileges requested. The report will be on a form provided by the Medical Staff Office and will also address category assignment.

(b) The Chief Nursing Officer will also review and report on the applications for all allied health professionals.

3.A.4. Credentials Committee Procedure:

(a) The Credentials Committee will consider the report prepared by the department chair(s) and Chief Nursing Officer, as applicable, and will make a recommendation, including whether the applicant satisfies the qualifications for appointment, clinical privileges, and the category assignment.

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

(c) After determining that an applicant is otherwise qualified for appointment and privileges, if there is any question about the applicant's ability to perform the privileges requested and the responsibilities of appointment, the Credentials Committee may require a fitness for practice evaluation by a physician(s) satisfactory to the Credentials Committee. The results of this evaluation will be made available to the Credentials Committee. The Credentials Committee may seek assistance from the Practitioner Health Committee.

(d) The Credentials Committee may recommend the imposition of specific conditions related to behavior, health or clinical issues. The Credentials Committee may also

recommend that appointment be granted for a period of less than two years in order to permit closer monitoring of the applicant's compliance with any conditions. A recommendation for the imposition of specific conditions or for appointment to be granted for a period of less than two years does not, in and of itself, entitle a member to request a hearing or appeal.

(e) Applicant files designated as Category I or Category II, in which the department chair and the Credentials Committee have indicated there are no adverse trends or areas of concern and where the recommendation is favorable, will be forwarded to the Medical Executive Committee.

(f) Applicant files classified as Category II with areas of concern, or Category III files that have at least two areas of concern, will be reviewed and the applicant will be interviewed by the Credentials Committee.

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

(h) Upon review and evaluation of the application and supporting documentation by the department chair and the Credentials Committee Chair, a determination may be made to:

(1) reassign as Category I;

(2) reassign as Category II – no trends or areas of concern;

(3) reassign as Category III – areas of concern requiring committee review and discussion;

(4) request additional documentation/information; or

(5) defer to next regularly scheduled meeting for discussion.

3.A.5. Division Executive Committee Recommendation:

(a) Upon receipt of the written report and recommendation of the Credentials Committee, each Division Executive Committee will make a recommendation.

(b) The recommendation of each Division Executive Committee will be forwarded to the Network Executive Committee.

3.A.6. Network Executive Committee Recommendation:

(a) At its next regular meeting after receipt of the written report and recommendation of the Division Executive Committees, the Network Executive Committee will:

(1) adopt the report and recommendation of the Division Executive Committees as its own; or

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

(3) state its reasons for disagreement with the report and recommendation of the Division Executive Committees and/or the Credentials Committee.

(b) If the recommendation of the Network Executive Committee is to appoint, the recommendation will be forwarded to the Board.

(c) If the recommendation of the Network Executive Committee would entitle the applicant to request a hearing, the Network Executive Committee will forward its recommendation to the Chief Physician Executive, who will promptly send Special Notice to the applicant. The Chief Physician Executive will 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, the Division Executive Committees, and the Network 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.

(b) Any decision reached by the Board Committee to appoint will be effective immediately and will be forwarded to the Board for consideration at its next meeting.

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

(2) refer the matter back to the Credentials Committee, the Division Executive Committees, the Network Executive Committee, or to another source for additional research or information; or

(3) modify the recommendation.

(d) If the Board disagrees with a favorable recommendation from the Network Executive Committee, it should first discuss the matter with the chair of the Network Executive Committee. If the Board's determination remains unfavorable, the Chief Physician Executive will promptly send Special Notice that the applicant is entitled to request a hearing.

(e) Any final decision by the Board to grant, deny, modify, or revoke appointment or clinical privileges will be disseminated to appropriate individuals and, as required, reported to appropriate entities.

3.A.8. Time Periods for Processing:

Once an application is deemed complete, it will be acted on by the Credentials Committee within 90 days, unless it becomes incomplete. The Division Executive Committees will act on a complete application within 45 days of its receipt of the recommendation of the Credentials Committee. The Network Executive Committee will act on a complete application within 45 days of its receipt of the recommendation of the Division Executive Committees. Thereafter, the Board will take action on a complete application within 60 days of receiving the recommendation of the Network Executive Committee. Thereafter, notice will be sent to the individual within 20 days of the Board's action.

ARTICLE 4

CLINICAL PRIVILEGES

4.A. CLINICAL PRIVILEGES

4.A.1. General:

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

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

(c) Requests for clinical privileges that are subject to an exclusive contract or arrangement will not be processed except as consistent with the applicable contract. Similarly, requests for clinical privileges will not be processed if the Hospital has determined not to accept an application in the specialty or service.

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

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

(2) appropriateness of utilization patterns;

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

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

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

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

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

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

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

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

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

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

(e) An applicant has the burden of establishing qualifications and current competence for clinical privileges requested.

(f) The report of the relevant department chair, and the Chief Nursing Officer, as applicable, will be processed as a part of the application for privileges.

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

4.A.2. Requests for Limited Privileges Within a Core or Specialty:

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

(b) In appropriate circumstances, the Board may grant limited clinical privileges within a core or specialty as requested by an individual on the application. The request must indicate the specific clinical privileges within the core or specialty that the individual does not wish to provide, state a basis for the request, and include evidence that the individual does **not** provide the patient care services in any health care facility in that area.

(c) A request for limited clinical privileges will be reviewed by the relevant department chair, Credentials Committee, Division Executive Committees, Network Executive Committee, and Board.

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

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

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

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

(4) fairness to the individual requesting limited privileges;

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

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

(e) No one is entitled to be granted limited clinical privileges within a core or specialty, and denial of such a request does not trigger a right to a hearing or appeal.

4.A.3. Resignation of Limited Clinical Privileges:

A request to resign limited clinical privileges, whether or not part of the core, must provide a basis for the request. All such requests will be processed in the same manner as a request for limited clinical privileges, as described above.

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

A request to resign **all** clinical privileges should (a) specify the desired date of resignation, (b) affirm that the individual has completed all medical records, and (c) affirm that the individual will be able to appropriately discharge or transfer responsibility for the care of any hospitalized patient. After consulting with the Chief Physician Executive, the Board will act on the request.

4.A.5. Clinical Privileges for New Procedures:

(a) Requests for clinical privileges to perform either a procedure not currently being performed at the Hospital or a new technique to perform an existing procedure ("new procedure") will not be processed until a determination has been made that the procedure will be offered by the Hospital and criteria for the clinical privilege(s) have been adopted.

(b) As an initial step in the process, the individual seeking to perform the new procedure will prepare and submit a report to the department or department chair and the Credentials Committee, or other appropriate committee. The report should, if possible, be supported by peer reviewed research, product literature, recommendations from relevant professional societies, and the names of any residency training directors responsible for providing training in this area. The report should also address the following:

(1) minimum education, training, and experience necessary to perform the new procedure safely and competently;

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

(3) whether there is empirical evidence addressing patient outcomes with the new procedure versus the standard procedure, including risks and 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 or department chair and the Credentials Committee, or other appropriate committee (e.g., Supply Chain Governance Committee), will review this report, conduct additional research as necessary, and make a preliminary recommendation as to whether the new procedure should be offered at the Hospital.

