MEDICAL STAFF BYLAWS, POLICIES, AND

RULES AND REGULATIONS

OF

CENTRACARE HEALTH ST. CLOUD HOSPITAL

PRIVILEGE AND HEARING MANUAL

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CLINICAL PRIVLEGES

1.A. CLINICAL PRIVILEGES

1.A.1. Waiver of Requirement that Privileges Be Granted by 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 limited circumstances, the Hospital may consider a waiver of the requirement that privileges are granted by core or specialty. If an individual wants to request such a waiver, the request must be submitted in writing to the Credentialing Verification Office. The request must indicate the specific privileges within the core or specialty that the individual does not wish to provide, state a good cause basis for the request, and include evidence that he or she does not provide the relevant patient care services in any health care facility. The department chairperson who will be significantly affected will review the request and submit a recommendation to the Credentials Committee, which will make a recommendation to the Medical Executive Committee. The Board will take final action on requests for a waiver.

(c) The following factors, among others, may be considered in deciding whether to grant a waiver related to privileges:

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

(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 the waiver;

(5) an undue burden on other Medical Staff members who serve on the call roster in the relevant specialty; 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.

(d) If the Board grants a waiver related to privileges, it will specify the effective date.

(e) No one is entitled to a waiver under this Section or to a hearing or appeal if a waiver is not granted.

1.A.2. Relinquishment of Individual Privileges:

A request to relinquish individual clinical privileges in the core or specialty must include a good cause basis. All such requests will be processed in the same manner as a request for waiver, as described above.

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

(a) Requests for clinical privileges to perform a procedure not currently being performed, 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 privilege have been adopted.

(b) As an initial step, the relevant department chairperson will determine whether a procedure or technique is a new procedure or an extension of a procedure or technique already being offered. If the procedure or technique involves clinical privileges that affect members in multiple specialties, the relevant department chairpersons will work cooperatively to determine if the procedure or technique is a new procedure or an extension of a procedure or technique already being offered. If the department chairperson(s) finds the procedure or technique is a new procedure, the department chairperson(s) will prepare a report that addresses the new procedure and its recommended criteria to present to the Credentials Committee.

(c) The Credentials Committee will review this report, conduct additional research as necessary, and make a preliminary recommendation based on the following factors, as to whether the new procedure should be offered to the community and the criteria for the privilege:

(1) whether there are greater risks to the patient in performing the new procedure;

(2) whether different equipment is required and whether different skills are required;

(3) whether the new procedure requires additional training for the staff;

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

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

(6) whether there is empirical evidence of improved patient outcomes with the new procedure or other clinical benefits to patients;

(7) whether proficiency for the new procedure is volume-sensitive and if the requisite volume would be available;

(8) whether the new procedure is being performed at other similar hospitals and the experiences of those institutions;

(9) whether other members of the Medical Staff are available to address complications outside of the scope of privileges granted to the individual seeking the new privilege and whether emergency call and alternative coverage is available; and

(10) whether the Hospital currently has the resources, including space, equipment, personnel, and other support services, to safely and effectively perform the new procedure.

(d) The Credentials Committee will forward its recommendations to the Medical Executive Committee, which will review the matter and forward its recommendations to the Board for final action.

(e) Specific requests from eligible Medical Staff members who wish to perform the new procedure or service may not be processed until the foregoing steps are completed. The individual seeking to perform the new procedure has the burden to provide any and all information requested during this process.

1.A.4. 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, the individual seeking the privilege will submit a report to the relevant department chairpersons and the Credentials Committee that includes a statement explaining why the individual wishes to perform the requested privilege and demonstrates: (i) that he/she meets the minimum qualifications needed to perform the procedure safely and competently, if already identified, or, if not already identified, specifies the minimum qualifications needed to perform the procedure safely and competently, (ii) whether the individual's specialty is performing the privilege at other similar hospitals, and (iii) the experiences of those other hospitals in terms of patient care outcomes and quality of care.

(c) The Credentials Committee shall then conduct additional research and consult with experts, as necessary, including those on the Medical Staff (e.g., department chairpersons, 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). All individuals on the Medical Staff who are involved in the process are expected to work cooperatively and make good faith efforts to reach an outcome that is in the best interest of the community served by the Hospital.

