MEDICAL STAFF BYLAWS, POLICIES, AND RULES AND REGULATIONS OF TUCSON MEDICAL CENTER

MEDICAL STAFF GLOSSARY

Approved by the Board: April 23, 2025

MEDICAL STAFF GLOSSARY

The following definitions shall apply to terms used in the Medical Staff Bylaws, the Medical Staff Credentials Policy, the Advanced Practice and Other Healthcare Professionals Policy, the Medical Staff Organization Manual, the Medical Staff Rules and Regulations and all associated Professional Practice Evaluation policies of the Medical Staff:

(1) "ADMINISTRATIVE TEAM" means the Chief Executive Officer, Chief Operating Officer, Chief Medical Officer, Vice President Medical Affairs, Chief Nursing Officer, Rincon Site Administrator, or any Administrator on call.

(2) "ADMITTING PRACTITIONER" means the Practitioner who orders the admission of a given patient to the Hospital.

(3) "ADVANCED PRACTICE PROFESSIONALS" means a type of Practitioner who provides a medical level of care or performs surgical tasks consistent with granted Clinical Privileges, but who may be required by law and/or the Hospital to exercise some or all of those Clinical Privileges under the direction of, or in collaboration with, a Collaborating/Supervising Physician pursuant to a written supervision or collaborative agreement. See Appendix A of the Advanced Practice and Other Healthcare Professionals Policy for a list of Advanced Practice Professionals.

(4) "AMBULATORY CARE LOCATION" means any department in the Hospital or provider-based site or facility where ambulatory care is provided (i.e., non-emergency health care services provided to patients without hospitalization, including, but not limited to, Day surgeries (with or without general anesthesia), blood transfusions, and I.V. therapy).

(5) "ASSIGNED REVIEWER" means a Practitioner appointed by a member of the Professional Practice Committee ("PPC"), or by the Advanced Practice Professionals Committee ("APPC"), Leadership Council, or PPC to either: (i) serve as a consultant to the individual or committee performing the review; or (ii) conduct a review, document his or her clinical findings on the ***AR Case Review Form***. The functions of an Assigned Reviewer may also be performed by a standing or ad hoc committee as requested by a PPC Member, the APPC, the Leadership Council or the PPC.

(6) "AUTOMATIC RELINQUISHMENT/AUTOMATIC RESIGNATION" of appointment and/or Clinical Privileges are administrative actions that occur by operation of the Medical Staff Credentials Policy or other applicable Medical Staff policy. They are not professional review actions that must be reported to the National Practitioner Data Bank or to any state licensing board or agency, nor do they entitle the Practitioner to a hearing or appeal.

(7) "BOARD" means the Board of Trustees of the Hospital, which has the overall responsibility of the Hospital, or its designated committee exercising delegated authority of the Board of Trustees (e.g., the Board Quality Care Committee).

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

(9) "CHIEF MEDICAL OFFICER" ("CMO") means the individual appointed by the Board to act as the chief medical officer of the Hospital, in cooperation with the VPMA and the Chief of Staff.

(10) "CLINICAL PRIVILEGES" or "PRIVILEGES" means the authorization granted by the Board to render specific patient care services, for which the Medical Staff Leaders and Board have developed eligibility and other credentialing criteria and FPPE and OPPE standards.

(11) "COLLABORATING/SUPERVISING PHYSICIAN" means a Medical Staff Member with Clinical Privileges, who has agreed in writing to supervise or collaborate with an Advanced Practice Professional and to accept full responsibility for the actions of the Advanced Practice Professional while he or she is practicing in the Hospital.

(12) "COLLABORATION/SUPERVISION" means the supervision of, or collaboration with, an Advanced Practice Professional by a Collaborating/Supervising Physician, that may or may not require the actual presence of the Collaborating/Supervising Physician, but that does require, at a minimum, that the Collaborating/Supervising Physician be readily available for consultation. The requisite level of supervision (general, direct, or personal) shall be determined at the time each Advanced Practice Professional is credentialed and shall be consistent with any applicable written supervision or collaboration agreement that may exist. ("General" supervision means that the Physician is immediately available by phone, "direct" supervision means that the Physician is on the Hospital's campus, and "personal" supervision means that the Physician is in the same room.)

(13) "COLLABORATIVE LEADERSHIP EFFORTS" means informal discussions, mentoring, counseling, sharing of comparative data, and similar efforts that do not meet the criteria for a Collegial Intervention.

(14) "COLLEGIAL INTERVENTION" means a formal, planned, face-to-face discussion between the Practitioner and one or more Medical Staff Leaders. Collegial Intervention only occurs after a Practitioner has had an opportunity to provide input regarding a concern.

(15) "CONFIDENTIAL FILE" means any file, paper or electronic, containing credentialing, privileging, PPE/peer review, or quality information related to a Practitioner.

(16) "CONSULTING PHYSICIAN" means a Physician who examines a patient to render an opinion and/or advice to a requesting Physician (or his or her designee).

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

(18) "DAYS" means calendar days, unless the specified time period is ten days or less, in which case it shall mean business days.

(19) "DENTIST" means a doctor of dental surgery ("D.D.S.") or doctor of dental medicine ("D.M.D.").

(20) "DEPARTMENT CHAIR" means the applicable head of a Medical Staff department at the Hospital (e.g., Chair of Medicine).

(21) "DIAGNOSTIC NURSING FNP" means a family nurse practitioner that performs APP duties, including performing history and physical examinations, to facilitate procedures performed by the team of diagnostic nurses in outpatient ancillary areas of the Hospital."

(22) "EDUCATIONAL LETTER" is a letter that describes the opportunities for improvement that were identified in the care reviewed and offers specific recommendations for future practice. An Educational Letter is sent only after the Practitioner has provided input regarding a matter. Additional guidance on the use of Educational Letters is found in the Professional Practice Evaluation Policy (Peer Review).

(23) "EMPLOYED PRACTITIONER" means a Practitioner who is employed by an Employer.

(24) "EMPLOYER" means:

(a) TMC Healthcare; or

(b) a private entity that has: (i) a formal peer review/professional practice evaluation process and an established peer review committee, as evidenced by internal bylaws or policy; and (ii) information sharing provisions in a professional services contract or in a separate agreement with the Hospital.

(25) "FOCUSED PROFESSIONAL PRACTICE EVALUATION" or "FPPE" means a time-limited period during which a Practitioner's professional performance is evaluated. All initially granted Clinical Privileges, whether at the time of initial appointment, reappointment, or during the term of appointment, shall be subject to FPPE.

(26) "HOSPITAL" means Tucson Medical Center, an Arizona non-profit corporation that operates the licensed hospital of the same name, and all of its provider-based sites and facilities, as defined by the Centers for Medicare & Medicaid Services. The term "Hospital" includes both the Tucson Medical Center Main Campus ("TMC-Main") and the Tucson Medical Center Rincon Campus ("TMC-Rincon"); references to "Hospital" herein shall govern over both campuses unless a campus- specific designation is specifically made. The term "Hospital" does not include any non-provider-based sites or TMC One.

(27) "INFORMATIONAL LETTER" is a letter that is intended to help Practitioners self-correct and improve their performance through timely feedback. The PPC will prepare a list of objective occurrences (i.e., not subject to interpretation) for which an Informational Letter is appropriate. Additional guidance on the use of Informational Letters is found in the Professional Practice Evaluation Policy (Peer Review).

(28) "INVESTIGATION" means a non-routine, formal process to review questions or concerns pertaining to a Practitioner. Only the Medical Executive Committee has the authority to initiate and conduct an Investigation. By contrast, the processes that address issues of clinical performance, professional conduct, and health involving Practitioners that utilize Collaborative Leadership Efforts or Progressive Steps do not constitute Investigations.

(29) "LEADERSHIP COUNCIL" is a peer review and quality assurance committee under Arizona law that:

(a) conducts reviews of, or determines the appropriate review process for, clinical issues that are administratively complex, as described in the Professional Practice Evaluation Policy (Peer Review);

(b) handles issues of professional conduct pursuant to the Medical Staff Professionalism Policy; and

(c) handles issues of Practitioner health pursuant to the Practitioner Health Policy.

The Leadership Council possesses no disciplinary authority. Only the Medical Executive Committee has the authority to conduct non-routine Investigations and to recommend Restrictions of Clinical Privileges. The composition and duties of the Leadership Council are described in the Medical Staff Organization Manual.

(30) "MEDICAL EXECUTIVE COMMITTEE" ("MEC") means the Medical Staff Executive Committee.

(31) "NOTICE" means written communication by regular U.S. mail, Hospital mail, hand delivery, e-mail, facsimile, website, or other electronic method.

(32) "ONGOING PROFESSIONAL PRACTICE EVALUATION" or "OPPE" means the ongoing review and analysis of data that helps to identify any issues or trends in Practitioners' performance that may impact quality of care and patient safety. OPPE promotes an efficient and effective evidence-based reappointment process. It is also part of the effort to provide educational opportunities that help all Practitioners consistently provide quality, safe, and effective patient care.

(33) "OPERATING PHYSICIAN" means a Physician (e.g., surgeon) who performs an operative procedure in the Hospital.

(34) "ORAL AND MAXILLOFACIAL SURGEON" means an individual with a D.D.S. or a D.M.D. degree, who has completed additional training in oral and maxillofacial surgery.

(35) "OTHER HEALTHCARE PROFESSIONALS" means a type of Practitioner who is permitted by law and by the Hospital to provide patient care services without direction or Collaboration/Supervision, within the scope of his or her license and consistent with the Clinical Privileges granted. Other Healthcare Professionals also include those Physicians not appointed to the Medical Staff who seek to exercise certain limited Clinical Privileges at the Hospital under the conditions set forth in the Advanced Practice and Other Healthcare Professionals Policy (i.e., moonlighting residents). See Appendix B of the Advanced Practice and Other Healthcare Professionals Policy for a list of Other Healthcare Professionals.

(36) "PATIENT CONTACTS" means any admission, consultation, procedure, on-site response to emergency call, evaluation, treatment or service performed in the Hospital or its outpatient facilities. Patient contacts do not include referrals for diagnostic or laboratory tests or x-rays.

(37) "PERFORMANCE IMPROVEMENT PLAN" or "PIP" is a voluntary agreement between a Practitioner and the PPC (for clinical matters) or the Leadership Council (for behavioral matters) by which the Practitioner takes certain steps to improve his or her clinical practice or conduct.

(38) "PERMISSION TO PRACTICE" means the authorization granted to Advanced Practice Professionals and Other Healthcare Professionals to exercise Clinical Privileges at the Hospital.

(39) "PHYSICIAN" means both doctors of medicine ("M.D.s") and doctors of osteopathy ("D.O.s").

(40) "PHYSICIAN ADVISOR" means a Physician who has been formally designated to play a role in the utilization review process and may also be referred to as Medical Advisors, Physician Champions, or similar terms. This includes, but is not limited to, Physicians who are appointed pursuant to Hospital or Medical Staff policy to perform utilization functions (e.g., via direct assignment or committee

membership) and Physicians who perform these functions pursuant to a contractual relationship involving the Hospital (e.g., Medical Director of Utilization Management), whose job responsibilities include utilization functions, or Physicians who provide utilization services through an external agency.

(41) "PODIATRIST" means a doctor of podiatric medicine ("D.P.M.").

(42) "PRACTITIONER" means any individual who has been granted Clinical Privileges and/or membership by the Board, including, but not limited to, Medical Staff Members and Advanced Practice and Other Healthcare Professionals.

(43) "PRIMARY TREATING PHYSICIAN" means the Physician who shall be responsible for directing and supervising a patient's overall medical care.

(44) "PROFESSIONAL PRACTICE COMMITTEE" or "PPC" is a multi-specialty peer review and quality assurance committee under Arizona law that oversees the professional practice evaluation process, conducts case reviews, works with Practitioners in a constructive and educational manner to help address any clinical performance issues, and develops Performance Improvement Plans as described in the Professional Practice Evaluation Policy (Peer Review). The PPC possesses no disciplinary authority. Only the Medical Executive Committee has the authority to conduct non-routine Investigations and to recommend Restrictions of Clinical Privileges. The composition and duties of the PPC are described in the Medical Staff Organization Manual.

(45) "PROFESSIONAL PRACTICE EVALUATION" or "PPE" refers to the Hospital's routine peer review process. It is used to evaluate a Practitioner's professional performance when any questions or concerns arise and includes all activities and documentation related to reviewing issues of clinical competence, professional conduct, care management, and health status. The PPE processes outlined in the Medical Staff policies are applicable to all Practitioners and are not intended to be a precursor to any disciplinary action, but rather are designed to promote improved patient safety and quality through continuous improvement.

(46) "MEDICAL STAFF" means all Physicians, Oral and Maxillofacial Surgeons, Dentists, Podiatrists, and Psychologists who have been appointed to the Medical Staff by the Board.

(47) "MEDICAL STAFF LEADER" means any Medical Staff Officer, Department Chair, Section Chief, and committee chair.

(48) "MEDICAL STAFF MEMBER" means any Physicians, Dentists, Oral and Maxillofacial Surgeons, Podiatrists and Psychologists who have been granted Medical Staff appointment by the Board.

(49) "MEDICAL STAFF OFFICE" means the clinical and non-clinical staff who support the professional practice evaluation processes described in the Medical Staff policies. Staff from the other departments in the Hospital (e.g., Human Resources, Risk Management, Quality & Safety) may assist the Medical Staff Office in performing the functions described in the Medical Staff Bylaws and policies, with such other staff being an integral part of the review process and bound by the same confidentiality and other requirements that apply to the Medical Staff Office.

(50) "PROGRESSIVE STEPS" means Informational Letters, Educational Letters, Collegial Interventions, and Performance Improvement Plans. See Section 6.A and Appendix C of the Professional Practice Evaluation Policy (Peer Review) for additional information.

(51) "PSYCHOLOGIST" means an individual with a Ph.D. or a Psy.D. in clinical psychology.

(52) "REQUESTING PRACTITIONER" means a Practitioner who makes a request for a consultation in accordance with Article 6 of the Medical Staff Rules and Regulations.

(53) "RESPONSIBLE PRACTITIONER" means any Practitioner, including a Consulting Physician, who is actively involved in the care of a patient at any point during the patient's treatment at the Hospital and who has the responsibilities outlined in the Medical Staff Rules and Regulations. These responsibilities include the completion of medical record entries related to the specific care/services he or she provides.

(54) "RESTRICTION" means a professional review action that:

(a) is recommended by the MEC as part of an Investigation or agreed to by the Practitioner while he or she is under Investigation or in exchange for the MEC not conducting an Investigation or taking an adverse professional review action; and

(b) limits the Practitioner's ability to independently exercise his or her clinical judgment (i.e., a mandatory concurring consulting requirement in which the consultant must approve the course of treatment in advance or a proctoring requirement in which the proctor must be present for the case and has the authority to intervene in the case, if necessary).

Restrictions do not include the following, whether recommended by the MEC or by any other Medical Staff committee:

(a) general consultation requirements, in which the Practitioner agrees to seek input from a consultant prior to providing care;

(b) observational proctoring requirements, in which the Practitioner agrees to have a proctor present to observe his or her provision of care; and

(c) other collegial performance improvement efforts, including Informational Letters, Educational Letters, or Performance Improvement Plans that are suggested by the Medical Staff leadership and voluntarily agreed to by the Practitioner as a part of the routine PPE process.

(55) "SECTION CHIEF" means the applicable head of a Medical Staff section at the Hospital (e.g., Chief of Neurosurgery).

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

(57) "SPECIAL PRIVILEGES" means Privileges that fall outside of the Core Privileges for a given specialty, which require additional education, training, and/or experience beyond that required for Core Privileges in order to demonstrate competence.

(58) "TELEMEDICINE" means the exchange of medical information from one site to another via electronic communications for the purpose of providing patient care, treatment, and services.

(59) "UNASSIGNED PATIENT" means any patient who comes to the Hospital for care and treatment who:

(a) does not have an established relationship with a Physician (i.e., the patient has never been treated by a Physician at the Hospital for his/her current condition), or

(b) has previously been treated by a Physician at the Hospital (the "Treating Physician") but:

(i) the Treating Physician is not supporting the patient's continuity of current care, or

(ii) the patient-physician relationship with the Treating Physician has been terminated, or

(iii) the Treating Physician and his or her covering Physician are unavailable to attend the patient or the covering Physician does not possess the clinical expertise to appropriately care for the patient, or

(iv) the patient does not want the Treating Physician to provide him/her care while at the Hospital.

(60) "VICE PRESIDENT MEDICAL AFFAIRS" ("VPMA") means the individual appointed by the CEO and the Board with primary responsibilities to the activities of the Medical Staff, in cooperation with the CMO.

MEDICAL STAFF BYLAWS, POLICIES, AND RULES AND REGULATIONS OF TUCSON MEDICAL CENTER

MEDICAL STAFF BYLAWS

Approved by the Board: October 22, 2025

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ARTICLE 1

GENERAL

1.A. DEFINITIONS

Unless otherwise indicated, the capitalized terms used in all of the Medical Staff documents are defined in the Medical Staff Glossary.

1.B. DELEGATION OF FUNCTIONS

(1) When a function under these Bylaws is to be carried out by a member of the Administrative Team, by a Medical Staff Member, or by a Medical Staff committee, the individual, or the committee through its chair, may delegate performance of the function to a qualified designee who is a Practitioner or Hospital employee (or a committee of such individuals). Any such designee must treat and maintain all credentialing, privileging, and peer review information in a strictly confidential manner and is bound by all other terms, conditions, and requirements of the Medical Staff Bylaws and related policies. In addition, the delegating individual or committee is responsible for ensuring that the designee appropriately performs the function in question. Any documentation created by the designee are records of the committee that is ultimately responsible for the review in a particular matter.

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

ARTICLE 2

CATEGORIES OF THE MEDICAL STAFF

Only those individuals who satisfy the qualifications and conditions for appointment to the Medical Staff contained in the Credentials Policy are eligible to apply for appointment to one of the categories listed below. All categories, with the respective rights and obligations of each, are summarized in the chart attached as **Appendix A** to these Bylaws.

2.A. ACTIVE STAFF

2.A.1. Qualifications:

The Active Staff shall consist of Physicians, Dentists, Oral and Maxillofacial Surgeons, Podiatrists and Psychologists who:

(a) are involved in at least 24 Patient Contacts per two-year appointment term;

(b) contribute to Medical Staff functions and/or demonstrate a commitment to the Medical Staff and Hospital through service on committees and/or active participation in performance improvement or Professional Practice Evaluation functions; and

(c) at each reappointment time, provide such quality data and other information as may be requested to assist in an appropriate assessment of current clinical competence and overall qualifications for appointment and Clinical Privileges (including, but not limited to, information from another hospital, information from the individual's office practice, information from insurers or managed care organizations in which the individual participates, and/or receipt of confidential evaluation forms completed by referring/referred to Physicians).

Guidelines:

Unless an Active Staff member can definitively demonstrate to the satisfaction of the Credentials Committee at the time of reappointment that his or her practice patterns have changed and that he/she will satisfy the activity requirements of this category:

* Any member who has fewer than 24 Patient Contacts during his or her two-year appointment term shall not be eligible to request Active Staff status at the time of his or her reappointment.

** The member will be transferred to another staff category that best reflects his or her relationship to the Medical Staff and the Hospital (options – Courtesy, Adjunct, Ambulatory Care, or Coverage).

2.A.2. Prerogatives:

Active Staff members may:

(a) admit patients consistent with granted Privileges or as stated on the individual's delineation of Privileges, except as otherwise provided in the Bylaws or Bylaws-related documents, or as limited by the Board;

(b) vote in all general and special meetings of the Medical Staff and applicable department, section, and committee meetings;

(c) hold office, serve as Department Chairs or Section Chiefs, serve on Medical Staff committees, and serve as chairs of committees; and

(d) exercise such Clinical Privileges as are granted to them.

2.A.3. Responsibilities:

Active Staff members must assume all the responsibilities of membership on the Active Staff, including:

(a) serving on committees, as requested;

(b) providing specialty coverage for the Emergency Department in accordance with the Medical Staff's Emergency Department On-Call Policy*;

(c) providing care for Unassigned Patients in accordance with the Medical Staff's Emergency Department On-Call Policy;

(d) participating in the evaluation of new Medical Staff Members;

(e) participating in quality and performance improvement processes (including constructive participation in the development of clinical practice protocols and guidelines pertinent to their medical specialties), as may be requested;

(f) accepting inpatient consultations in accordance with the Medical Staff Rules and Regulations;

(g) paying any required application fees and assessments; and

(h) performing assigned duties.

* An Active Staff member may be excused by the MEC from the obligation to provide specialty coverage for the Emergency Department on the recommendation of his/her department in any of the following circumstances:

(i) the member has served at least 20 years on the Medical Staff; or

(ii) the member has reached the age of 55 and has at least five years of service on the Medical Staff.

2.B. COURTESY STAFF

2.B.1. Qualifications:

The Courtesy Staff shall consist of Physicians, Dentists, Oral and Maxillofacial Surgeons, Podiatrists and Psychologists who:

(a) are involved in fewer than 24 Patient Contacts per two-year appointment term;

(b) meet all the same threshold eligibility criteria as other Medical Staff Members, including specifically those relating to availability and response times with respect to the care of their patients; and

(c) at each reappointment time, provide such quality data and other information as may be requested to assist in an appropriate assessment of current clinical competence and overall qualifications for appointment and Clinical Privileges (including, but not limited to, information from another hospital, information from the individual's office practice, information from insurers or managed care organizations in which the individual participates, and/or receipt of confidential evaluation forms completed by referring/referred to Physicians).

Guidelines:

Unless a Courtesy Staff member can definitively demonstrate to the satisfaction of the Credentials Committee at the time of reappointment that his or her practice patterns have changed and that he/she will satisfy the activity requirements of this category:

* Any member who has no Patient Contacts during his or her two-year appointment term will be transferred to another staff category that best reflects his or her relationship to the Medical Staff and the Hospital (options – Adjunct, Ambulatory Care, or Coverage).

** Any member who has 24 or more Patient Contacts during his or her two-year appointment term shall be automatically transferred to Active Staff status.

2.B.2. Prerogatives and Responsibilities:

Courtesy Staff members:

(a) may attend and participate in Medical Staff, department, and section meetings (without vote);

(b) may not hold office or serve as Department Chairs, Section Chiefs, or committee chairs (unless waived by the MEC and ratified by the Board);

(c) may be invited to serve on committees (with vote);

(d) are generally excused from providing specialty coverage for the Emergency Department for Unassigned Patients, but:

(1) must assume the care of any of their patients who present to the Emergency Department when requested to do so by an Emergency Department Physician,

(2) must accept referrals from the Emergency Department for follow-up care of their patients treated in the Emergency Department, and

(3) may be requested to provide specialty coverage if the MEC, in consultation with the applicable Department Chair, finds that there are insufficient Active Staff members in a particular specialty area to perform these responsibilities;

(e) may be requested to participate in quality and performance improvement processes (including constructive participation in the development of clinical practice protocols and guidelines pertinent to their medical specialties);

(f) shall exercise such Clinical Privileges as are granted to them; and

(g) shall pay any required application fees and assessments.