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

(1) the minimum education, training, and experience necessary to perform the procedure or service;

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

(3) the extent (time frame and mechanism) of initial focused professional practice evaluation and supervision that should occur if the privileges are granted; and

(4) the manner in which the procedure would be reviewed as part of the Hospital's ongoing and focused professional practice evaluation activities.

(d) If another committee is used, it will forward its recommendation to the Credentials Committee. The Credentials Committee will forward its recommendations to each Division Executive Committee, which will review the matter and forward its recommendations to the Network Executive Committee. The recommendations of the Network Executive Committee will be forwarded to the Board for final action.

4.A.6. Clinical Privileges That Cross Specialty Lines:

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

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

(c) The Credentials Committee, or other appropriate committee (e.g., Supply Chain Governance Committee), will 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, or other appropriate committee, may or may not recommend that individuals from different specialties be permitted to request the clinical privileges at issue. If the committee recommends that individuals from different specialties be permitted to request clinical privileges, it 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 initial focused professional practice evaluation 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) If another committee is used, it will forward its recommendation to the Credentials Committee. The Credentials Committee will forward its recommendations to each Division Executive Committee, which will review the matter and forward its recommendations to the Network Executive Committee. The Network Executive Committee will forward its recommendations to the Board for final action.

4.A.7. Clinical Privileges for Dentists and Oral Surgeons:

(a) Dentist members of the Medical Staff may co-admit a patient in need of dental services with a physician member of the Medical Staff. The physician member of the Medical Staff will be responsible for conducting and recording the results of a medical history and physical examination of the patient and for the medical care of the patient throughout the period of hospitalization.

(b) Oral surgeon members of the Medical Staff may admit a patient in need of dental services, conduct and record the results of a medical history and physical examination of the patient, and assess the medical risks of the procedure on the patient, if they are deemed qualified to do so by the Credentials Committee and the System Executive Committee. The oral surgeon shall obtain indicated consults in complicated cases.

(c) The dentist or oral surgeon will 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 surgeons may write orders within the scope of their licenses and consistent with relevant Hospital policies and rules and regulations.

4.A.8. Clinical Privileges for Podiatrists:

(a) Podiatrists may co-admit a patient in need of podiatric services with a physician member of the Medical Staff. The physician member of the Medical Staff will be

responsible for conducting and recording the results of a medical history and physical examination of the patient and the medical care of the patient throughout the period of hospitalization.

(b) The podiatrist will 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.9. Physicians and Other Practitioners in Training:

Physicians and other practitioners in training, including but not limited to medical students, advanced practice nurses, and physician assistants in training programs ("Trainees"), will not be granted appointment or clinical privileges. The clinical faculty or attending staff member will be responsible for the direction and supervision of the on-site or day-to-day patient care activities of each Trainee, who will be permitted to perform only those clinical functions set out in curriculum requirements, affiliation agreements, or training protocols. The applicable training program will be responsible for verifying and evaluating the qualifications of each physician in training.

4.A.10. Telemedicine Privileges:

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

(b) A request for telemedicine privileges will be processed through the same process for Medical Staff and Allied Health Staff applications, as set forth in this Policy. In such case, the individual must satisfy all qualifications and requirements set forth in this Policy, except those relating to geographic location, coverage arrangements, and emergency call responsibilities.

(c) Telemedicine privileges, if granted, will be for a period of not more than two years.

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

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

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

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

(b) This initial focused professional practice evaluation may include chart review, monitoring, proctoring, external review, and other information. The clinical activity requirements, including numbers and types of cases to be reviewed, will be determined by the Credentials Committee or department chair.

(c) A newly appointed member's appointment and privileges will expire if he or she fails to fulfill the clinical activity requirements within the time frame recommended by the Credentials Committee. In such case, the individual may not reapply for initial appointment or privileges for two years.

(d) If a member who has been granted additional clinical privileges fails to fulfill the clinical activity requirements within the time frame recommended by the Credentials Committee, the additional clinical privileges will expire and the member may not reapply for the privileges in question for two years.

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

4.B. INTERIM PRIVILEGES FOR INITIAL APPOINTMENT

(1) Upon completion of a Category I application for initial appointment, review and recommendation of the application by the Credentials Chair or the Credentials Committee, the Hospital Chief Executive Officer, after consultation with the chair of the relevant department and the Chief of Staff, may grant interim privileges to the applicant pending a final decision by the Board. Supervision may be required for interim privileges as determined by the chair of the relevant department. Interim privileges will expire after 90 days.

(2) The following verified information will be considered prior to the granting of interim clinical privileges: education; current licensure; relevant training; experience; current competence; current professional liability coverage acceptable to the Hospital; professional references; and results of a query to the National Practitioner Data Bank and the Office of Inspector General, Medicare/Medicaid Exclusions.

(3) Under no circumstances may interim privileges be granted or renewed if the application is still pending because the applicant has not responded in a satisfactory manner to a request for clarification of a matter or for additional information.

(4) Prior to interim 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.

(5) Should the application for initial appointment ultimately be denied by the Board, interim privileges will automatically expire and there will be no right to a hearing pertaining to the expiration of interim privileges.

4.C. TEMPORARY CLINICAL PRIVILEGES

(1) Temporary privileges may be granted by the Hospital Chief Executive Officer, or a designee, upon recommendation of the Chair of the Network Executive Committee or the Chief of Staff, to non-applicants, when there is an important patient care, treatment, or service need, including the following:

(a) the care of a specific patient;

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

(c) proctoring; or

(d) when serving as a locum tenens for a member of the Medical Staff or Allied Health Staff.

(2) The following verified information will be considered prior to the granting of temporary clinical privileges: education; current licensure; relevant training; experience; current competence; current professional liability coverage acceptable to the Hospital; professional references; and results of a query to the National Practitioner Data Bank and the Office of Inspector General, Medicare/Medicaid Exclusions.

(3) The initial grant of temporary clinical privileges will not exceed 60 days. Temporary privileges for applicants may be granted for up to one additional term of 60 days.

(4) If an individual who has been granted temporary privileges as a locum tenens wants to exercise locum tenens privileges for a term of longer than 120 days, the individual will be required to request appointment to the Medical Staff and clinical privileges. This request will be processed in a manner consistent with other applications for appointment.

(5) Prior to any temporary clinical privileges being granted, the individual must agree in writing to be bound by the bylaws, rules and regulations, policies, procedures and protocols of the Medical Staff and the Hospital.

