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Duncan Regional Hospital, Inc., d/b/a DRH Health policies apply to Duncan Regional Hospital, Jefferson County Hospital and Rural Health Clinics, Solutions Specialty Clinics and Practice Management, and Advanced Medical Supply.			

Policies and Procedures

of

Duncan Regional Hospital, Inc. d/b/a DRH Health

Governing the

Allied Health Practitioner Staff

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ARTICLE I - DEFINITIONS AND INTERPRETATIONS

1.1 Definitions. For purposes of these Policies and Procedures, the following terms shall have the meanings indicated:

1.1-1 **"Act"** shall mean the Health Care Quality Improvement Act of 1986, Section 401 of Public Law 99-660, codified at 42 U.S.C. '11101 et. seq., and the rules and regulations promulgated thereunder, as amended from time to time, or any successor legislation conferring comparable privileges and immunities.

1.1-2 **"Active Staff Member"** shall mean any Medical Staff Member who has been assigned to the Active Staff, as such category of the Medical Staff is designated in the Bylaws.

1.1-3 **"AHP Applicant"** shall mean any Allied Health Practitioner who has submitted or on whose behalf there has been submitted a completed application for initial appointment to the AHP Staff.

1.1-4 **"AHP Member"** shall mean any Allied Health Practitioner who has been duly appointed to the AHP Staff pursuant to these Policies and Procedures.

1.1-5 **"AHP Staff"** shall mean all AHP Members who are duly appointed and privileged to attend patients in the Hospital.

1.1-6 **"Allied Health Practitioner" or "AHP"** an individual other than a licensed Physician, Dentist, or Podiatrist whose patient care activities require their authority to perform specified patient care services be processed through Medical Staff channels or with involvement of Medical Staff representatives, and who is either (i) to the extent required under Oklahoma law, licensed, certified or registered to provide such patient care services, or (ii) to the extent no license, certificate or registration is required under Oklahoma law, otherwise meets the requirements for membership on the AHP Staff, as set forth herein.

1.1-7 **"Advanced Practice Registered Nurse" or "APRN"** shall mean a Certified Nurse Practitioner ("CNP"), a Clinical Nurse Specialist ("CNS"), Certified Nurse Midwife "CNM"), or a Certified Registered Nurse Anesthetist ("CRNA").

1.1-8 **"Board of Directors" or "Governing Board"** shall mean the Board of Directors of Duncan Regional Hospital, Inc., d/b/a DRH Health.

1.1-9 **"Bylaws" or "Medical Staff Bylaws"** shall mean the Bylaws of the Medical Staff of DRH Health, and, the following related materials: (i) Medical Staff Fair Hearing Plan; and (iii) Medical Staff Rules and Regulations.

1.1-10 **"Chief of Staff"** shall mean the Chief of Staff of the Medical Staff.

1.1-11 **"Credentials"** shall mean and relate to any AHP Applicant's or AHP Member's professional qualifications, background, clinical ability, training, experience, competence, judgment, character, reputation, professional conduct, physical and mental health (to the extent permitted by applicable laws and regulations), professional ethics, ability to work cooperatively with others, adherence to these Policies and Procedures and all other policies and procedures of the Hospital, and any other factors bearing upon such AHP Applicant's or AHP Member's ability to provide quality patient care and to contribute to the efficient operation of the Hospital.

1.1-12 **"Credentials Committee"** shall mean the Credentials Committee of the Medical Staff.

1.1-13 **"Dependent Practitioner"** shall mean an AHP Member who is licensed or certified under state law and is authorized to function in the Hospital only under the direction or supervision of, or in collaboration with a Medical Staff Member.

1.1-14 "**Emergency Room Staff Member**" shall mean any Medical Staff Member who has been assigned to the Emergency Room Staff as such category of the Medical Staff is designated in the Medical Staff Bylaws.

1.1-15 **"Hospital"** shall mean Duncan Regional Hospital and Jefferson County Hospital and includes all inpatient and outpatient locations and services. Except as otherwise specified, references to "Hospital" shall be deemed to include all of the Hospital inpatient and outpatient facilities that are serviced by the Medical Staff.

1.1-16 **"Hospital Representative"** shall mean and include any member of the Board or of any committee thereof, any member of the Credentials Committee, any member of the Investigative Committee, any member of any Hearing Committee, any member of any Appellate Review Body, any member of any ad hoc investigation committee, the President and designees, any member of the Medical Executive Committee, the Chief of Staff and designees, any other officer of the Medical Staff, any Chairman of any medical staff committee, and any other officer, employee or agent of the Hospital and any other medical staff member who has been delegated responsibility for or requested to assist the Hospital or the Governing Body in (i) documenting, investigating, evaluating or providing information regarding the credentials of any applicant or medical staff

member, or (ii) acting upon or making recommendations with respect to any application or request for appointment or reappointment to the Medical Staff or particular clinical privileges, or (iii) acting upon or making recommendations with respect to a medical staff member's competence or professional conduct, or (iv) gathering, maintaining or reporting information bearing upon an applicant's or Medical Staff member's credentials, or (v) participating in any other peer review process.

1.1-17 **"Independent Practitioner"** shall mean an AHP Member whose licenses and/or certifications permit such member to practice independently, without direction or supervision. A Certified Registered Nurse Anesthetist (CRNA) shall be considered an Independent Practitioner; provided, however, they shall be required to meet the supervision and other requirements set forth in Section 2.05(d)(iv) of the Medical Staff Bylaws. An Advanced Practice Registered Nurse (APRN) shall also be considered an Independent Practitioner; provided, however, if they have prescriptive authority, they must meet the collaboration and other requirements in Section 2.05(d)(iv) of the Bylaws.

1.1-18 **"Medical Executive Committee" or "MEC"** shall mean the Medical Executive Committee of the Medical Staff.

1.1-19 **"Medical Staff"** shall mean the formally organized self-governing body consisting of those physicians, dentists and podiatrists who have been granted recognition as members of the Medical Staff pursuant to the terms of the Medical Staff Bylaws.

1.1-20 **"Medical Staff Member"** shall mean any practitioner who has been duly appointed to the Medical Staff and who is privileged to attend patients in the Hospital.

1.1-21 **"National Data Bank"** shall mean the National Practitioner Data Bank established pursuant to Section 421 of the Health Care Quality Improvement Act for the reporting of medical malpractice payments on behalf of, sanctioning by Boards of Medical Examiners against, and Professional Review Actions against Practitioners.

1.1-22 **"Organized Health Care Arrangement" or "OHCA"** shall mean an organizational structure recognized in the Health Insurance Portability and Accountability Act ("HIPAA") Privacy Standards, which consists of one or more legally separate covered entities that are integrated clinically or operationally and in which participants need to share protected health information about their patients to manage their delivery of health care services.

1.1-23 **"Peer Review Information"** shall have the meaning set forth at 63 Okla. Stat. §1-1709.1(a)(5).

1.1-24 **"Peer Review Process"** shall mean any process, program or proceeding utilized by the Hospital to assess, review, study or evaluate the credentials, professional conduct or health care services of an applicant or staff member, including any activity of a professional review body which is based on competence or professional conduct of an individual practitioner (i) to determine whether an applicant or Medical Staff member may have clinical privileges at the Hospital or membership on the Medical Staff; (ii) to determine the scope or conditions of such privileges or membership; or (iii) to change or modify such privileges or membership.

1.1-25 **"President"** shall mean the person appointed by the Board of Directors to act as P President of the Hospital.

1.1-26 **"Special Notice"** shall mean written notification sent by certified mail, return receipt requested, or by personal delivery with signed acknowledgement of receipt. Notice is deemed given when mailed postage prepaid addressed to the last known address of the addressee.

1.1-27 **"Sponsor"** shall mean the Medical Staff Member who makes a recommendation for appointment to the AHP Staff for an Allied Health Practitioner and serves as a liaison between one AHP member, once appointed, and the Hospital.

1.1-28 **"Supervising Staff Member"** shall mean a Medical Staff Member who employs and/or is affiliated with an Allied Health Practitioner, who recommends the Allied Health Practitioner for appointment to the AHP Staff, and who assumes total responsibility for the patient's care and the care provided by such AHP Member.