(d) The Credentials Committee may or may not recommend that individuals from different specialties be permitted to request the privileges at issue. If it does, the Committee may develop recommendations regarding:

(1) the minimum education, training, and experience necessary to perform the clinical privileges in question;

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

(3) the manner of addressing the most common complications that arise which may be outside of the scope of the clinical privileges that have been granted to the requesting individual;

(4) the extent (time frame and mechanism) of focused monitoring and supervision that should occur if the privileges are granted;

(5) the manner in which the procedure would be reviewed as part of the Hospital's ongoing and focused professional practice evaluation activities (which may include assessment of both long-term and short-term outcomes for all relevant specialties); and

(6) the impact, if any, on emergency call responsibilities.

(e) The Credentials Committee will forward its recommendations to the Medical Executive Committee, which will review the matter and forward its recommendations to the Board for final action.

(f) Specific requests from eligible Medical Staff members who wish to exercise the privileges in question may not be processed until the foregoing steps are completed. The individual seeking to perform the new procedure has the burden to provide any and all information requested during this process.

1.B. TEMPORARY CLINICAL PRIVILEGES

(1) Temporary privileges may be granted by the President of the Hospital, upon recommendation of the Chief of Staff, to:

(a) applicants for initial appointment whose complete application is pending review by the Medical Executive Committee and Board, following a favorable recommendation of the Credentials Committee. In order to be eligible for temporary privileges, an applicant must have demonstrated ability to perform the privileges requested and have had no (i) current or previously successful challenges to licensure or registration or (ii) involuntary restriction, reduction, denial or termination of membership or clinical privileges at another health care facility.

(b) non-applicants, when there is an important patient care, treatment, or service need, including the following:

(i) the care of a specific patient;

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

(iii) proctoring; or

(iv) when serving as a locum tenens for a member of the Medical Staff/APP/MAS.

(2) The following verified information will be considered prior to the granting of any temporary privileges:

(a) current licensure;

(b) relevant training and experience;

(c) current competence;

(d) professional liability coverage acceptable to the Hospital;

(e) confirmation that the individual is not on the List of Excluded Individuals and Entities;

(f) the results of a query to the National Practitioner Data Bank; and

(g) in the case of advanced practice providers confirmation from the individual's Supervising/Collaborating Physician.

(3) The grant of temporary clinical privileges will not exceed ~~120~~ days. For non-applicants the days need not be consecutive and may be renewed.

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

(5) In the case of an individual serving as a locum tenens for a member of the Medical Staff/APP/MAS who is on vacation, attending an educational seminar, or ill and/or otherwise needs coverage assistance for a period of time to meet the needs of patients in the member's absence, failure to submit a complete application two weeks prior to his or her start date may result in a processing fee.

(6) The granting of temporary privileges is a courtesy. Temporary privileges may be withdrawn for any reason by the President of the Hospital at any time, after consulting with the Chief of Staff, the Chairperson of the Credentials Committee, the department chairperson, or the Chief Nursing Officer. The individual may be afforded an opportunity to refrain from exercising privileges.

(7) The department chairperson or the Chief of Staff 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.

1.C. 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 his or her specific grant of clinical privileges.

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

1.D. DISASTER PRIVILEGES

(1) When the disaster plan has been implemented and the immediate needs of patients in the facility cannot be met, the President of the Hospital or the Chief of Staff may use a modified credentialing process to grant disaster privileges to eligible volunteer licensed independent practitioners and APPs and MASs ("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: (i) current Hospital picture ID card that clearly identifies the individual's professional designation; (ii) current license to practice; (iii) primary source verification of the license; (iv) 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 (v) identification by a current Hospital employee or member of the Medical Staff/APP/MAS 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 volunteers who are licensed independent practitioners and APPs and MASs. This oversight will be conducted through direct observation, mentoring, clinical record review, or other appropriate mechanism developed by the Medical Staff and Hospital.

1.E. CONTRACTS FOR SERVICES

(1) The Hospital may enter into contracts for the performance of clinical and administrative services.

(2) To the extent that a contract confers the exclusive right to perform specified services to one or more practitioners or the Board adopts a resolution that limits the practitioners who may exercise privileges in any clinical specialty to employees of the Hospital or its affiliates, no other practitioner except those authorized by the exclusive contract or resolution may exercise clinical privileges to perform the

specified services while the contract or resolution is in effect. This means only practitioners authorized by the exclusive contract or Board resolution are eligible to apply for the clinical privileges in question at the time of initial appointment, during the term of an appointment, or at reappointment. No other applications will be processed.