2.C. ADJUNCT STAFF

2.C.1. Qualifications:

The Adjunct Staff shall consist of Physicians, Dentists, Oral and Maxillofacial Surgeons, Podiatrists and Psychologists who:

(a) in the discretion of the Credentials Committee, are demonstrated professional ability and expertise;

(b) provide a service not otherwise available or in very limited supply on the Active Staff (should the service become readily available on the Active Staff, the Adjunct Staff members would not be eligible to request continued Adjunct Staff status at the time of their next reappointments and would have to transfer to a different staff category if they desire continued appointment);

(c) meet the eligibility criteria set forth in the Medical Staff Credentials Policy, with the exception of those pertaining to emergency department call coverage and coverage arrangements. Instead, Adjunct Staff members provide services at the Hospital only at the request of, and in coordination with, other Medical Staff Members who request their services; and

(d) at each reappointment time, provide such quality data and other information as may be requested to assist in an appropriate assessment of current clinical competence and overall qualifications for appointment and Clinical Privileges (including, but not limited to, information from another hospital, information from the individual's office practice, information from insurers or managed care organizations in which the individual participates, and/or receipt of confidential evaluation forms completed by referring/referred to Physicians).

2.C.2. Prerogatives and Responsibilities:

Adjunct Staff members:

(a) may evaluate and treat patients in conjunction with other Medical Staff Members;

(b) may not hold office or serve as Department Chairs, Section Chiefs, or committee chairs (unless waived by the MEC and ratified by the Board);

(c) may attend meetings of the Medical Staff and applicable department and section meetings (without vote);

(d) may be invited to serve on committees (with vote);

(e) are excused from providing specialty coverage for the Emergency Department and providing care for Unassigned Patients;

(f) may be requested to participate in quality and performance improvement processes (including constructive participation in the development of clinical practice protocols and guidelines pertinent to their medical specialties); and

(g) shall pay any required application fees and assessments.

2.D. AMBULATORY CARE STAFF

2.D.1. Qualifications:

The Ambulatory Care Staff consists of Physicians, Dentists, Oral and Maxillofacial Surgeons, Podiatrists, Psychologists, and any Practitioner who is licensed to practice independently outside of the Hospital who:

(a) desire to be associated with, but who do not intend to establish a clinical practice at, this Hospital and meet the eligibility criteria set forth in the Medical Staff Credentials Policy, with the exception of those pertaining to response times, board certification, emergency department call coverage, coverage arrangements, and eligibility criteria for Clinical Privileges (unless specific Privileges are requested (e.g., to order infusion services)); and

(b) have indicated or demonstrated a willingness to assume all the responsibilities of membership on the Ambulatory Care Staff as outlined in Section 2.D.2.

The primary purpose of the Ambulatory Care Staff is to promote professional and educational opportunities, including continuing medical education, and to permit these individuals to access Hospital services for their patients by referral of patients to Active Staff members for admission and care. The grant of Ambulatory Care Staff appointment is a courtesy only, which may be terminated by the Board upon recommendation of the MEC, with no right to a hearing or appeal.

2.D.2. Prerogatives and Responsibilities:

Ambulatory Care Staff members:

(a) may attend meetings of the Medical Staff and applicable departments (without voting);

(b) may not hold office or serve as Department Chairs, Section Chiefs, or committee chairs (unless waived by the MEC and ratified by the Board);

(c) shall generally have no staff committee responsibilities, but may be invited to serve on committees (with vote);

(d) may attend educational activities sponsored by the Medical Staff and the Hospital;

(e) may refer patients to members of the Active Staff for admission and/or care;

(f) are encouraged to submit their relevant outpatient records for inclusion in the Hospital's medical records for any patients who are referred;

(g) are encouraged to communicate directly with Active Staff members about the care of any patients referred, as well as to visit any such patients;

(h) may review the medical records and test results (via paper or electronic access) for any patients who are referred;

(i) may perform history and physical examinations in the office and have those reports entered into the Hospital's medical records;

(j) may not: admit patients, attend patients, exercise Clinical Privileges (unless specific Privileges are requested (e.g., to order infusion services), write inpatient orders, perform consultations, assist in surgery, or otherwise participate in the provision or management of clinical care to patients at the Hospital;

(k) may refer patients to the Hospital's diagnostic facilities and order such tests;

(l) may be requested to participate in quality and performance improvement processes (including constructive participation in the development of clinical practice protocols and guidelines pertinent to their medical specialties); and

(m) must pay any required application fees and assessments.

2.E. COVERAGE STAFF

2.E.1. Qualifications:

The Coverage Staff shall consist of Physicians, Dentists, Oral and Maxillofacial Surgeons, Podiatrists and Psychologists who:

(a) desire appointment to the Medical Staff solely for the purpose of being able to provide coverage assistance to Active Staff members who are members of their group practice or coverage group;

(b) at each reappointment time, provide such quality data and other information as may be requested to assist in an appropriate assessment of current clinical competence and overall qualifications for appointment and Clinical Privileges (including, but not limited to, information from another hospital, information from the individual's office practice, information from managed care organizations in which the individual participates, and/or receipt of confidential evaluation forms completed by referring/referred to Physicians);

(c) are not required to satisfy any defined response time requirements in place at the Hospital, except for those times when they are providing coverage; and

(d) agree that their Medical Staff appointment and Clinical Privileges will be automatically relinquished, with no right to a hearing or appeal, if their coverage arrangement with the Active Staff member(s) terminates for any reason.

2.E.2. Prerogatives and Responsibilities:

Coverage Staff members:

(a) when providing coverage assistance for an Active Staff member, shall be entitled to admit and/or treat patients who are the responsibility of the Active Staff member who is being covered (i.e., the Active Staff member's own patients or Unassigned Patients who present through the Emergency Department when the Active Staff member is on call);

(b) shall assume all Medical Staff functions and responsibilities as may be assigned, including, where appropriate, care for Unassigned Patients, emergency service care, consultation, and teaching assignments when covering for members of their group practice or coverage group;

(c) shall be entitled to attend Medical Staff, department, and section meetings (without vote);

(d) may not hold office or serve as Department Chairs, Section Chiefs, or committee chairs (unless waived by the MEC and ratified by the Board);

(e) shall generally have no staff committee responsibilities, but may be invited to serve on committees (with vote); and

(f) shall pay any required application fees and assessments.

2.F. EMERITUS STAFF

2.F.1. Qualifications:

(a) The Emeritus Staff shall consist of Physicians, Dentists, Oral and Maxillofacial Surgeons, Podiatrists, and Psychologists who the MEC believes deserve special recognition based on their contributions to the Medical Staff (e.g., years of service), the community, or to the field of medicine (e.g., developed or pioneered a new therapy or procedure).

(b) Candidates for Emeritus Staff status must meet the following qualifications:

1.Peer Nomination: Must be nominated by at least two Peers of Active Members of the Medical Staff. Nominations should include written endorsements detailing the nominee's professional achievements and ongoing interest in supporting the medical community.

2 Distinguished Service: Must have demonstrated an outstanding professional reputation, defined by:

a) A minimum of fifteen (15) years of continuous active clinical service at the TMC hospital.

b) Significant contributions to medical science, education, or leadership within the institution or broader healthcare community.

c) Recognition by peers or professional organizations for excellence in clinical practice, research, or mentorship.

3. Retirement from Clinical Practice: Must no longer be engaged in active clinical duties and express a desire to maintain a formal affiliation with the Medical Staff

2.F.2. Prerogatives and Responsibilities:

Emeritus Staff members:

(a) may not consult, admit, or attend to patients;

(b) may attend Medical Staff, department, and section meetings (without voting);

(c) may be appointed to committees (with vote);

(d) are entitled to attend educational programs of the Medical Staff and the Hospital;

(e) may not hold office or serve as Department Chairs, Section Chiefs, or committee chairs; and

(f) are not required to pay application fees or assessments.

ARTICLE 3

OFFICERS

3.A. DESIGNATION

The officers of the Medical Staff shall be the Chief of Staff, Chief of Staff-Elect, and Immediate Past Chief of Staff.

3.B. ELIGIBILITY CRITERIA

Only those members of the Active Staff, who satisfy the following criteria initially and continuously, shall be eligible to serve as an officer of the Medical Staff, unless a waiver is recommended by the MEC and approved by the Board. They must:

(1) be a Physician (M.D./D.O.) appointed in good standing to the Active Staff;

(2) have no past or pending adverse recommendations concerning Medical Staff appointment or Clinical Privileges;

(3) not presently serving as a Medical Staff officer, an MEC or Board member, a Department Chair, or a committee chair at any other hospital (excluding LTACHs) and shall not so serve during their term of office;

(4) be willing to faithfully discharge the duties and responsibilities of the position;

(5) have experience in a leadership position or other involvement in performance improvement functions;

(6) attend continuing education relating to Medical Staff leadership, credentialing, and/or Professional Practice Evaluation/peer review functions prior to or during the term of the office;

(7) have demonstrated an ability to work well with others; and

(8) disclose any financial relationship (i.e., an ownership or investment interest or a compensation arrangement) with an entity that competes with the Hospital or any affiliate. This does not apply to services provided within a Medical Staff Member's office and billed under the same provider number used by the Medical Staff Member. The MEC shall assess any such conflicts to determine whether they are such that they render the individual ineligible for the position.

3.C. DUTIES

3.C.1. Chief of Staff:

The Chief of Staff shall:

(a) act in coordination and cooperation with Hospital Administration in matters of mutual concern involving the care of patients in the Hospital;

(b) represent and communicate the views, policies and needs, and report on the activities of the Medical Staff to the CEO and the Board;

(c) serve as an *ex officio* trustee on the Board, with vote;

(d) call, preside at, and be responsible for the agenda of all meetings of the Medical Staff and the MEC;

(e) serve as a voting member and chair the MEC and the Leadership Council;

(f) be a member of all other Medical Staff committees, *ex officio*, without vote;

(g) promote adherence to the Bylaws, policies, Rules and Regulations of the Medical Staff and to the policies and procedures of the Hospital; and

(h) perform all functions authorized in all applicable policies, including Collegial Intervention in the Credentials Policy.

3.C.2. Chief of Staff-Elect:

The Chief of Staff-Elect shall:

(a) assume all duties of the Chief of Staff and act with full authority as Chief of Staff when the Chief of Staff is unavailable within a reasonable period of time;

(b) serve as a voting member on the Credentials Committee (as chair), the Leadership Council, and the MEC (as vice chair);

(c) serve as an *ex officio* trustee on the Board, without vote, unless the Chief of Staff is absent, in which case the Chief of Staff-Elect will assume his/her vote;

(d) assume all such additional duties as are assigned to him or her by the Chief of Staff or the MEC; and

(e) become Chief of Staff upon completion of his or her term.

3.C.3. Immediate Past Chief of Staff:

The Immediate Past Chief of Staff shall:

(a) serve as a voting member on the Leadership Council;

(b) serve as a member of the MEC, *ex officio*, without vote;

(c) serve as an advisor to other Medical Staff leaders; and

(d) assume all duties assigned by the Chief of Staff or the MEC.

3.D. NOMINATIONS

The Leadership Council shall convene at least 90 Days prior to the election and shall submit the names of at least one qualified nominee for the office of Chief of Staff Elect. All nominees must meet the eligibility criteria in Section 3.B and agree to serve, if elected. Notice of the nominees should be provided to the Medical Staff at least 21 Days prior to the election.

3.E. ELECTION

(1) Elections shall be held solely by written and/or electronic ballot returned to the Medical Staff Office in the manner as indicated on the ballot at the time it is distributed. Ballots shall be provided to all members of the Active Staff and completed ballots must be received in the Medical Staff Office by the date indicated on the ballot. Those who receive a majority of the votes cast shall be elected, subject to Board confirmation, which confirmation shall signify that the individual is entitled to legal protections and indemnification by the Board for acting in a Medical Staff leadership role.

(2) In the alternative, and in the discretion of the MEC, elections may occur at called meetings of the Medical Staff. Candidates receiving a majority of votes cast at the meeting by those members of the Active Staff present and voting at that meeting shall be elected, subject to Board confirmation, which confirmation shall signify that the individual is entitled to legal protections and indemnification by the Board for acting in a Medical Staff leadership role. If no candidate receives a simple majority vote on the first ballot, a run-off election shall be held promptly between the two candidates receiving the highest number of votes.

3.F. TERM OF OFFICE

Each officer shall serve a two-year term. The term of office shall commence on the first Day of the Medical Staff year following the election. Each officer shall serve in office until the end his or her term or until a successor is duly elected and has qualified, unless he or she resigns, or is removed from office, or is otherwise unable to complete the term.

At the end of the Chief of Staff's term, the Chief of Staff-Elect shall automatically assume the Chief of Staff office and the Chief of Staff shall automatically serve as the Immediate Past Chief of Staff.

3.G. REMOVAL

(1) Removal of an elected officer may be effectuated by a two-thirds vote of the MEC for:

(a) failure to comply with applicable policies, Bylaws, or Rules and Regulations;

(b) failure to perform the duties of the position held;

(c) conduct detrimental to the interests of the Hospital and/or its Medical Staff; or

(d) an infirmity that renders the individual incapable of fulfilling the duties of that office.

(2) At least 10 Days prior to the initiation of any removal action, the individual shall be given written Notice of the date of the meeting at which action is to be considered. The individual shall be afforded an opportunity to speak to the MEC prior to a vote on removal.

3.H. VACANCIES

(1) When a vacancy occurs in the office of the Chief of Staff, the Chief of Staff-Elect shall serve the remaining term of the former Chief of Staff. The vacancy then created in the office of Chief of Staff-Elect shall be filled as described in these Bylaws. In the event of the simultaneous vacancy in both the Chief of Staff and Chief of Staff-Elect positions or in all of the officer positions, the Board shall appoint interim officers to fill these positions, and an election shall be conducted within 90 Days. The Leadership Council shall then convene as soon as possible to nominate candidates to fill the unexpired terms of office. Following nomination of candidates, the Medical Staff shall hold a special meeting to conduct elections for these offices, using the election procedures described in these Bylaws.

(2) When a vacancy occurs in the office of the Chief of Staff-Elect, the MEC shall appoint an interim officer to fill the office until the next regular election, when both a Chief of Staff and Chief of Staff-Elect shall be elected. When a vacancy occurs in the office of the Immediate Past Chief of Staff, the office shall remain vacant until after the next election.

ARTICLE 4

CLINICAL DEPARTMENTS AND SECTIONS

4.A. ORGANIZATION

(1) The Medical Staff shall be organized into departments and sections as determined by the MEC and listed in the Organization Manual.

(2) Subject to the approval of the Board, the MEC may create new departments, eliminate departments, create or eliminate sections within departments, or otherwise reorganize the department structure.

4.B. ASSIGNMENT TO DEPARTMENTS AND SECTIONS

(1) Upon initial appointment to the Medical Staff, each Medical Staff Member shall be assigned to a clinical department and section, if applicable. Assignment to a particular department or section does not preclude a Medical Staff Member from seeking and being granted Clinical Privileges typically associated with another department.

(2) A Medical Staff Member may request a change in department or section assignment to reflect a change in his or her clinical practice.

(3) Department or section assignments may be transferred at the discretion of the MEC.

4.C. FUNCTIONS OF DEPARTMENTS

The departments shall be organized for the purpose of implementing processes (i) to monitor and evaluate the quality and appropriateness of the care of patients served by the departments; (ii) to monitor the practice of all those with Clinical Privileges in a given department; and (iii) to organize appropriate specialty coverage of the Emergency Department, consistent with the provisions in these Bylaws and related policies.

4.D. QUALIFICATIONS OF DEPARTMENT CHAIRS AND VICE CHAIRS

Each Department Chair and Vice Chair shall satisfy the following, unless waived by the Board after considering the recommendation of the MEC:

(1) be certified by an appropriate specialty board or possess comparable competence, as determined through the credentialing and privileging process; and

(2) satisfy the eligibility criteria in Section 3.B.

4.E. APPOINTMENT OF DEPARTMENT CHAIRS AND VICE CHAIRS

(1) DEPARTMENT CHAIRS

(a) Except as otherwise provided by contract, Department Chairs shall be elected by the department, subject to MEC approval and confirmation by the Board. The Leadership Council shall consult with the current Department Chair to identify candidates and confirm the candidates meet the qualifications in Section 3.B (unless waived by the MEC) and are willing to serve.

(b) The chairs of the Departments of Anesthesia, Emergency Medicine, Medicine, OB/GYN, shall be elected in the month prior to that of the annual meeting of the Medical Staff in odd-numbered years. The chairs of the departments of Diagnostic Services, Pathology, Pediatrics, and Surgery shall be elected in the month prior to that of the annual meeting of the Medical Staff in even-numbered years.

(c) The election shall be by written and/or electronic ballot. Ballots must be returned by the date indicated on the ballot at the time it is distributed. Those who receive a majority of the votes cast shall be elected, subject to Board confirmation, which confirmation shall signify that the individual is entitled to legal protections and indemnification by the Board for acting in a Medical Staff leadership role.

(e) If no one is willing to serve as a Department Chair, the Leadership Council, in consultation with the MEC, shall appoint an individual to serve.

(f) Elected Department Chairs shall serve a term of two years and may be reelected for two consecutive terms.

(2) VICE CHAIRS

(a) A Vice Chair may be appointed for a specific Department where the CMO and MEC have determined a need for such a position. This decision will be based on factors such as the size of the department and the clinical and administrative demands on the Department Chair.

(b) For Departments where a Vice Chair has been approved, the relevant Department Chair, in consultation with the Leadership Council, shall appoint a Vice Chair, subject to MEC approval and confirmation by the Board.

(c) Vice Chairs shall serve a term of two years and may be reelected for two consecutive terms.

4.F. REMOVAL OF DEPARTMENT CHAIRS AND VICE CHAIR

(1) Any Department Chair or Vice Chair may be removed by a two-thirds vote of the department or by a two-thirds vote of the MEC after reasonable Notice and opportunity to be heard. Grounds for removal shall be:

(a) failure to comply with applicable policies, Bylaws, or Rules and Regulations;

(b) failure to perform the duties of the position held;

(c) conduct detrimental to the interests of the Hospital and/or its Medical Staff; or

(d) an infirmity that renders the Department Chair or vice Chair incapable of fulfilling the duties of that office.

(2) Prior to the initiation of any removal action, the Department Chair or Vice Chair shall be given written Notice of the date of the meeting at which such action shall be taken at least 10 Days prior to the date of the meeting. The Department Chair or Vice Chair shall be afforded an opportunity to speak to the department or MEC, as applicable, prior to a vote on such removal being taken.

4.G. DUTIES OF DEPARTMENT CHAIRS

Department Chairs shall work in collaboration with Medical Staff Leaders and other Hospital personnel to collectively be responsible for the following:

(1) all clinically related activities of the department;

(2) all administratively related activities of the department, unless otherwise provided for by the Hospital;

(3) continuing surveillance of the professional performance of all individuals in the department who have delineated Clinical Privileges;

(4) recommending criteria for Clinical Privileges that are relevant to the care provided in the department;

(5) evaluating requests for Clinical Privileges for each member of the department;

(6) the integration of the department into the primary functions of the Hospital;

(7) the coordination and integration of interdepartmental and intradepartmental services;

(8) the development and implementation of policies and procedures that guide and support the provision of care, treatment and services;

(9) determination of the qualifications and competence of department personnel who are not licensed independent Practitioners and who provide patient care, treatment and services;

(10) recommendations for a sufficient number of qualified and competent persons to provide care or services;

(11) continuous assessment and improvement of the quality of care and services provided;

(12) maintenance of quality monitoring programs, as appropriate;

(13) recommendations for space and other resources needed by the department;

(14) assessing and recommending off-site sources for needed patient care services not provided by the department or the Hospital;

(15) the orientation and continuing education of all persons in the department;

(16) evaluation of individuals to assist with Ongoing Professional Practice Evaluation and Focused Professional Practice Evaluation;

(17) reviewing and reporting on applications for appointments, reappointments, and Clinical Privileges, and participating in interviews as necessary; and

(18) appointing a Vice Chair, in consultation with the Leadership Council, where the CMO and MEC have determined a need for such a position; and

(19) performing all functions authorized in the Credentials Policy, including Collegial Intervention.

4.H. DUTIES OF DEPARTMENT VICE CHAIIRS

A Vice Chair shall carry out the duties requested by his or her Department Chair. These duties may include, but are not limited to:

(1) assisting with the review of applications for initial appointment, reappointment, and clinical privileges, including interviewing applicants;

(2) evaluation of individuals to assist with Ongoing Professional Practice Evaluation and Focused Professional Practice Evaluation;

(3) participation in the development of criteria for clinical privileges;

(4) reviewing and reporting on the professional performance of individuals practicing within the section; and

(5) serving in the absence of the Department Chair.

4.I. CLINICAL SECTIONS

4.I.1. Functions of Sections:

(a) Sections may perform any of the following activities:

(1) continuing education;

(2) discussion of policy;

(3) discussion of equipment needs;

(4) development of recommendations to the applicable department or the MEC;

(5) participation in the development of criteria for Clinical Privileges (when requested by the Department Chair);

(6) reviewing and reporting on applications for appointment, reappointment, and Clinical Privileges, and participating in interviews as necessary; and

(7) performing all functions authorized in the Credentials Policy, including Collegial Intervention.

(b) No minutes or reports will be required reflecting the activities of sections, except when a section is making a formal recommendation to a department, Department Chair, the Credentials Committee, or the MEC.

(c) Sections shall not be required to hold any number of regularly scheduled meetings.

4.I.2. Qualifications, Selection and Removal of Section Chiefs:

(a) Except as otherwise provided by contract, Section Chiefs will be elected in the same manner as Department Chairs.

(b) Section Chiefs must meet the same qualifications as Department Chairs.

(c) The Department Chair has the authority, subject to consultation with the MEC, to remove a Section Chief from office.

(d) If requested by two-thirds of the Active Staff in a section, the Department Chair will evaluate the performance of a Section Chief to determine whether he or she should be removed from office.

4.I.3. Duties of Section Chiefs:

The Section Chief shall carry out those functions delegated by the department or the MEC, which may include the following:

(a) review and report on applications for initial appointment and Clinical Privileges;

(b) review and report on applications for reappointment and renewal of Clinical Privileges;

(c) evaluate individuals who are granted Privileges in order to confirm competence;

(d) participate in the development of criteria for Clinical Privileges within the section.

(e) review and report regarding the professional performance of individuals practicing within the section; and

(f) support the applicable department in making recommendations regarding the coordination of section activities, as well as the Hospital resources necessary for the section to function effectively.

ARTICLE 5

MEDICAL STAFF COMMITTEES AND
PERFORMANCE IMPROVEMENT FUNCTIONS

5.A. MEDICAL STAFF COMMITTEES AND FUNCTIONS

(1) This Article and the Medical Staff Organization Manual outline the Medical Staff committees that carry out OPPE, FPPE, and other performance improvement functions that are delegated to the Medical Staff by the Board.

(2) Unless otherwise indicated, each committee described in these Bylaws or in the Organization Manual shall meet as necessary to accomplish its functions, and shall maintain a permanent record of its findings, proceedings, and actions. Each committee shall make a timely written report after each meeting to the MEC and to other committees and individuals as may be indicated.

5.B. APPOINTMENT OF COMMITTEE CHAIRS AND MEMBERS

(1) Unless otherwise indicated in a specific committee composition, all committee chairs and members shall be appointed by the Leadership Council. Advanced Practice Professionals may be appointed to serve as members of Medical Staff committees. Committee chairs shall be selected based on the criteria set forth in Section 3.B of these Bylaws, and all committee members must signify their willingness to meet basic expectations of committee membership as set forth in Section 3.B of the Organization Manual.