(6) The granting of temporary clinical privileges is a courtesy that may be withdrawn by the Chief Physician Executive at any time, after consulting with the Chair of the Network Executive Committee, the Chief of Staff, or the department chair.

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

4.D. EMERGENCY SITUATIONS

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

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

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

4.E. DISASTER PRIVILEGES

(1) When the disaster plan has been implemented and the immediate needs of patients in the facility cannot be met, the Hospital Chief Executive Officer, the Chief Physician Executive, or the Chair of the Network Executive Committee may use a modified credentialing process to grant disaster privileges to eligible volunteer licensed independent practitioners who will function as volunteers ("volunteers"). Safeguards must be in place to verify that volunteers are competent to provide safe and adequate care.

(2) Disaster privileges are granted on a case-by-case basis after verification of identity and licensure.

(a) A volunteer's identity may be verified through a valid government-issued photo identification (i.e., driver's license or passport).

(b) A volunteer's license may be verified in any of the following ways: (1) current Hospital picture ID card that clearly identifies the individual's professional designation; (2) current license to practice; (3) primary source verification of the license; (4) identification indicating that the individual has been granted authority to render patient care in disaster circumstances or is a member of a Disaster Medical Assistance Team, the Medical Resource Corps, the Emergency System for Advance Registration of

Volunteer Health Professionals, or other recognized state or federal organizations or groups; or (5) identification by a current Hospital employee or Medical Staff or Allied Health Staff member who possesses personal knowledge regarding the individual's ability to act as a volunteer during a disaster.

(3) Primary source verification of a volunteer's license will begin as soon as the immediate situation is under control and must be completed within 72 hours from the time the volunteer begins to provide service at the Hospital.

(4) In extraordinary circumstances when primary source verification cannot be completed within 72 hours, it should be completed as soon as possible. In these situations, there must be documentation of the following: (a) the reason primary source verification could not be performed in the required time frame; (b) evidence of the volunteer's demonstrated ability to continue to provide adequate care; and (c) an attempt to obtain primary source verification as soon as possible. If a volunteer has not provided care, then primary source verification is not required.

(5) The Medical Staff will oversee the care provided by volunteer licensed independent practitioners. This oversight will be conducted through direct observation, mentoring, clinical record review, or other appropriate mechanism developed by the Medical Staff and Hospital.

ARTICLE 5

PROCEDURE FOR REAPPOINTMENT

5.A. PROCEDURE FOR REAPPOINTMENT

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

5.B. REAPPOINTMENT CRITERIA

5.B.1. Eligibility for Reappointment:

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

(a) completed all medical records consistent with the requirements outlined in the appropriate policies and procedures;

(b) completed all continuing medical education requirements;

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

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

(e) paid any applicable reappointment processing fee; and

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

5.B.2. Factors for Evaluation:

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

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

(d) any ongoing professional practice evaluation or focused professional practice evaluations;

(e) verified complaints received from patients or staff; and

(f) other reasonable indicators of continuing qualifications.

5.C. REAPPOINTMENT PROCESS

5.C.1. Reappointment Application Form:

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

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

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

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

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

(f) The criteria for designation of Category I, II, or III for initial reappointment are outlined in Appendix C.

5.C.2. Conditional Reappointments:

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

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

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

5.C.3. Potential Adverse Recommendation:

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

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

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

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

ARTICLE 6

QUESTIONS INVOLVING MEDICAL STAFF OR ALLIED HEALTH STAFF MEMBERS

6.A. OVERVIEW AND GENERAL PRINCIPLES

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

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

(1) collegial intervention and progressive steps;

(2) ongoing and focused professional practice evaluations;

(3) mandatory meeting;

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

(5) competency assessment;

(6) automatic relinquishment of appointment and clinical privileges;

(7) leaves of absence;

(8) precautionary suspension; and

(9) formal investigation.

(b) In addition to these options, Medical Staff Leaders and Hospital Administration also have the discretion to determine whether a matter should be handled in accordance with another policy (e.g., Professionalism and Code of Conduct Policy, Practitioner Health Policy, Professional Practice Evaluation Policy) or should be referred to the Network Executive Committee for further action.

6.A.2. Documentation:

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

(b) A summary of documentation that is prepared for and maintained in the individual's confidential file may be shared with the individual; however, the identity of any person who prepared a complaint or written concern will not be shared. The individual will have an opportunity to review the summary of the documentation and respond to it. The initial documentation, along with any response that is submitted, will also be maintained in the individual's confidential file.

6.A.3. No Recordings of Meetings:

It is the policy of the Hospital to maintain the confidentiality of all Medical Staff meetings, including, but not limited to, discussions relating to credentialing, quality assessment, performance improvement, professionalism, code of conduct, and other peer review activities. The discussions that take place at such meetings are private conversations that occur in a private place. In addition to existing bylaws and policies governing confidentiality, individuals in attendance at such meetings are prohibited from making audio or video recordings at such meetings unless authorized to do so in writing by the individual chairing the meeting or by the Chief Physician Executive.

6.A.4. No Right to Counsel:

(a) The processes and procedures outlined in this Article are designed to be carried out in an informal manner. Therefore, the individual may not be accompanied by a lawyer at any meeting that takes place pursuant to this Article. By agreement of the Chief of Staff and Chief Physician Executive, an exception may be made to this general rule.

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

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

Peer review activities are confidential and privileged to the fullest extent permitted by law. Accordingly, the individual may not be accompanied by friends, relatives or colleagues when attending a meeting that takes place pursuant to this Article.

6.A.6. Involvement of Supervising Physician in Matters Pertaining to Allied Health Staff Members:

If any peer review activity pertains to the clinical competence or professional conduct of a member of the Allied Health Staff, the Supervising Physician (if any) will be notified and may be invited to participate.

6.B. COLLEGIAL INTERVENTION AND PROGRESSIVE STEPS

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

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

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

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

(b) counseling, mentoring, monitoring, proctoring, consultation, and education;

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

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

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

(f) performance improvement plans.

6.C. ONGOING AND FOCUSED PROFESSIONAL PRACTICE EVALUATION

(1) Individuals who are granted clinical privileges, whether at the time of initial appointment, reappointment, or during the term of appointment, will be subject to an initial focused professional practice evaluation to confirm their competence.

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

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

6.D. MANDATORY MEETING

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

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

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

6.E. FITNESS FOR PRACTICE EVALUATION

(1) An individual may be requested to submit to an appropriate evaluation (such as blood and/or urine test), or a comprehensive fitness for practice evaluation, which may include a physical, psychological, or cognitive assessment, to determine his or her ability to safely and competently practice.

(2) A request for a fitness for practice evaluation may be made of an applicant during the initial appointment or reappointment processes or of a member during an investigation.

(3) A request for an **immediate** evaluation may also be made when two Medical Staff Leaders (or one Medical Staff Leader and one member of the Hospital Administration) are concerned with the individual's ability to safely and competently care for patients.