(3) Prior to the Hospital signing any exclusive contract and/or passing any Board resolution described above, the Board will request input from the Medical Executive Committee pertaining to quality of care issues and service implications.

(4) After receiving the Medical Executive Committee's report, the Board will determine whether to proceed with the exclusive contract or Board resolution. If the Board determines to proceed, and if that determination would have the effect of preventing an existing member from exercising clinical privileges that had previously been granted, the following notice and review procedures apply:

(a) The affected member(s) will be given at least 30 days advance notice of the exclusive contract or Board resolution and have the right to meet with a committee designated by the Board to discuss the matter prior to the contract being signed by the Hospital or the Board resolution becoming effective.

(b) At the meeting, the affected member(s) will be entitled to present any information relevant to the Hospital's decision to enter into the exclusive contract or enact the Board resolution. If, following this meeting, the Board decides to enter into the exclusive contract, or enact the Board resolution, the affected member(s) will be ineligible to continue to exercise the clinical privileges covered by the exclusive contract, or resolution, unless a waiver has been granted. In that circumstance, the ineligibility begins as of the effective date of the exclusive contract or Board resolution and continues for as long as the contract or resolution is in effect.

(c) The affected member(s) will not be entitled to any other procedural rights beyond those outlined above with respect to the Board's decision or the effect of the decision on his or her clinical privileges.

(d) The inability of a physician to exercise clinical privileges because of an exclusive contract or Board resolution is not a matter that requires a report to the Minnesota licensure board or to the National Practitioner Data Bank.

ARTICLE 2

PEER REVIEW PROCEDURES FOR QUESTIONS INVOLVING MEDICAL STAFF, ADVANCED PRACTICE PROVIDERS AND MEDICAL ASSOCIATE STAFF MEMBERS

2.A. COLLEGIAL INTERVENTION

(1) This Policy encourages the use of progressive steps by Medical Staff leaders and Hospital management, beginning with collegial and educational efforts, to address issues pertaining to clinical competence or professional conduct. The goal of these efforts is to arrive at voluntary actions by the individual to resolve an issue that has been raised. Collegial intervention may be carried out, within the discretion of Medical Staff leaders and Hospital management, but is not mandatory.

(2) Collegial intervention is a part of the Hospital's professional review activities and may include counseling, education, and related steps, such as the following:

(a) advising colleagues of applicable policies and standards, including policies and standards pertaining to appropriate behavior, emergency call obligations, conditions and responsibilities of staff members, and the timely and adequate completion of medical records;

(b proctoring, monitoring, consultation, and letters of guidance; and

(c) sharing comparative quality, utilization, and other relevant information, including any variations from clinical protocols or guidelines, in order to assist individuals to conform their practices to appropriate norms.

(3) If an issue is raised pertaining to clinical competence or professional conduct of a member of the APP Staff, the Supervising/Collaborating Physician will be notified and may be invited to participate in the collegial intervention.

(4) The relevant Medical Staff leader(s), in conjunction with the Vice President for Medical Affairs, may determine whether a matter should be handled in accordance with another policy (e.g., code of conduct policy, practitioner health policy, peer review policy) or should be referred to the Credentials Committee or the Medical Executive Committee for further action.

(5) The relevant Medical Staff leader(s) will determine whether to document a collegial intervention effort. Any documentation that is prepared will be placed in an individual's confidential file. The individual will have an opportunity to review the documentation and respond to it. The response will be maintained in the individual's file along with the original documentation.

(6) All ongoing and focused professional practice evaluations will be conducted in accordance with the peer review policy. Matters that cannot be appropriately resolved through collegial intervention or through the peer review policy will be referred to the Credentials Committee.

2.B. INVESTIGATIONS

2.B.1. Initial Review:

(a) Whenever a serious question has been raised, or where collegial efforts have not resolved an issue regarding the following, the question may be referred to the Chief of Staff, the department chairperson, the chairperson of the Credentials Committee, the Vice President for Medical Affairs, the President of the Hospital, or the chairperson of the Board:

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

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

(3) conduct that is considered lower than the standards of the Hospital or disruptive to the orderly operation of the Hospital or its Medical Staff and Allied Health Staff, including the inability of the member to work harmoniously with others.

(b) In addition, if the Board becomes aware of information that raises concerns about the qualifications of any member of the Medical Staff /APP/MAS, the matter will be referred to the Chief of Staff, the Vice President for Medical Affairs, or the President of the Hospital.