(2) Unless otherwise provided in a specific committee composition, committee chairs and members shall be appointed for an initial term of two years and may serve additional terms. All appointed chairs and members may be removed and vacancies filled by the Leadership Council at its discretion.

(3) Unless otherwise indicated, all Hospital and administrative representatives on the committees shall be appointed by the CEO, in consultation with the CMO and/or VPMA, and the Chief of Staff. All such representatives shall serve on the committees, without vote.

(4) Unless otherwise indicated, the Chief of Staff, CMO, VPMA, and the CEO shall be members, *ex officio*, without vote, on all committees.

5.C. MEDICAL EXECUTIVE COMMITTEE

5.C.1. Composition:

(a) The MEC shall consist of the following voting members:

- the Chief of Staff;
- the Chief of Staff-Elect; and
- the Department Chairs.

(b) The Section Chiefs, the Chair of the Advanced Practice Professional Committee, the Chair of the Ethics Committee, the CEO, the Director of THMEP, the Immediate Past Chief of Staff, the CMO, and the VPMA shall serve as *ex officio*, non-voting members.

(c) The Chief of Staff will chair the MEC, while the Chief of Staff-Elect shall serve as vice chair.

(d) Other Medical Staff Members or Hospital personnel may be invited to attend a particular MEC meeting (as guests, without vote) in order to assist the MEC in its discussions and deliberations regarding an issue on its agenda. These individuals shall be present only for the relevant agenda item and shall be excused for all others. Such individuals are an integral part of the committee's functioning and are bound by the same confidentiality requirements as the standing members of the MEC.

(e) At the discretion of the Chief of Staff, discussions or meetings of the MEC may be conducted in Executive Session, meaning only the voting members of the committee may attend, along with appropriate Hospital personnel (e.g., the CEO, CMO and/or the VPMA) and any invitees of the Chief of Staff. The conduct and activities of the MEC while in Executive Session shall be consistent with the duties and responsibilities of the committee. In addition, discussions or meetings shall be conducted in a manner consistent with applicable federal and state law, which includes maintaining the strict confidentiality of the proceedings.

5.C.2. Duties:

The MEC has the primary oversight authority related to professional activities and functions of the Medical Staff and performance improvement activities regarding the professional services provided by Medical Staff Members with Clinical Privileges. This authority may be removed or modified by amending these Bylaws and related policies. The MEC is responsible for the following:

(a) acting on behalf of the Medical Staff in the intervals between Medical Staff meetings;

(b) recommending directly to the Board on at least the following:

(1) the Medical Staff's structure;

(2) the mechanism used to review credentials and to delineate individual Clinical Privileges;

(3) applicants for Medical Staff appointment and reappointment;

(4) delineation of Clinical Privileges for each eligible individual;

(5) participation of the Medical Staff in Hospital performance improvement activities and the quality of professional services being provided by the Medical Staff;

(6) the mechanism by which Medical Staff appointment may be terminated;

(7) hearing procedures; and

(8) reports and recommendations from Medical Staff committees, departments, and other groups, as appropriate;

(c) consulting with the CEO on quality-related aspects of contracts for patient care services;

(d) receiving and acting on reports and recommendations from Medical Staff committees, departments, and other groups as appropriate, and making appropriate recommendations for improvement when there are significant departures from established or expected clinical practice patterns;

(e) reviewing (or delegating the review of) quality indicators to ensure uniformity regarding patient care services;

(f) providing leadership in activities related to patient safety;

(g) providing oversight in the process of analyzing and improving patient satisfaction;

(h) prioritizing continuing medical education activities;

(i) reviewing, or delegating to a Task Force the responsibility to review, at least once every five years, the Bylaws, policies, Rules and Regulations, and associated documents of the Medical Staff and recommending such changes as may be necessary or desirable; and

(j) performing such other functions as are assigned to it by these Bylaws, the Credentials Policy, the Board or other applicable policies.

5.C.3. Meetings:

The MEC shall meet a minimum of ten times a year at monthly intervals and shall report the activities of the Medical Staff and the MEC to the Board.

5.D. PERFORMANCE IMPROVEMENT FUNCTIONS

The Medical Staff is actively involved in performance improvement functions, including reviewing data and recommending and implementing processes to address the following:

(1) patient safety, including processes to respond to patient safety alerts, meet patient safety goals and reduce patient safety risks;

(2) the Hospital's and individual Practitioners' performance on Joint Commission and Centers for Medicare & Medicaid Services ("CMS") core measures;

(3) medical assessment and treatment of patients;

(4) the appropriate review and consideration of information received about an adverse privileging determination regarding any Practitioner;

(5) medication usage, including review of significant adverse drug reactions, medication errors and the use of experimental drugs and procedures;

(6) the utilization of blood and blood components, including review of significant transfusion reactions;

(7) operative and other procedures, including tissue review and review of discrepancies between pre-operative and post-operative diagnoses;

(8) appropriateness of clinical practice patterns;

(9) significant departures from established patterns of clinical practice;

(10) education of patients and families;

(11) coordination of care, treatment and services with other Practitioners and Hospital personnel;

(12) accurate, timely and legible completion of medical records;

(13) the required content and quality of history and physical examinations, as well as the time frames required for completion, all of which are set forth in **Appendix B** of these Bylaws;

(14) the use of developed criteria for autopsies;

(15) sentinel events, including root cause analyses and responses to unanticipated adverse events;

(16) nosocomial infections and the potential for infection;

(17) unnecessary procedures or treatment; and

(18) appropriate resource utilization.

5.E. CREATION OF STANDING COMMITTEES

In accordance with the amendment provisions in the Organization Manual, the MEC may establish additional committees to perform one or more staff functions and may dissolve or rearrange committee structure, duties, or composition as needed to better accomplish Medical Staff functions. Any function required to be performed by these Bylaws which is not assigned to an individual Medical Staff Member, a standing committee, or a special task force shall be performed by the MEC.

5.F. SPECIAL COMMITTEES

Special committees shall be created and their Medical Staff Members and chairs shall be appointed by the Chief of Staff. Such task forces shall confine their activities to the purpose for which they were appointed and shall report to the MEC.

ARTICLE 6

MEETINGS

6.A. MEDICAL STAFF YEAR

The Medical Staff year is January 1 to December 31.

6.B. MEDICAL STAFF MEETINGS

6.B.1. Regular Meetings:

The Medical Staff shall meet as needed.

6.B.2. Special Meetings:

Special meetings of the Medical Staff may be called by the Chief of Staff, the MEC, the Board, or by a petition signed by not less than 10% of the Active Staff.

6.C. DEPARTMENT AND COMMITTEE MEETINGS

6.C.1. Regular Meetings:

Except as otherwise provided in these Bylaws or in the Medical Staff Organization Manual, each department and committee shall meet as often as necessary to fulfill their responsibilities, at times set by the Presiding Officer.

6.C.2. Special Meetings:

A special meeting of any department or committee may be called by or at the request of the Presiding Officer, the Chief of Staff, or by a petition signed by not less than 10% of the Active Staff members of the department or committee, but not by fewer than two members.

6.D. PROVISIONS COMMON TO ALL MEETINGS

6.D.1. Notice of Meetings:

(a) Medical Staff Members shall be provided Notice of all regular meetings of the Medical Staff and regular meetings of departments and committees at least 14 Days in advance of the meetings. The primary mechanism utilized for providing Notice will be e-mail; however, Notice may also be provided by mail, facsimile, hand delivery, posting in a designated electronic or physical location, or telephone at least 14 Days prior to the meetings. All Notices shall provide the date, time, and place of the meetings.

(b) When a special meeting of the Medical Staff, a department, and/or a committee is called, all of the provisions in paragraph (a) shall apply except that the Notice period shall be reduced to 48 hours and posting may not be the sole mechanism used for providing Notice of a special meeting.

(c) The attendance of any individual Medical Staff Member at any meeting shall constitute a waiver of that individual's objection to the Notice given for the meeting.

6.D.2. Quorum and Voting:

(a) For any regular or special meetings of the Medical Staff, department, or committee, those voting members present (but not fewer than two) shall constitute a quorum. The only exception to this general rule is for meetings of the MEC, the Professional Practice Committee ("PPC"), and the Leadership Council, where the presence of at least 50% of the voting members of the committee shall constitute a quorum.

(b) Once a quorum is established, the business of the meeting may continue and all actions taken shall be binding, even if attendance drops below the quorum during the course of the meeting.

(c) Recommendations and actions of the Medical Staff, departments, and committees shall be by consensus. In the event it is necessary to vote on an issue, that issue will be determined by a majority vote of those voting members present.

(d) When determining whether a specific percentage or a majority has been achieved with respect to a vote of the Medical Staff or a department or committee, an individual who has recused himself or herself from participation in the vote shall not be counted as a voting member (for example, if there are ten voting members of a committee and one recuses himself or herself on a particular matter, the majority vote for that matter would be calculated as five of the remaining nine votes).

(e) The voting Medical Staff Members, a department, or a committee may also be presented with a question by mail, facsimile, e-mail, hand delivery, website posting, or telephone, or other technology approved by the Chief of Staff, and their votes returned to the Presiding Officer by the method designated in the Notice. Except as noted in (a) above (i.e., meetings of the MEC, the PPC, and the Leadership Council), a quorum for purposes of these votes shall be the number of responses returned to the Presiding Officer by the date indicated. The question raised shall be determined in the affirmative if a majority of the responses returned has so indicated.

(f) At the discretion of the Presiding Officer, one or more Medical Staff Members may participate in a meeting by telephone or video conference.

6.D.3. Agenda:

The Presiding Officer for the meeting shall set the agenda for any regular or special meeting of the Medical Staff, department, or committee.

6.D.4. Rules of Order:

Robert's Rules of Order may be used for reference at all meetings and elections, but shall not be binding. Specific provisions of these Bylaws and Medical Staff, department, or committee custom shall prevail at all meetings, and the Presiding Officer (i.e., Chief of Staff, Department Chair, or committee chair, as applicable) shall have the authority to rule definitively on all matters of procedure.

6.D.5. Minutes, Reports, and Recommendations:

(a) Minutes of all meetings of the Medical Staff, departments, and committees shall be prepared and shall include a record of the attendance of Medical Staff Members and the recommendations made and the votes taken on each matter. The minutes shall be signed by the Presiding Officer.

(b) A summary of all recommendations and actions of the Medical Staff, departments, and committees shall be transmitted to the MEC and to the CEO for purposes of keeping the Board apprised of the activities of the Medical Staff and its departments and committees.

(c) A permanent file of the minutes of all meetings shall be maintained by the Hospital.

6.D.6. Confidentiality:

All Medical Staff business conducted by committees or departments is considered confidential and proprietary and should be treated as such. However, Medical Staff Members who have access to, or are the subject of, credentialing and/or peer review information understand that this information is subject to heightened sensitivity and, as such, agree to maintain the confidentiality of this information. Credentialing and peer review documents, and information contained therein, must not be disclosed to any individual not involved in the credentialing or peer review processes, except as authorized by the Credentials Policy or other applicable Medical Staff or Hospital policy. A breach of confidentiality with regard to any Medical Staff information may result in the imposition of disciplinary action.

6.D.7. Attendance Requirements:

(a) Attendance at meetings of the MEC, the PPC, the Leadership Council, and the Credentials Committee is required. All members are required to attend at least

50% of all regular and special meetings of these committees. Failure to attend the required number of meetings may result in replacement of the member.

(b) Each Active Staff member is encouraged, but not required, to attend and participate in all Medical Staff meetings and applicable department, section, and committee meetings each year.

ARTICLE 7

INDEMNIFICATION

The Hospital shall indemnify all Practitioners who act for and on behalf of the Hospital in discharging their responsibilities and professional review activities pursuant to these Bylaws, the Credentials Policy, the Medical Staff Organization Manual, the Policy on Advanced Practice and Other Healthcare Professionals, and all associated Professional Practice Evaluation policies of the Medical Staff to the fullest extent permitted by law, in accordance with applicable provisions of the Hospital's corporate bylaws.

ARTICLE 8

BASIC STEPS AND DETAILS

The details associated with the following Basic Steps are contained in the Credentials Policy and the Policy on Advanced Practice and Other Healthcare Professionals in a more expansive form.

8.A. QUALIFICATIONS FOR APPOINTMENT

To be eligible to apply for initial appointment or reappointment to the Medical Staff or for the grant of Clinical Privileges, an applicant must demonstrate appropriate education, training, experience, current clinical competence, professional conduct, licensure, and ability to safely and competently perform the Clinical Privileges requested as set forth in the Credentials Policy and the Policy on Advanced Practice and Other Healthcare Professionals.

8.B. PROCESS FOR PRIVILEGING

Requests for Privileges are provided to the applicable Department Chair/Section Chief, who reviews the individual's education, training, and experience and prepares a form provided by the Medical Staff Office stating whether the individual meets all qualifications. The Credentials Committee then reviews the assessment of the Department Chair/Section Chief, the application, and all supporting materials and makes a recommendation to the MEC. The MEC may accept the recommendation of the Credentials Committee, refer the application back to the Credentials Committee for further review, or state specific reasons for disagreement with the recommendation of the Credentials Committee. If the recommendation of the MEC to grant Privileges is favorable, it is forwarded to the Board for final action. If the recommendation of the MEC is unfavorable, the individual is notified by the CEO of the right to request a hearing.

8.C. PROCESS FOR CREDENTIALING (APPOINTMENT AND REAPPOINTMENT)

Complete applications are provided to the applicable Department Chair/Section Chief, who reviews the individual's education, training, and experience and prepares a form provided by the Medical Staff Office stating whether the individual meets all qualifications. The Credentials Committee then reviews the assessment of the Department Chair/Section Chief, the application, and all supporting materials and makes a recommendation to the MEC. The MEC may accept the recommendation of the Credentials Committee, refer the application back to the Credentials Committee for further review, or state specific reasons for disagreement with the recommendation of the Credentials Committee. If the recommendation of the MEC to grant appointment or reappointment is favorable, it is forwarded to the Board for final action. If the

recommendation of the MEC is unfavorable, the individual is notified by the CEO of the right to request a hearing.

8.D. DISASTER PRIVILEGING

When the disaster plan has been implemented, the CEO, CMO, VPMA, or Chief of Staff may use a modified credentialing process to grant disaster Privileges after verification of the volunteer's identity and licensure.

8.E. INDICATIONS AND PROCESS FOR AUTOMATIC RELINQUISHMENT OF APPOINTMENT AND/OR PRIVILEGES

(1) Appointment and Clinical Privileges may be automatically relinquished if an individual:

(a) fails to do any of the following:

(i) timely complete medical records;

(ii) satisfy threshold eligibility criteria;

(iii) provide requested information;

(iv) complete and/or comply with educational or training requirements; or

(v) attend a special conference to discuss issues or concerns;

(b) is involved or alleged to be involved in defined criminal activity;

(c) makes a misstatement or omission on an application form; or

(d) remains absent on leave for longer than one year, unless an extension is granted.

(2) Automatic Relinquishment shall take effect immediately and shall continue until the matter is resolved, if applicable.

8.F. INDICATIONS AND PROCESS FOR PRECAUTIONARY SUSPENSION

(1) Whenever failure to take action may result in imminent danger to the health and/or safety of any individual, the MEC, OR any Medical Staff Officer, Department Chair or Section Chief, acting in conjunction with the CMO, VPMA, or the CEO, is authorized to suspend or restrict all or any portion of an individual's Clinical Privileges as a precaution pending an Investigation.

(2) A precautionary suspension is effective immediately and will remain in effect unless it is modified by the MEC or CEO.

(3) The individual shall be provided a brief written description of the reason(s) for the precautionary suspension.

(4) The MEC will review the reasons for the suspension within a reasonable time under the circumstances, not to exceed 14 Days.

(5) Prior to, or as part of, this review, the individual may be given an opportunity to meet with the MEC.

8.G. INDICATIONS AND PROCESS FOR RECOMMENDING TERMINATION OR SUSPENSION OF APPOINTMENT AND PRIVILEGES OR REDUCTION OF PRIVILEGES

Following an Investigation or a determination that there is sufficient information upon which to base a recommendation, the MEC may recommend suspension or revocation of appointment or Clinical Privileges based on concerns about (a) clinical competence or practice; (b) safety or proper care being provided to patients; (c) violation of ethical standards or the Bylaws, policies, or Rules and Regulations of the Hospital or the Medical Staff; or (d) conduct that is considered lower than the standards of the Medical Staff Professionalism Policy or is disruptive to the orderly operation of the Hospital or its Medical Staff.

8.H. HEARING AND APPEAL PROCESS, INCLUDING PROCESS FOR SCHEDULING AND CONDUCTING HEARINGS AND THE COMPOSITION OF THE HEARING PANEL

(1) The hearing will begin no sooner than 30 Days after the Notice of the hearing, unless an earlier date is agreed upon by the parties.

(2) The Hearing Panel will consist of at least three members or there will be a Hearing Officer.

(3) The hearing process will be conducted in an informal manner; formal rules of evidence or procedure will not apply.

(4) A stenographic reporter will be present to make a record of the hearing.

(5) Both sides will have the following rights, subject to reasonable limits determined by the Presiding Officer: (a) to call and examine witnesses, to the extent they are available and willing to testify; (b) to introduce exhibits; (c) to cross-examine any witness on any matter relevant to the issues; (d) to have representation by counsel who may call, examine, and cross-examine witnesses and present the case; and (e) to submit proposed findings, conclusions, and recommendations to the

Hearing Panel in the form of a post-hearing statement submitted at the close of the hearing.

(6) The personal presence of the affected individual is mandatory. If the individual who requested the hearing does not testify, he or she may be called and questioned.

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

(8) The affected individual and the MEC may request an appeal of the recommendations of the Hearing Panel to the Board.

ARTICLE 9

AMENDMENTS

9.A. MEDICAL STAFF BYLAWS

(1) Amendments to these Bylaws may be proposed by the Bylaws Committee, MEC, or by a petition signed by at least 10% of the voting Medical Staff Members.

(2) In the discretion of the MEC, amendments to the Bylaws shall be presented to the Medical Staff in one of the following two ways:

(a) Amendments Subject to Vote via Written and/or Electronic Ballot: The MEC shall present proposed amendments to the Active Staff by written and/or electronic ballot, to be returned by the date and in the manner indicated when the ballot is distributed, which date shall be at least 14 Days after the proposed amendment was provided to the Active Staff. Along with the proposed amendments, the MEC shall provide a report on the amendments either favorably or unfavorably. To be adopted, the amendment must receive a majority of the votes cast by the members of the Active Staff.

(b) Amendments Subject to Vote at a Meeting: In the alternative, the MEC may elect to report on the proposed amendments either favorably or unfavorably at the next regular meeting of the Medical Staff, or at a special meeting called for such purpose. The proposed amendments may be voted upon at any meeting if Notice has been provided at least 14 Days prior to the meeting. To be adopted, the amendment must receive a majority of the votes cast by the Active Staff members present at the meeting.

(3) The MEC shall have the power to adopt such clarifications to these Bylaws which are needed because of renumbering, punctuation, spelling or errors of grammar, or change of name(s) or title(s).

(4) All amendments shall be effective only after approval by the Board.

(5) If the Board has determined not to accept a recommendation submitted to it by the MEC or the Medical Staff, the MEC may request a conference between the officers of the Board and the officers of the Medical Staff. Such conference shall be for the purpose of further communicating the Board's rationale for its contemplated action and permitting the officers of the Medical Staff to discuss the rationale for the recommendation. Such a conference will be scheduled by the CEO within two weeks after receipt of a request for same submitted by the Chief of Staff.

(6) Neither the MEC, the Medical Staff, nor the Board may unilaterally amend these Bylaws.

9.B. OTHER MEDICAL STAFF DOCUMENTS

(1) In addition to the Medical Staff Bylaws, there shall be policies, procedures and Rules and Regulations that shall be applicable to all Medical Staff Members and other individuals who have been granted Clinical Privileges. All Medical Staff policies, procedures, and Rules and Regulations shall be considered an integral part of the Medical Staff Bylaws, but will be amended in accordance with this section. These additional documents include, among other policies, the Medical Staff Glossary, the Medical Staff Credentials Policy, the Policy on Advanced Practice and Other Healthcare Professionals, the Medical Staff Organization Manual, and the Medical Staff Rules and Regulations.

(2) An amendment to the Medical Staff Glossary, the Medical Staff Credentials Policy, the Policy on Advanced Practice and Other Healthcare Professionals, the Medical Staff Organization Manual, and the Medical Staff Rules and Regulations may be made by a majority vote of the members of the MEC present and voting at any meeting of that committee where a quorum exists. Notice of all proposed amendments to these documents shall be provided to each voting Medical Staff Member at least 14 Days prior to the MEC meeting when the vote is to take place. Any member of the Active Staff may submit written comments on the amendments to the MEC.

(3) All other policies of the Medical Staff may be adopted and amended by a majority vote of the MEC. No prior Notice is required.

(4) Amendments to the Medical Staff policies and to the Rules and Regulations may also be proposed by a petition signed by at least 20% of the voting Medical Staff Members. Any such proposed amendments will be reviewed by the MEC, which shall report on the proposed amendments either favorably or unfavorably before they are forwarded to the Board for its final action.

(5) Adoption of and changes to the Credentials Policy, Medical Staff Organization Manual, Policy on Advanced Practice and Other Healthcare Professionals, Medical Staff Rules and Regulations, and other Medical Staff policies will become effective only when approved by the Board.

9.C. CONFLICT MANAGEMENT PROCESS

(1) When there is a conflict between the Medical Staff and the MEC with regard to:

(a) proposed amendments to the Medical Staff Rules and Regulations,

(b) a new policy proposed or adopted by the MEC, or

(c) proposed amendments to an existing policy that is under the authority of the MEC,

a special meeting of the Medical Staff to discuss the conflict may be called by a petition signed by at least 10% of the Active Staff. The agenda for that meeting will be limited to attempting to resolve the differences that exist with respect to the amendment(s) or policy at issue.

(2) If the differences cannot be resolved, the MEC shall forward its recommendations, along with the proposed recommendations pertaining to the amendment or policy at issue offered by the Active Staff members, to the Board for final action.

(3) This conflict management section is limited to the matters noted above. It is not to be used to address any other issue, including, but not limited to, professional review actions concerning individual Medical Staff Members.

(4) Nothing in this section is intended to prevent individual Medical Staff Members from communicating positions or concerns related to the adoption of, or amendments to, the Medical Staff Bylaws, the Medical Staff Rules and Regulations, or other Medical Staff policies directly to the Board. Communication from Medical Staff Members to the Board will be directed through the CEO, who will forward the request for communication to the Chair of the Board. The CEO will also provide notification to the MEC by informing the Chief of Staff of all such exchanges. The Chair of the Board will determine the manner and method of the Board's response to the Medical Staff Member(s).

ARTICLE 10

ADOPTION

These Medical Staff Bylaws are adopted and made effective upon approval of the Board, superseding and replacing any and all previous Medical Staff Bylaws, Rules and Regulations, policies, manuals or Hospital policies pertaining to the subject matter thereof.