1.1-29 **"Third Party"** shall mean and include any individual, organization, association, corporation, partnership, hospital, health care entity or other person from whom information has been requested by the Hospital or any Hospital Representative or to whom information has been provided by the Hospital or any Hospital Representative.

1.2 Privileges and Immunities. The Board of Directors, any Committees and/or representatives of the Medical Staff and/or of the Board which conduct Peer Review Processes, hereby constitute themselves as Professional Review Bodies as defined in the Act and in the Oklahoma Act. Each Professional Review Body hereby claims all privileges and immunities afforded to it by said state and federal statutes. Any action taken by a Professional Review Body pursuant to these Policies and Procedures shall be in the reasonable belief that it is in furtherance of quality health care (including the provision of care in a manner that is not disruptive to the delivery of quality

medical care at the Hospital) only after a reasonable effort has been made to obtain the true facts of the matter, after adequate notice and hearing procedures are afforded to any AHP Applicant or Member, and only in the reasonable belief that the action is warranted by the facts known after a reasonable effort has been made to obtain the facts.

1.3 **Severability Clause.** In case any provision in these Policies and Procedures shall be invalid, illegal or unenforceable, the validity, legality and enforceability of the remaining provisions shall not in any way be affected or impaired thereby.

1.4 **Governing Law.** These Policies and Procedures shall be governed by, and construed in accordance with the Act and, to the extent not inconsistent therewith, the Oklahoma Act, and to the extent not so governed, with the other laws of the State of Oklahoma without giving effect to its conflict of laws principles.

1.5 **Counting of Days.** In any instance in which the counting of days is required in these Policies and Procedures in connection with the giving of notice or for any other purpose, the day of the event shall not count, but the day upon which the notice is given shall count. In any case where the date on which some action is to be taken, notice given or period expired occurs on a holiday, a Saturday or a Sunday, such action shall be taken, such notice given or such period extended to the next succeeding Monday, Tuesday, Wednesday, Thursday or Friday, which is not a holiday. The term "holiday" shall mean such days as are commonly recognized as holidays by the City of Duncan, Oklahoma. Nor shall holidays, Saturdays, or Sundays be counted against the total of days allowed for the notice or action in question.

1.7 **Notices**. All notices, requests, demands, reports, written statements and other communications required or permitted to be given to any AHP Applicant or Member in these Policies and Procedures shall be deemed to have been duly given, if in writing and delivered personally, electronically or deposited in the United States certified or registered mail, postpaid, return receipt requested, to the address of the AHP Applicant or Member on their application or to their last known address according to the records of the Hospital.

1.8 **Confidentiality and Reporting.** Actions taken and recommendations made pursuant to these Policies and Procedures shall be treated as confidential in accordance with the Peer Review Statute and with such policies regarding confidentiality as may be adopted by the Board. In addition, reports of actions taken pursuant to these Policies and Procedures shall be made by the President of the Hospital to such governmental agencies as may be required by law.

1.9 **Commencement and Termination of a Peer Review Process.** A Peer Review Process is deemed to commence (i) with respect to a potential corrective action, upon receipt of the first

complaint or expression of the first concern regarding any AHP Applicant or Member; (ii) with respect to a Credentialing Process, upon the first contact by the Hospital with such AHP Applicant or proposed AHP Applicant; and (iii) for other Peer Review Processes, as specified by the applicable Hospital Representatives. The quality assurance and other on-going quality of care monitoring by the Hospital of AHP Members shall constitute continuous Peer Review Processes. A Peer Review Process will be deemed to have terminated (i) as to a proposed corrective action, when the concerns regarding the particular AHP Applicant or Member have been resolved or a final determination has been made respecting such AHP Applicant or Member; (ii) as to a Credentialing Process, upon a final determination by the Board regarding the application for appointment and/or reappointment; and (iii) for other Peer Review Processes, as specified by the applicable Hospital Representatives. The commencement and termination of particular Peer Review Processes shall be documented in a manner designed to achieve maximum protection for Peer Review Information under the Peer Review Statute.

1.10 **Peer Review Information.** All Peer Review Information and any other documents utilized during a Peer Review Process shall be maintained in accordance with the Hospital's record retention policy pertaining to such information.

1.11 **References to the President.** Any responsibility, authority or function herein assigned to the President may be delegated by the President to any other officer or employee of the Hospital.

1.12 **Compliance with Regulations, Policies and Procedures.** Each AHP Member specifically agrees to observe, comply with and be bound by all regulations, policies and procedures of the Hospital and other rules, regulations, policies and procedures of the Hospital, as may be adopted and/or amended from time to time during the term of such AHP Member's appointment to the AHP Staff, which regulations, policies and procedures may address, without limitation, administrative matters, patient care matters, standards of conduct, compliance plan matters and other matters pertinent to AHP Member's obligations.

ARTICLE II - QUALIFICATIONS

2.1 **Appointment Required.** Allied Health Practitioners who provide patient care services shall be eligible for consideration for appointment to the AHP Staff. No Allied Health Practitioner shall (i) provide medical services to any patient in the Hospital; (ii) assist in the rendering of medical services to any patient in the Hospital; or (iii) otherwise engage in any professional activities within the Hospital, unless they have been appointed to the AHP Staff, granted clinical privileges in accordance with the procedures hereinafter set forth and satisfied the requisite supervision requirements, if any.

2.2 Hospital Employees.

2.2-1 A request for clinical privileges, on an initial basis or for renewal, submitted by a Dependent Practitioner or an Independent Practitioner who is seeking employment or who is employed by the Hospital will be processed in accordance with the terms of Article II of this policy. The findings of the Board regarding each individual's qualifications will be forwarded to Hospital management personnel or Human Resources (as appropriate) to assist the Hospital in making employment decisions.

2.2-2 All Dependent Practitioners who are seeking employment or who are employed by the Hospital shall be evaluated by Human Resources through the processes and procedures applicable to and adopted by that Department, but they must meet the qualifications set forth in this Policy.

2.2-3 Any disciplinary concern or action with respect to an employed Allied Health Professional will be governed by the Hospital's employment policies and manuals and the terms of the individual's employment relationship and/or written contract. If an Allied Health Professional's employment is terminated by the Hospital for any reason, the individual's permission to practice in the Hospital will automatically expire without any procedural rights set forth in this Policy.

2.2-4 Except as otherwise provided above, to the extent that the Hospital's employment policies or manuals, or the terms of any applicable employment contract, conflict with this Policy, the employment policies, manuals, and descriptions and terms of the individual's employment relationship and/or written contract will apply.

2.3 General Qualifications. To be eligible for initial appointment or reappointment to the AHP Staff, an Allied Health Practitioner must:

A. Have a current, unrestricted license or certification to practice their respective professions in the State of Oklahoma (as applicable) and have never had a license or certification to practice revoked or suspended by any state licensing agency;

B. Where applicable to their practice, have current, unrestricted DEA and Oklahoma controlled substances certificates;

C. Be located close enough to the Hospital to provide timely and continuous care for patients in the Hospital;

D. Maintain (or cause to be maintained by their Supervising Staff Member) at least the minimum professional liability insurance coverage established from time to time by the Board;

E. Have never been convicted of Medicare, Medicaid, or other federal or state government or private third-party payer fraud or program abuse or have been required to pay civil penalties for the same;

F. Have never been, and is not currently, excluded or precluded from participation in Medicare, Medicaid, or other federal or state governmental health care program;

G. Have never had clinical privileges or scope of practice denied, revoked, suspended, or terminated by any health care facility or health plan for reasons related to clinical competence or professional conduct, and have never resigned or relinquished clinical privileges or scope of practice during an investigation or in exchange for not conducting an investigation;

H. Have never been convicted or, or entered a plea of guilty or no contest to, any felony; or to any misdemeanor relating to controlled substances, illegal drugs, insurance or health care fraud or abuse, or violence;

I. Satisfy the minimum requirements set forth in Section 2.4 hereof (as applicable);

J. Provide information concerning the physical and mental health, in the manner and to the extent permitted by applicable laws and regulations. Immunization history and current tuberculosis skin test is required (initial appointment). Distant site AHP's with telemedicine-only privileges are excluded from this requirement.