(c) The person to whom the question is referred will make a sufficient inquiry to determine whether the question is credible and, if so, may forward it to the Vice President for Medical Affairs, an officer of the Medical Staff, or the Chairperson of the Credentials Committee, who may gather additional information before presenting it to the Credentials Committee. If the question pertains to a member of the APP Staff, the Supervising/Collaborating Physician may also be notified.

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

2.B.2. Initiation of Investigation:

(a) The Credentials Committee will review the question, may discuss the matter with the individual, and determine whether to conduct an investigation or direct that the question be handled pursuant to another policy. An investigation will commence only after a determination by the Credentials Committee.

(b) The Credentials Committee will inform the individual that an investigation has begun. Notification may be delayed if, in the judgment of the Credentials

Committee, informing the individual immediately would compromise the investigation or disrupt the operation of the Hospital or Medical Staff.

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

2.B.3. Investigative Procedure:

(a) Once a determination has been made to begin an investigation, the Credentials Committee will investigate the matter itself or appoint an individual or committee ("Investigating Committee") to do so. In appointing the Investigating Committee, the Credentials Committee will not include partners, non-partner associates, relatives of the individual being investigated, or any other individual with a significant conflict of interest. The Credentials Committee may appoint individuals not on the Medical Staff/APP/MAS to serve on the Investigating Committee.

(b) 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 outside consultants, as needed, for timeliness, expertise, thoroughness and objectivity; and/or

(4) require an examination or assessment by a health care professional(s) acceptable to the Investigating Committee. 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.

(c) The Investigating Committee will make a reasonable effort to complete the investigation and issue its report within 30 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.

(d) 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. If the individual who is the subject of the investigation is a member

of the APP Staff, the Supervising/Collaborating Physician may also be invited to meet with the Investigating Committee. 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.

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

2.B.4. Recommendation:

(a) The Credentials Committee may accept, modify, or reject any recommendation it receives from an Investigating Committee. Specifically, the Credentials 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 of clinical privileges;

(7) recommend suspension of clinical privileges for a term;

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

(9) make any other recommendation that it deems necessary or appropriate.

(b) The Credentials Committee will report to the Medical Executive Committee for recommendation.

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

(c) A recommendation by the Medical Executive Committee that would entitle the individual to request a hearing will be forwarded to the President of the Hospital, 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.

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

2.C. PRECAUTIONARY SUSPENSION OR RESTRICTION OF CLINICAL PRIVILEGES

2.C.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, the President of the Hospital, the Chief of Staff, the Chairperson of the Credentials Committee, the chairperson of the relevant clinical department, the Vice President for Medical Affairs, the Medical Executive Committee, or the Board chairperson is authorized to (1) afford the individual an opportunity to voluntarily refrain from exercising privileges pending an investigation; or (2) suspend or restrict all or any portion of an individual's clinical privileges pending an investigation.

(b) A precautionary suspension can be imposed at any time including after a specific event, a pattern of events, or a recommendation by the Medical 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 President of the Hospital, the Chief of Staff, and the Chairperson of the Credentials Committee. A precautionary suspension will remain in effect unless it is modified by the President of the Hospital or the Credentials Committee.

(e) Within three days of the imposition of a suspension, 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), will be provided to the individual.

2.C.2. Credentials Committee Procedure:

(a) Within a reasonable time, not to exceed 30 days of the imposition of the suspension, the Credentials Committee will review the reasons for the suspension.

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

(c) At the meeting, the individual may provide information to the Credentials Committee and should respond to questions that may be raised by committee members. The individual may also propose ways, other than precautionary suspension, to protect patients, employees or others while an investigation is conducted.

(d) After considering the reasons for the suspension and the individual's response, if any, the Credentials Committee will determine whether the precautionary suspension should be continued, modified, or lifted. The Credentials Committee will also determine whether to begin an investigation.

(e) If the Credentials Committee decides to continue the suspension, it will send the individual written notice of its decision, including the basis for it and that suspensions lasting longer than 30 days must be reported to the National Practitioner Data Bank.

(f) There is no right to a hearing based on the imposition or continuation of a precautionary suspension. The procedures outlined above are deemed to be fair under the circumstances.