Adopted by the Medical Staff: _____

Approved by the Board: October 22, 2025

APPENDIX A

MEDICAL STAFF CATEGORIES SUMMARY

	Active	Courtesy	Adjunct	Ambulatory Care	Coverage	Emeritus
Category Descriptions						
Qualifications	Active attending or specialists within the Hospital who meet minimum activity requirements	Use Hospital for convenience, but if exceed maximum activity requirements, automatic transfer to Active Staff	Demonstrate professional ability and expertise and provide a service not otherwise available or in very limited supply on the Active Staff	Desire to be associated with Hospital, but do not intend to establish a clinical practice and do not exercise any Clinical Privileges	Associated with an Active Staff member(s) at the Hospital and provide coverage support for that member(s)	Deserve special recognition for their contributions to the Medical Staff, the community, or the field of medicine, as recommended by the MEC
Basic Requirements						
Number of patient contacts/2-year	≥ 24	< 24	NA	NA	NA	NA
Rights						
Eligible for admitting Privileges	Y	Y	N	N	Y	N
Eligible for Clinical Privileges	Y	Y	Y	N*	Y	N
May attend meetings	Y	Y	Y	Y	Y	Y
Voting Privileges	Y	P	P	P	P	P
Hold office	Y	N, unless waiver	N, unless waiver	N, unless waiver	N, unless waiver	N, unless waiver
Responsibilities						
Serve on committees	Y	Y	Y	Y	Y	Y
Meeting requirements	N	N	N	N	N	N
ED call coverage	Y	Y	N	N	Y**	N
OPPE/FPPE	Y	Y**	Y	N	Y	N
Comply with guidelines	Y	Y	Y	NA	Y	NA

Y = Yes
N = No
NA = Not Applicable
P = Partial (with respect to voting, only when appointed to a committee)
* = Unless specific Privileges are requested (e.g., to order infusion services)
** = Only when covering for members of their group practice or coverage group or as otherwise requested

APPENDIX B

HISTORY AND PHYSICAL EXAMINATIONS

(a) General Documentation Requirements

(1) A complete medical history and physical examination must be performed and documented in the patient's medical record within 24 hours after admission or registration (but in all cases prior to surgery or an invasive procedure requiring anesthesia services) by an individual who has been granted Privileges by the Hospital to perform histories and physicals.

(2) The scope of the medical history and physical examination will include, as pertinent:

- patient identification;
- chief complaint;
- history of present illness and co-morbidities;
- relevant personal (e.g., allergies and medications, if any), social, and family histories;
- review of systems;
- physical examination, to include pertinent findings in those organ systems relevant to the presenting illness and to co-existing diagnoses;
- diagnosis with a plan of treatment; and
- if applicable, signs of abuse, neglect, addiction, or emotional/behavioral disorder, which will be specifically documented in the physical examination, and any need for restraint or seclusion which will be documented in the plan of treatment.

(3) In the case of a pediatric patient, the history and physical examination report must also include, as pertinent: (i) developmental age; (ii) length or height; (iii) weight; (iv) head circumference (if appropriate); and (v) immunization status.

(4) Obstetrical records must contain prenatal information. The pre-natal record, submitted within 30 Days of the estimated due date, must be a

legible copy of the attending practitioner's office record transferred to the Hospital before admission.

(b) Individuals Who May Perform H&Ps

The following types of Practitioners may generally perform histories and physicals at the Hospital pursuant to appropriately granted Medical Staff appointment or permission to practice and Clinical Privileges:

(1) Physicians;

(2) Dentists, who are responsible for the part of their patients' history and physical examination that relates to Dentistry;

(3) Oral and Maxillofacial Surgeons, who have successfully completed a postgraduate program in oral and maxillofacial surgery accredited by a nationally recognized accrediting body approved by the U.S. Department of Education, and who have been determined by the Medical Staff to be currently competent to perform a history and physical examination, may be granted the Clinical Privilege to perform the medical history and physical examination;

(4) Podiatrists, who are responsible for the part of their patient's history and physical examination that relates to podiatry;

(5) Psychiatrists, who are responsible for the psychiatric history portion of the record and for requesting a medical history and physical from an appropriate Practitioner;

(6) appropriately privileged Advanced Practice Professionals (subject to any countersignature requirements in the Medical Staff Rules and Regulations);

(7) residents, fellows, interns or medical students who have been granted Practitioner-specific Privileges, or given permission by the Hospital, to perform history and physical examinations, but the H&P must be countersigned by the Physician within 30 Days, with the exception of a preoperative H&P, which must be cosigned before the patient goes to surgery; and

(8) individuals who are not licensed independent practitioners, who may contribute information to be used as part of a patient's medical history and physical examination, under the supervision of, or through appropriate delegation by, a specific qualified doctor of medicine or osteopathy who is accountable for the patient's medical history and physical examination.

(c) H&Ps Performed Prior to Admission

(1) Any history and physical performed more than 30 Days prior to an admission or registration is invalid and may not be entered into the medical record.

(2) If a medical history and physical examination has been completed within the 30-Day period prior to admission or registration, a durable, legible copy of this report may be used in the patient's medical record. However, in these circumstances, the patient must also be evaluated within 24 hours of the time of admission/registration or prior to surgery/invasive procedure, whichever comes first, and an update recorded in the medical record by an individual who has been granted Clinical Privileges to complete histories and physicals.

(3) The update of the history and physical examination shall be based on an examination of the patient and must (i) reflect any changes in the patient's condition since the date of the original history and physical that might be significant for the planned course of treatment or (ii) state that there have been no changes in the patient's condition. An interval progress note by the patient's Primary Treating Physician or other responsible Physician may serve as the update.

(4) In the case of readmission of a patient, all previous records will be made available by the Hospital for review and use by the Primary Treating Physician.

(d) Cancellations, Delays, and Emergency Situations

(1) When the history and physical examination is not recorded in the medical record before a surgical or other invasive procedure (including, but not limited to, procedures performed in the operating suites, endoscopy, colonoscopy, bronchoscopy, cardiac catheterizations, or radiological procedures with sedation), the operation or procedure will be canceled or delayed until an appropriate history and physical examination is recorded in the medical record, unless the responsible Physician states in writing that an emergency situation exists.

(2) In an emergency situation, when there is no time to record a history and physical, the responsible Physician will record an admission or progress note immediately following the emergency procedure. The responsible Physician will then document a complete history and physical examination after the emergency situation is resolved.

MEDICAL STAFF BYLAWS, POLICIES, AND RULES AND REGULATIONS OF TUCSON MEDICAL CENTER

MEDICAL STAFF ORGANIZATION MANUAL

Approved by the Board: October 22, 2025

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ARTICLE 1

GENERAL

1.A. DEFINITIONS

Unless otherwise indicated, the capitalized terms used in all of the Medical Staff documents are defined in the Medical Staff Glossary.

1.B. DELEGATION OF FUNCTIONS

(1) When a function under this Manual is to be carried out by a member of the Administrative Team, by a Medical Staff Member, or by a Medical Staff committee, the individual, or the committee through its chair, may delegate performance of the function to a qualified designee who is a Practitioner or Hospital employee (or a committee of such individuals). Any designee must treat and maintain all credentialing, privileging, and peer review information in a strictly confidential manner and is bound by all other terms, conditions, and requirements of the Medical Staff Bylaws and related policies. In addition, the delegating individual or committee is responsible for ensuring that the designee appropriately performs the function in question. Any documentation created by the designee are records of the committee that is ultimately responsible for the review in a particular matter.

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

ARTICLE 2

CLINICAL DEPARTMENTS

2.A. CREATION AND DISSOLUTION OF CLINICAL DEPARTMENTS AND SECTIONS

(1) Clinical departments and sections shall be created and may be consolidated or dissolved by the MEC upon approval by the Board as set forth below.

(2) The following factors shall be considered in determining whether a clinical department or section should be created:

(a) there exists a number of Medical Staff Members who are available for appointments to, and are expected to actively participate in, the proposed new department or section (this number must be sufficiently large to enable the department or section to accomplish its functions as set forth in this Manual and in the Bylaws);

(b) the level of clinical activity that will be affected by the new department or section is substantial enough to warrant imposing the responsibility to accomplish its functions on a routine basis;

(c) a majority of the voting members of the proposed department or section vote in favor of the creation of a new department or section;

(d) it has been determined by the MEC and the CEO that there is a clinical and administrative need for a new department or section; and

(e) the voting Medical Staff Members of the proposed department or section have offered a reasonable proposal for how the new department or section will fulfill all of the designated responsibilities and functions, including, where applicable, meeting requirements.

(3) The following factors shall be considered in determining whether the dissolution of a clinical department or section is warranted:

(a) there is no longer an adequate number of Medical Staff Members in the clinical department or section to enable it to accomplish the functions set forth in this Manual or in the Bylaws;

(b) there is an insubstantial number of patients or an insignificant amount of clinical activity to warrant the imposition of the designated duties on the members in the department or section;

(c) the department or section fails to fulfill all designated responsibilities and functions, including, where applicable, its meeting requirements;

(d) no qualified individual is willing to serve as Department Chair or Section Chief; or

(e) a majority of the voting members of the department or section vote for its dissolution.

2.B. LIST OF CLINICAL DEPARTMENTS AND SECTIONS

The following clinical departments and their respective sections are established:

Department of Anesthesia

Department of Diagnostic Services:

Nuclear Medicine

Radiology

Department of Emergency Medicine:

Pediatric Emergency Medicine

Department of Medicine:
Cardiology
Critical Care
Gastroenterology
Hospitalist
Infectious Disease
Nephrology
Neurology
Palliative Medicine
Psychiatry
Pulmonary Medicine

Department of Obstetrics/Gynecology

Department of Pathology

Department of Pediatrics

Department of Surgery:

Cardiothoracic Surgery
General Surgery
Neurosurgery
Ophthalmology
Otorhinolaryngology
Orthopedic Surgery
Pediatric Surgery
Plastic Surgery
Podiatry
Restorative Dentistry & Oral Surgery
Urology
Vascular Surgery

2.C. FUNCTIONS AND RESPONSIBILITIES OF DEPARTMENTS AND SECTIONS

The functions and responsibilities of departments and Department Chairs and sections and Section Chiefs are set forth in the Medical Staff Bylaws.

ARTICLE 3

MEDICAL STAFF COMMITTEES

3.A. MEDICAL STAFF COMMITTEES AND FUNCTIONS

(1) This Article outlines the Medical Staff committees of the Hospital that carry out peer review and other performance improvement functions that are delegated to the Medical Staff by the Board.

(2) Procedures for the appointment of committee chairs and members of the committees are set forth in Article 5 of the Medical Staff Bylaws.

(3) This Article details the standing members of each Medical Staff committee. However, other Medical Staff Members or Hospital personnel may be invited to attend a particular Medical Staff committee meeting in order to assist such committee in its discussions and deliberations regarding the issues on its agenda. All such individuals are an integral part of the credentialing, quality assurance, and Professional Practice Evaluation process and are bound by the same confidentiality requirements as the standing members of such committees.

3.B. EXPECTATIONS AND REQUIREMENTS FOR COMMITTEE MEMBERSHIP

To be eligible to serve on a Medical Staff committee, members must acknowledge and agree to the following:

(1) have the willingness and ability to devote the necessary time and energy to committee service, recognizing that the success of a committee is highly dependent on the full participation of its members;

(2) complete any orientation, training, and/or education related to the functions of the committee in advance of the first meeting;

(3) come prepared to each meeting – review the agenda and any related information provided in advance so that the committee's functions may be performed in an informed, efficient, and effective manner;

(4) attend meetings on a regular basis to promote consistency and good group dynamics;

(5) participate in discussions in a meaningful and measured manner that facilitates deliberate thought and decision-making, and avoid off-topic or sidebar conversations;

(6) voice disagreement in a respectful manner that encourages consensus-building;

(7) understand and strive for "consensus" decision-making, thereby avoiding the majority vote whenever possible;

(8) be willing to complete assigned or delegated committee tasks in a timely manner between meetings of the committee;

(9) bring any conflicts of interest to the attention of the committee chair, in advance of the committee meeting, when possible;

(10) if the individual has any questions about his or her role or any concerns regarding the committee functioning, seek guidance directly from the committee chair outside of committee meetings;

(11) participate in the development of an annual committee work plan and ensure that committee plans are in alignment with the strategic goals of the Hospital and Medical Staff; and

(12) maintain the confidentiality of all matters reviewed and/or discussed by the committee.

3.C. MEETINGS, REPORTS AND RECOMMENDATIONS

Meetings will be conducted within the provisions outlined in Article 6 of the Medical Staff Bylaws. Unless otherwise indicated, each committee described in this Manual shall meet as necessary to accomplish its functions, and shall maintain a permanent record of its findings, proceedings, and actions. Each committee shall make a timely written report after each meeting to the MEC and to other committees and individuals as may be indicated in this Manual.

3.D. ADVANCED PRACTICE PROFESSIONALS COMMITTEE ("APPC")

3.D.1. Composition:

(a) The Advanced Practice Professionals Committee ("APPC") shall consist of individuals appointed by the Leadership Council, one of whom will be appointed as Chair.

(b) The following individuals shall serve as non-voting *ex officio* members to facilitate the APPC's activities:

(1) the Chief of Staff or designee;

(2) the CMO;

(3) the VPMA;

(4) the CNO and/or designees; and

(5) Medical Staff Office representative(s).

(c) Before any APPC member begins serving, the member must review the expectations and requirements of the position and affirmatively accept them. Members must also participate in periodic training on Professional Practice Evaluation, with the nature of the training to be identified by the Leadership Council or PPC.

3.D.2. Duties:

The APPC shall perform the following functions:

(a) perform those functions outlined in the Professional Practice Evaluation Policy (Peer Review) ("PPE Policy");

(b) review, approve, and periodically update Ongoing Professional Practice Evaluation ("OPPE") data elements for Advanced Practice Professionals practicing at the Hospital; and

(c) perform any additional functions as may be set forth in applicable policy or as requested by the PPC, the MEC, or the Board.

3.D.3. Meetings, Reports, and Recommendations:

The APPC shall meet as often as necessary to perform its duties and shall maintain a permanent record of its findings, proceedings, and actions. The APPC shall submit reports of its activities to the PPC on a regular basis, and to the MEC as necessary.

3.E. CREDENTIALS COMMITTEE

3.E.1. Composition:

(a) The Credentials Committee shall consist of at least five Medical Staff Members with preference given to individuals who have served as Medical Staff Leaders and/or who have a particular interest in the credentialing functions. The Chief of Staff-Elect shall chair the committee. An Advanced Practice Professional shall also serve on the committee as a voting member.

(b) To the fullest extent possible, Credentials Committee members shall serve staggered, three-year terms, so that the committee always includes experienced members. Members may be reappointed for additional, consecutive terms.

(c) The CMO, VPMA, and Medical Staff Office representatives shall serve as *ex officio* members, without vote, to facilitate the Credentials Committee's activities.

3.E.2. Duties:

The Credentials Committee shall perform the following functions:

(a) review the credentials of all applicants for appointment, reappointment, and Clinical Privileges, conduct a thorough review of the applications, interview such applicants as may be necessary, and make written reports of its findings and recommendations;

(b) review, as may be requested, all information available regarding the current clinical competence of individuals currently appointed to the Medical Staff or Advanced Practice Professionals and, as a result of such review, make a written report of its findings and recommendations;

(c) recommend appropriate threshold eligibility criteria for Clinical Privileges, including Clinical Privileges for new procedures and Clinical Privileges that cross specialty lines; and

(d) carry out all other functions of the committee as described in the Medical Staff Credentials Policy and the Policy on Advanced Practice and Other Healthcare Professionals.

3.F. ETHICS COMMITTEE

3.F.1. Composition:

The Ethics Committee shall consist of interested participants of interdisciplinary backgrounds including clinical staff, Medical Staff, quality department staff, and community members.

3.F.2. Duties:

The role of the committee is a supportive one. Its purpose is to inform the Board, management and professional and Hospital staff about the development and processing of medical ethics issues. The committee may assist in the development of policies and procedures for patient care and initiate support programs to raise consciousness of ethical issues. The committee also promotes inquiries into ethical issues and serves as a resource for consultation on difficult cases or issues before the Board.

3.F.3. Meetings, Reports, and Recommendations:

The committee shall meet as often as necessary to perform its duties. The minutes of the meetings shall be reported to the MEC. Recommendations in patient care issues are consultative and nonbinding. Policies and procedures are forwarded to the MEC for final approval.

3.G. LEADERSHIP COUNCIL

3.G.1. Composition:

(a) The Leadership Council shall consist of the following voting members:

(1) Chief of Staff, who shall serve as Chair;

(2) Chief of Staff-Elect; and

(3) Immediate Past Chief of Staff. If the Immediate Past Chief of Staff is unwilling or unable to serve, another former physician leader (e.g., Medical Staff Officer, Department Chair, Section Chief, or committee chair) who is experienced in credentialing, privileging, PPE, or Medical Staff matters shall be appointed.

(b) The following individuals shall serve as non-voting members to facilitate the Leadership Council's activities:

(1) CMO;

(2) Chair, Professional Practice Committee ("PPC");

(3) VPMA; and

(4) Medical Staff Office representative(s).

3.G.2. Duties:

The Leadership Council shall perform the following functions:

(a) review and address concerns about Practitioners' professional conduct as outlined in the Professionalism Policy;

(b) review and address possible health issues that may affect a Practitioner's ability to practice safely as outlined in the Practitioner Health Policy;

(c) review and address issues regarding Practitioners' clinical practice as outlined in the Professional Practice Evaluation Policy;

(d) meet, as necessary, to consider and address any situation involving a Practitioner that may require immediate action;

(e) serve as a forum to discuss and help coordinate any quality or patient safety initiative that impacts any or all services within the Hospital;

(f) identify and nominate a slate of qualified individuals to serve as the Medical Staff Officers, to be presented to and elected by the Medical Staff;

(g) identify and nominate, in consultation with the current Department Chairs, qualified individuals to serve as Department Chairs, to be presented to and elected by the relevant departments;

(h) appoint the chairs and members of all Medical Staff committees (including the APPC), except for the MEC;

(i) cultivate a Physician leadership identification, development, education, and succession process to promote effective and successful Medical Staff Leaders at present and in the future; and

(j) perform any additional functions as may be requested by the MEC or the Board.

3.G.3. Meetings, Reports, and Recommendations:

The Leadership Council shall meet as often as necessary to perform its duties and shall maintain a permanent record of its findings, proceedings, and actions. The Leadership Council shall report to the PPC, the MEC, and others as described in the Policies noted above. The Leadership Council's reports to the MEC will provide summary and aggregate information regarding the committee's activities. These reports will generally not include the details of any reviews or findings regarding specific Practitioners.

3.H. MEDICAL EXECUTIVE COMMITTEE

The composition and duties of the MEC are set forth in Section 5.C of the Medical Staff Bylaws.

3.I. PHARMACY AND THERAPEUTICS COMMITTEE

3.I.1. Composition:

The Pharmacy and Therapeutics Committee shall consist of Active Staff members and community Physicians with an interest in inpatient care representing all different specialties. The Chair will be an Active Staff member. The Director of Pharmacy and other pharmacy staff, the CMO, the VPMA, and the CNO shall serve as *ex officio* members. Clinical staff may be asked to appear as needed.

3.I.2. Duties:

The Pharmacy and Therapeutics Committee has oversight for the Hospital pharmacy formulary (additions and deletions), the use of the medications on the formulary and therapeutic substitutions for the Hospital.

3.I.3. Meetings, Reports, and Recommendations:

The committee shall meet as often as necessary to perform its duties and all decisions are subject to the approval of the MEC.

3.J. PROFESSIONAL PRACTICE COMMITTEE ("PPC")

3.J.1. Composition:

(a) The PPC shall consist of the following (one of whom will be appointed as Chair):

(1) Medical Staff Members who are:

(i) broadly representative of the clinical specialties on the Medical Staff;

(ii) interested or experienced in credentialing, privileging, PPE/peer review, or other Medical Staff affairs; and

(iii) supportive of evidence-based medicine protocols; and

(2) the Chair of the Advanced Practice Professional Committee, who may vote on matter related to Advanced Practice Professionals only.

(b) The following individuals shall serve as non-voting *ex officio* members to facilitate the PPC's activities:

(1) the CMO;

(2) the VPMA;

(3) the CNO; and

(4) Medical Staff Office representative(s).

(c) To the fullest extent possible, PPC members shall serve staggered, three-year terms, so that the committee always includes experienced members. Members may be reappointed for additional, consecutive terms. Current Department Chairs and voting MEC members are not eligible to serve on the PPC.

(d) Before any PPC member begins serving, the member must review the expectations and requirements of the position and affirmatively accept them. Members must also participate in periodic training on Professional Practice Evaluation, with the nature of the training to be identified by the Leadership Council or PPC.

3.J.2. Duties:

The PPC shall perform the following functions:

(a) oversee the implementation of the Professional Practice Evaluation Policy (Peer Review) ("PPE Policy") and ensure that all components of the process receive appropriate training and support;

(b) review reports showing the number of cases being reviewed through the PPE Policy, by department or specialty, in order to help ensure consistency and effectiveness of the process, and recommend revisions to the process as may be necessary;

(c) review, approve, and periodically update Ongoing Professional Practice Evaluation ("OPPE") data elements that are identified by individual departments, and adopt Medical Staff-wide data elements;

(d) review, approve, and periodically update the specialty-specific quality indicators identified by the departments that will trigger the Professional Practice Evaluation/peer review process;

(e) identify those variances from rules, regulations, policies, or protocols which do not require Physician review, but for which an Informational Letter may be sent to the Practitioner involved in the case;

(f) review cases referred to it as outlined in the PPE Policy;

(g) develop, when appropriate, Performance Improvement Plans for Practitioners, as described in the PPE Policy;

(h) monitor and determine that system issues that are identified as part of Professional Practice Evaluation activities are successfully resolved;

(i) work with Department Chairs and Section Chiefs to disseminate educational lessons learned from the review of cases pursuant to the PPE Policy, either through educational sessions in the department, section, or through some other mechanism; and

(j) perform any additional functions as may be set forth in applicable policy or as requested by the MEC or the Board.

3.J.3. Meetings, Reports, and Recommendations:

The PPC shall meet as often as necessary to perform its duties and shall maintain a permanent record of its findings, proceedings, and actions. The PPC shall submit reports of its activities to the MEC and the Board on a regular basis. The PPC's reports will provide aggregate information regarding the PPE process (e.g., numbers of cases reviewed by department or specialty; types and numbers of dispositions for the cases; listing of education initiatives based on reviews; listing of system issues identified). These reports will generally not include the details of any reviews or findings regarding specific Practitioners.

3.K. UTILIZATION MANAGEMENT COMMITTEE

3.K.1. Composition:

The Utilization Management Committee shall consist of at least three members of the Medical Staff, along with representatives from administration.

3.K.2. Duties:

The Utilization Management Committee shall perform the following functions:

(a) evaluate the appropriate utilization of resources in the delivery of optimal, safe, quality and cost-effective care provided to patients we serve;

(b) assess whether patients meet medical necessity for admission/services and continued stay;

(c) assess whether patients are at the appropriate level of care for their medical condition;

(d) evaluate whether timely, appropriate, and safe transitional plans are in place at the time of the patient's discharge;

(e) oversee compliance with federal and state regulations, accreditation standards, and third-party payor groups; and

(f) perform such other functions as described in the Policy on Review of Concerns Related to Utilization.