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

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

6.F. COMPETENCY ASSESSMENT

(1) An individual may be requested to participate in a competency assessment to determine his or her ability to safely and competently practice.

(2) A request for a competency assessment may be made of a member during the reappointment process, as part of the collegial intervention process, or during an investigation. The request may be made by Medical Staff Leaders, the Credentials Committee, a Division Executive Committee, an Investigating Committee, the Network Executive Committee, or a Professional Practice Evaluation Committee.

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

(4) Failure to obtain the requested assessment may result in an automatic relinquishment of appointment and privileges as set forth below.

6.G. AUTOMATIC RELINQUISHMENT

(1) Any of the occurrences described in this Section will constitute grounds for the automatic relinquishment of an individual's appointment and clinical privileges. An automatic relinquishment is considered an administrative action and, as such, it generally does not trigger an obligation on the part of the Hospital to file a report with the National Practitioner Data Bank.

(2) Except as otherwise provided below, an automatic relinquishment of appointment and privileges will be effective immediately upon actual or Special Notice to the individual.

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

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

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

Failure of an individual to satisfy any of the threshold eligibility criteria set forth in this Policy will result in automatic relinquishment of appointment and clinical privileges.

6.G.3. Criminal Activity:

The occurrence of specific criminal actions may, as recommended by the Network Executive Committee and confirmed by the Chief Physician Executive, result in the

automatic relinquishment of appointment and clinical privileges. Specifically, an arrest, charge, indictment, conviction, plea of guilty or plea of no contest pertaining to any felony or misdemeanor involving the following may result in an automatic relinquishment: (a) Medicare, Medicaid, or other federal or state governmental or private third-party payer fraud or program abuse; (b) controlled substances; (c) illegal drugs; (d) violent act; (e) sexual misconduct; (f) moral turpitude; or (g) child or elder abuse.

6.G.4. Failure to Provide Information:

(a) Failure of an individual to notify in writing the Medical Staff Office, the Chief of Staff, or the Chief Physician Executive of any change in any information provided on an application for initial appointment or reappointment within 14 days of the change may, as determined by the Network Executive Committee, result in the automatic relinquishment of appointment and clinical privileges.

(b) Failure of an individual to provide information in writing pertaining to an individual's qualifications for appointment or clinical privileges in response to a written request from the Medical Staff Office, Credentials Committee, a Division Executive Committee, the Network Executive Committee, or any other authorized committee within 14 days of the request may, as determined by the Network Executive Committee, result in the automatic relinquishment of appointment and clinical privileges until the information is provided to the satisfaction of the requesting party.

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

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

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

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

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

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

Medical Staff Leaders or relevant committee) will be considered a voluntary withdrawal of the application.

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

6.G.8. Failure to Comply with Request for Competency Assessment:

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

6.G.9. Reinstatement from Automatic Relinquishment and Automatic Resignation:

(a) If an individual believes that the matter leading to the automatic relinquishment of appointment and privileges has been resolved within 90 days of the relinquishment, the individual may request to be reinstated.

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

(c) Requests for reinstatement from an automatic relinquishment following the expiration or lapse of a license, controlled substance authorization, or insurance coverage will be processed by the Medical Staff Office. If any questions or concerns are noted, the Medical Staff Office will refer the matter for further review in accordance with (d) below. If an automatic relinquishment occurred due to an individual's failure to complete medical records, Medical Staff Office may automatically reinstate that individual once the delinquent medical records are completed.

(d) All other requests for reinstatement from an automatic relinquishment will be reviewed by the relevant department chair, the chair of the Credentials Committee, the Chief of Staff, the Chair of the Network Executive Committee, and the Chief Physician Executive. If all these individuals make a favorable recommendation on reinstatement, the individual may immediately resume clinical practice at the Hospital. If, however, any of the individuals reviewing the request have any

questions or concerns, those questions will be noted and the reinstatement request will be forwarded to the full Credentials Committee, the Division Executive Committees, the Network Executive Committee, and Board for review and recommendation.

(e) Failure to resolve a matter leading to an automatic relinquishment within 90 days of the relinquishment, and to be reinstated as set forth above, will result in an automatic resignation from the Medical Staff or Allied Health Staff.

6.H. LEAVES OF ABSENCE

6.H.1. Initiation:

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

(b) The Chief of Staff or Chief Physician Executive will determine whether a request for a leave of absence will be granted, after consulting with the relevant department chair. The granting of a leave of absence or reinstatement may be conditioned upon the individual's completion of all medical records.

(c) Members of the Medical Staff or Allied Health Staff must report to the Chief of Staff or Chief Physician Executive any time they are away from Medical Staff, Allied Health Staff, or patient care responsibilities for longer than 30 days and the reason for such absence is related to their physical or mental health or otherwise to their ability to care for patients safely and competently. Upon becoming aware of such circumstances, the Chief Physician Executive or Chief of Staff may trigger an automatic medical leave of absence at any point after becoming aware of the Medical Staff member's absence from patient care.

(d) The Chief of Staff or the Chief Physician Executive will inform the Division Executive Committees whenever a leave of absence is approved.

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

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

During a leave of absence, the individual will not exercise any clinical privileges and will be excused from Medical Staff and Allied Health Staff responsibilities (e.g., meeting attendance, committee service, emergency service call obligations). The obligation to pay

dues will continue during a leave of absence except that a member granted a leave of absence for U.S. military service will be exempt from this obligation.

6.H.3. Reinstatement:

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

(b) If a favorable recommendation on reinstatement is made, the individual may immediately resume clinical practice. Notice of the reinstatement will be forwarded to the Division Executive Committees. However, if any of the individuals reviewing the request have any questions, those questions will be noted and the reinstatement request will be forwarded to the full Credentials Committee, the Division Executive Committees, the Network Executive Committee, and the Board. Questions noted during the reinstatement request may be addressed by a recommendation from the Credentials Committee, the Division Executive Committees, the Network Executive Committee, or the Board for a period of focused professional practice evaluation.

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

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

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

6.I. PRECAUTIONARY SUSPENSION OR RESTRICTION OF CLINICAL PRIVILEGES

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

(a) Whenever failure to take action may result in imminent danger to the health and/or safety of any individual, a Division Executive Committee or the Network Executive Committee, or any combination of the Hospital or Network Chief Executive Officer, the Chief Physician Executive, the Chief of Staff, and the Board Chair, is authorized to (1) afford the individual an opportunity to voluntarily refrain from

exercising clinical privileges while the matter is being reviewed; or (2) suspend or restrict all or any portion of an individual's clinical privileges.

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

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

(d) A precautionary suspension is effective immediately and will be promptly reported to the Hospital and Network Chief Executive Officer, the Chief Physician Executive, and the Chiefs of Staff. The Chief Physician Executive will notify the Board. A precautionary suspension will remain in effect unless it is modified by the Chief Physician Executive or Network Executive Committee.