K. If seeking to practice as a dependent practitioner, have a supervision agreement with a supervising/employing physician who is appointed to the Medical Staff;

L. Be able to document their:
(1) Relevant training, experience, demonstrated current competence, including medical/clinical knowledge, technical and clinical skills, and clinical judgment, and an understanding of the contexts and systems within which care is provided;
(2) Adherence to the ethics of the professional, continuous professional development, an understanding of sensitivity to diversity, and responsible attitude toward patients and the profession;

(3) Good reputation and character;
(4) Ability to work harmoniously with others, including, but not limited to, interpersonal and communication skills sufficient to enable him or her to maintain professional relationships with patients, families and other members of health care teams;
(5) Ability to safely and competently perform the clinical privileges or scope of practice requested, and;
(6) Recognition of the importance of, and willingness to support, the Hospital's commitment to quality care and a recognition that interpersonal skills and collegiality are essential to the provision of quality patient care.

All AHP Applicants shall have the burden of adequately documenting and demonstrating that their Credentials meet the standards necessary to assure the Credentials Committee, MEC, and the Board of Directors that patients in the Hospital will receive quality health care.

2.4 AHP-Specific Qualifications. Each AHP Applicant must meet the following minimum requirements (as applicable):

2.4-1 Clinical and Counseling Psychologists.

A. Must have a doctoral degree in psychology from an institution of higher education regionally accredited by an organization recognized by the U.S. Department of Education.

B. Must have completed two years of supervised professional experience, one year of which must be post-doctoral. The two years of supervised experience must be as a psychologist and in line with the doctoral program of study. One year of the supervised experience must be a formal, full-time pre-doctoral internship.

C. Must have a valid and unrestricted license to practice psychology issued by the Oklahoma State Board of Examiners of Psychologists.

D. Must be certified as a Health Service Psychologist by the Oklahoma State Board of Examiners of Psychologists.

2.4-2 Social Workers.

A. Must have received training in the field of social work at the Masters or Doctoral level at an accredited graduate school of social work.

B. Must have a valid and unrestricted license to practice social work issued by the Oklahoma State Board of Licensed Social Workers.

C. Must be a member of the Academy of Certified Social Workers and must subscribe to the Code of Ethics of the National Association of Social Workers.

2.4-3 Physician's Assistants (PA)

A. Must be a graduate of a physician's assistant program accredited by the Council on Medical Education of the American Medical Association.

B Must hold a valid and unrestricted certificate as a physician's assistant issued by the Oklahoma State Board of Medical Licensure and Supervision.

C. Must maintain ACLS and PALS certification if the PA has privileges to work in the Emergency Department.

2.4-4 Advanced Practice Registered Nurses (APRN).

A. Must hold a license to practice as an advanced practice registered nurse issued by the Oklahoma Board of Nursing.

B. Must have successfully completed an accredited graduate level advanced practice registered nursing education program accredited by or holding preliminary approval or candidacy status with the Accreditation Commission for Education in Nursing or the Commission on Collegiate Nursing Education in at least one of the following population foci: (i) family/individual across the lifespan; (ii) adult-gerontology (acute and/or primary); (iii) neonatal, pediatrics (acute and/or primary); (iv) women's health/gender related; or (v) psychiatric/mental health. If licensed as an APRN prior to January 1, 2016, must have successfully completed a formal program of study designed to prepare registered nurses in an expanded role in the delivery of healthcare.

C Must be nationally certified by an appropriate certifying body, recognized by the Oklahoma Board of Nursing.

D. If the APRN holds prescriptive authority, must have a supervising physician on the Medical Staff of DRH Health.

F. Must maintain ACLS and PALS certification if the APRN has privileges to work in the Emergency Department or if licensed as a CRNA.

F. Family Nurse Practitioners (FNP) with privileges to work in the Emergency Department must have 40 emergency-related continuing education hours completed within the two years prior to initial appointment and at each reappointment.

2.4-5. Registered Nurse First Assistants (RNFA) and Certified Surgical First Assistants (CSFA)

A. The RNFA must hold a license to practice as a registered nurse issued by the Oklahoma Board of Nursing and perform duties in compliance with the Association of Perioperative Registered Nurses (AORN) Official Statement on RN First Assistants as established by the (AORN) and shall meet the AORN Standards for the RN First Assistant Education Programs as required by the Oklahoma Board of Nursing. Or, must have completed an accredited surgical first assisting program and be certified as a CSFA by the National Board of Surgical Technology and Surgical Assistants (NBTSA).

B. The performance of the duties of a Registered Nurse First Assistant and Certified Surgical First Assistants must be under the supervision and in the physical presence of the Supervising Physician. The term "physical presence" shall require the Supervising Staff Member to be in the surgery department.

C. Certified Nurse Midwives, who have received certificates of recognition by the Oklahoma Board of Nursing, may complete the American College of Nurse-Midwives process for incorporating first assistant responsibilities for obstetrical and/or gynecological procedures into their scope of practice in lieu of completing an AORN course/program accepted by the Competency and Credentialing Institute.

2.4-6. Licensed Professional Counselor.

A. Must hold a license to offer professional counseling services issued by the Oklahoma State Department of Health.

B. Must be certified by the National Academy of Clinical Mental Health Counselors (NACMHC) as a licensed professional counselor.

2.4-7 Technicians.

A. Must have received a high school diploma or its equivalency.

B. Must have received adequate training from their Supervising Staff Member or other appropriate source.

C. Technicians shall perform their responsibilities and tasks only under the direct supervision and control of their supervising staff member. The term "direct supervision and control" shall require that the technicians be in the same department as the supervising medical staff member at all times while engaging in their permitted activities within the Hospital.

2.5 Supervision - Responsibilities of Supervising Physician. Dependent practitioners may function in the Hospital only so long as:

A. They are supervised by a Medical Staff Member, and

B. They have a current, supervision agreement with that physician.

In addition, should the Medical Staff appointment or clinical privileges of the supervising staff member of a dependent practitioner be revoked or terminated, the dependent practitioner's permission to practice at the Hospital and clinical privileges shall be automatically relinquished pursuant to Section 7.3 of this Policy (unless the individual will be supervised by another supervising staff member).
The number of dependent practitioners acting under the supervision of one physician, as well as the acts they may undertake, must be consistent with applicable state statutes and regulations, the rules and regulations of the Medical Staff and the policies of the Board.

2.6 Effect of Other Affiliations. No Allied Health Practitioner shall be entitled to appointment to the AHP Staff or to exercise particular clinical privileges or engage in particular activities in the Hospital merely by virtue of the fact that they are duly licensed or certified to practice in the State of Oklahoma or any other state, or that they meet the minimum qualifications for appointment, or that they are a member of any professional organization, or that they have in the past, or presently has, such privileges at another hospital.

2.7 Nondiscrimination. The Hospital will comply with all applicable federal and state laws prohibiting discrimination in evaluating applications for appointment to the AHP Staff.

2.8 Professional Liability Insurance Coverage. Each AHP Member shall maintain, or cause to be maintained by their Sponsor or Supervising Staff Member, as applicable, professional liability insurance coverage in an amount at least equal to the minimum amount of coverage from time to time established by the Board and shall be required to provide satisfactory evidence of such coverage to the President on an annual basis. Any AHP Member who is unable to obtain professional liability insurance coverage in the amount specified by the Board may request a waiver or reduction of the required minimum liability insurance coverage by submitting a written application to the Board. The Board shall make a decision, which shall be final and non-appealable.

ARTICLE III - APPOINTMENT PROCEDURE

3.1 Application for Initial Appointment:

3.1-1. Pre-Application/Application Form. Each request for pre-application materials shall be submitted in writing on the form prescribed by the Board, and signed by the potential applicant. All individuals claiming to be practitioners who provide a written request for application materials shall be forwarded an application request form by the President in a timely fashion.

3.1-2 Content of pre-application. The application request form shall include such provisions as are necessary to secure information which will document the potential applicant's ability to meet the general qualifications for AHP Staff membership. Such information shall include without limitation the following:

A. Hospital Affiliations: A listing of all hospitals in which the potential applicant has had clinical privileges during the past five (5) years;

B. Board Certification: A copy of the potential applicant's certification from their specialty board, OR a letter from the specialty board indicating the practitioner's eligibility to take the board's examination OR evidence of training requisite to board certification.