3.L. PRACTICE TECHNOLOGY STEERIN COMMITTEE

3.L.1. Composition:

The Practice Technology Steering Committee shall consist of Active Staff members, Physicians, and Advanced Practice Professionals with an interest in hospital based technology. The CMO is the executive sponsor. Clinical Informatics, a representative from Professional Staff Office, and the Pharmacy Director will serve as non-voting members. The Chief Information Officer, Chief Nursing Officer, Chief Operational Officer, Chief of Staff, and Chief of Staff elect may be asked to appear as needed.

3.L.2. Duties:

The PTSC shall perform the following functions:

(a) make clinical Information Technology (IT) decisions on behalf of the MEC;

(b) serve as a forum to discuss technologies throughout the Hospital;

(c) design technology system(s) to be patient-centric to facilitate care in a safe, timely, and effective manner;

(d) review, approve, and periodically update clinical content and workflows;

(e) oversee, assess, and implement technology related clinical policy issues;

(f) oversee compliance with regulatory, accreditation, and financial requirements;

(g) oversee ongoing optimization for sustainable transformation;

(h) drive efficiencies through redesigning provider processes supported by automating technologies;

(i) perform any additional functions as may be set forth in applicable policy or as requested by the MEC or the Board.

ARTICLE 4

AMENDMENTS

This Manual may be amended pursuant to Article 9 of the Medical Staff Bylaws.

ARTICLE 5

ADOPTION

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

Adopted by the Medical Staff: _____

Approved by the Board: October 22, 2025

MEDICAL STAFF BYLAWS, POLICIES, AND RULES AND REGULATIONS OF TUCSON MEDICAL CENTER

MEDICAL STAFF CREDENTIALS POLICY

Approved by the Board: October 22, 2025

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ARTICLE 1

GENERAL

1.A. DEFINITIONS

Unless otherwise indicated, the capitalized terms used in all of the Medical Staff documents are defined in the Medical Staff Glossary.

1.B. DELEGATION OF FUNCTIONS

(1) When a function under this Policy is to be carried out by a member of the Administrative Team, by a Medical Staff Member, or by a Medical Staff committee, the individual, or the committee through its chair, may delegate performance of the function to a qualified designee who is a Practitioner or Hospital employee (or a committee of such individuals). Any such designee must treat and maintain all credentialing, privileging, and peer review information in a strictly confidential manner and is bound by all other terms, conditions, and requirements of the Medical Staff Bylaws and related policies. In addition, the delegating individual or committee is responsible for ensuring that the designee appropriately performs the function in question. Any documentation created by the designee are records of the committee that is ultimately responsible for the review in a particular matter.

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

1.C. MULTI-CAMPUS DESIGNATIONS

The Hospital includes two campuses: the TMC-Main Campus and the TMC- Rincon campus. Clinical privileges are granted to an individual extend to both Hospital campuses unless either such campus cannot accommodate the procedures or types of care, treatment, or services represented by such clinical privileges. The purpose of the Primary Campus designation is to clarify a member's Medical Staff responsibilities. Further, clinical privileges granted to an individual are permissive rather than mandatory.

(1) All applicants and Medical Staff members shall designate either TMC – Main or TMC – Rincon as their Primary Campus, subject to standard review by the Credentials Committee and the Board. At the end of an individual's appointment or reappointment period, the Credentials Committee will review the individual's Primary Campus designation, and it will be presumed that the individual's Primary Campus designation for their next reappointment period will be the Hospital campus where they saw the most patients during the previous appointment or reappointment period. At any point, a member of the Medical Staff may request a change in their Primary Campus designation to the Credentials Committee. Specifically, members will be expected to provide on-call coverage for the Emergency Department only at their Primary Campus.

(2) Members of the Medical Staff will not be assigned responsibility for any patient at their non-Primary Campus without the express consent of the member.

ARTICLE 2

QUALIFICATIONS, CONDITIONS, AND RESPONSIBILITIES

2.A. QUALIFICATIONS

2.A.1. Threshold Eligibility Criteria:

To be eligible to apply for initial appointment or reappointment to the Medical Staff, Physicians, Dentists, Oral and Maxillofacial Surgeons, Podiatrists and Psychologists must:

(a) have a current, unrestricted license to practice in Arizona that is not subject to probation and have never had a license to practice revoked or suspended by any state licensing agency;

(b) where applicable to their practice, have a current, unrestricted DEA registration;

(c) be available on a continuous basis, either personally or by arranging appropriate coverage, to respond to the urgent needs of any of their patients who have been admitted to the Hospital and to cover the Emergency Department in accordance with the Medical Staff's Emergency Department On-Call Policy. ("Appropriate coverage" means coverage by another credentialed Medical Staff Member with appropriate specialty-specific Privileges as determined by the Credentials Committee.) Compliance with this eligibility requirement means that the Medical Staff Member must document that he or she is willing and able to:

(1) respond within 20 minutes, via phone, to an initial contact from the Hospital; and

(2) appear in person (or via technology-enabled direct communication and evaluation, i.e., Telemedicine) to attend to a patient within 60 minutes of being requested to do so (or more quickly based upon (i) the acute nature of the patient's condition or (ii) as required for a particular specialty as recommended by the MEC and approved by the Board);

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

(e) have not been convicted of, or entered a plea of guilty or no contest to, Medicare, Medicaid, or other federal or state governmental or private third-party payer fraud or program abuse, nor have been required to pay civil monetary penalties for the same;

(f) have not been, and are not currently, excluded, precluded, or debarred from participation in Medicare, Medicaid, or other federal or state governmental health care program and have not entered into any Program Integrity Agreement or similar settlement agreement with any such health care program;

(g) have not had Medical Staff appointment or Clinical Privileges denied, suspended, revoked, or terminated by any health care facility or health plan for reasons related to clinical competence or professional conduct;

(h) have not resigned Medical Staff appointment or relinquished Privileges at any health care facility during a Medical Staff Investigation or in exchange for not conducting such an Investigation;

(i) have not been convicted of, or entered a plea of guilty or no contest to, (i) any felony; (ii) any misdemeanor relating to controlled substances, illegal drugs, insurance or health care fraud or abuse, child abuse, elder abuse, or violence; (iii) any crime involving moral turpitude or immoral conduct so as to discredit the reputation, character or standing of the Hospital or of any Hospital affiliate or personnel; or (iv) any crime relevant to the provision of medical services or the practice of medicine;

(j) have not been found to have engaged in unprofessional or unethical conduct by any governmental or non-governmental board or professional organization having a right or privilege to pass upon the professional conduct and/or to discipline the individual therefor;

(k) agree to fulfill all responsibilities regarding emergency service call coverage in accordance with the Medical Staff's Emergency Department On-Call Policy;

(l) have or agree to make appropriate coverage arrangements (as determined by the Credentials Committee) with other Medical Staff Members for those times when the individual will be unavailable;

(m) demonstrate recent clinical activity in their primary area of practice during the last year;

(n) meet any current or future eligibility requirements that are applicable to the Clinical Privileges being sought;

(o) if applying for Privileges in an area that is covered by an exclusive contract, meet the specific requirements set forth in that contract;

(p) document compliance with all applicable training and educational protocols as well as orientation requirements that may be adopted by the MEC or required by the Board, including, but not limited to, those involving electronic medical

records, computerized Physician order entry ("CPOE"), the privacy and security of protected health information, infection control, and patient safety;

(q) document compliance with any immunizations and/or health screening requirements as may be adopted by the MEC or Hospital (e.g., TB testing, mandatory flu vaccines, and infectious agent exposures);

(r) agree to maintain and regularly monitor a current, secure Hospital e-mail address with the Medical Staff Office (or use any other technology approved by the MEC or the Board), which will be the primary mechanism used to communicate all Medical Staff information to the individual;

(s) provide a valid phone number in order to facilitate Practitioner-to-Practitioner communication (e.g., office or mobile phone number or answering service information);

(t) have successfully completed:

(1) a residency or fellowship training program approved by the Accreditation Council for Graduate Medical Education ("ACGME") or the American Osteopathic Association ("AOA") in the specialty in which the applicant seeks Clinical Privileges;

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

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

(u) be certified in their primary area of practice at the Hospital by the appropriate specialty/subspecialty board of the American Board of Medical Specialties ("ABMS"), the AOA, the American Board of Oral and Maxillofacial Surgery, the ADA, or the American Board of Foot and Ankle Surgery, as applicable. Those applicants who are not board certified at the time of application but who have completed their residency or fellowship training within the last 60 months shall be eligible for Medical Staff appointment. However, in order to remain eligible, those applicants must achieve board certification in their primary area of practice within 60 months from the date of completion of their residency or fellowship training; and*

(v) maintain board certification with the appropriate specialty/subspecialty board of the American Board of Medical Specialties ("ABMS"), the AOA, the American Board of Oral and Maxillofacial Surgery, the ADA, or the American Board of Foot and Ankle Surgery, as applicable, in their primary area of practice at the Hospital on a continuous basis, and satisfy all requirements of the relevant

specialty/subspecialty board necessary to do so (board certification status will be assessed at reappointment).*

* The requirements pertaining to board certification and recertification are applicable to those individuals who apply for initial staff appointment after 2009 and are not applicable to Medical Staff Members who were appointed prior to that date. Those Medical Staff Members shall be grandfathered and shall be governed by any board certification requirements that may have been in effect at the time of their initial appointments. These grandfathered Medical Staff Members will demonstrate that they are maintaining current competence by being subject to the Hospital's OPPE and FPPE processes and other performance improvement activities.

In addition, in exceptional circumstances, the 60-month time frame for initial applicants and the time frame for recertification by existing Medical Staff Members may be extended for one additional period, not to exceed 24 months, in order to permit an individual an additional opportunity to obtain certification. In order to be eligible to request an extension in these situations, an individual must, at a minimum, satisfy the following criteria:

(1) the individual has been on the Hospital's Medical Staff for at least 24 months;

(2) there have been no significant documented peer review concerns related to the individual's competence or behavior at the Hospital during the individual's tenure;

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

(4) the appropriate Department Chair and/or Section Chief at the Hospital provides a favorable report concerning the individual's qualifications.

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

(a) Any applicant who does not satisfy one or more of the threshold eligibility criteria outlined above may request that it be waived. The applicant requesting the waiver bears the burden of demonstrating (i) that he or she is otherwise qualified, and (ii) **exceptional** circumstances exist (e.g., when there is a demonstrated Hospital or Medical Staff need for the services in question). Exceptional circumstances generally do not include situations where a waiver is sought for the convenience of an applicant (e.g., applicants who wish to defer taking board examinations).

(b) A request for a waiver shall be submitted to the Credentials Committee for consideration. In reviewing the request for a waiver, the Credentials Committee

may consider the specific qualifications of the applicant in question, input from the relevant Department Chair and/or Section Chief, and the best interests of the Hospital's patients and the communities it serves. Additionally, the Credentials Committee may, in its discretion, consider the application form and other information supplied by the applicant. The Credentials Committee's recommendation will be forwarded to the MEC. Any recommendation to grant a waiver must include the specific basis for the recommendation.

(c) The MEC shall review the recommendation of the Credentials Committee and make a recommendation to the Board regarding whether to grant or deny the request for a waiver. Any recommendation to grant a waiver must include the specific basis for the recommendation.

(d) No applicant is entitled to a waiver or to a hearing if the Board determines not to grant a waiver. A determination that an applicant is not entitled to a waiver is not a "denial" of appointment or Clinical Privileges. Rather, that individual is ineligible to request appointment or Clinical Privileges. A determination of ineligibility is not a matter that is reportable to either the state licensure board or the National Practitioner Data Bank.

(e) The granting of a waiver in a particular case does not set a precedent for any other applicant or group of applicants.

(f) An application for appointment that does not satisfy an eligibility criterion will not be processed until the Board has determined that a waiver should be granted.

(g) If a waiver is granted that does not specifically include a time limitation, the waiver is considered to be permanent and the individual does not have to request a waiver at subsequent reappointment cycles.

2.A.3. Factors for Evaluation:

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

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

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

(c) good reputation and character;

(d) ability to safely and competently perform the Clinical Privileges requested;

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

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

2.A.4. No Entitlement to Appointment:

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

(a) is employed by the Hospital or its subsidiaries or has a contract with the Hospital;

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

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

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

(e) has had in the past, or currently has, Medical Staff appointment or Privileges at any hospital or health care facility;

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

(g) is affiliated with, or under contract to, any managed care plan, insurance plan, HMO, PPO, or other entity.

2.A.5. Nondiscrimination:

No person shall be denied appointment or Clinical Privileges solely on the basis of age, national origin, culture, race, gender, sexual orientation, gender identity, ethnic background, religion, creed, or disability unrelated to the provision of patient care to the extent the individual is otherwise qualified.

2.B. GENERAL CONDITIONS OF APPOINTMENT AND REAPPOINTMENT

2.B.1. Basic Responsibilities and Requirements:

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

(a) to provide continuous and timely quality care to all patients for whom the individual has responsibility;

(b) to abide by all Bylaws, policies, and Rules and Regulations of the Hospital and Medical Staff in force during the time the individual is appointed;

(c) to participate in Medical Staff affairs through committee service, participation in quality improvement and Professional Practice Evaluation activities, and by performing such other reasonable duties and responsibilities as may be assigned;

(d) within the scope of his or her Privileges, to provide emergency service call coverage, consultations, and care for Unassigned Patients in accordance with the Medical Staff's Emergency Department Call Policy;

(e) to comply with clinical practice or evidence-based medicine protocols that are established by, and must be reported to, regulatory or accrediting agencies or patient safety organizations, including those related to national patient safety initiatives and core measures, or clearly document in the EMR the clinical reasons for variance;

(f) to comply with clinical practice or evidence-based medicine protocols pertinent to his or her medical specialty, as may be adopted by the Medical Staff or the Medical Staff Leadership, or to clearly document in the EMR the clinical reasons for variance;

(g) to comply with all applicable training and educational protocols as well as orientation requirements that may be adopted by the MEC or required by the Board, including, but not limited to, those involving electronic medical records, computerized Physician order entry ("CPOE"), the privacy and security of protected health information, infection control, and patient safety;

(h) to inform the Medical Staff Office, in writing or via e-mail, as soon as possible, but in all cases within 10 Days, of any change in the Medical Staff Member's status or any change in the information provided on the individual's application form. This information shall be provided with or without request and shall include, but not be limited to:

- any and all complaints regarding, or changes in, licensure status or DEA controlled substance authorization,
- adverse changes in professional liability insurance coverage,
- the filing of a professional liability lawsuit against the Medical Staff Member,

- changes in the Medical Staff Member's status (appointment or Privileges) at any other hospital or health care entity as a result of peer review activities or in order to avoid initiation of peer review activities,

- changes in the Medical Staff Member's coverage arrangements,

- changes in the Medical Staff Member's employment status at any medical group or hospital as a result of issues related to clinical competence or professional conduct,

- knowledge of a criminal investigation involving the individual, arrest, charge, indictment, conviction, or a plea of guilty or no contest in any criminal matter other than a misdemeanor traffic citation,

- exclusion or preclusion from participation in Medicare/Medicaid or any sanctions imposed,

- any changes in the Medical Staff Member's ability to safely and competently exercise Clinical Privileges or perform the duties and responsibilities of appointment because of health status issues, including, but not limited to, a physical, mental, or emotional condition that could adversely affect the Medical Staff Member's ability to practice safely and competently, or impairment due to addiction, alcohol use, or other similar issue (all of which shall be referred for review under the Practitioner Health Policy),

- any referral to a state board health-related program, and

- any charge of, or arrest for, driving under the influence ("DUI") (which shall be referred for review under the Practitioner Health Policy);

(i) to immediately submit to an appropriate evaluation, which may include diagnostic testing (including, but not limited to, a blood and/or urine test) and/or a complete physical, mental, and/or behavioral evaluation, if at least two Medical Staff Leaders (or one Medical Staff Leader and one member of the Administrative Team) are concerned with the individual's ability to safely and competently care for patients. The health care professional(s) to perform the testing and/or evaluations shall be determined by the Medical Staff Leaders, and the Medical Staff Member must execute all appropriate releases to permit the sharing of information with the Medical Staff Leaders;

(j) to meet with Medical Staff Leaders and/or Hospital administration upon request, to provide information regarding professional qualifications upon written request, and to participate in collegial efforts as may be requested;

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

(l) to maintain and regularly monitor a current, secure Hospital e-mail address with the Medical Staff Office (or use any other technology approved by the MEC or the Board), which will be the primary mechanism used to communicate all Medical Staff information to the individual;

(m) to provide a valid phone number in order to facilitate Practitioner-to-Practitioner communication (e.g., office or mobile phone number or answering service information);

(n) to refrain from illegal fee splitting or other illegal inducements relating to patient referral;

(o) to refrain from delegating responsibility for hospitalized patients to any individual who is not qualified or adequately supervised;

(p) to refrain from deceiving patients as to the identity of any individual providing treatment or services;

(q) to seek consultation whenever required or necessary;

(r) to complete in a timely and legible manner all medical and other required records, containing all information required by the Hospital, and to utilize the electronic medical record as required;

(s) to cooperate with all utilization oversight activities;

(t) to participate in an Organized Health Care Arrangement with the Hospital and abide by the terms of the Hospital's Notice of Privacy Practices with respect to health care delivered in the Hospital;

(u) to perform all services and conduct himself or herself at all times in a cooperative and professional manner;

(v) to promptly pay any applicable fees and assessments;

(w) to satisfy continuing medical education requirements; and

(x) that, if there is any misstatement in, or omission from, the application, the Hospital may stop processing the application (or, if appointment has been granted prior to the discovery of a misstatement or omission, appointment and Privileges may be deemed to be Automatically Relinquished as described in Section 6.E.1). In either situation, there shall be no entitlement to a hearing or appeal. The individual will be informed in writing of the nature of the misstatement or

omission and permitted to provide a written response for the Credentials Committee's consideration. If the determination is made to not process an application or that appointment and Clinical Privileges should be Automatically Relinquished pursuant to this provision, the individual may not reapply to the Medical Staff for a period of at least two years.

2.B.2. Burden of Providing Information:

(a) Individuals seeking appointment and reappointment have the burden of producing information deemed adequate by the Hospital for a proper evaluation of current competence, character, ethics, and other qualifications and for resolving any doubts about an individual's qualifications. The information to be produced includes such quality data and other information as may be needed to assist in an appropriate assessment of overall qualifications for appointment, reappointment, and current clinical competence for any requested Clinical Privileges, including, but not limited to, information from other hospitals, information from the individual's office practice, information from insurers or managed care organizations in which the individual participates, and/or receipt of confidential evaluation forms completed by referring/referred to Physicians.

(b) Individuals seeking appointment and reappointment have the burden of providing evidence that all the statements made and information given on the application are accurate and complete.

(c) Complete Application: An application shall be complete when all questions on the application form have been answered, all supporting documentation has been supplied, all information has been verified from primary sources, and any required application fees and applicable fines have been paid. An application shall become incomplete if the need arises for new, additional, or clarifying information at any time during the credentialing process. Any application that continues to be incomplete 30 Days after the individual has been notified of the additional information required shall be deemed to be withdrawn.

(d) The individual seeking appointment or reappointment is responsible for providing a complete application, including adequate responses from references. An incomplete application shall not be processed.

2.C. APPLICATION

2.C.1. Information:

(a) The applications for initial appointment and reappointment existing now and as may be revised are incorporated by reference and made a part of this Policy. These applications shall require detailed information concerning the applicant's professional qualifications, including copies of their most recent OPPE report if the applicant has affiliations with other hospitals.

(b) In addition to other information, the applications shall seek the following:

(1) information as to whether the applicant's Medical Staff appointment or Clinical Privileges have been voluntarily or involuntarily relinquished, withdrawn, denied, revoked, suspended, subjected to probationary or other conditions, reduced, limited, terminated, or not renewed at any other hospital, health care facility, or other organization, or are currently being investigated or challenged;

(2) information as to whether the applicant's license to practice any relevant profession in any state, DEA registration, or any state's controlled substance license has been voluntarily or involuntarily suspended, modified, terminated, restricted, or relinquished or is currently being investigated or challenged;

(3) information concerning the applicant's professional liability litigation experience, including past and pending claims, final judgments, or settlements; the substance of the allegations as well as the findings and the ultimate disposition; and any additional information concerning such proceedings or actions as the Credentials Committee, the MEC, or the Board may request;

(4) current information regarding the applicant's ability to safely and competently exercise the Clinical Privileges requested; and

(5) a copy of a government-issued photo identification.

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

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

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

(a) Immunity:

To the fullest extent of the law, the individual releases from any and all liability, extends immunity to, and agrees not to sue the Hospital or the Board, any Medical Staff Member or the Board, their authorized representatives, and third parties who provide information for any matter relating to appointment, reappointment, Clinical Privileges, or the individual's qualifications for the same. This immunity covers any actions, recommendations, communications, and/or disclosures involving the individual that are made or taken by the Hospital, its authorized agents, or third parties in quality assurance activities, including credentialing and

peer review activities. This immunity also extends to any reports that are made to government regulatory and licensure boards or agencies pursuant to federal or state law.

(b) Authorization to Obtain Information from Third Parties:

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

(c) Authorization to Release Information to Third Parties:

The individual also authorizes Hospital representatives to release information to (i) other hospitals, health care facilities, managed care organizations, and their agents when information is requested in order to evaluate his or her professional qualifications for appointment, Privileges, and/or participation at the requesting organization/facility, and (ii) government regulatory and licensure boards or agencies pursuant to federal or state law. The disclosure of any such information does not waive any associated privilege and all such disclosures shall be made with the understanding that the receiving entity will only use such information for appropriate purposes.

(d) Authorization to Share Information among TMC Entities:

The individual specifically authorizes the Hospital and its affiliates to make requests and disclosures of quality assurance information pertaining to the individual for the purpose of engaging in quality assurance activities as described in the Hospital's Sharing of Quality Assurance Information Policy.

(e) Hearing and Appeal Procedures:

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

(f) Legal Actions:

If, despite this Section, an individual institutes legal action challenging any credentialing, privileging, peer review, or other action affecting appointment or Privileges, or any report that may be made to a regulatory board or agency, and does not prevail, he or she shall reimburse the Hospital and any Medical Staff Member or Board involved in the action for all costs incurred in defending such legal action, including reasonable attorney's fees, expert witness fees, and lost revenues.

(g) Scope of Section:

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

(1) whether or not appointment or Clinical Privileges are granted;

(2) throughout the term of any appointment or reappointment period and thereafter;

(3) should appointment, reappointment, or Clinical Privileges be revoked, reduced, restricted, suspended, and/or otherwise affected as part of the Hospital's professional review activities;

(4) as applicable, to any third-party inquiries received after the individual leaves the Medical Staff about his or her tenure as a Medical Staff Member; and

(5) as applicable, to any reports that may be made to government regulatory and licensing boards or agencies pursuant to federal or state law.

ARTICLE 3

PROCEDURE FOR INITIAL APPOINTMENT

3.A. PROCEDURE FOR INITIAL APPOINTMENT

3.A.1. Request for Application:

(a) Applications for appointment shall be approved by the Board, upon recommendation by the MEC and Credentials Committee.

(b) An individual seeking initial appointment will be sent information that (i) outlines the threshold eligibility criteria for appointment outlined earlier in this Policy, (ii) outlines the applicable criteria for the Clinical Privileges being sought, and (iii) provides access to the application form.

(c) Residents or fellows who are in the final six months of their training may apply to the Medical Staff. Such applications may be processed, but final action on the applications shall not become effective until all applicable threshold eligibility criteria are satisfied.