(e) Within three days of the imposition of a suspension, the individual will be provided with a brief written description of the reason(s) for the action, including the names and medical record numbers of the patient(s) involved (if any). The notice will advise the individual that a suspension, restriction, or voluntary agreement to refrain from exercising privileges will be reported as required by state law and regulation and, if in effect for longer than 30 days, will be reported to the National Practitioner Data Bank.

(f) The relevant Supervising Physician will be notified when the affected individual is a member of the Allied Health Staff.

6.I.2. Network Executive Committee Procedure:

(a) Within a reasonable time, not to exceed 14 days of the imposition of the suspension, restriction, or voluntary agreement to refrain from exercising privileges, the Network Executive Committee will call a special meeting and review the reasons for the suspension.

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

(c) At the meeting, the individual may provide information to the Network Executive Committee and should respond to questions that may be raised by committee members. The individual may also propose ways, other than precautionary suspension, restriction, or voluntary agreement to refrain from exercising privileges, to protect patients, employees or others while the matter is being reviewed.

(d) After considering the reasons for the suspension and the individual's response, if any, the Network Executive Committee will determine whether the precautionary suspension, restriction, or voluntary agreement to refrain from exercising privileges should be continued, modified, or lifted. If the Network Executive Committee determines that the precautionary suspension should be continued in whole or in part, the Network Executive Committee will begin an investigation.

(e) If the Network Executive Committee decides that the suspension, restriction, or voluntary agreement to refrain from exercising privileges must be continued, it will send the individual written notice of its decision, including the basis for it.

(f) There is no right to a hearing based on the imposition or continuation of a precautionary suspension, restriction, or voluntary agreement to refrain from exercising privileges. The procedures outlined above are deemed to be fair under the circumstances.

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

6.J. INVESTIGATIONS

6.J.1. Initial Review:

(a) Whenever a serious question has been raised, or where collegial efforts have not resolved an issue regarding the following, the matter may be referred to the Chief of Staff, the department chair, the chair of a standing committee, the Chief Physician Executive, the Hospital or Network Chief Executive Officer, or the chair of the Board:

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

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

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

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

(b) If the Board becomes aware of information that raises concerns about the qualifications of any Medical Staff or Allied Health Staff member, the matter will be referred to the Chief of Staff, the Chief Physician Executive, or the Hospital or Network Chief Executive Officer.

(c) The person to whom the question is referred will make a sufficient inquiry to determine whether the question is credible and, if so, will forward it to the Division Executive Committee. If the question pertains to a member of the Allied Health Staff, the Supervising Physician may also be notified.

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

(e) No action taken pursuant to this section will constitute an investigation.

6.J.2. Initiation of Investigation:

(a) The Division Executive Committee will review the matter in question, may discuss the matter with the individual, may direct that the matter be handled pursuant to another policy, or refer the matter to the Network Executive Committee for consideration of whether there should be an investigation.

(b) An investigation will commence only after a determination by the Network Executive Committee.

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

(d) The Board may also determine to commence an investigation and may delegate the investigation to the Network Executive Committee, a subcommittee of the Board, or an ad hoc committee.

6.J.3. Investigative Procedure:

(a) Once a determination has been made to begin an investigation, the Network Executive Committee will investigate the matter itself or appoint an individual or committee ("Investigating Committee") to do so. The Investigating Committee may include individuals not on the Medical Staff or Allied Health Staff. The Investigating Committee will not include any individual who:

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

(2) is a relative of the individual being investigated;

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

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

(b) Whenever the questions raised concern the clinical competence of the individual under review, the Investigating Committee will include a peer of the individual (e.g., physician, dentist, oral surgeon, podiatrist, advanced practice nurse, or physician assistant). In the absence of a qualified peer on the Medical Staff, an outside consultant may be used.

(c) The individual will be notified of the composition of the Investigating Committee.

(d) The Investigating Committee may:

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

(2) conduct interviews;

(3) use (but not be compelled to use by the individual under investigation) outside consultants, as needed, for timeliness, expertise, thoroughness and objectivity; or

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

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

(f) The Investigating Committee will make a reasonable effort to complete the investigation and issue its report within 60 days, provided that an outside review is not necessary. When an outside review is used, the Investigating Committee will

make a reasonable effort to complete the investigation and issue its report within 30 days of receiving the results of the outside review. These time frames are intended to serve as guidelines and, as such, will not be deemed to create any right for an individual to have an investigation completed within such time periods.

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

6.J.4. Recommendation:

(a) The Network Executive Committee may accept, modify, or reject any recommendation it receives from an Investigating Committee. Specifically, the Network 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) require monitoring, proctoring or consultation;

(5) require additional training or education;

(6) recommend reduction or restriction of clinical privileges;

(7) recommend suspension of clinical privileges for a specific period of time or until specified conditions have been met;

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

(9) make any other recommendation that it deems necessary or appropriate, including a recommendation for a competency assessment or fitness for practice evaluation.

(b) A recommendation by the Network Executive Committee that does not entitle the individual to request a hearing, will take effect immediately and will remain in effect unless modified by the Board.

(c) A recommendation by the Network Executive Committee that would entitle the individual to request a hearing will be forwarded to the Chief Physician Executive, who will promptly inform the individual by Special Notice. The recommendation will not be forwarded to the Board until after the individual has completed or waived a hearing and appeal, but the Board shall be kept apprised of the matter generally.

(d) If the Board makes a modification to the recommendation of the Network Executive Committee that would entitle the individual to request a hearing, the Chief Physician Executive will inform the individual by Special Notice. No final action will occur until the individual has completed or waived a hearing and appeal.

6.K. ACTIONS OCCURRING AT ANY HONORHEALTH HOSPITAL

(1) Each HonorHealth Hospital will share information regarding the implementation or occurrence of any of the following actions with other HonorHealth Hospitals and affiliated entities at which an individual maintains medical staff appointment, allied health appointment, clinical privileges, or any other permission to care for patients:

(a) automatic relinquishment of appointment or clinical privileges;

(b) leave of absence;

(c) a performance improvement plan;

(d) any involuntary or involuntary modification of appointment or clinical privileges; and

(e) a professional review action.

(2) Upon receipt of notice that any of the actions set forth above have occurred at, or been implemented by, any HonorHealth Hospital, that action will automatically and immediately take effect at the other HonorHealth Hospitals and affiliated entities.

(3) The effectiveness of an action at the Hospital, as set forth above, may be waived by the Board after receipt of the recommendation of the Network Executive Committee. The automatic effectiveness of the action will continue unless a waiver has been granted and the practitioner has been notified in writing. Waivers are within the discretion of the Board and are final. They will be granted only as follows:

(a) in exceptional circumstances;

(b) based on a finding that the granting of a waiver will not affect patient safety, quality of care, or Hospital operations; and

(c) after a full review of the specific circumstances and any relevant documents (including peer review documents) from the Hospital where the action first occurred. The burden is on the practitioner to provide evidence showing that a waiver is appropriate.