C. Licensure: Current licensure and controlled substances certificates as applicable;

D. Liability Insurance: Verification of required professional liability insurance coverage as required.

3.1-3 Verification of Information on Pre-application Request Form. The potential applicant shall deliver a completed pre-application request form to the President, who shall, in timely fashion, seek to collect or verify the licensure and other qualification evidence

submitted. The President shall promptly notify the potential applicant of any problem in obtaining the information required, and it shall then be the applicant's obligation to obtain the required information.

3.1-4 Submission of Pre Application Request Form. The President, in consultation with the Credentials Committee, shall review the pre-application request form, supporting documentation, and such other information that may be relevant to determine whether the potential applicant meets the basic requirements for AHP Staff membership. If the resident makes a favorable determination, an application form shall be provided to the potential applicant. If the potential applicant is found to not meet the basic requirements for AHP membership as outlined in this document, the individual shall be so notified.

3.1-5 Application Form. Each application for AHP membership shall be in writing on the form prescribed by the Board, and signed by the applicant. All practitioners determined by the President, in consultation with Credentials Committee, to meet the basic qualifications for AHP membership outlined in this document shall be provided an application for AHP Staff membership by the President. A copy of the Medical Staff Bylaws, Rules and Regulations, and AHP Policy shall be furnished, or shall be accessible, to each such person.

3.2 Effect of Application. By applying for appointment (or reappointment) to the AHP Staff, or for particular clinical privileges or permitted activities or changes therein, the AHP applicant or AHP Member, as the case may be:

A. Signifies their willingness to appear for interviews in regard to the application;

B. Authorizes Hospital Representatives to consult with others who have been associated with such AHP applicant and who may have information, including peer review information and otherwise privileged and confidential information, bearing on competence and qualifications, and agrees that information so provided shall not be required to be disclosed to him or her if the party providing such information does so on the condition that it be kept confidential;

C. Consents to the inspection by Hospital Representatives of all records and documents that may be material to an evaluation of such AHP applicant’s personal and professional qualifications, ability to carry out the clinical privileges requested, health status (in the manner and to the extent permitted by applicable laws and regulations) and professional ethical qualifications;

D. Authorizes and consents to Hospital Representatives providing other hospitals, healthcare facilities, medical associations, licensing boards, and other organizations concerned with provider performance and the quality and efficiency of patient care with any information relevant to such matters that the Hospital may have concerning such AHP Applicant; and

E. Agrees that, if any adverse recommendation or action is made or taken with respect to them, (i) they will follow and exhaust the administrative remedies afforded hereunder which shall be the exclusive remedy afforded to the AHP applicant or AHP Member as to such recommendation or action, and (ii) they will have the burden of demonstrating that they meet the standards for appointment or continued appointment to the AHP Staff or for the clinical privileges or permitted activities requested.

3.3 Release; Immunity from Liability.

3.3-1 Persons Protected. By signing or submitting an application for and/or accepting appointment to the AHP Staff, and by signing or submitting an application for, accepting and/or exercising clinical privileges or engaging in activities within the Hospital, each AHP applicant and AHP Member extends absolute immunity to, and releases from all claims, damages and liability whatsoever:

A. The Hospital and any Hospital Representative for any action taken, or statement or recommendation made, by any Hospital Representative within the scope of their duties as a Hospital Representative, including disclosures made pursuant to Section 3.2 above.

B. All individuals and organizations for releasing or disclosing information, including otherwise privileged or confidential information, to any Hospital Representative concerning any former or current AHP applicant or AHP Member.

3.3-2 Acts Covered. The immunity provided by Section 3.3 hereof shall apply to all acts, communications, reports, recommendations, or disclosures performed or made in connection with the Hospital's activities, including, but not limited to:

A. Applications for appointment and/or clinical privileges or permitted activities;

B. Periodic reappraisals undertaken for reappointment or for changes in clinical privileges or permitted activities;

C. Evaluating requests for changes in clinical privileges;

D. Corrective action;

E. Patient care audits;

F. Medical care evaluations;

G. Utilization reviews;

H. Other Hospital, staff, department, service, committee and subcommittee activities related to monitoring and maintaining quality patient care and appropriate professional conduct;

I. Matters or inquiries concerning the credentials of any AHP applicant or AHP Member; and

J. Matters directly or indirectly affecting patient care or the efficient operation of the Hospital.

3.4 Cumulative Effect. The provisions set forth in these Policies and Procedures and in application and request forms relating to authorizations and immunities from liability shall be in addition to other protections provided by law and not in limitation thereof.

3.5 Processing of Applications. AHP applications shall be considered in a timely and good faith manner by all individuals and groups required hereby to act thereon, and except for good cause, shall be processed within the time periods specified in this Section 3.5. That notwithstanding, the time periods specified herein are intended to assist those named in accomplishing their tasks and shall not be deemed to create any right for an AHP applicant to have their application processed within such time periods. Notwithstanding the foregoing, no application for appointment shall be processed if it shows on its face that the AHP applicant does not meet the minimum qualifications for appointment set forth in Sections 2.2 and 2.3 hereof.

3.5-1 Determination of Completeness/Verification of Information by Medical Staff Coordinator. Upon receipt of a fully executed application from an AHP applicant, the Medical Staff Coordinator shall, in timely fashion, seek to collect or verify the references, licensure, and other qualification evidence submitted and, if desired, interview the AHP applicant. The Medical Staff Coordinator shall promptly notify the AHP applicant of any problem in obtaining the information required and it shall then be the AHP applicant's obligation to assure that the required information is transmitted to the Medical Staff

Coordinator. In such regard, the AHP applicant shall be informed that processing of the application will not begin until it has been entirely completed. For the purposes hereof, an application shall be deemed to be complete when all information requested in the application, has been provided, letters of reference have been received from a minimum of three (3) individuals, and all information has been adequately verified. In the event such verification and collection process is not completed within sixty (60) days of receipt of the application, the Medical Staff Coordinator shall submit a status report to the Credentials Committee indicating the same at its next regular meeting. When collection and verification are completed, the Medical Staff Coordinator shall transmit the application and all supporting materials to the Credentials Committee for its review and consideration.

3.5-2 Credentials Committee Action. The Credentials Committee shall review the application, supporting documentation, and other information available, that may be relevant to consideration of the AHP applicant's qualifications for the AHP Staff category and clinical privileges requested, at its first meeting subsequent to receipt of the completed application. The Credentials Committee may also conduct an interview of the AHP applicant. The Credentials Committee shall take action as to an application, in accordance with Section 3.5 within ninety (90) days of receipt of the application from the Medical Staff Coordinator. The findings and recommendations of the Credentials Committee will be forwarded to the Medical Executive Committee for consideration.

3.5-3 Medical Executive Committee Action. At its next meeting, after receipt of the written findings and recommendations of the Credentials Committee, the MEC shall:

A. Adopt the findings and recommendations of the Credentials Committee as its own; or

B. Refer the matter back to the Credentials Committee for further consideration and responses to specific questions raised by the MEC prior to its final recommendation; or

C. State its reasons in its report and recommendation, along with supporting information for its disagreement with the Credentials Committee's recommendation.

If the recommendation of the MEC is favorable to the AHP applicant, the MEC shall forward its recommendation to the Board, through the President, including the findings and recommendation of the Credentials Committee. If the MEC's recommendation would entitle the AHP applicant to the procedural rights set forth in this Policy, the MEC shall forward its recommendation to the President

who shall notify the AHP applicant of the recommendation and their procedural rights. The President shall then hold the MEC's recommendation until after the AHP applicant has completed or waived the procedural rights outlined in this Policy. The Board will not review an adverse recommendation until the AHP applicant's procedural rights have been exercised or waived.

3.5-4 Board Action. The Board, or a committee thereof, shall take final action on the AHP application at its next regular meeting following receipt of all recommendations, reports and additional information collected under this Section 3.5. Upon receipt of a favorable recommendation concerning an AHP applicant from the Credentials Committee and MEC, the Board may:

A. Grant the AHP applicant permission to practice the clinical privileges or scope of practice as recommended; or

B. Refer the matter back to the Credentials Committee or MEC or to another source inside or outside the Hospital for additional research or information; or

C. Reject or modify the recommendation.

If the Board determines to reject a favorable recommendation, the President shall notify the AHP applicant of its determination and the applicant's procedural rights as outlined in this Policy.

The AHP applicant shall have the right to exhaust such procedural rights before the Board takes final action on the application.