3.A.2. Initial Review of Application:

(a) A completed application form with copies of all required documents must be returned to the Medical Staff Office accompanied by any required application fee.

(b) As a preliminary step, the application shall be reviewed by the Medical Staff Office to determine that all questions have been answered and that the individual satisfies all threshold eligibility criteria. Incomplete applications shall not be processed. Individuals who fail to return completed applications or fail to meet the eligibility criteria set forth in Section 2.A.1 of this Policy shall be notified that they are not eligible for appointment to the Medical Staff and that their applications shall not be processed. A determination of ineligibility does not entitle the individual to the hearing and appeal rights outlined in this Policy and is not reportable to any state agency or to the National Practitioner Data Bank.

(c) The Medical Staff Office shall oversee the process of gathering and verifying relevant information and confirming that all references and other information or materials deemed pertinent have been received. Once an application is complete, it shall be transmitted, along with all supporting documentation, to the applicable Department Chair and/or Section Chief.

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

(a) Evidence of the applicant's character, professional competence, qualifications, behavior, and ethical standing shall be examined. This information may be contained in the application and obtained from peer references (from the same discipline where practicable) and from other available sources, including the applicant's past or current Department Chairs at other health care entities, residency training director, and others who may have knowledge about the applicant's education, training, experience, and ability to work with others. The review process described in this Article will also be guided by the Medical Staff Office's Guidelines for Evaluating Malpractice Judgements and Settlements for Credentialing and Privileging and the Medical Staff's Policy for the Continued Safe Practice of Aging Practitioners.

(b) An interview(s) with the applicant may be conducted. The purpose of the interview is to discuss and review any aspect of the applicant's application, qualifications, and requested Clinical Privileges. This interview may be conducted by a combination of any of the following: the Department Chair, the Section Chief, the Credentials Committee, a Credentials Committee representative, the MEC, the Chief of Staff, the CMO, the VPMA, and/or the CEO.

3.A.4. Department Chair/Section Chief Procedure:

(a) The Medical Staff Office shall transmit the complete application and all supporting materials to the appropriate Department Chair and/or Section Chief in which the applicant seeks Clinical Privileges. The Department Chair/Section Chief shall prepare a report regarding whether the applicant has satisfied all of the qualifications for appointment and the Clinical Privileges requested on a form provided by the Medical Staff Office.

(b) The Department Chair/Section Chief shall be available to the Credentials Committee, the MEC, and the Board to answer any questions that may be raised with respect to the report and findings of that individual.

3.A.5. Credentials Committee Procedure:

(a) The Credentials Committee shall review and consider the reports prepared by the relevant Department Chair/Section Chief and shall make a recommendation to the MEC.

(b) The Credentials Committee may use the expertise of the Department Chair/Section Chief or any member of the department or section, or an outside consultant, if additional information is required regarding the applicant's qualifications.

(c) After determining that an applicant is otherwise qualified for appointment and Privileges, the Credentials Committee may require the applicant to undergo a physical, mental, and/or behavioral examination by a Physician(s) satisfactory to the Credentials Committee if there is any question about the applicant's ability to perform the Privileges requested and the responsibilities of appointment. The results of this examination shall be made available to the committee for its consideration. Failure of an applicant to undergo an examination within a reasonable time after being requested to do so in writing by the Credentials Committee shall be considered a voluntary withdrawal of the application and all processing of the application shall cease. The cost of the health assessment will be borne by the applicant.

(d) The Credentials Committee may recommend specific conditions on Medical Staff appointment and/or Clinical Privileges. These conditions may relate to behavior (e.g., personal code of conduct) or to clinical issues (e.g., general consultation requirements, appropriate documentation requirements, proctoring, completion of CME requirements). The Credentials Committee may also recommend that appointment be granted for a period of less than two years in order to permit closer monitoring of an individual's compliance with any conditions. Unless these matters involve the specific recommendations set forth in Section 7.A.1(a) of this Policy, such conditions do not entitle an individual to request the procedural rights set forth in Article 7 of this Policy.

3.A.6. MEC Recommendation:

(a) At its next regular meeting after receipt of the written findings and recommendation of the Credentials Committee, the MEC shall:

(1) adopt the findings and recommendation of the Credentials Committee as its own; or

(2) refer the matter back to the Credentials Committee for further consideration and responses to specific questions raised by the MEC prior to its final recommendation; or

(3) state its reasons in its report and recommendation, along with supporting information, for its disagreement with the Credentials Committee's recommendation.

(b) If the recommendation of the MEC is to appoint, the recommendation shall be forwarded to the Board.

(c) If the recommendation of the MEC is unfavorable and would entitle the applicant to request a hearing in accordance with Section 7.A.1(a) of this Policy, the MEC shall forward its recommendation to the CEO, who shall promptly send Special

Notice to the applicant. The CEO shall then hold the application until after the applicant has completed or waived a hearing and appeal.

3.A.7. Board Action:

(a) Expedited Review: The Board (including any committee exercising delegated authority of the Board) may delegate to a sub-committee, consisting of at least two Board members, action on appointment, reappointment, and Clinical Privileges if there has been a favorable recommendation from the Credentials Committee and the MEC and there is no evidence of any of the following:

(1) a current or previously successful challenge to any license or registration;

(2) an involuntary termination, limitation, reduction, denial, or loss of appointment or Privileges at any other hospital or other entity; or

(3) an unusual pattern of, or an excessive number of, professional liability actions resulting in a final judgment against the applicant.

Any decision reached by a Board sub-committee to appoint following expedited review shall be effective immediately and shall be forwarded to the Board for ratification at its next meeting.

(b) Board Review: Upon receipt of a recommendation that the applicant be granted appointment and Clinical Privileges, the Board may:

(1) appoint the applicant and grant Clinical Privileges as recommended; or

(2) refer the matter back to the Credentials Committee or MEC for additional research or information; or

(3) reject or modify the recommendation.

(c) If the Board determines to reject a favorable recommendation, it should first discuss the matter with the Chair of the Credentials Committee and the Chief of Staff. If the Board's determination remains unfavorable to the applicant, the CEO shall promptly send Special Notice to the applicant that the applicant is entitled to request a hearing.

(d) Any final decision by the Board to grant, deny, revise or revoke appointment and/or Clinical Privileges will be disseminated to appropriate individuals and, as required, reported to appropriate entities.

3.A.8. Time Periods for Processing:

Once an application is deemed complete and verified, it is expected to be processed within 120 Days, unless it becomes incomplete. This time period is intended to be a guideline only and shall not create any right for the applicant to have the application processed within this precise time period.

3.B. FPPE TO CONFIRM COMPETENCE AND PROFESSIONALISM

All initially-granted Clinical Privileges, whether at the time of initial appointment, reappointment, or during the term of appointment, will be subject to FPPE in order to confirm competence. The FPPE process for these situations is outlined in the FPPE Policy to Confirm Practitioner Competence and Professionalism.

ARTICLE 4

CLINICAL PRIVILEGES

4.A. CLINICAL PRIVILEGES

4.A.1. General:

(a) Appointment or reappointment shall not confer any Clinical Privileges or right to admit or treat patients at the Hospital. Each individual who has been appointed to the Medical Staff is entitled to exercise only those Clinical Privileges specifically granted by the Board.

(b) For Clinical Privilege requests to be processed, the applicant must satisfy any applicable threshold eligibility criteria.

(c) Requests for Clinical Privileges that are subject to an exclusive contract will not be processed except as consistent with the contract.

(d) If Clinical Privileges have been grouped into Core Privileges, any requests for Privileges will not be processed unless the individual has applied for the full Core and satisfied all threshold eligibility criteria (or has obtained a waiver in accordance with Section 4.A.2).

(e) The Clinical Privileges recommended to the Board shall be based on consideration of the following factors:

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

(2) appropriateness of utilization patterns;

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

(4) information resulting from OPPE, FPPE, and other performance improvement activities, as applicable;

(5) availability of other Medical Staff Members with appropriate Privileges (as determined by the Credentials Committee) to provide coverage in case of the applicant's illness or unavailability;

(6) adequate professional liability insurance coverage for the Clinical Privileges requested;

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

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

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

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

(11) morbidity and mortality data related to the specific individual, and when statistically and qualitatively significant and meaningful, when available; and

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

(f) Core Privileges, special Privileges, Clinical Privilege delineations, and/or the criteria for the same shall be developed by the relevant Department Chair and/or Section Chief and shall be forwarded to the Credentials Committee for review and recommendation. The Credentials Committee will forward its recommendations to the MEC, which will review the matter and forward its recommendations to the Board for final action.

(g) The applicant has the burden of establishing his or her qualifications and current competence for all Clinical Privileges requested.

(h) The report of the Department Chair and/or Section Chief in which Privileges are sought shall be forwarded to the Chair of the Credentials Committee and processed as a part of the initial application for staff appointment.

4.A.2. Privilege Modifications and Waivers:

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

(b) Submitting a Request. Requests for Clinical Privilege modifications, waivers, and resignations must be submitted in writing or electronically to the Medical Staff Office.

(c) Increased Privileges.

(1) Requests for increased Privileges must state the specific additional Clinical Privileges requested and provide information sufficient to establish eligibility, as specified in applicable criteria, and current clinical competence.

(2) If the individual is eligible and the application is complete, it will be processed in the same manner as an application for initial Clinical Privileges.

(d) Waivers.

(1) Any individual who does not satisfy one or more eligibility criteria for Clinical Privileges may request that it be waived. The individual requesting the waiver bears the burden of demonstrating **exceptional** circumstances and that his or her qualifications are equivalent to, or exceed, the criterion in question. All such requests shall be processed in accordance with Section 2.A.2 of this Policy. In addition to the factors defined in Section 2.A.2, the Medical Staff leadership may also consider the additional factors set forth in Section 4.A.2 (f) in considering all such requests.

(2) If the individual is requesting a waiver of the requirement that each Medical Staff Member apply for the full Core Privileges in his or her specialty, the process set forth in this paragraph shall apply.

(i) Formal Request: The individual must forward a written or electronic request to the Medical Staff Office, which must indicate the specific patient care services within a Core Privilege that the Medical Staff Member does not wish to provide, state a good cause basis for the request, and include evidence that the individual does not provide the patient care services at issue in any health care facility.

(ii) Review Process: A request for a waiver shall be submitted to the Credentials Committee for consideration. In reviewing the request for a waiver, the Credentials Committee shall specifically consider the factors outlined in Paragraph (f) below and may obtain input from the relevant Department Chair and/or Section Chief. The Credentials Committee's recommendation will be forwarded to the MEC, which shall review the recommendation of the Credentials Committee and make a recommendation to the Board regarding whether to grant or deny the request for a waiver. Any recommendation to grant a waiver must include the specific basis for the recommendation.

(iii) Emergency Department On-Call Obligations: By applying for a waiver related to limiting the scope of Core Privileges, the individual nevertheless agrees to participate in the general Emergency Department on-call schedule for the relevant specialty and to maintain sufficient competency to assist other Physicians on the Medical Staff in assessing and stabilizing patients who require services within that specialty, if this call responsibility is required by the Medical Staff Leadership after review of the specific circumstances involved. If, upon assessment, a patient needs a service that is no longer provided by the individual pursuant to the waiver, the individual shall work cooperatively with the other Physicians in arranging for another individual with appropriate Clinical Privileges to care for the patient or, if such an individual is not available, in arranging for the patient's transfer.

(e) Relinquishment and Resignation of Privileges.

(1) Relinquishment of Individual Privileges. A request to relinquish any individual Clinical Privilege, whether or not part of Core Privileges, must provide a good cause basis for the modification of Privileges. All such requests will be processed in the same manner as a request for waiver, as described above.

(2) Resignation of Appointment and Privileges. A request to resign Medical Staff appointment and relinquish all Clinical Privileges must specify the desired date of resignation, which must be at least 30 Days from the date of the request, and be accompanied by evidence that the individual will be able to accomplish the following by the specified end date:

(i) completion of all medical records;

(ii) appropriate discharge or transfer of responsibility for the care of any hospitalized patient who is under the individual's care at the time of resignation; and

(iii) completion of scheduled emergency service call or formal arrangement for appropriate coverage to satisfy this responsibility.

After consulting with the Chief of Staff, the CEO will act on the resignation request with a report on the matter forwarded to the MEC. If an individual fails to complete the tasks listed above prior to the effective date of the resignation, he or she will not be considered to have left the Medical Staff "in good standing" for purposes of future reference responses.

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

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

(2) whether sufficient Notice has been given to provide a smooth transition of patient care services;

(3) fairness to the individual requesting the modification or waiver, including past service and the other demands placed on the individual;

(4) fairness to other Medical Staff Members who serve on the Emergency Department call roster in the relevant specialty, including the effect that the modification would have on them;

(5) the expectations of other Medical Staff Members who are in different specialties but who rely on the specialty in question in the care of patients who present to the Hospital;

(6) any perceived inequities in modifications or waivers being provided to some, but not others;

(7) any gaps in Emergency Department call coverage that might/would result from an individual's removal from the call roster for the relevant Clinical Privilege and the feasibility and safety of transferring patients to other facilities in that situation; and

(8) how the request may affect the Hospital's ability to comply with applicable regulatory requirements, including the Emergency Medical Treatment and Active Labor Act.

(g) Effective Date. If the Board grants a modification or waiver related to Privileges, it shall specify the date that the modification or waiver will be effective. Failure of a Medical Staff Member to request Clinical Privilege modifications or waivers in accordance with this section shall, as applicable, result in the individual retaining Medical Staff appointment and Clinical Privileges and all associated responsibilities.

(h) Procedural Rights. No individual is entitled to a modification or waiver related to Privileges. Individuals are also not entitled to a hearing or appeal or other process if a waiver or a modification related to a relinquishment of Privileges is not granted. The granting of a waiver or modification of Privileges in a particular case does not set a precedent for any other Medical Staff Member.

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

(a) Requests for Clinical Privileges to perform either a procedure not currently being performed at the Hospital or a new technique to perform an existing procedure (hereafter, "new procedure") shall not be processed until (1) a determination has been made that the procedure shall be offered by the Hospital, and (2) criteria to be eligible to request those Clinical Privileges have been established as set forth in this Section.

(b) As an initial step in the process, CMO will review the request and make a determination as to whether it (i) constitutes a "new procedure" to be reviewed under this Section, or (ii) is an extension of an existing Clinical Privilege or procedure, in which case no further review is necessary. As a part of this review process, the CMO may consult with the Credentials Committee, its Chair, or any other individuals in or outside of the Hospital. The CMO may also ask the individual making the request to provide additional information, including a report as described in paragraph (c) below.

(c) If the CMO determines the request constitutes a new procedure that should be reviewed under this Section, the individual seeking to perform the new procedure will prepare and submit a report addressing the following:

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

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

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

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

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

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

Hospital administration shall review this report and consult with the Chief of Staff, the Department Chair and/or Section Chief, and the Credentials Committee (any of which may conduct additional research as may be necessary) and shall make a preliminary determination as to whether the new procedure should be offered to the community.

(d) If the preliminary determination of the Hospital is favorable, the Credentials Committee will then develop threshold credentialing criteria to determine those individuals who are eligible to request the Clinical Privileges at the Hospital. In developing the criteria, the Credentials Committee may conduct additional research and consult with experts, as necessary, and develop recommendations regarding:

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

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

(3) the manner of addressing the most common complications that may arise in the performance of the new procedure;

(4) the extent (time frame and mechanism) of focused monitoring and supervision that should occur if the Privileges are granted in order to confirm competence; and

(5) the manner in which the procedure would be reviewed as part of the Hospital's OPPE and FPPE activities.

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

(f) The Board will make a reasonable effort to render the final decision within 60 Days of receipt of the MEC's recommendation. If the Board determines to offer the procedure or service, it will then establish the minimum threshold qualifications that an individual must demonstrate in order to be eligible to request the Clinical Privileges in question.

(g) Once the foregoing steps are completed, specific requests from eligible Medical Staff Members who wish to perform the procedure or service may be processed.

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

(a) Requests for Clinical Privileges that previously at the Hospital have been exercised only by individuals from another specialty shall not be processed until the steps outlined in this Section have been completed and a determination has been made regarding the individual's eligibility to request the Clinical Privileges in question.

(b) As an initial step in the process, the individual seeking the Clinical Privilege will prepare and submit a report to the Credentials Committee that specifies the

minimum qualifications needed to perform the procedure safely and competently, whether the individual's specialty is performing the Clinical Privilege at other similar hospitals, and the experiences of those other hospitals in terms of patient care outcomes and quality of care.

(c) The Credentials Committee shall then conduct additional research and consult with experts, as necessary, including those on the Medical Staff (e.g., Department Chairs, Section Chiefs, individuals on the Medical Staff with special interest and/or expertise) and those outside the Hospital (e.g., other hospitals, residency training programs, specialty societies).

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

(1) the appropriate education, training, and experience necessary to perform the Clinical Privileges in question;

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

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

(4) the extent (time frame and mechanism) of focused monitoring and supervision that should occur if the Privileges are granted in order to confirm competence;

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

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

(e) The Credentials Committee shall forward its recommendations to the MEC, which shall review the matter and forward its recommendations to the Board for final action. The Board shall make a reasonable effort to render the final decision within 60 Days of receipt of the MEC's recommendation.

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

4.A.5. Physicians in Training:

(a) Physicians in residency training shall not hold appointments to the Medical Staff and shall not be granted Clinical Privileges in an area for which they have not

already completed residency training. The program director, clinical faculty, and/or attending staff member shall be responsible for the direction and supervision of the on-site and/or Day-to-Day patient care activities of each trainee, who shall be permitted to perform only those clinical functions set out in curriculum requirements, affiliation agreements, and/or training protocols approved by the Hospital and the MEC or their designee(s). The applicable program director shall be responsible for verifying and evaluating the qualifications of each Physician in training.

(b) A Physician in training at the residency or fellowship level may request Clinical Privileges in an area for which he or she has already completed residency training if he or she can demonstrate that all necessary eligibility criteria as set forth in this Policy have been met. Requests for Privileges shall be reviewed in accordance with the initial credentialing process outlined in this Policy and, if granted, shall be subject to all relevant oversight provisions, including OPPE and FPPE activities. Physicians in training at the fellowship level may only be granted Clinical Privileges in those areas for which they can demonstrate current clinical competence.

4.A.6. Telemedicine Privileges:

(a) A qualified individual may be granted Telemedicine Privileges regardless of whether the individual is appointed to the Medical Staff.

(b) Requests for initial or renewed Telemedicine Privileges shall be processed through one of the following options, as determined by the CEO in consultation with the Chief of Staff:

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

(2) If the individual requesting Telemedicine Privileges is practicing at a distant hospital that participates in Medicare or a Telemedicine entity (as that term is defined by Medicare), a request for Telemedicine Privileges may be processed using an abbreviated process that relies on the credentialing and privileging decisions made by the distant hospital or Telemedicine entity. In such cases, the Hospital must ensure, through a written agreement, that the distant hospital or Telemedicine entity will comply with all applicable Medicare regulations and accreditation standards. The distant hospital or Telemedicine entity must provide:

(i) confirmation that the individual is licensed in Arizona;

(ii) a current list of Privileges granted to the individual;

(iii) information indicating that the applicant has actively exercised the relevant Privileges during the previous 12 months and has done so in a competent manner;

(iv) a signed attestation that the applicant satisfies all of the distant hospital or Telemedicine entity's qualifications for the Clinical Privileges granted;

(v) a signed attestation that all information provided by the distant hospital or Telemedicine entity is complete, accurate, and up-to-date; and

(vi) any other attestations or information required by the agreement or requested by the Hospital.

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

(c) Telemedicine Privileges, if granted, shall be for a period of not more than 24 months.

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

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

4.B. TEMPORARY CLINICAL PRIVILEGES

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

(a) Applicants. Temporary Privileges for an applicant for initial appointment may be granted by a member of the Administrative Team under the following conditions:

(1) the applicant has met all threshold eligibility criteria and submitted a complete application, along with any application fee;

(2) the verification process is complete, including verification of current licensure, relevant training or experience, current competence, ability to exercise the Privileges requested, and current professional liability coverage; compliance with Privileges criteria; and consideration of information from the National Practitioner Data Bank and from OIG queries;

(3) the applicant demonstrates that (i) there are no current or previously successful challenges to his or her licensure or registration, and (ii) he or she has not been subject to involuntary termination of Medical Staff Membership or involuntary limitation, reduction, denial, or loss of Clinical Privileges, at another health care facility;

(4) the applicant receives a favorable recommendation from the Department Chair and/or Section Chief, the Chief of Staff or designee;

(5) the application is pending review by the Credentials Committee, the MEC and the Board; and

(6) temporary Privileges for a Medical Staff applicant will be granted for a maximum period of 120 consecutive Days.

(b) Locum Tenens. A member of the Administrative Team may grant temporary Privileges to an individual serving as a locum tenens for a Medical Staff Member who is on vacation, attending an educational seminar, or ill, and/or otherwise needs coverage assistance for a period of time, under the following conditions:

(1) the applicant has submitted an appropriate application, along with any application fee;

(2) the verification process is complete, including verification of current licensure, current competence (verification of good standing in hospitals where the individual practiced for at least the previous year), ability to exercise the Privileges requested, and current professional liability coverage; compliance with Privileges criteria; and consideration of information from the National Practitioner Data Bank and from OIG queries;

(3) the applicant demonstrates that (i) there are no current or previously successful challenges to his or her licensure or registration, and (ii) he or she has not been subject to involuntary termination of Medical Staff Membership or involuntary limitation, reduction, denial, or loss of Clinical Privileges, at another health care facility;

(4) the applicant has received a favorable recommendation from the Chief of Staff and/or Credentials Committee Chair, after considering the evaluation of the Department Chair and/or Section Chief;

(5) the applicant will be subject to any FPPE requirements established by the Hospital; and

(6) the individual may exercise locum tenens Privileges for a maximum of 180 Days, consecutive or not, anytime during the 24-month period following the date they are granted, subject to the following conditions:

(i) the individual must notify the Medical Staff Office at least 10 Days prior to each time that he or she will be exercising these Privileges (exceptions for shorter Notice periods may be considered in situations involving health issues); and

(ii) along with this notification, the individual must inform the Medical Staff Office of any change that has occurred to any of the information provided on the initial application for locum tenens Privileges.

(c) Visiting. Temporary Privileges may also be granted in other limited situations by a member of the Administrative Team when there is an important patient care, treatment, or service need. Specifically, temporary Privileges may be granted for situations such as the following:

(1) the care of a specific patient;

(2) when a proctoring or consulting Physician is needed, but is otherwise unavailable; or

(3) when necessary to prevent a lack or lapse of services in a needed specialty area.

The following factors will be considered and/or verified prior to the granting of temporary Privileges in these situations: a favorable recommendation of the Chief of Staff, current licensure, relevant training or experience, current competence (verification of good standing in the individual's most recent hospital affiliation), current professional liability coverage acceptable to the Hospital, and results of a query to the National Practitioner Data Bank, and from OIG queries. The grant of Clinical Privileges in these situations will not exceed 60 Days. The verifications for such grants of Privileges shall generally be accomplished in advance; however, in an emergency situation, where life-threatening circumstances exist, the verifications listed above may be completed immediately after the grant of Privileges. In exceptional situations, this period of time may be extended in the discretion of the CEO and the Chief of Staff.