(4) Neither the automatic effectiveness of any action set forth above at the Hospital, nor the denial of a waiver, will entitle any individual to any procedural rights, formal investigation, hearing, or appeal.

ARTICLE 7

HEARING AND APPEAL PROCEDURES FOR MEDICAL STAFF MEMBERS

7.A. INITIATION OF HEARING

7.A.1. Grounds for Hearing:

(a) An individual is entitled to request a hearing whenever the Network Executive Committee makes one of the following recommendations:

(1) denial of initial appointment, reappointment or requested clinical privileges;

(2) revocation of appointment or all or part of clinical privileges;

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

(4) restriction of clinical privileges, meaning a mandatory concurring consultation requirement, in which the consultant must approve the course of treatment in advance for a period longer than 30 days; or

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

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

(c) If the Board determines to take any of these actions without an adverse recommendation by the Network Executive Committee, an individual is entitled to request a hearing. For ease of use, this Article refers to adverse recommendations of the Network Executive Committee. When a hearing is triggered by an adverse proposed action of the Board, any reference in this Article to the "Network Executive Committee" will be interpreted as a reference to the "Board."

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

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

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

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

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

(d) automatic relinquishment of appointment or privileges;

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

(f) precautionary suspension;

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

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

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

(j) determination that an application is incomplete;

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

(l) determination of ineligibility based on a failure to meet threshold eligibility criteria, a lack of need or resources, or an exclusive contract or because the Hospital is not accepting applications in the specialty or service.

7.A.3. Notice of Recommendation:

The Chief Physician Executive will promptly give Special Notice of a recommendation which entitles an individual to request a hearing. This notice will contain:

(a) a statement of the recommendation and the general reasons for it;

(b) a statement that the individual has the right to request a hearing on the recommendation within 30 days of receipt of this notice; and

(c) a copy of this Policy.

7.A.4. Request for Hearing:

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

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

(a) The Chief Physician Executive will schedule the hearing and provide to the individual requesting the hearing, by Special Notice, the following:

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

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

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

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

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

7.A.6. Witness List:

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

(b) The witness list will include a brief summary of the anticipated testimony.

(c) The witness list of either party may, in the discretion of the Presiding Officer, be amended at any time during the course of the hearing, provided that notice of the change is promptly given to the other party. If the witness list is amended, the other party may request a postponement if additional time is needed to prepare for the new witness.

7.A.7. Hearing Panel, Presiding Officer, and Hearing Officer:

(a) Hearing Panel:

The Chief Physician Executive, after consulting with the Chair of the Network Executive Committee, will appoint a Hearing Panel in accordance with the following guidelines:

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

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

(i) any member of the Medical Staff, or

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

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

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

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

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

(ii) is a relative of the individual requesting the hearing;

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

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

(b) Presiding Officer:

(1) The Chief Physician Executive, after consultation with the Chair of the Network Executive Committee, will appoint an attorney to serve as Presiding Officer. The Presiding Officer will not act as an advocate for either side at the hearing.

(2) The Presiding Officer will:

(i) schedule and conduct one or more pre-hearing conferences;

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

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

(iv) maintain decorum throughout the hearing;

(v) determine the order of procedure;

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

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

(3) The Presiding Officer may be advised by legal counsel to the Hospital with regard to the hearing procedure.

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

(c) Hearing Officer:

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

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

(d) Compensation:

Members of the Hearing Panel, the Presiding Officer, or the Hearing Officer may be compensated for their service by the Hospital. The individual requesting the hearing may participate in the payment of that compensation. Compensation will not constitute grounds for challenging the impartiality of the Hearing Panel members.

(e) Objections:

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

7.A.8. Counsel:

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

7.B. PRE-HEARING PROCEDURES

7.B.1. General Procedures:

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

7.B.2. Provision of Relevant Information:

(a) Prior to receiving any confidential documents, the individual requesting the hearing must agree that all documents and information will be maintained as confidential and will not be disclosed or used for any purpose outside of the hearing. The individual must also provide a written representation that his or her counsel and any expert(s) have executed 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 will be provided with a copy of the following:

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

(2) reports of experts relied upon by the Network 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 Network Executive Committee.

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

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

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

(e) Neither the individual, nor any other person acting on behalf of the individual, may contact Hospital employees, Medical Staff members or Allied Health Staff members whose names appear on the Network 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 requested the hearing once it has contacted such employees, Medical Staff members or Allied Health Staff members, and confirmed their willingness to meet. Any employee, Medical Staff or Allied Health Staff member may agree or decline to be interviewed by or on behalf of the individual who requested a hearing.

7.B.3. Pre-Hearing Conference:

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

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

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

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

(e) The Presiding Officer will establish the time to be allotted to each witness's testimony and cross-examination.

7.B.4. Stipulations:

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

7.B.5. Provision of Information to the Hearing Panel:

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

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

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

(c) stipulations agreed to by the parties.

7.C. THE HEARING

7.C.1. Time Allotted for Hearing:

It is expected that the hearing will last no more than 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. Unless a lesser time period is ordered by the Presiding Officer, both parties are required to prepare their case so that a hearing will 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.

7.C.2. Record of Hearing:

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

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

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

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

(2) to introduce exhibits;

(3) to cross-examine any witness;

(4) to have representation by counsel who may be present and call, examine, and cross-examine witnesses and present the case;

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

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

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

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

7.C.4. Order of Presentation:

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

7.C.5. Admissibility of Evidence:

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

7.C.6. Persons to Be Present:

The hearing will be restricted to those individuals involved in the proceeding. Administrative personnel may be present as requested by the Chief Physician Executive.

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

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

7.C.8. Failure to Appear:

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

7.C.9. Postponements and Extensions:

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

7.D. HEARING CONCLUSION, DELIBERATIONS, AND RECOMMENDATIONS

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

Consistent with the burden on the individual to demonstrate that he or she satisfies, on a continuing basis, all criteria for initial appointment, reappointment and clinical privileges, the Hearing Panel will recommend in favor of the Network 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.

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

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

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

The Hearing Panel will deliver its report to the Chief Physician Executive. The Chief Physician Executive will provide the report to the Network Executive Committee and send by Special Notice a copy of the report to the individual who requested the hearing. Within 45 days after receipt of the report from the Hearing Panel, the Network Executive Committee will make its final recommendation, which will be sent by Special Notice to the individual who requested the hearing.

7.E. APPEAL PROCEDURE

7.E.1. Time for Appeal:

(a) If the Network Executive Committee's final recommendation is adverse to the individual who requested the hearing, the individual may request an appeal within ten days of notice of the Network Executive Committee's final recommendation.