3.5-5 Denial for Hospital's Inability to Accommodate. In accordance with Section 3.8 of the Hospital Bylaws, a recommendation by the Medical Executive Committee or a decision by the Board to deny AHP Staff membership, staff category assignment or particular clinical privileges either:

A. On the basis of the Hospital's determination that it is not feasible, economically or otherwise, to provide adequate facilities for the AHP applicant and their patients;

B. On the basis of an insufficient current or projected patient load to support an additional AHP Staff Member with the skills and training of the AHP applicant;

C. On the basis of inconsistency with the Hospital's written plan of development, including the mix of patient care services to be provided, as currently being implemented; or

D. On the basis of a numerical limitation on the admission of AHP applicants to a particular specialty or service;

This shall not be considered adverse in nature and shall not entitle the AHP applicant to the procedural rights as provided in this Policy. In such instance, upon written request by the AHP applicant to the President, the application shall be kept in a pending status for the next six (6) months. If during this period the Board determines justification for expenditure, increased permissive usage of facilities or other economic factors render it feasible to accept staff application for which an AHP applicant is eligible, the President shall promptly so inform the AHP applicant by Special Notice. This notification is the only obligation as to AHP applicants with pending application status. Within thirty (30) days of receipt of such Special Notice, the AHP applicant shall provide, in writing on the prescribed form, any information necessary to update all elements of the original application. Thereafter, the procedure provided in Section 3.5 for initial appointments shall apply.

3.6-6 Conflict Resolution. Whenever the Board's proposed decision is contrary to the Medical Executive Committee's proposed recommendation, the Board shall submit the matter to the Joint Conference Committee for review and recommendation before making its final decision and giving notice of its final decision.

3.6-7 Notice of Final Decision.

A. **Manner of Notice.** Notice of the Board's final decision shall be given, through the President, to the Chief of Medical Staff and to the AHP applicant by means of Special Notice. A decision and notice to appoint shall include (i) the AHP Staff category to which the AHP applicant is appointed, (ii) the clinical privileges they may exercise, and (iii) any special conditions attached to the appointment.

B. **Adverse Final Decision.** Should the final decision be adverse to the AHP applicant's request, notification to the AHP applicant shall state the adverse action taken and include a statement of the reasons for the adverse action which, in the case of a denial of an initial application for staff appointment shall be sufficient if it contains a statement of the areas in which AHP applicant's qualifications were found deficient.

C. **Mandatory Waiting Period.** Any AHP applicant who receives Special Notice of adverse final decision on an initial appointment application may not submit another application for appointment to the AHP Staff for a period of twelve (12) months following the date such AHP applicant received the Special Notice of adverse final decision.

ARTICLE IV - PREROGATIVES

4.1 Scope of Appointment. An AHP Member may only exercise the specific clinical privileges or engage in the specific activities within the delineation of clinical privileges granted to them by the Board of Directors. An AHP Member shall not be entitled to the rights and privileges of appointment to the Medical Staff. An AHP Member may attend meetings of the Medical Staff but shall not be entitled to vote at meetings of the Medical Staff, hold office in the Medical Staff, or serve as chair of any committee of the Medical Staff, but may be assigned to serve as a nonvoting member on committees of the Hospital or of the Medical Staff.

4.2 Responsibility for Patients.

4.2-1 Admissions. Except for psychologists, AHP Members may not admit patients to the hospital. Psychologists may admit patients to the hospital only upon the conditions set forth in Section 4.2-2 hereof (as applicable). AHP Staff may enter the admission and/or discharge orders on behalf of their supervising physician, who is an active member of the medical staff if permitted by applicable law and if so authorized in the delineation of clinical privileges granted by the Board of Directors and authorized by their supervising staff member.

4.2-2 Patient Care.

A. Clinical psychologists, counseling psychologists, licensed professional counselors, and social workers who are appointed to the AHP Staff and shall exercise clinical privileges as delineated by the Board. A clinical or counseling psychologist may admit a patient to, or treat or write orders for a patient at, the Hospital, only to the extent an Active Staff Member has agreed to assume responsibility for the general medical management of that patient and to make a medical evaluation of the patient promptly upon their admission. Neither a social worker nor a licensed professional counselor shall have the authority to admit patients to the Hospital.

B. A physician's assistant or APRN appointed to the AHP Staff may write patient orders if so authorized by applicable law and in the delineation of clinical privileges granted by the Board of Directors and authorized by their supervising staff member and may perform an admitting history and physical and discharge summary if permitted by applicable law and if so authorized in the delineation of clinical privileges granted by the Board of Directors and authorized by their supervising staff member.

C. A CRNA shall be authorized, pursuant to rules adopted by the Oklahoma Board of Nursing, to order, select, obtain and administer legend drugs, Schedules II through V controlled substances, devices, and medical gases only when engaged in the preanesthetic preparation and evaluation; anesthesia induction, maintenance and emergence; and postanesthesia care; and only during the perioperative or periobstetrical period.

D. Care provided by Allied Health Practitioners in the DRH Emergency Department is under the supervision of the Emergency Department attending physician and includes care as per their approved privileges. The attending physician may be briefly absent from the DRH Emergency Department, but is expected to be in the Hospital and immediately available to provide direction or direct care during the operating hours of the Emergency Department (CMS 482.55(b)(1). Care provided by Allied Health Practitioner's in the JCH Emergency Department is per their approved privileges and under the direction of a qualified member of the Critical Access Hospital's (CAH) medical staff. (CMS 485.618)

4.2-4 On Call Assignment.

A. A PA or APRN may take primary call with an active medical staff member back up if specifically approved by the Credentials and Medical Executive Committees.

B. On-call CRNA's are expected to respond within a reasonable amount of time from initial contact attempt or time notified (CMS 489.24(i): EMTALA Interpretive Guidelines; OSDH Hospital Standards 310:667-59-9). Guidelines for response times: Telephone response within 15 minutes; In-Person response within 30 minutes.

4.3 Organized Health Care Arrangement (OHCA).

4.3-1 The Hospital and its AHP Staff Members operate as an OHCA, in that they provide direct patient care services through clinically integrated settings (including but not limited to in-patient, outpatient and Hospital clinic settings).

4.3-2 Members of the OHCA treating patients at any such clinically integrated settings shall use a joint notice of privacy policies and joint acknowledgment of receipt of such notice, as designated by the Hospital on behalf of the OHCA and consistent with the HIPAA Privacy Standards, 45 C.F.R. Parts 160 and 164.

4.3-3 Each Member of the OHCA shall abide by the terms of the joint notice of privacy practices, and all other Hospital policies and procedures related to compliance with the HIPAA Privacy Standards, with respect to protected health information (PHI) created or received by such Member as part of its participation in such OHCA.

4.3-4 Each Member of the OHCA shall take reasonable steps to ensure the privacy and security of all PHI, including PHI created, used, transmitted or maintained as part of this OHCA, and shall use and disclose only the minimum necessary PHI to meet a particular need for treatment, payment or health care operational purposes.

4.3-5 The designation of such OHCA among the Hospital and its AHP Staff Members is solely for the purposes set forth above to facilitate compliance with the Privacy Standards, and shall not, in any way, alter the independence of the OHCA members for all other purposes or create any liability of a member for the independent judgment, conduct or actions of the other members of the OHCA.

4.3-6 Failure of any AHP Staff Member to comply with the requirements of the OHCA, as set forth above, may subject such Member to corrective action as provided in Article VII of these Policies and Procedures.

ARTICLE V - CLINICAL PRIVILEGES/PERMITTED ACTIVITIES

5.1 Delineation of Clinical Privileges/Permitted Activities.

5.1-1 General.

Each AHP Member providing direct clinical services at the Hospital may exercise only those clinical privileges or provide patient care services as are specifically granted by the Board of Directors. The clinical privileges granted to, or the specific activities which may be engaged in by, an AHP Member shall be determined based upon such individual's Credentials and the written

criteria recommended by the Credentials Committee for the specific profession. The scope of clinical privileges and permitted activities are subject to the consideration and approval of the Medical Executive Committee and shall be granted in conformance with the Hospital's Bylaws, Rules and Regulations, other applicable policies, procedures or regulations, and applicable law. Initial determinations of clinical privileges and permissible activities shall be made pursuant to the procedures outlined in Article III hereof.