(d) Automatic Expiration. All grants of temporary Privileges shall automatically expire upon the date specified at the time of initial granting unless further affirmative action is taken to renew such temporary Privileges by the relevant Department Chair, Section Chief, the Chair of the Credentials Committee, the Chief of Staff, and the CEO.

(e) Compliance with Bylaws and Policies. Prior to any temporary Privileges being granted, the individual must agree in writing to be bound by the Bylaws, Rules and Regulations, policies, procedures, and protocols of the Medical Staff and the Hospital.

(f) FPPE. Individuals who are granted temporary Privileges will be subject to the Hospital policy regarding FPPE.

4.B.2. Supervision Requirements:

Special requirements of supervision and reporting may be imposed on any individual granted temporary Clinical Privileges.

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

(a) The CEO may withdraw temporary admitting Privileges at any time, after consulting with the Chief of Staff, the Chair of the Credentials Committee, the Department Chair, Section Chief, the VPMA, or the CMO. Clinical Privileges shall then expire as soon as patients have been discharged or alternate care has been arranged.

(b) If the care or safety of patients might be endangered by continued treatment by the individual granted temporary Privileges, the CEO, the Department Chair, the Section Chief, the Chief of Staff, the VPMA, or the CMO may immediately withdraw all temporary Privileges. The Department Chair, the Section Chief, or the Chief of Staff shall assign to another Medical Staff Member responsibility for the care of such individual's patients until they are discharged or an appropriate transfer arranged. Whenever possible, consideration shall be given to the wishes of the patient in the selection of a substitute Physician.

4.C. EMERGENCY SITUATIONS

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

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

(3) When the emergency situation no longer exists, the patient shall be assigned by the Department Chair, the Section Chief, or the Chief of Staff to a Medical Staff Member with appropriate Clinical Privileges, considering the wishes of the patient.

4.D. DISASTER PRIVILEGES

(1) When the disaster plan has been activated and the immediate needs of patients in the facility cannot be met, the CEO, the CMO, the VPMA, or the Chief of Staff may use a modified credentialing process to grant disaster Privileges to eligible volunteer licensed independent practitioners ("Emergency Volunteers"). Safeguards must be in place to verify that Emergency 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) An Emergency Volunteer's identity may be verified through a valid government-issued photo identification (i.e., driver's license or passport).

(b) An Emergency 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 Reserve 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 Medical Staff Member who possesses personal knowledge regarding the individual's ability to act as an Emergency Volunteer during a disaster.

(3) Primary source verification of an Emergency 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 Emergency 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 Emergency Volunteer's demonstrated ability to continue to provide adequate care; and (c) an attempt to obtain primary source verification as

soon as possible. If an Emergency Volunteer has not provided care, then primary source verification is not required.

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

4.E. CONTRACTS FOR SERVICES

(1) From time to time, the Hospital may enter into contracts with Medical Staff Members and/or groups of Medical Staff Members for the performance of clinical and administrative services at the Hospital. All individuals providing clinical services pursuant to such contracts will obtain and maintain Clinical Privileges at the Hospital, in accordance with the terms of this Policy.

(2) To the extent that:

(a) any such contract confers the exclusive right to perform specified services to one or more Medical Staff Members or groups of Medical Staff Members, or

(b) the Board by resolution limits the Medical Staff Members who may exercise Privileges in any clinical specialty to employees of the Hospital or its affiliates,

no other Medical Staff Member except those authorized by or pursuant to the contract or resolution may exercise Clinical Privileges to perform the specified services while the contract or resolution is in effect. This means that only authorized Medical Staff Members are eligible to apply for appointment or reappointment to the Medical Staff and for the Clinical Privileges in question. No other applications will be processed.

(3) Prior to the Hospital signing any exclusive contract and/or passing any Board resolution described in paragraph (2) in a specialty service and/or specialty area that has not previously been subject to such a contract or resolution, the Board will request the MEC's review of the matter. The MEC (or a subcommittee of its members appointed by the Chief of Staff) will review the quality of care and service implications of the proposed exclusive contract or Board resolution, and provide a report of its findings and recommendations to the Board within 30 Days of the Board's request.

As part of its review, the MEC (or subcommittee) may obtain relevant information concerning quality of care and service matters from (i) members of the applicable specialty involved, (ii) members of other specialties who directly utilize or rely on the specialty in question, and (iii) Hospital administration.

However, the actual terms of any such exclusive arrangement or employment contract, and any financial information related to them, including but not limited to the remuneration to be paid to Medical Staff Members who may be a party to the arrangement, are not relevant and shall neither be disclosed to the MEC nor discussed as part of the MEC's review.

(4) After receiving the MEC's report, the Board shall determine whether or not to proceed with the exclusive contract or Board resolution. If the Board determines to do so, and if that determination would have the effect of preventing an existing Medical Staff Member from exercising Clinical Privileges that had previously been granted, the affected Medical Staff Member is entitled to the following Notice and review procedures (Note: If more than one Physician in a relevant specialty area will be affected by the determination of the Board, the following procedures will be coordinated to address all requested meetings in a combined and consolidated manner):

(a) The affected Medical Staff Member shall be given at least 60 Days' advance Notice of the anticipated effective date of the exclusive contract or Board resolution and shall have the right to meet with the Board or a committee designated by the Board to discuss the matter prior to the contract in question being signed by the Hospital or the Board resolution becoming effective. Any such meeting must be requested by the affected Medical Staff Member and held within 30 Days of the Notice, unless this time frame is extended by mutual agreement.

(b) At the meeting, the affected Medical Staff Member shall be entitled to present any information that he or she deems relevant to the Board's initial determination to enter into the exclusive contract or enact the resolution.

(c) If, following this meeting, the Board confirms its initial determination to enter into the exclusive contract or enact the Board resolution, the affected Medical Staff Member shall be notified that he or she is ineligible to continue to exercise the Clinical Privileges covered by the exclusive contract or Board resolution. In that circumstance, the ineligibility begins as of the effective date of the exclusive contract or Board resolution and continues for as long as the contract or Board resolution is in effect.

(d) The affected Medical Staff Member shall not be entitled to any procedural rights beyond those outlined above with respect to the Board's decision or the effect of the decision on his or her Clinical Privileges, notwithstanding the provisions in Article 7 of this Policy.

(e) The inability of a Physician to exercise Clinical Privileges because of an exclusive contract or resolution is not a matter that requires a report to the state licensure board or to the National Practitioner Data Bank.

(5) Except as provided in paragraph (1), in the event of any conflict between this Policy or the Medical Staff Bylaws and the terms of any contract, the terms of the contract shall control.

ARTICLE 5

PROCEDURE FOR REAPPOINTMENT

5.A. PROCEDURE FOR REAPPOINTMENT

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

5.A.1. Eligibility for Reappointment:

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

(a) completed all medical records and be current at the time of reappointment;

(b) completed all continuing medical education requirements;

(c) satisfied all Medical Staff responsibilities, including payment of fees and assessments;

(d) continued to meet all qualifications and criteria for appointment and the Clinical Privileges requested, including those set forth in Section 2.A.1 of this Policy;

(e) if applying for Clinical Privileges, had sufficient Patient Contacts to enable the assessment of current clinical judgment and competence for the Privileges requested. Any individual seeking reappointment who has minimal activity at the Hospital must submit such information as may be requested (such as a copy of his or her confidential quality profile from his or her primary hospital, clinical information from the individual's private office practice, and/or a quality profile from a managed care organization or insurer) before the application shall be considered complete and processed further; and

(f) paid the reappointment processing fee, if any.

5.A.2. Factors for Evaluation:

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

(a) compliance with the Bylaws, Rules and Regulations, and policies of the Medical Staff and the Hospital;

(b) participation in Medical Staff duties, including committee assignments, emergency call, consultation requests, quality of medical record documentation, cooperation with case management, participation in quality improvement, utilization activities, and Professional Practice Evaluation activities, and such other reasonable duties and responsibilities as assigned;

(c) the results of the Hospital's performance improvement and Professional Practice Evaluation activities, taking into consideration Practitioner-specific information compared to aggregate information concerning other individuals in the same or similar specialty (provided that, other Medical Staff Members will not be identified);

(d) any FPPE activities;

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

(f) other reasonable indicators of continuing qualifications.

5.A.3. Reappointment Application:

(a) An application for reappointment shall be furnished to Medical Staff Members at least four months prior to the expiration of their current appointment term. A completed reappointment application must be returned to the Medical Staff Office within 30 Days.

(b) Failure to submit a complete application at least three months prior to the expiration of the individual's current term may result in the automatic expiration of appointment and Clinical Privileges at the end of the then current term of appointment unless the application can still be processed in the normal course, without extraordinary effort on the part of the Medical Staff Office and the Medical Staff Leaders. If an individual's Privileges lapse due to a processing delay, subsequent Board action may be to grant reappointment and renewal of Clinical Privileges using the filed application, in accordance with the expedited process set forth in Section 3.A.7(a).

(c) Reappointment shall be for a period of not more than two years.

(d) The application shall be reviewed by the Medical Staff Office to determine that all questions have been answered and that the individual satisfies all threshold eligibility criteria for reappointment and for the Clinical Privileges requested.

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

5.A.4. Processing Applications for Reappointment:

(a) The Medical Staff Office shall forward the application to the relevant Department Chair and/or Section Chief and the application for reappointment shall be processed in a manner consistent with applications for initial appointment.

(b) Additional information may be requested from the applicant if any questions or concerns are raised with the application or if new Privileges are requested.

5.A.5. Conditional Reappointments:

(a) Recommendations for reappointment and renewed Privileges may be contingent upon an individual's compliance with certain specific conditions that have been recommended. These conditions may relate to behavior (e.g., personal code of conduct) or to clinical issues (e.g., general consultation requirements, appropriate documentation requirements, including timely completion of medical records, proctoring, completion of CME requirements). Unless the conditions involve the matters set forth in Section 7.A.1(a) of this Policy, such conditions do not entitle an individual to request the procedural rights set forth in Article 7 of this Policy.

(b) Reappointments may be recommended for periods of less than two years in order to permit closer monitoring of an individual's compliance with any conditions that have been recommended. A recommendation for reappointment for a period of less than two years does not, in and of itself, entitle an individual to the procedural rights set forth in Article 7.

(c) In addition, in the event the applicant for reappointment is the subject of an unresolved Professional Practice Evaluation concern, an Investigation, or a hearing at the time reappointment is being considered, a conditional reappointment for a period of less than two years may be granted pending the completion of that process.

5.A.6. Potential Adverse Recommendation:

(a) If the Credentials Committee or MEC is considering a recommendation to deny reappointment or to reduce Clinical Privileges, the applicable committee chair will notify the Medical Staff Member of the possible recommendation and invite the Medical Staff Member to meet prior to any final recommendation being made.

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

(c) At the meeting, the Medical Staff Member will be invited to discuss, explain, or refute this information. A summary of the interview will be made and included with the Credentials Committee's and/or MEC's recommendation.

(d) This meeting is not a hearing, and none of the procedural rules for hearings will apply. The Medical Staff Member will not have the right to be accompanied by legal counsel at this meeting and no recording (audio or video) of the meeting shall be permitted or made.

5.A.7. Time Periods for Processing:

Once an application is deemed complete and verified, it is expected to be processed within 120 business Days, unless it becomes incomplete. This time period is intended to be a guideline only and shall not create any right for the applicant to have the application processed within this precise time period.

5.B. FPPE TO CONFIRM COMPETENCE AND PROFESSIONALISM

All initially-granted Clinical Privileges, whether at the time of initial appointment, reappointment, or during the term of appointment, will be subject to FPPE in order to confirm competence. The FPPE process for these situations is outlined in the FPPE Policy to Confirm Practitioner Competence and Professionalism.

ARTICLE 6

QUESTIONS INVOLVING MEDICAL STAFF MEMBERS

6.A. COLLABORATIVE LEADERSHIP EFFORTS AND PROGRESSIVE STEPS

(1) This Policy encourages the use of Collaborative Leadership Efforts and Progressive Steps by Medical Staff Leaders and Hospital management to address questions relating to an individual's clinical practice, professional conduct, and/or health. The goal of these efforts is to arrive at voluntary, responsive actions by the individual to resolve questions that have been raised. Medical Staff Leaders and Hospital administration have been authorized by the MEC, Leadership Council, and Professional Practice Committee ("PPC") to engage in Collaborative Leadership Efforts and Progressive Steps and all of these activities are undertaken on behalf of these committees as part of their Professional Practice Evaluation functions.

(2) Collaborative Leadership Efforts include activities such as:

(a) informal mentoring, coaching, or counseling by a Medical Staff Leader (e.g., advising an individual of policies regarding appropriate behavior, communication issues, emergency call obligations, or the timely and adequate completion of medical records); and

(b) sharing comparative data, including any variations from clinical practice or evidence-based protocols or guidelines, in order to assist the individual with conforming his or her practice to appropriate norms.

There is no expectation that these efforts be documented, though documentation may be created in the discretion of the Medical Staff Leader and maintained in the individual's Confidential File.

(3) Progressive Steps are defined as follows:

(a) addressing minor performance issues through Informational Letters (i.e., a non-punitive, educational tool to help individuals self-correct and improve their performance through feedback);

(b) sending an Educational Letter (i.e., a letter that describes opportunities for improvement and provides specific guidance and suggestions);

(c) facilitating a formal Collegial Intervention (i.e., a planned, face-to-face meeting between an individual and one or more Medical Staff Leaders) in order to directly discuss a matter and the steps needed to be taken to resolve it; and

(d) developing a Performance Improvement Plan, which may include a wide variety of tools and techniques that can result in a constructive and successful resolution of the concern.

All Progressive Steps shall be documented in a constructive manner and included in an individual's Confidential File and maintained in a confidential manner consistent with its privileged status. Any written responses to any of these Progressive Steps by the individual shall also be included in the individual's Confidential File.

(4) All of these efforts are fundamental and integral components of the Hospital's Professional Practice Evaluation activities, and are privileged, confidential and protected in accordance with state law.

(5) Initial collegial leadership efforts and Progressive Steps are encouraged, but are not mandatory, and shall be within the discretion of the appropriate Medical Staff Leaders and Hospital management. When a question arises, the Medical Staff Leaders and/or Hospital management may:

(a) address it pursuant to the Collaborative Leadership Efforts and Progressive Steps provisions of this Section;

(b) refer the matter for review in accordance with the Professional Practice Evaluation Policy, Professionalism Policy, Practitioner Health Policy, and/or other relevant policy; or

(c) refer it to the MEC for its review and consideration in accordance with Section 6.D of this Article.

(6) Should any recommendation be made or an action taken that entitles an individual to a hearing in accordance with this Policy, the individual is entitled to be accompanied by legal counsel at that hearing. However, Medical Staff Members do not have the right to be accompanied by counsel when the Medical Staff Leaders and Hospital management are engaged in Collaborative Leadership Efforts or other Progressive Steps. These efforts are intended to resolve issues in a constructive manner and do not involve the formal hearing process. In addition, there shall be no recording (audio or video) or transcript made of any meetings that involve Collaborative Leadership Efforts or Progressive Steps activities.

6.B. PROFESSIONAL PRACTICE EVALUATION ACTIVITIES

Professional Practice Evaluation activities shall be conducted in accordance with the Professional Practice Evaluation Policy, Professionalism Policy, Practitioner Health Policy, and/or other relevant policy. Matters that are not satisfactorily resolved through collegial efforts or through one of these policies shall be referred to the MEC for its

review in accordance with Section 6.D below. Such interventions and evaluations, however, are not mandatory prerequisites to MEC review.

6.C. REQUEST TO REFRAIN FROM PRACTICING/PRECAUTIONARY SUSPENSION OR RESTRICTION OF CLINICAL PRIVILEGES

6.C.1. Grounds for Voluntarily Refraining/Precautionary Suspension or Restriction of Privileges:

(a) Whenever, in their sole discretion, failure to take such action may result in imminent danger to the health and/or safety of any individual, the MEC OR any Medical Staff Officer, Department Chair, or Section Chief, acting in conjunction with the CEO, the CMO or the VPMA, shall have the authority to proceed as follows:

(1) request that the individual agree to voluntarily refrain from exercising Privileges pending further review of the circumstances by the Leadership Council in accordance with Section 6.C.2 of this Policy (agreements to voluntarily refrain may also be utilized in other Professional Practice Evaluation contexts such as a voluntary Performance Improvement Plan, the details of which are addressed in the relevant Professional Practice Evaluation policy); or

(2) if the individual is unwilling to voluntarily refrain from practicing pending further review, to suspend or restrict all or any portion of the individual's Clinical Privileges as a precaution, which actions shall be reviewed by the MEC in accordance with Section 6.C.3 of this Policy.

(b) The above actions can be taken at any time, including, but not limited to, immediately after the occurrence of an event that causes concern, following a pattern of occurrences that raises concern, or following a recommendation of the MEC that would entitle the individual to request a hearing.

(c) Precautionary suspension or Restriction, or an agreement to refrain, is an interim step in the professional review activity, but it is not a complete professional review action in and of itself. It shall not imply any final finding of responsibility for the situation that caused the suspension, Restriction, or agreement.

(d) These actions shall become effective immediately, shall promptly be reported in writing to the CEO, the CMO, the VPMA, and the Chief of Staff, and shall remain in effect unless the action is modified by the CEO or MEC.

(e) The individual in question shall be provided a letter via Special Notice that memorializes the individual's agreement to voluntarily refrain from practicing or the imposition of a precautionary suspension and terms related to the same. The correspondence shall also contain 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), within three Days of the action.

6.C.2. Leadership Council Review Process for an Agreement to Voluntarily Refrain from Practicing:

(a) The Leadership Council shall review the matter resulting in an individual's agreement to voluntarily refrain from exercising Clinical Privileges within a reasonable time under the circumstances, not to exceed 14 Days. As part of this review, the individual shall be given an opportunity to meet with the Leadership Council. Neither the Leadership Council nor the individual shall be accompanied by legal counsel at this meeting, and no recording (audio or video) or transcript of the meeting shall be permitted or made; however, minutes of the meeting shall be prepared.

(b) After considering the matter resulting in an individual's agreement to voluntarily refrain and the individual's response, if any, the Leadership Council shall determine the appropriate next steps, which may include, but not be limited to, commencing a focused review, referring the matter for review pursuant to another policy, referring the matter to the MEC with a recommendation to initiate an Investigation, or taking some other action that is deemed appropriate under the circumstances. The Leadership Council shall also determine whether the agreement to voluntarily refrain from practicing should be continued throughout any further review process.

(c) There is no right to a hearing based on an individual's agreement to voluntarily refrain from exercising his or her Clinical Privileges in accordance with this Section.

6.C.3. MEC Review Process for Precautionary Suspensions or Restrictions:

(a) The MEC shall review the matter resulting in a precautionary suspension or Restriction within a reasonable time under the circumstances, not to exceed 14 Days. As part of this review, the individual shall be given an opportunity to meet with the MEC. The individual may propose ways other than precautionary suspension or Restriction to protect patients and/or employees, depending on the circumstances. Neither the MEC nor the individual shall be accompanied by legal counsel at this meeting, and no recording (audio or video) or transcript of the meeting shall be permitted or made; however, minutes of the meeting shall be prepared.

(b) After considering the matters resulting in the suspension or Restriction and the individual's response, if any, the MEC shall determine the appropriate next steps, which may include, but not be limited to, commencing a focused review or an Investigation, or recommending some other action that is deemed appropriate under the circumstances. The MEC shall also determine whether the

precautionary suspension or Restriction should be continued, modified, or terminated pending the completion of the focused review or Investigation (and hearing and appeal, if applicable).

(c) There is no right to a hearing based on the imposition or continuation of a precautionary suspension or Restriction.

6.C.4. Care of Patients:

(a) Immediately upon an individual's agreement to voluntarily refrain from practicing or the imposition of a precautionary suspension or Restriction, the Department Chair, Section Chief, or the Chief of Staff shall assign to another individual with appropriate Clinical Privileges responsibility for care of the individual's hospitalized patients, or to otherwise aid in implementing the precautionary suspension, Restriction, or agreement to refrain from practicing, as appropriate. The assignment shall be effective until the patients are discharged. The wishes of the patient shall be considered in the selection of a covering Physician.

(b) All Medical Staff Members have a duty to cooperate with the Chief of Staff, the Department Chair, the Section Chief, the MEC, and the CEO in enforcing precautionary suspensions or Restrictions, or agreements to voluntarily refrain from practicing.

6.D. INVESTIGATIONS

6.D.1. Initial Review:

(a) Where Collaborative Leadership Efforts or Progressive Steps under one or more of the policies referenced in this Article have not resolved an issue and/or when there is a single instance of such severity that in the discretion of Medical Staff Leaders it requires further review, regarding:

(1) the clinical competence or clinical practice of any Medical Staff Member, including the care, treatment or management of a patient or patients;

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

(3) the known or suspected violation by any Medical Staff Member of applicable ethical standards or the Bylaws, Rules and Regulations, and policies of the Hospital or the Medical Staff; and/or

(4) conduct by any Medical Staff Member that is considered lower than the standards of the Hospital or disruptive to the orderly operation of the Hospital or its Medical Staff, including the inability of the Medical Staff Member to work harmoniously with others,

the matter may be referred to the Chief of Staff, the Department Chair, the Section Chief, the chair of a standing committee, or the CEO.

(b) In addition, if the Board becomes aware of information that raises concerns about any Medical Staff Member, the matter shall be referred to the Chief of Staff, the Department Chair, the Section Chief, the chair of a standing committee, or the CEO for review and appropriate action in accordance with this Policy.

(c) The person to whom the matter is referred shall conduct or arrange for an inquiry to determine whether the question raised has sufficient credibility to warrant further review and, if so, shall forward it in writing to the MEC.

(d) No action taken pursuant to this Section shall constitute an Investigation.

6.D.2. Initiation of Investigation:

(a) When a question involving clinical competence or professional conduct is referred to, or raised by, the MEC, the MEC shall review the matter and determine whether to conduct an Investigation, to direct the matter to be handled pursuant to another policy (e.g., Professional Practice Evaluation Policy, Professionalism Policy, Practitioner Health Policy), or to proceed in another manner that the MEC believes is appropriate. Prior to making its determination, the MEC may discuss the matter with the individual involved. An Investigation shall begin only after a formal determination by the MEC to do so. The MEC's determination shall be recorded in the minutes of the meeting where the determination is made.

(b) The MEC shall inform the individual that an Investigation has begun. The notification shall include:

(1) the date on which the Investigation was commenced;

(2) the committee that will be conducting the Investigation, if already identified;

(3) a statement that the Physician will be given the opportunity to meet with the committee conducting the Investigation before the Investigation concludes; and

(4) a copy of Section 6.D.3 of this Policy, which outlines the process for Investigations.

This notification may be delayed if, in the MEC's judgment, informing the individual immediately would compromise the Investigation or disrupt the operation of the Hospital or Medical Staff.

6.D.3. Investigative Procedure:

(a) Selection of Investigating Committee.

Once a determination has been made to begin an Investigation, the MEC shall either investigate the matter itself or appoint an ad hoc committee to conduct the Investigation, keeping in mind the conflict of interest guidelines outlined in Article 8. Any ad hoc committee may include individuals not on the Medical Staff. Whenever the questions raised concern the clinical competence of the individual under review, the ad hoc committee shall include a peer of the individual (e.g., Physicians, Dentists, Oral and Maxillofacial Surgeons, Podiatrists or Psychologists).