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

2.D. AUTOMATIC RELINQUISHMENT

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

Failure to complete medical records will result in automatic relinquishment of all clinical privileges, after notification by the medical records department of delinquency. Relinquishment will continue until all delinquent records are completed and reinstatement accomplished in accordance with applicable rules and regulations. Failure to complete the medical records that caused relinquishment within the time required by applicable rules and regulations will result in automatic resignation from the Medical Staff/APP/MAS.

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

(a) Any action taken by any licensing board, professional liability insurance company, court or government agency regarding any of the matters set forth below, or failure to satisfy any of the threshold eligibility criteria, must be promptly reported to the Vice President for Medical Affairs, or Chief of Staff.

(b) An individual's appointment and clinical privileges will be automatically relinquished, without right to hearing or appeal, if any of the following occur:

(1) Licensure: Revocation, probation, expiration, suspension, or the placement of conditions or restrictions on an individual's license.

(2) DEA Registration: Revocation, expiration, suspension, or the placement of conditions or restrictions on an individual's DEA registration, as applicable to his/her practice.

(3) Insurance Coverage: Termination or lapse of an individual's professional liability insurance coverage, or other action causing the coverage to fall below the minimum required by the Hospital.

(4) Medicare and Medicaid Participation: Termination, exclusion, or preclusion by government action from participation in the Medicare/Medicaid or other federal or state health care programs.

(5) Criminal Activity: Arrest, indictment, conviction, or a plea of guilty or no contest pertaining to any felony, or to any misdemeanor involving (i) controlled substances; (ii) illegal drugs; (iii) Medicare, Medicaid, or insurance or health care fraud or abuse; (iv) violence; (v) sexual misconduct; or (vi) moral turpitude.

(c) An individual's appointment and clinical privileges will be automatically relinquished, without entitlement to a hearing and appeal, if the individual fails to satisfy any of the threshold eligibility criteria or perform his or her responsibilities during the provisional period.

(d) Automatic relinquishment will take effect immediately upon notice to the Hospital and continue until the matter is resolved and the individual is reinstated.

(e) If the underlying matter leading to automatic relinquishment is resolved or if the individual contends that there are exceptional circumstances which warrant an exception to an automatic relinquishment, the individual may request reinstatement. Failure to resolve the matter within 60 days of the date of relinquishment will result in an automatic resignation from the Medical Staff/APP/MAS.

(f) Requests for reinstatement will be reviewed by the relevant department chairperson, the Chairperson of the Credentials Committee, the Chief of Staff, the Vice President for Medical Affairs, the President of the Hospital, and, if applicable, the Chief Nursing Officer. If all these individuals make a favorable recommendation on reinstatement, the individual may immediately resume clinical practice at the Hospital. This determination will 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 will be noted and the reinstatement request will be forwarded to the full Credentials Committee, Medical Executive Committee and Board for review and recommendation.

2.D.3. Failure to Provide Information:

Appointment and clinical privileges will be deemed to be automatically relinquished upon the occurrence of:

(a) failure to notify the Chief of Staff, the Vice President for Medical Affairs, or the President of the Hospital of any change in any information provided on an application for initial appointment or reappointment, after review by the Chief of Staff and the Vice President for Medical Affairs and after considering any written or oral explanation provided by the individual;

(b) failure to provide information or to otherwise respond to requests pertaining to an individual's qualifications for appointment or clinical privileges in response to a written request specifying the time frame for response from the Medical Executive Committee or any other committee authorized to request such information, until the information is provided to the satisfaction of the requesting party; or

(c) failure to undergo a blood, hair or urine test or a complete physical or mental examination if at least two Medical Staff leaders (or one Medical Staff leader and the President of the Hospital or Vice President for Medical Affairs) are concerned about the member's ability to safely and competently care for patients.

2.D.4. Failure to Attend Requested Meeting:

(a) Whenever there is a concern regarding an individual's clinical practice or professional conduct, the individual may be requested to attend a meeting with one or more Medical Staff leaders and/or a committee of the Medical Staff.

(b) Special notice will be given to inform the individual that attendance at the meeting is mandatory and that the individual must make himself or herself available in at least three days, or earlier if agreed upon by the parties.

(c) Failure of the individual to attend the meeting will be reported to the Credentials Committee. Unless excused by the Credentials Committee upon a showing of good cause, failure to attend will result in the automatic relinquishment of all or such portion of the individual's clinical privileges as the Credentials Committee may direct. Such relinquishment will remain in effect until the individual attends the requested meeting.