5.1-2 Notification to AHP Member.

Upon determination of the same, the Board of Directors shall promptly delineate in writing to each AHP Member the specific clinical privileges which may be exercised, or the specific activities which may be engaged in, by such AHP Member within the scope of their profession.

5.1-3 Notification to Patient Care Units.

Upon the initial appointment of any AHP Member, and periodically thereafter, the President shall provide notification to all patient care units of the Hospital of such appointment, together with a detailed description of the activities which may be engaged in by such AHP Member within the Hospital.

5.2 Changes in Clinical Privileges or Permitted Activities.

5.2-1 General. An AHP Member (or the supervising staff member of the AHP Member in the case of physician's assistants, APRN's [other than CRNAs] and technicians) may, either in connection with reappointment or at any other time, request modification of clinical privileges granted to, or activities permitted to be engaged in by, the AHP Member by submitting a written application to the Medical Staff Coordinator, on the form prescribed by the President from time to time.

5.2-2 Social Workers and Licensed Professional Counselors. Any written request for a change in clinical privileges made by a social worker or a licensed professional counselor must be signed by both the AHP Member and the sponsor.

5.2-3 Processing of Request. Written requests for modification of clinical privileges granted to, or activities permitted to be engaged in by, and AHP Member, submitted in accordance with this Section, shall be processed pursuant to the procedures outlined in Article III hereof.

5.3 Temporary Privileges.

5.3-1 Circumstances. In the event of a critical institutional need and upon the written concurrence of the chair of the Credentials Committee, Chief of Medical Staff, and the President, or their respective designees, temporary privileges may be granted in the circumstances outlined below. In the event such temporary privileges are granted they shall be subject to the review and concurrence of the Credentials Committee at its next regular meeting.

A. AHP with Pending Application. Temporary privileges may be granted to an AHP applicant only after (i) receipt of an application for AHP Staff appointment; (ii) verification of the qualifications required by Sections 2.2 and 2.3 of these Policies and Procedures; (iii) a minimum of two (2) positive oral or written professional references; and (iv) verification of satisfactory performance and AHP Staff membership at each of their principal hospital affiliations over the past five (5) years where they must have exercised the particular privileges being requested. Additional information regarding the AHP applicant may be obtained from the President or designee of each such institution. Temporary privileges may be granted in this circumstance for an initial period of sixty (60) days, with a single subsequent renewal not to exceed an additional sixty (60) days. Any such renewal shall be made upon the written recommendation of the chair of the Credentials Committee and the written concurrence of the President and the Chief of Medical Staff and may be made only when the information available continues to support a favorable determination regarding the AHP applicant's application for membership and privileges. Under no circumstances may temporary privileges be initially granted or renewed if the application is still pending because the AHP applicant has not responded in a satisfactory manner to a request for clarification of a matter or for additional information. In the event that a medical service to the Hospital and its patient population is curtailed or restricted by the sudden absence of an approved provider, the President and Chief of Medical Staff, or their respective designees, may grant initial temporary privileges for a maximum of five (5) days pending completion of the application by the AHP applicant.

B. For Care of a Specific Patient. Temporary privileges may be granted to an AHP for the care of a specific patient only after (i) receipt of a written request for the specific privileges desired; (ii) verification of the qualifications required by Sections 2.2 and 2.3 of these Policies and Procedures; and (iii) a minimum of two (2) positive oral or written professional references specific to the privileges being requested. The President or designee shall verify satisfactory

performance and AHP Staff membership at the AHP's current principal hospital affiliation. Additional information regarding the AHP may be obtained from the President or designee of such institution. These temporary privileges shall be restricted to treatment of a specific patient and will be for no longer than thirty (30) days. Temporary privileges of this nature may not be granted in more than four (4) instances in any twelve (12) month period, after which the AHP may apply for AHP Staff appointment, and are restricted to the specific patients for which they are granted.

C. Short Term Locum Tenens. Temporary privileges may be granted to an AHP who will be serving as a locum tenens for an AHP Staff Member, in their established profession, only after (i) receipt of a current resume documenting the fact that the AHP meets the board certification and professional education and training requirements of Sections 2.2 and 2.3 of these Policies and Procedures; (ii) receipt of a minimum of two (2) positive written or oral professional references specific to the privileges being requested; (iii) receipt of a letter from the AHP Member engaging such proposed locum tenens AHP verifying the need for the services, the qualifications of the AHP, the anticipated length of service and verification of licensure and controlled substance registration, as applicable (iv) receipt of documentation that the AHP is covered under a professional liability insurance policy in an amount meeting the current AHP Staff requirements; and (v) receipt of a signed waiver of liability statement from the AHP. The President or designee shall verify satisfactory performance and AHP Staff membership at the prior three (3) principal hospitals where the AHP has exercised the particular privileges being requested during the previous five (5) years. Additional information regarding the AHP may be obtained from any hospital in which the AHP has held privileges, at the discretion of the President, Chief of Medical Staff or Credentials Committee. A short term locum tenens is granted privileges for a period not to exceed thirty (30) consecutive calendar days and may not be renewed. Any extension of short term locum tenens privileges should be conducted in accordance with the provisions for long term locum tenens privileges in Section 5.3(D) below.

D. Long Term Locum Tenens. Temporary privileges may be granted to an AHP who will be serving as a locum tenens for an AHP Staff Member, in their established profession, only after (i) receipt of a complete application for appointment as a locum tenens, including a request for specific privileges; (ii) verification of the qualifications required by Sections 2.2 and 2.3 of these Policies and Procedures; (iii) receipt of a minimum of three (3) positive written

or oral professional references specific to the privileges being requested; (iv) receipt of a letter from the AHP Member engaging the proposed locum tenens AHP verifying the need for the services, the qualifications of the AHP, and the anticipated length of service. The President or designee shall verify satisfactory performance and AHP Staff membership at the prior three (3) principal hospitals where the AHP has exercised the particular privileges being requested during the previous five (5) years. Additional information may be obtained from any hospital in which the AHP has held privileges, at the discretion of the President, Chief of Medical Staff or Credentials Committee. A long term locum tenens is granted for a two (2) year period and shall apply to a maximum of sixty (60) cumulative days of service during each year. A long term locum tenens may be renewed biannually for a maximum of sixty (60) additional cumulative calendar days annually or the AHP may be required to seek permanent privileges, in accordance with these Policies and Procedures, at the discretion of the Credentials Committee. Temporary privileges may be granted during the pendency of an application for long term locum tenens privileges provided that the limitations on the maximum days of service provided under this section shall still apply.

5.3-2 Conditions. Temporary privileges shall be granted only after verification of information outlined in Section 5.3 above and only when the information available reasonably supports a favorable determination regarding the requesting AHP's qualifications, ability, and judgment to exercise the privileges requested. Special requirements of consultation and reporting may be imposed by the Chief of Medical Staff. Before temporary privileges are granted, the AHP must acknowledge in writing that they have received and read these Policies and Procedures and the Hospital's Bylaws, and that they agree to be bound by the terms thereof in all matters relating to the temporary privileges. Whether or not such written agreement is obtained, said Policies and Procedures and Bylaws control in all matters relating to the exercise of temporary privileges.

5.3-3 Termination of Temporary Privileges. On the discovery of any information, or the occurrence of any event of a professionally questionable nature, pertinent to an AHP's qualifications or ability to exercise any or all of the temporary privileges granted, the President, in conjunction with the Chief of Medical Staff, or in their absence their official designees, may terminate any or all of such AHP's temporary privileges, provided that the conduct or activities of the AHP pose a threat to the life, health or safety of any patient, employee or other person present at the Hospital and the failure to take prompt action may result in imminent danger to the life, health or safety of any such persons. Such termination may be effected by those entitled to impose summary suspensions

pursuant to these Policies and Procedures. In the event of any such termination, the patients then in the Hospital to which the AHP was attending, shall be assigned to another AHP by the Chief of Medical Staff. The wishes of the patient shall be considered, where feasible, in choosing a substitute AHP. The terminated AHP shall confer with the substitute AHP to the extent necessary to safeguard the patient.

5.3-4 Rights of the AHP. An AHP shall not be entitled to the procedural rights afforded by Article VIII because of their inability to obtain temporary privileges or because of any termination or suspension of temporary privileges, except where such termination is based upon an assessment of the professional competency or conduct of the AHP.