The request will be in writing, delivered to the Chief Physician Executive in person or by certified mail, return receipt requested, and will include a statement of the reasons for appeal and the specific facts or circumstances which justify further review. The Chief Physician Executive will forward the request for an appeal, along with the Network Executive Committee's final recommendation and the Hearing Panel's report, to the Board.

(b) If an appeal is not requested within ten days, an appeal is deemed to be waived and the Chief Physician Executive will forward the Network Executive Committee's final recommendation and the Hearing Panel's report to the Board. The Board will take final action on the Network Executive Committee's final recommendation.

7.E.2. Grounds for Appeal:

The grounds for appeal will be limited to the following:

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

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

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

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

7.E.4. Nature of Appellate Review:

(a) The Board may serve as the Review Panel or the chair of the Board may appoint a Review Panel, composed of members of the Board or others, including but not limited to reputable persons outside the Hospital.

(b) The Review Panel may consider the record upon which the recommendation was made, including the hearing transcripts and exhibits, post-hearing statements, the findings and recommendations of the Network Executive Committee and Hearing Panel and any other information that it deems relevant, and recommend final action to the Board.

(c) Each party will have the right to present a written statement in support of its position on appeal. The party requesting the appeal will submit a statement first and the other party will then have 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 30 minutes.

(d) When requested by either party, the Review Panel may, in its discretion, accept additional oral or written evidence subject to the same rights of cross-examination provided at the Hearing Panel proceedings. Additional evidence will be accepted only if the Review Panel determines that the party seeking to admit it can demonstrate that it is new, relevant evidence or that any opportunity to admit it at the hearing was improperly denied.

7.F. BOARD ACTION

7.F.1. Final Decision of the Board:

(a) The Board will take final action within 30 days after it (i) considers the appeal as a Review Panel, (ii) receives a recommendation from a separate Review Panel, or (iii) receives the Network Executive Committee's final recommendation when no appeal has been requested.

(b) The Board may review any information that it deems relevant, including, but not limited to, the findings and recommendations of the Network Executive Committee, Hearing Panel, and Review Panel (if applicable).

(c) Consistent with its ultimate legal authority for the operation of the Hospital and the quality of care provided, the Board may adopt, modify, or reverse any recommendation that it receives or refer the matter for further review.

(d) The Board will render its final decision in writing, including the basis for its decision, and will send Special Notice to the individual. A copy will also be provided to the Chair of the Network Executive Committee and each Chief of Staff.

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

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

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

ARTICLE 8

CONDITIONS OF PRACTICE APPLICABLE
TO ALLIED HEALTH PROFESSIONALS

8.A. CONDITIONS OF PRACTICE APPLICABLE TO ALLIED HEALTH PROFESSIONALS

8.A.1. Standards of Practice for the Utilization of Allied Health Professionals in the Inpatient Setting:

(a) Allied health professionals are not permitted to function independently in the inpatient Hospital setting. As a condition of being granted permission to practice at the Hospital, allied health professionals specifically agree to abide by the standards of practice in this Section. In addition, as a condition of being permitted to utilize the services of allied health professionals in the Hospital, Medical Staff members who serve as Supervising Physicians also specifically agree to abide by the standards in this Section.

(b) The following standards of practice apply to the functioning of allied health professionals in the inpatient hospital setting:

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

(2) Consultations. Allied health professionals may not independently provide patient consultations in lieu of the Supervising Physician. An allied health professional may gather data and order tests; however, the Supervising Physician must personally perform the requested consultation within 24 hours (or more timely in the case of any emergency consultation request).

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

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

(5) Daily Inpatient Rounds. An allied health professional may assist his or her Supervising Physician in fulfilling the responsibility to round daily on all inpatients for whom the Supervising Physician is the designated attending physician, as appropriate.

8.A.2. Oversight by Supervising Physician:

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

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

(c) If the medical staff appointment or clinical privileges of a Supervising Physician are resigned, revoked or terminated, or the allied health professional fails, for any reason, to maintain an appropriate supervision relationship with a Supervising Physician as defined in this Policy, the allied health professional's clinical privileges will be automatically relinquished, unless he or she has another Supervising Physician who has been approved as part of the credentialing process.

(d) As a condition of clinical privileges, an allied health professional and the Supervising Physician must provide the Hospital with notice of any revisions or modifications that are made to the agreement between them. This notice must be provided to the Medical Staff Office within three days of any such change.

8.A.3. Questions Regarding the Authority of an Allied Health Professional:

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

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

8.A.4. Responsibilities of Supervising Physicians:

(a) Physicians who wish to utilize the services of an allied health professional in their clinical practice at the Hospital must notify the Medical Staff Office in advance and must ensure that the individual has been appropriately credentialed before the allied health professional performs services or engages in any kind of activity in the Hospital.

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

(c) The number of allied health professionals acting under the supervision of one Medical Staff member, as well as the care they may provide, will be consistent with applicable state statutes and regulations and any other policies adopted by the Hospital. The Supervising Physician will make all appropriate filings with the state regarding the supervision and responsibilities of the allied health professional, to the extent that such filings are required.

(d) It will be the responsibility of the Supervising Physician to provide, or to arrange for, professional liability insurance coverage for the allied health professional in amounts required by the Board. The insurance must cover all clinical activities of the allied health professional in the Hospital. The Supervising Physician will furnish evidence of such coverage to the Hospital, including the specialty and medical care covered. The allied health professional will act in the Hospital only while such coverage is in effect.

8.B. PROCEDURAL RIGHTS FOR ALLIED HEALTH PROFESSIONALS

(1) Any and all procedural rights to which allied health professionals are entitled are set forth in this Article.

(2) In the event a recommendation is made by the Network Executive Committee that an allied health professional not be granted clinical privileges or that the clinical privileges previously granted be restricted for a period of more than 30 days, terminated, or not renewed, the individual will receive Special Notice of the recommendation. The notice will include a general statement of the reasons for the recommendation and will advise the individual that he or she may request a hearing before the Credentials Committee.

(3) If a hearing is requested, the hearing will be scheduled to take place within a reasonable time frame. The hearing will be informal. The Supervising Physician and the allied health professional will both be permitted to attend this hearing. However, no counsel for either party will be present.

(4) Following this hearing, the Credentials Committee will make a recommendation. This recommendation will be provided to the allied health professional by Special Notice.

(5) Within 30 days of receipt of notice of the Credentials Committee recommendation, the allied health professional may submit a written request for appeal to the Chief Physician Executive. The request must state the reasons for the appeal.

(6) The written request for appeal will be reviewed by the Network Executive Committee which will make a final recommendation to the Board. The allied health professional will receive Special Notice of the Board's action. A copy of the Board's final action will also be sent to the Network Executive Committee for information.