2.D.5. Failure to Complete or Comply with Training or Educational Requirements:

Failure to complete or comply with training, educational, and patient care protocol requirements that are adopted by the Medical Executive Committee and required by the Hospital, including but not limited to, those pertinent to electronic medical records, patient safety, and infection control, may result in the automatic relinquishment of all clinical privileges. Any relinquishment will continue in effect until documentation of compliance is provided to the satisfaction of the Medical Executive Committee, the Credentials Committee or the MSPPEC. If the requested information is not provided within 30 days of the date of relinquishment, it may result in automatic resignation from the Medical Staff.

2.E. LEAVES OF ABSENCE

2.E.1. Initiation:

(a) Except for requests related to physical or mental health (as addressed in (d) below), any leave of absence that is expected to last for 90 days or more must be requested in writing and submitted to the Vice President for Medical Affairs. The request must state the beginning and ending dates of the leave, the reasons for the leave, and the arrangement that has been made for patient coverage.

(b) Except in extraordinary circumstances, this request should be submitted at least 30 days prior to the anticipated start of the leave.

(c) The Vice President for Medical Affairs will determine whether a request for a leave of absence will be granted, after consulting with the Chief of Staff, the Chairperson of the Credentials Committee, and the relevant department chairperson. The granting of a leave of absence or reinstatement may be conditioned upon the individual's completion of all medical records.

(d) Members of the Medical Staff/APP/MAS must report to the Vice President for Medical Affairs anytime they are away from the Hospital or patient care responsibilities for longer than 30 days and the reason for the absence is related to their physical or mental health or otherwise to their ability to care for patients safely and competently. Under such circumstances, the Vice President for Medical Affairs, in consultation with the Chief of Staff and the Chairperson of the Credentials Committee, may trigger an automatic medical leave of absence.

(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.

2.E.2. Duties of Member on Leave:

During the leave of absence, the individual will not exercise any clinical privileges and will be excused from all Medical Staff/APP/MAS responsibilities (e.g., meeting attendance, committee service, emergency service call obligations, and payment of dues). All medical records must be completed as soon as reasonably possible.

2.E.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 chairperson, the Chairperson of the Credentials Committee, the Chief of Staff, and the Vice President for Medical Affairs, and in accordance with the practitioner health policy, if applicable.

(b) If a favorable recommendation on reinstatement is made, the individual may immediately resume clinical practice. 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; if the Credentials Committee recommends reinstatement without question, the individual may immediately resume clinical practice. However, if the Credentials Committee has questions, those questions will be forwarded to the Medical Executive Committee, and Board.

(c) If any request for reinstatement is not granted for reasons related to clinical competence or professional conduct, and if a report to the National Practitioner Data Bank is determined to be required, the individual will be entitled to request a hearing and appeal.

(d) 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 simultaneously with the request for reinstatement.

ARTICLE 3

HEARING AND APPEAL PROCEDURES

3.A. INITIATION OF HEARING

3.A.1. Grounds for Hearing:

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

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

(2) revocation of appointment to the Medical Staff/APP/MAS or 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; or

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

(b) No other recommendations will entitle the individual to a hearing.

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

3.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 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) determination that an application is incomplete;

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

(j) determination of ineligibility based on a failure to meet threshold eligibility criteria, a lack of need or resources, or because of an exclusive contract; or

(k) a recommendation for or commencement of a focused professional practice evaluation.

3.A.3. Notice of Recommendation:

The President of the Hospital 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 Article.

3.A.4. Request for Hearing:

An individual has 30 days following receipt of the notice to request a hearing, in writing, to the President of the Hospital, 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.

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

(a) The President of the Hospital will schedule the hearing and provide, 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, 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.

3.A.6. Witness List:

(a) At least 15 days before the pre-hearing conference, the individual requesting the hearing will provide the President of the Hospital with 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 given to the other party.

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

(a) Hearing Panel:

The President of the Hospital, after consulting with the Chief of Staff, 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 chairperson.

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

(i) any member of the Medical Staff/APP/MAS; or

(ii) physicians or laypersons not connected with the Hospital (i.e., physicians or allied health professionals not on the Medical Staff/APP/MAS 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 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 Panel will not include any individual who:

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

(ii) is professionally associated with, related to, or involved in a formal referral relationship with, the individual requesting the hearing;

(iii) is demonstrated to have 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 President of the Hospital will appoint a Presiding Officer who may be an attorney. The Presiding Officer will not act as an advocate for either side at the hearing.