5.3-5 Definition of "Designee". For purposes of this Section 5.3, when the phrase "or their respective designees" is used in referring to the President, the chair of the Credentials Committee or the Chief of Medical Staff, the "designee" shall be, as follows:

A. For President: The officer of the Hospital designated in administrative or Board policy as being authorized to act on behalf of the President in the granting of temporary privileges;

B. For the Chair of the Credentials Committee: The Vice Chair of the Credentials Committee; and

C. For the Chief of Medical Staff: The Vice Chief of Medical Staff. In the event of the Vice Chief of Medical Staff's absence, the Secretary of Staff may act on their behalf. In the event of the Secretary of Staff's absence, the Member at Large may act on their behalf. In the event of the Member at Large's absence, the Past Chief of Staff may act on their behalf.

5.4 Emergency Privileges. For the purpose of this Section, an "emergency" is defined as a condition in which serious or permanent harm would result to a patient, or in which the life of a patient is in immediate danger and any delay in administering treatment would add to that danger. In the case of an emergency, any AHP, to the degree permitted by their license or certification, regardless of the scope of their specific clinical privileges, shall be permitted to do, and shall be assisted by Hospital personnel in doing, everything possible to save the life of a patient or to save a patient from serious harm. When the emergency situation no longer exists, such AHP must request the privileges necessary to continue to treat the patient. Any AHP exercising emergency privileges is obligated to summon all consultative assistance deemed necessary and to arrange for appropriate follow-up. An AHP utilizing emergency privileges shall promptly provide to the MEC in writing a statement explaining the circumstances giving rise to the emergency. In

addition, emergency privileges may be authorized in the event that a service to the Hospital and its patient population is curtailed or restricted by the sudden absence of an approved provider. The decision that such a situation exists will be made by the President and the Chief of Medical Staff and initial temporary privileges may be granted for a maximum of five (5) days pending completion of the application by the AHP applicant. The application shall be submitted within five (5) days.

ARTICLE VI - REAPPOINTMENT

6.1 **Duration.** Appointments to the AHP Staff shall normally be made by the Board of Directors for a period of two (2) years. If reappointment occurs during a voluntary leave of absence, the reinstatement requirements continue to apply following the end of the leave period.

6.2 **Criteria for Reappointment.** Reappointment determination shall be based upon the following criteria for each AHP Member:

A. Clinical competence, ethical behavior and clinical judgment in the treatment of patients;

B. Satisfactory completion of assigned responsibilities, including but not limited to the timely and thorough completion of medical records;

C. Compliance with the requirements set forth in Section 2.2 hereof;

D. Professional behavior in the Hospital, ability to work with others, cooperation with personnel of the Hospital as it relates to patient care and the orderly operation of the Hospital, and attitude toward patients, the AHP Staff, the Medical Staff and the Hospital and its personnel;

E. Sufficient utilization of the Hospital to permit assessment of clinical competency and conduct;

F. Physical and mental health, as allowed by applicable laws and regulations;

G. Satisfactory completion of continuing education requirements as may be imposed by law, the Hospital, or applicable accreditation agencies; and

H. Satisfactory liaison or supervision by the Sponsor or Supervising Active or Emergency Room Staff Member, as applicable (except in the case of psychologists and CRNAs); and

I. Any other factors bearing upon the AHP Member's Credentials.

6.3 Reappointment Process. Requests for reappointment to the AHP Staff shall be processed in accordance with the following procedure:

6.3-1 Request for Reappointment. A reapplication form shall be mailed by the Medical Staff Coordinator to each AHP Member approximately ninety (90) days prior to the expiration of their current term of appointment. Each AHP Member who desires to be reappointed shall, within forty-five (45) days prior to such expiration, submit the form, signed by both the AHP Member and Supervising Staff Member or Sponsor, if applicable, to the Medical Staff Coordinator. Upon a showing of good cause, the Medical Staff Coordinator may waive this forty-five (45) day requirement. An AHP Member whose membership is terminated for failure to comply with the forty-five (45) day requirement shall not be entitled to the procedural rights provided in this document. Upon receipt of a reapplication form, in addition to their other responsibilities, the Medical Staff Coordinator shall verify the AHP Member's current professional liability insurance coverage and licensure or certification.

6.3-2 Processing of Request. A written request for reappointment, submitted in accordance with this Section 6.3, shall be processed pursuant to the procedures outlined in Article III hereof; provided that, (i) in addition to the information required to be submitted by the Medical Staff Coordinator to the Credentials Committee in the case of initial application, the Medical Staff Coordinator shall additionally provide information and documentation supporting and/or evidencing the AHP Member's conformance with the criteria of Section 6.2 hereof, (ii) recommendations made in the consideration process shall be for either (a) renewal of appointment, (b) renewal of appointment with modified staff category or clinical privileges, or (c) termination of the AHP Member; and (iii) a copy of any recommendation, reports and/or information forwarded by the Credentials Committee to the MEC shall also be provided to the Medical Staff

ARTICLE VII - DISCIPLINE

7.1 Corrective Actions.

7.1-1 Responsibility for Corrective Action. In the case of a dependent practitioner, the supervising staff member shall be primarily responsible for taking corrective action, if warranted, and the supervising staff member's agreement to supervise a dependent practitioner shall include the responsibility for taking corrective action whenever warranted. However, corrective action may be initiated against any AHP Member by any of the persons so authorized in this Article VII.

7.1-2 Grounds for Corrective Action. Corrective action may be taken against any AHP Member if the activities or conduct of such AHP Member are detrimental to patient safety or the delivery of quality patient care, or below the standards and aims of the Hospital and the Medical Staff, or disruptive to the operation of the Hospital, or in violation of these Policies and Procedures, the Rules and Regulations of the Medical Staff, any departmental rules, regulations, policies or procedures, or the bylaws, rules, regulations, policies and procedures of the Hospital.

7.1-3 Initiating Corrective Action. Whenever it appears that corrective action against an AHP Member may be necessary or advisable, the President may initiate an investigation by an ad hoc investigation committee or, in the case of a dependent practitioner, request that the supervising staff member conduct an investigation and/or take corrective action. Requests for corrective action may also be initiated by the Chief of Medical Staff, the Chair of any standing committee of the Medical Staff, any Medical Staff Member, any AHP Member, or any member of the Board of Directors. Any request for corrective action shall be in writing and shall be submitted to the President, together with detailed information concerning the specific activities or conduct which constitute the grounds for the request. The President shall then consult with the Chief of Medical Staff or the Medical Executive Committee to determine whether the request for corrective action should be investigated as to any AHP Member, or, in the case of a dependent practitioner, whether the supervising staff member should be requested to conduct an investigation and/or take corrective action. The initiation of an investigation shall not preclude either (i) the imposition of summary suspension or termination under Section 7.2 hereof or (ii) in the case of dependent practitioners, the imposition of corrective action or discharge by the supervising staff member.

7.1-4 Appointment of Ad Hoc Investigation Committee. If a determination is made to investigate the necessity or advisability of corrective action against an AHP Member, the President shall appoint an ad hoc investigation committee consisting of at least three (3) committee members, including the Chief of Medical Staff or their designee. If an investigation involves an AHP Member who is a clinical psychologist, counseling psychologist, social worker, physician's assistant or APRN, an AHP Member in the same area of practice as the affected AHP Member may serve as a consultant to the ad hoc investigation committee. Upon completion of its investigation, the ad hoc investigation committee shall submit a written recommendation to the Board of Directors. An AHP Member's clinical privileges or permitted activities may be restricted or suspended while the investigation is pending for a period of no longer than fourteen (14) days. Upon expiration of such 14-day period, such restriction or suspension shall be lifted

automatically, unless the decision is made to impose summary suspension or termination in accordance with the provisions of Section 7.2 hereof.