ARTICLE 9

CONFLICTS OF INTEREST

(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.

(c) Any member with knowledge of the existence of a potential conflict of interest or bias on the part of any other member may call the conflict of interest to the attention of the Chief Physician Executive, the Chief of Staff, the Chief Medical Officer(s), the applicable department or committee chair, or the Chair of the Network Executive Committee.

(d) The Chief Physician Executive, the Chief of Staff, the applicable department or committee chair, or the Chair of the Network Executive Committee will make a final determination as to whether the provisions in this Article should be triggered or may submit the issue of whether there is a conflict of interest to a vote of the entire committee.

(e) Any member who has been determined to have an actual or perceived conflict will not participate in the final discussion or voting on the matter, and will be excused from any meeting during that time. However, the member may provide relevant information and may answer any questions concerning the matter before leaving.

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

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

(h) Additional guidance in addressing potential conflicts of interest is included in Appendix F of the Professional Practice Evaluation Policy.

ARTICLE 10

AMENDMENTS AND ADOPTION

(a) The amendment process for this Policy is set forth in the Bylaws.

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

Adopted by the Deer Valley Medical Center Medical Staff:

10/1/2018

Adopted by the John C. Lincoln Medical Center Medical Staff:

10/1/2018

Adopted by the Scottsdale Osborn Medical Center Medical Staff:

10/1/2018

Adopted by the Scottsdale Shea Medical Center Medical Staff:

10/1/2018

Adopted by the Scottsdale Thompson Peak Medical Center Medical Staff:

10/1/2018

Approved by the Board:

9/25/2018 (effective 10/1/2018)

APPENDIX A

ALLIED HEALTH PROFESSIONALS

The allied health professionals currently practicing at the Hospital include the following:

Certified Cardiac Perfusionists (CCP)

Certified First Assists (CFA)

Certified Registered Nurse Anesthetists (CRNA)

Certified Nurse Midwives (CNM)

Certified Scrub Techs

Certified Surgical Assistants (CSA)

Certified Surgical First Assistants (CSFA)

Nurse Practitioners (NP)

Physician Assistants (PA)

RN First Assistants (RNFA)

Surgical Technicians (ST)

APPENDIX B

INITIAL APPLICATION CRITERIA FOR THE DESIGNATION OF APPLICANT FILES

(1) The following criteria define a CATEGORY I application:

(a) satisfactory references;

(b) no disciplinary actions;

(c) no licensure restrictions;

(d) CME related to privileges requested;

(e) no record of malpractice payments within the past ten years or currently pending claims; and

(f) applicant meets all criteria for privileges requested and has provided documentation of training or expertise (requests for privileges will be deferred if documentation of training or experience is not provided).

(2) The following criteria define a CATEGORY II application:

(a) references from peers and/or affiliations suggest potential or minor problems (i.e., difficulty in interpersonal relations, minor patient care issues, etc.);

(b) no more than two malpractice claims made during the past ten years that are either currently pending claims or claims upon which a payment has been made, either due to a judgment or settlement. Individual claim payments may not exceed $500,000;

(c) open investigation or non-disciplinary action by a state licensure board or Medicare;

(d) privileges requested vary from those typically requested by other practitioners in the same specialty;

(e) delinquent for Medical Records leading to suspension more than five times during the past two years; or

(f) chronic or recurring illness, mental or physical disability that may affect your ability to perform privileges requested. (I would suggest leaving this out)

(3) The following criteria define a CATEGORY III application:

(a) sanctions or disciplinary action taken by a state licensure board, Federal Drug Enforcement Agency or Medicare;

(b) any investigation or conviction of a felony or a misdemeanor within the past 15 years (traffic, Animal Control, or Game and Fish violations are excluded with the exception of drug or alcohol related charges);

(c) clinical privileges revoked, diminished or otherwise altered within the past 15 years by another health care entity or organization;

(d) denial of insurance coverage by a professional liability carrier or non-renewal of insurance coverage (except where carrier no longer writes professional liability insurance);

(e) applicant has practiced without insurance at any time during the last ten years;

(f) more than two malpractice claims made during the past ten years that are either currently pending claims or claims upon which a single payment has been made, either due to a judgment or settlement for an amount in excess of $500,000;

(g) references from peers and/or hospital affiliations that suggest potential significant problems (i.e., fair or less ratings; difficulty in interpersonal relations, etc.); or

(h) more than three medical practice affiliations within the past five years.

APPENDIX C

CRITERIA FOR REVIEW OF APPLICANTS FOR REAPPOINTMENT

(1) The following criteria define a CATEGORY I application:

(a) satisfactory references;

(b) no disciplinary actions;

(c) no licensure restrictions;

(d) CME related to privileges requested;

(e) no record of malpractice payments within the past two years or currently pending claims;

(f) applicant meets all criteria for privileges requested and has provided documentation of training or expertise (requests for privileges will be deferred if documentation of training or experience is not provided); and

(g) practitioner-specific profile indicates that performance has been satisfactory in all areas (clinical practice, behavior, etc.) and absence of problematic trends specific to patient care.

(2) The following criteria define a CATEGORY II application:

(a) references from peers and/or affiliations suggest potential or minor problems (i.e., difficulty in interpersonal relations, minor patient care issues, etc.);

(b) no more than two malpractice claims made during the past two years that are either currently pending claims or claims upon which a payment has been made, either due to a judgment or settlement. Individual claim payments may not exceed $500,000;

(c) open investigation or nondisciplinary action by a state licensure board or Medicare;

(d) privileges requested vary from those typically requested by other practitioners in the same specialty;

(e) delinquent Medical Records leading to suspension more than five times during the past two years; or

(f) chronic or recurring illness, mental or physical disability that may affect your ability to perform privileges requested. (I would leave this out)

(3) The following criteria define a CATEGORY III application:

(a) sanctions or disciplinary action taken by a state licensure board, Federal Drug Enforcement Agency or Medicare;

(b) any investigation or conviction of a felony or a misdemeanor within the past 15 years (traffic, Animal Control, or Game and Fish violations are excluded with the exception of drug or alcohol related charges);

(c) clinical privileges revoked, diminished or otherwise altered within the past 15 years by another health care entity or organization;

(d) denial of insurance coverage by a professional liability carrier or non-renewal of insurance coverage (except where carrier no longer writes professional liability insurance);

(e) applicant has practiced without insurance at any time during the last ten years;

(f) more than two malpractice claims made during the past two years that are either currently pending claims or claims upon which a single payment has been made, either due to a judgment or settlement for an amount in excess of $500,000;

(g) references from peers and/or hospital affiliations that suggest potential significant problems (i.e., fair or less ratings; difficulty in interpersonal relations, etc.);

(h) more than three medical practice affiliations within the past two years; or

(i) practitioner-specific profile identifies adverse trends related to clinical performance; medical management and/or behavior, etc.