(2) The Presiding Officer will:

(i) schedule and conduct a pre-hearing conference;

(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 all 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 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, the President of the Hospital, after consulting with the Chief of Staff, may appoint a Hearing Officer, preferably an attorney, to 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) Objections:

Any objection to any member of the Hearing Panel, the Hearing Officer, or the Presiding Officer will be made in writing, within ten days of receipt of notice, to the President of the Hospital. A copy of such written objection must be provided to the Chief of Staff and must include the basis for the objection. The Chief of Staff will be given a reasonable opportunity to comment. The President of the Hospital will rule on the objection and give notice to the parties. The President of the Hospital may request that the Presiding Officer make a recommendation as to the validity of the objection.

3.A.8. Counsel:

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

3.B. PRE-HEARING PROCEDURES

3.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.

3.B.2. Provision of Relevant Information:

(a) Prior to receiving any confidential documents, the individual requesting the hearing must agree, in writing, 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/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 the following:

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

(2) reports of experts relied upon by the Medical Executive Committee;

(3) copies of relevant minutes (with portions regarding other physicians and unrelated matters deleted); and

(4) copies of any other documents relied upon by the Medical Executive Committee.

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

(c) The individual will have no right to discovery beyond the above information. No information will be provided regarding other members. 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 or members whose names appear on the Medical Executive Committee's witness list or in documents provided pursuant to this section concerning the subject matter of the hearing, until the Hospital has been notified and has contacted the individuals about their willingness to be interviewed. The Hospital will advise the individual who requested the hearing once it has contacted such employees or members and confirmed their willingness to meet. Any employee or member of the Medical Staff/APP/MAS may agree or decline to be interviewed by or on behalf of the individual who requested a hearing.

3.B.3. Pre-Hearing Conference:

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

(b) All objections to documents and 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.

(f) 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. 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.

3.B.4. Stipulations:

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

3.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.

3.B.6. Time Frames:

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

(a) the pre-hearing conference will be scheduled at least 14 days prior to the hearing;

(b) the parties will exchange witness lists and proposed documentary exhibits at least 10 days prior to the pre-hearing conference; and

(c) any objections to witnesses and/or proposed documentary exhibits must be provided at least five days prior to the pre-hearing conference.

3.C. THE HEARING

3.C.1. 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.

3.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 evidence will be taken on oath or affirmation administered by any authorized person.

3.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 but not 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.

3.C.4. Order of Presentation:

The Medical 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.

3.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.

3.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 President of the Hospital or the Chief of Staff.

3.C.7. Postponements and Extensions:

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

3.C.8. 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, he or she will read the entire transcript of the portion of the hearing from which he or she was absent.

3.D. HEARING CONCLUSION, DELIBERATIONS, AND RECOMMENDATIONS

3.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 Medical Executive Committee unless it finds that the individual who requested the hearing has proved, by clear and convincing evidence, that the recommendation that prompted the hearing was arbitrary, capricious, or not supported by credible evidence.

3.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.

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

The Hearing Panel will deliver its report to the President of the Hospital. The President of the Hospital will send by special notice a copy of the report to the individual who requested the hearing. The President of the Hospital will also provide a copy of the report to the Chief of Staff.

3.E. APPEAL PROCEDURE

3.E.1. Time for Appeal:

(a) Within ten days after notice of the Hearing Panel's recommendation, either party may request an appeal. The request will be in writing, delivered to the President of the Hospital either 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.

(b) If an appeal is not requested within ten days, an appeal is deemed to be waived and the Hearing Panel's report and recommendation will be forwarded to the Board for final action.

3.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 were made arbitrarily or capriciously or were not supported by credible evidence.

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

Whenever an appeal is requested, the chairperson 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.

3.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 Medical 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) 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.

3.F. BOARD ACTION

3.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 Hearing Panel's report when no appeal has been requested.

(b) 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.

(c) 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 Chief of Staff.

(d) 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.

3.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. If the Board denies initial appointment or reappointment or revokes appointment or clinical privileges, that individual may not apply for appointment or clinical privileges for a period of five years, from the date of the Board's final action, unless the Board provides otherwise.

Adopted by the Medical Staff on:

Date: _____

_____

_____Chief of Staff, Approved by the Board:

Date: _____

_____

_____Chair, Board