7.1-5 Recommendation of Ad Hoc Investigation Committee. The written report of the ad hoc investigation committee may recommend one or more of the following:

A. Reject the request for corrective action;

B. Recommend that a letter of warning, admonition or reprimand be issued to the AHP Member;

C. Recommend that the AHP Member be placed on probation (such recommendation to include the length and conditions of probation);

D. Recommend that the AHP Member obtain retraining, additional training or continuing education;

E. Recommend a reduction, restriction, suspension or revocation of the AHP Member's clinical privileges or permitted activities; or

F. Recommend termination or revocation of the AHP Member's appointment to the AHP Staff.

7.1-6 Procedure upon Recommendation. If the ad hoc investigation committee recommends any of the actions set forth in Sections 7.1hereof, or the action set forth in Section 7.1 if the terms of the probation do not reduce, limit, restrict, suspend or revoke the AHP's privileges, the President shall implement the corrective action. If the ad hoc investigation committee recommends any of the corrective actions set forth in Sections 7.1hereof, or the action set forth in Section 7.1 if the terms of the probation reduce, limit, restrict, suspend or revoke the AHP's privileges, or any combination thereof, the affected AHP Member shall be entitled to a hearing as hereinafter provided before final action is taken by the Board of Directors.

7.2 Summary Suspension or Termination.

7.2-1 Initiation of Summary Suspension or Termination. Whenever there are reasonable grounds to believe that the conduct or activities of an AHP Member pose a threat to the life, health or safety of any patient, employee, or other person present at the Hospital and that the failure to take prompt action may result in imminent danger to the life, health or

safety of any such person, the Chief of Medical Staff, the Medical Executive Committee, the President or the Board of Directors shall have the authority to summarily terminate the appointment of such AHP Member and/or to summarily suspend or restrict all or any portion of their clinical privileges or permitted activities. Summary suspension or termination shall become effective immediately upon imposition, and thereafter the President shall promptly give notice of the suspension or termination to the affected AHP Member (and in the case of a dependent practitioner, the supervising staff member).

7.2-2 Procedural Rights. If a summary suspension or termination is imposed pursuant to Section 7.2 hereof, the affected AHP Member shall be entitled to the procedural rights set forth in Article VIII. The terms of the summary suspension or termination shall remain in full force and effect pending a final decision by the Board of Directors.

7.3 Automatic Termination.

7.3-1 Events Resulting in Automatic Termination. An AHP Member's appointment to the AHP Staff shall be automatically terminated upon the occurrence of any of the following events:

A. If the AHP Member loses their license or certificate to practice their profession, or if such license or certificate is restricted in any manner.

B. If the AHP Member has their license or right to prescribe or administer any controlled substances revoked or suspended (if applicable).

C. If the AHP Member fails to maintain, or cause to be maintained, the minimum professional liability insurance coverage established from time to time by the Board, unless a waiver or reduction of such coverage has been timely requested and is awaiting final action.

D. In the case of a dependent practitioner, if the AHP Member is discharged or otherwise terminates their relationship with the supervising staff member or if the supervising staff member withdraws their agreement to supervise the AHP Member, or if the supervising staff member ceases to be an Active or Emergency Room Staff Member.

E. Clinical privileges that require current certification in Neonatal Resuscitation (NRP), Basic Life Support (BLS), Advanced Cardiac Life Support (ACLS), Pediatric Advanced Life Support (ACLS), or Advanced Trauma Life Support (ATLS),

(Certification), such Certifications shall be maintained and not allowed to expire or lapse. In the event a practitioner's Certification has expired or lapsed, the practitioner will be provided with a notice of delinquency giving him/her ninety (90) calendar days to obtain the appropriate recertification. If the practitioner does not obtain recertification within the timeframe listed in the notice of delinquency, such practitioner's clinical privileges that are relative to the Certification will be automatically suspended. This administrative restriction of privileges is not reportable to the National Provider Databank. Clinical privileges may be reinstated by the Chief of Staff upon successful recertification.

7.2-3 Procedural Rights. If any AHP Member is subject to automatic termination for any reason, they shall not be entitled to a hearing, but they may re-apply for appointment upon curing the event which resulted in the automatic termination.

7.4 Leave of Absence.

7.4-1 An AHP Member may request a leave of absence, for a period not to exceed one year, by submitting a written request to the Chief Executive Officer. The Chief Executive Officer will determine whether a request for a leave of absence shall be granted.

7.4-2 Individuals requesting reinstatement shall submit a written summary of their professional activities during the leave, and any other information that may be requested by the Hospital, at least 30 days prior to the conclusion of the leave of absence. If the leave of absence was for health reasons, the request for reinstatement must be accompanied by a report from the individual's physician indicating that the individual is physically and/or mentally capable of resuming a hospital practice and safely exercising the clinical privileges or scope of practice requested.

7.4-3 Requests for reinstatement shall be reviewed by the Chair of the Credentials Committee, the Chief of the Medical Staff and the Chief Executive Officer. If all these individuals make a favorable recommendation on reinstatement, the Allied Health Professional may immediately resume clinical practice at the Hospital. This determination shall then be forwarded to the Credentials Committee, the Medical Executive Committee and the Board for ratification. If, however, any of the individuals reviewing the request have any questions or concerns, those questions shall be noted and the reinstatement request shall be forwarded to the full Credentials Committee, Medical Executive Committee, and Board for review and recommendation. If a request for reinstatement is not granted, for reasons related to clinical competence or professional conduct, the individual shall be entitled to the procedural rights set forth in Article VIII of this Policy.

ARTICLE VIII - HEARING AND APPELLATE REVIEW PROCEDURE

8.1 **Right to Hearing.** AHP's are not entitled to the Fair Hearing Plan and appeals procedures set forth in the Medical Staff Bylaws.

8.2 **Right to Appear Before Committee.** If an AHP is not granted permission to provide services designated in the AHP's delineation of privileges, or their permission to provide patient care services has been suspended and/or terminated, the AHP and their supervising physician, if applicable, shall only have the right to appear personally before the applicable Committee Chairperson within thirty (30) days from a written request, to discuss the recommended action. Such request must be in writing and presented to the Hospital President or the Medical Staff Coordinator.

8.3 **Right to Appeal.** AHP's will be able to appeal the decision of the Committee Chairperson to the MEC. Such appeal must be in writing and must be submitted to the Hospital President or the Medical Staff Coordinator within thirty (30) days from the date of the decision of the Committee Chairperson. The AHP will not have the right to appear personally. The MEC will review this matter at its next regularly scheduled meeting and may, at the MEC's discretion, request the AHP be present at the meeting or a future meeting. The MEC's decision will be the final decision with no further right of appeal.

ARTICLE IX- MISCELLANEOUS

9.1 **Distribution.** A copy of these Policies and Procedures shall be delivered to all Medical Staff Members and all AHP Members at the time of their adoption, and a copy of each amendment hereto shall be delivered to all Medical Staff Members and all AHP Members promptly upon its approval of the Board of Directors. A copy of these Policies and Procedures, as amended and in effect, shall also be delivered to each person who requests an application for appointment to the AHP Staff. Copies of these Policies and Procedures and all amendments hereto shall be maintained in the Executive Offices of the Hospital.

9.2 **Amendments.**

9.2-1 **At Initiation of Medical Staff.** The Medical Executive Committee may, at any regular or special meeting, recommend to the Board of Directors that amendment(s) be made in these Policies and Procedures provided that a copy of the proposed amendment(s) is distributed or made available to each member of the Medical Executive Committee at least thirty (30) days in advance of such meeting. The Board of Directors shall consider

such recommendations within sixty (60) days. If the Board of Directors is in disagreement with the recommendations of the Medical Executive Committee, the matter shall be referred to the Joint Conference Committee for further study and recommendation before final action is taken by the Board of Directors.

9.2-2 At Initiation of Board of Directors. The Board of Directors may propose amendments to these Policies and Procedures at any time. A copy of any proposed amendment(s) to these Policies and Procedures shall be distributed to each member of the Medical Executive Committee at least thirty (30) days in advance of the meeting at which the Board of Directors proposes to take final action thereon. If a majority of the members of the Medical Executive Committee are in disagreement with the proposed amendment(s), the matter shall be referred to the Joint Conference Committee for further study and recommendation before final action is taken by the Board of Directors. Notwithstanding the foregoing, the Board of Directors may amend these Policies and Procedures without prior notification to the Medical Executive Committee if immediate action is necessary in order to comply with any federal, state or local law or regulation or to enable the Hospital or the Medical Staff to avoid potential liability.

9.2-3 Effective Date. Any amendments to these Policies and Procedures adopted by the Board of Directors shall become effective when adopted by the Board of Directors.