(b) Investigating Committee's Review Process.

(1) The committee conducting the Investigation ("investigating committee") shall have the authority to review relevant documents and interview individuals. A summary of each interview will be prepared and the interviewee will be asked to review, revise, and sign his or her summary, which will then be included as an attachment to the investigating committee's report.

(2) The investigating committee shall also have available to it the full resources of the Medical Staff and the Hospital, including the authority to arrange for an external review, if needed. An external review may be used whenever the Hospital and investigating committee determine that:

(i) there are ambiguous or conflicting findings by internal reviewers;

(ii) the clinical expertise needed to conduct the review is not available on the Medical Staff;

(iii) an external review is advisable to prevent allegations of bias, even if unfounded; or

(iv) the thoroughness and objectivity of the Investigation would be aided by such an external review.

If a decision is made to obtain an external review, the individual under Investigation shall be notified of that decision and the nature of the external review. Upon completion of the external review, the individual shall be provided a copy of the reviewer's report.

(3) The investigating committee may require a physical, mental, and/or behavioral examination of the individual by a health care professional(s) acceptable to it. The individual being investigated shall execute a release (in a form approved or provided by the investigating committee) allowing

(i) the investigating committee (or its representative) to discuss with the health care professional(s) conducting the examination the reasons for the examination; and (ii) the health care professional(s) conducting the examination to discuss and provide documentation of the results of such examination directly to the investigating committee. The cost of such health examination shall be borne by the individual.

(c) Meeting with the Investigating Committee.

(1) The individual under Investigation shall have an opportunity to meet with the investigating committee before it makes its report. Prior to this meeting, the individual shall be informed of the general questions being investigated. The investigating committee may also ask the individual to provide written responses to specific questions related to the Investigation and/or a written explanation of his or her perspective on the events that led to the Investigation for review by the investigating committee prior to the meeting.

(2) This meeting is not a hearing, and none of the procedural rules for hearings shall apply. No recording (audio or video) or transcript of the meeting shall be permitted or made. Neither the individual being investigated nor the investigating committee will be accompanied by legal counsel at this meeting.

(3) At the meeting, the individual shall be invited to discuss, explain, or refute the questions that gave rise to the Investigation or that have been identified by the investigating committee during its review. A summary of the interview shall be prepared by the investigating committee and included with its report. The interview summary will be shared with the individual prior to the investigating committee finalizing its report, so that he or she may review it and recommend suggested changes. A suggested change should only be accepted if the investigating committee believes it more accurately reflects what occurred at the meeting.

(d) Time Frames for Investigation.

The investigating committee shall make a reasonable effort to complete the Investigation and issue its report within 30 Days of the commencement of the Investigation, provided that an external review is not necessary. When an external review is necessary, the investigating committee shall make a reasonable effort to complete the Investigation and issue its report within 30 Days of receiving the results of the external review. These time frames are intended to serve as guidelines and, as such, shall not be deemed to create any right for an individual to have an Investigation completed within such time periods.

(e) Investigating Committee's Report.

(1) At the conclusion of the Investigation, the investigating committee shall prepare a report of the Investigation. The report should include a summary of the review process (e.g., a list of documents that were reviewed, any individuals who were interviewed, etc.), specific findings and conclusions regarding each concern that was under review, and the investigating committee's recommendations.

(2) In making its recommendations, the investigating committee shall strive to achieve a consensus as to what is in the best interests of patient care and the smooth operation of the Hospital, while balancing fairness to the individual, recognizing that fairness does not require that the individual agree with the recommendation. Specifically, the committee may consider:

(i) relevant literature and clinical practice guidelines, as appropriate;

(ii) all of the opinions and views that were expressed throughout the review, including report(s) from any external review(s);

(iii) any information or explanations provided by the individual under review; and

(iv) other information as deemed relevant, reasonable, and necessary by the investigating committee.

6.D.4. Recommendation:

(a) The MEC may accept, modify, or reject any recommendation it receives from an ad hoc investigating committee if one was appointed by the MEC. In either case, at the conclusion of the Investigation, the MEC may:

(1) determine that no action is justified;

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

(3) impose conditions for continued appointment;

(4) impose a requirement for monitoring, proctoring, or consultation;

(5) impose a requirement for additional training or education;

(6) recommend reduction of Clinical Privileges;

(7) recommend suspension of Clinical Privileges for a term;

(8) recommend revocation of appointment and/or Clinical Privileges; or

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

(b) A recommendation by the MEC that would entitle the individual to request a hearing shall be forwarded to the CEO, who shall promptly inform the individual by Special Notice. The CEO shall hold the recommendation until after the individual has completed or waived a hearing and appeal.

(c) If the determination of the MEC does not entitle the individual to request a hearing, it shall take effect immediately and shall remain in effect unless modified by the MEC or the Board.

(d) In the event the Board adopts a modification to the recommendation of the MEC that would entitle the individual to request a hearing, the CEO shall inform the individual by Special Notice. No final action shall occur until the individual has completed or waived a hearing and appeal.

(e) When applicable, any recommendations or actions that are the result of an Investigation or hearing and appeal shall be monitored by Medical Staff Leaders on an ongoing basis through the Hospital's performance improvement activities or pursuant to the applicable policies regarding conduct, as appropriate.

6.E. AUTOMATIC RELINQUISHMENT/ACTIONS

6.E.1. General:

(a) An Automatic Relinquishment is considered an administrative action that occurs by operation of this Policy. As such, it does not trigger an obligation on the part of the Hospital to file a report with the National Practitioner Data Bank or any state licensing agency and will take effect without hearing or appeal.

(b) Except as otherwise provided below, an Automatic Relinquishment of appointment and Clinical Privileges will be effective immediately upon actual or Special Notice to the individual. Such Notice will be provided after confirmation of the event(s) that led to the Automatic Relinquishment by the Chief of Staff, the CMO, the VPMA, and/or CEO. Notice will also be given to the applicable Department Chair.

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

(a) Any action taken by any licensing board, professional liability insurance company, court or government agency regarding any of the matters set forth below, or any failure to satisfy any of the threshold eligibility criteria set forth in

this Policy, must be promptly reported by the Medical Staff Member to the Medical Staff Office.

(b) An individual's appointment and Clinical Privileges shall be Automatically Relinquished, without the right to the procedural rights outlined in this Policy, if an individual fails to satisfy any of the threshold eligibility criteria set forth in Section 2.A.1 of this Policy on a continuous basis (except for board certification requirements, which shall be assessed at time of reappointment). This includes, but is not limited to, the following occurrences:

(1) Licensure: Revocation, expiration, suspension, the placement of restrictions on an individual's license, or an individual's license being placed on probationary status.

(2) Controlled Substance Authorization: Revocation, expiration, suspension or the placement of restrictions on an individual's DEA controlled substance authorization.

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

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

(5) Criminal Activity: Arrest, charge, indictment, conviction, or a plea of guilty or no contest pertaining to any felony; or to any misdemeanor involving (i) controlled substances; (ii) illegal drugs; (iii) Medicare, Medicaid, or insurance or health care fraud or abuse; (iv) child abuse; (i) elder abuse; or (vi) violence against another. (DUIs will be reviewed in accordance with the Practitioner Health Policy.)

(c) Automatic Relinquishment shall take effect immediately upon written Notice to the individual provided via Special Notice, and shall continue until the matter is resolved and the individual is reinstated, if applicable.

(d) If the underlying matter leading to Automatic Relinquishment is resolved within 60 Days, the individual may request reinstatement. Failure to resolve the matter within 60 Days of the date of relinquishment shall result in an automatic resignation from the Medical Staff.

6.E.3. Failure to Complete Medical Records:

Failure to complete medical records, after notification as described in the Medical Staff Rules and Regulations, may result in Automatic Relinquishment of all Clinical Privileges in accordance with the time frames as set forth in the Medical Staff Rules and Regulations (except that the individual must complete all scheduled emergency service obligations or arrange appropriate coverage). Relinquishment shall continue until all delinquent records are completed and reinstatement accomplished in accordance with the Medical Staff Rules and Regulations. Failure to complete the medical records that caused relinquishment within the time frames required in the Medical Staff Rules and Regulations shall result in Automatic Resignation from the Medical Staff.

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

(a) Failure to provide information pertaining to a Medical Staff Member's qualifications for continued appointment or Clinical Privileges, in response to a written request from the CEO, the CMO, the VPMA, the Credentials Committee, the MEC, the Leadership Council, the Professional Practice Committee, or any other committee authorized to request such information, shall result in a requirement that the individual meet with the Leadership Council to discuss why the requested input was not provided.

(b) Failure of the individual to either meet with the Leadership Council or complete or to provide the requested information prior to the meeting will result in the Automatic Relinquishment of the individual's Clinical Privileges until the information is provided to the satisfaction of the requesting party. If the individual fails to provide input requested within 30 Days of the Automatic Relinquishment, the individual's Medical Staff Membership and Clinical Privileges will be deemed to have been automatically resigned.

6.E.5. Failure to Complete or Comply with Training, Educational, or Orientation Requirements:

(a) Failure to complete or comply with training, educational, or orientation requirements that are adopted by the MEC or required by the Board, including, but not limited to, those pertinent to electronic medical records, computerized Physician order entry ("CPOE"), the privacy and security of protected health information, infection control, or patient safety, shall result in a requirement that the individual meet with the Leadership Council to discuss why the requirement was not met.

(b) Failure of the Medical Staff Member to either meet with the Leadership Council or complete and comply with the pertinent requirement prior to the meeting will result in the Automatic Relinquishment of the individual's Clinical Privileges until the individual demonstrates completion or compliance with the relevant requirement. If the individual fails to do so within 30 Days of the Automatic

Relinquishment, the individual's Medical Staff Membership and Clinical Privileges will be deemed to have been automatically resigned.

6.E.6. Failure to Attend Special Meeting:

(a) Whenever there is a concern regarding the clinical practice or professional conduct involving any individual, the Credentials Committee, PPC, Leadership Council or MEC may require the individual to attend a special meeting with it.

(b) No legal counsel shall be present at this meeting, and no recording (audio or video) or transcript shall be permitted or made.

(c) The Notice to the individual regarding this meeting shall be given by Special Notice at least three Days prior to the meeting and shall inform the individual that attendance at the meeting is mandatory.

(d) Failure of the individual to attend the meeting shall result in the Automatic Relinquishment of all Clinical Privileges until such time as the individual does attend the special meeting. If the individual does not attend the special meeting within 30 Days of the date of relinquishment, it shall result in automatic resignation from the Medical Staff.

6.E.7. Request for Reinstatement:

(a) Requests for reinstatement following the expiration or lapse of a license, controlled substance authorization, and/or insurance coverage will be processed by the Medical Staff Office. If any questions or concerns are noted, the Medical Staff Office will refer the matter for further review in accordance with (c) below.

(b) Requests for reinstatement following the relinquishment of Clinical Privileges due to (i) failure to provide requested information, (ii) failure to complete medical records, (iii) failure to complete or comply with training, educational, or orientation requirements, and/or (iv) failure to attend a special meeting shall be reviewed by the Leadership Council Chair. If the Leadership Council Chair recommends favorably on reinstatement, the individual may immediately resume clinical practice. If, however, any questions or concerns are noted, the matter will be referred to the full Leadership Council in accordance with (c) below.

(c) All other requests for reinstatement shall be reviewed by the Leadership Council. If the Leadership Council makes a favorable recommendation on reinstatement, the Medical Staff Member may immediately resume clinical practice at the Hospital. This determination shall then be forwarded to the Credentials Committee, the MEC, and the Board for ratification. If, however, the Leadership Council has any questions or concerns, those questions shall be noted and the reinstatement request shall be forwarded to the Credentials Committee, MEC, and Board for review and recommendation.

6.F. LEAVES OF ABSENCE

6.F.1. Initiation:

(a) An Active Staff member may request a leave of absence by submitting a written request to the Medical Staff Office. The request must state the beginning and ending dates of the leave, which shall not exceed one year, and the reasons for the leave. Except in extraordinary circumstances, this request will be submitted at least 30 Days prior to the anticipated start of the leave in order to permit adjustment of the call roster and assure adequate coverage of clinical and/or administrative activities. The request must state the beginning and ending dates of the leave, which shall not exceed 12 months, and the reasons for the leave.

(b) The CMO and/or VPMA shall determine whether a request for a leave of absence shall be granted. In determining whether to grant a request, the CMO and/or VPMA shall consult with the Chief of Staff and the relevant Department Chair and/or Section Chief. The granting of a leave of absence, or reinstatement, as appropriate, may be conditioned upon the individual's completion of all medical records.

(c) Except for maternity leaves, all Medical Staff Members with Clinical Privileges must report to the Medical Staff Office any time they are away from Medical Staff and/or patient care responsibilities for longer than 30 Days and the reason for such absence is related to their physical or mental health or otherwise to their ability to care for patients safely and competently. Failure to report such circumstances may trigger an automatic medical leave of absence.

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

During the leave of absence, the individual shall not exercise any Clinical Privileges. In addition, the individual shall be excused from all Medical Staff responsibilities (e.g., meeting attendance, committee service, emergency service call obligations) during this period.

6.F.3. Reinstatement:

(a) Individuals requesting reinstatement shall submit to the Medical Staff Office a written summary of their professional activities during the leave, evidence demonstrating that they continue to maintain current licensure, DEA registration, and adequate malpractice coverage, and any other information that may be requested by the Hospital. Requests for reinstatement shall then be reviewed by the Leadership Council. If the Leadership Council makes a favorable recommendation on reinstatement, the Medical Staff Member may immediately resume clinical practice at the Hospital. This determination shall then be forwarded to the Credentials Committee, the MEC, and the Board for ratification.

If, however, the Leadership Council has any questions or concerns, those questions shall be noted and the reinstatement request shall be forwarded to the full Credentials Committee, MEC, and Board for review and recommendation. If a request for reinstatement is not granted, for reasons related to clinical competence or professional conduct, the individual shall be entitled to request a hearing and appeal.

(b) If the leave of absence was for health reasons (except for maternity leave), the request for reinstatement must be accompanied by a report from the individual's Physician indicating that the individual is physically and/or mentally capable of resuming a hospital practice and safely exercising the Clinical Privileges requested and the request for reinstatement shall be processed in accordance with the Practitioner Health Policy.

(c) Absence for longer than one year shall result in Automatic Relinquishment of Medical Staff appointment and Clinical Privileges unless an extension is granted by the CMO and/or VPMA. Extensions shall be considered only in extraordinary cases where the extension of a leave is in the best interest of the Hospital.

(d) If an individual's current appointment is due to expire during the leave, the individual must apply for reappointment, or appointment and Clinical Privileges shall lapse at the end of the appointment period.

(e) Failure to request reinstatement from a leave of absence in a timely manner shall be deemed a voluntary resignation of Medical Staff appointment and Clinical Privileges.

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

ARTICLE 7

HEARING AND APPEAL PROCEDURES

7.A. INITIATION OF HEARING

7.A.1. Grounds for Hearing:

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

(1) denial of initial appointment to the Medical Staff;

(2) denial of reappointment to the Medical Staff;

(3) revocation of appointment to the Medical Staff;

(4) denial of requested Clinical Privileges;

(5) revocation of Clinical Privileges;

(6) suspension of Clinical Privileges for more than 30 Days (other than precautionary suspension);

(7) a Restriction of Clinical Privileges for more than 30 Days; or

(8) denial of reinstatement following a leave of absence if the reasons relate to clinical competence or professional conduct.

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

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

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

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

(a) determination that an applicant for membership fails to meet the threshold eligibility qualifications or criteria for membership;

(b) ineligibility to request membership or Privileges, or to continue Privileges, because a relevant specialty is closed under a Medical Staff development plan or is covered under an exclusive provider agreement;

(c) failure to process a request for a Clinical Privilege when the individual does not meet the eligibility criteria to hold the Clinical Privilege;

(d) determination that an application is incomplete or untimely;

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

(f) change in assigned staff category or a determination that an individual is not eligible for a specific staff category;

(g) determination of a member of the applicant's Primary Campus designation;

(h) expiration of membership and Privileges as a result of failure to submit an application for reappointment within the allowable time period;

(i) issuance of an Informational Letter, Educational Letter, or other letter of guidance, counsel, warning, or reprimand;

(j) participation in a Collegial Intervention, documented in a follow-up letter;

(k) determination that conditions, monitoring, supervision, proctoring, general consultation, additional training or continuing education is appropriate for an individual;

(l) voluntary acceptance of a Performance Improvement Plan;

(m) any requirement to complete a health assessment, diagnostic testing, a complete physical, mental or behavioral evaluation, or a clinical competency evaluation pursuant to any Bylaws-related document;

(n) conducting an Investigation into any matter or the appointment of an ad hoc investigating committee;

(o) grant of conditional appointment or reappointment or of an appointment or reappointment period that is less than 24 months;

(p) refusal of the Hospital to consider a request for appointment, reappointment, or Privileges within 60 months of a final adverse decision regarding such request;

(q) precautionary suspension;

(r) Restriction or suspension of Clinical Privileges for less than 30 Days;

(s) Automatic Relinquishment of appointment or Privileges or automatic resignation;

(t) denial of a request for a leave of absence, for an extension of a leave or for reinstatement from a leave if the reasons do not relate to clinical competence or professional conduct;

(u) removal from the Emergency Department on-call roster or any other reading panel;

(v) withdrawal of temporary Privileges;

(w) requirement to appear for a special meeting;

(x) termination of any contract with or employment by the Hospital; and

(y) any other action that is not specifically listed in Section 7.A.1(a).

7.B. THE HEARING

7.B.1. Notice of Recommendation:

The CEO shall promptly give Special Notice of a recommendation which entitles an individual to request a hearing. This Notice shall contain:

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

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

(c) a copy of this Article.

7.B.2. Request for Hearing:

An individual has 30 Days following receipt of the Notice to request a hearing. The request shall be in writing to the CEO and shall include the name, address, and telephone number of the individual's counsel, if any. Failure to request a hearing shall constitute waiver of the right to a hearing, and the recommendation shall be transmitted to the Board for final action.

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

(a) The CEO shall schedule the hearing and provide, by Special Notice to the individual requesting the hearing, the following:

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

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

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

(4) a statement of the specific reasons for the recommendation, including a list of patient records (if applicable), and a general description of the information supporting the recommendation. This statement does not bar presentation of additional evidence or information at the hearing, so long as the additional material is relevant to the recommendation or the individual's qualifications and the individual has a sufficient opportunity to review and rebut the additional information.

(b) The hearing shall begin no sooner than 30 Days after the Notice of the hearing, unless an earlier hearing date has been specifically agreed to in writing by the parties.

7.B.4. Hearing Panel, Presiding Officer, and Hearing Officer:

(a) Hearing Panel:

The CEO, after consulting with the Chief of Staff, shall appoint a Hearing Panel in accordance with the following guidelines:

(1) The Hearing Panel shall consist of at least three members and may include any combination of:

(i) any Medical Staff Member, provided the member has not actively participated in the matter at any previous level; and/or

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

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

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

(4) The Panel shall not include any individual who is in direct economic competition with the individual requesting the hearing.

(5) The Panel shall not include any individual who is demonstrated to have an actual bias, prejudice, or conflict of interest that would prevent the individual from fairly and impartially considering the matter.

(6) In addition, the appointment of the Hearing Panel shall comply with the guidelines set forth in the conflict of interest provisions found in Article 8 of this Policy.

(b) Presiding Officer:

(1) The CEO, after consulting with the Chief of Staff, shall appoint a Presiding Officer who shall be an attorney. The Presiding Officer may not be, or represent clients who are, in direct competition with the individual who requested the hearing and may not currently represent the Hospital in any legal matters. The Presiding Officer shall not act as an advocate for either side at the hearing.

(2) The Presiding Officer shall:

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

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

(iii) maintain decorum throughout the hearing;

(iv) determine the order of procedure;

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

(vi) conduct argument by counsel on procedural points within or outside the presence of the Hearing Panel at the Presiding Officer's discretion.

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

(4) The Presiding Officer may participate in the private deliberations of the Hearing Panel and be a legal advisor to it, but shall not be entitled to vote on its recommendations.

(c) Hearing Officer:

(1) As an alternative to a Hearing Panel, for matters limited to issues involving professional conduct, the CEO, 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 who are, 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" shall be deemed to refer to the Hearing Officer.

(d) Objections:

Any objection to any member of the Hearing Panel, to the Presiding Officer, or to the Hearing Officer, shall be made in writing, within 10 Days of receipt of Notice, to the CEO. 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 shall be given a reasonable opportunity to comment. The CEO shall rule on the objection and give Notice to the parties. The CEO may request that the Presiding Officer make a recommendation as to the validity of the objection.

(e) Compensation:

The Hearing Panel, Presiding Officer, and/or Hearing Officer may be compensated by the Hospital, but the individual requesting the hearing may share the costs of any such compensation should the individual who requested the hearing wish to do so.

7.B.5. 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.

7.C. PRE-HEARING PROCEDURES

7.C.1. General Procedures:

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

(b) The hearing shall last no more than 15 hours, with each side being afforded approximately seven and one half hours to present its case, in terms of both direct and cross-examination of witnesses. Both parties are required to prepare their case so that a hearing shall be concluded after a maximum of 15 hours. The Presiding Officer may, after considering any objections, grant limited extensions upon a demonstration of good cause and to the extent compelled by fundamental fairness.

(c) Neither party has the right to issue subpoenas or interrogatories or to depose witnesses or other individuals prior to the hearing or to otherwise compel any individual to participate in the hearing or pre-hearing process.

(d) Neither the individual who has requested the hearing, nor any other person acting on behalf of the individual, may contact Hospital employees or Medical Staff Members whose names appear on the MEC's witness list or in documents provided pursuant to this Article concerning the subject matter of the hearing, until the Hospital has been notified and has contacted the individuals about their willingness to be interviewed. The Hospital will advise the individual who has requested the hearing once it has contacted such employees or Medical Staff Members and confirmed their willingness to meet. Any employee or Medical Staff Member may agree or decline to be interviewed by or on behalf of the individual who requested a hearing. If an employee or Medical Staff Member who is on the MEC's witness list agrees to be interviewed pursuant to this provision, counsel for the MEC may be present during the interview.

7.C.2. Time Frames:

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

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

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

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

7.C.3. Witness List:

(a) At least 10 Days before the pre-hearing conference, the individual requesting the hearing shall provide a written list of the names of witnesses expected to offer testimony on his or her behalf.

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

(c) The witness list of either party may, in the discretion of the Presiding Officer, be amended at any time during the course of the hearing, provided that Notice of the change is given to the other party.

7.C.4. Provision of Relevant Information:

(a) Prior to receiving any confidential documents, the individual requesting the hearing must agree that all documents and information shall be maintained as confidential and shall not be disclosed or used for any purpose outside of the hearing. The individual must also provide a written representation that his or her counsel and any expert(s) have executed Business Associate agreements in connection with any patient Protected Health Information contained in any documents provided.

(b) Upon receipt of the above agreement and representation, the individual requesting the hearing shall be provided with a copy of the following:

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

(2) reports of experts relied upon by the MEC;

(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 MEC.

The provision of this information shall not waive any privilege under the state peer review protection statutes.

(c) The individual shall have no right to discovery beyond the above information. No information shall be provided regarding other Medical Staff Members.

(d) At least 10 Days prior to the pre-hearing conference (or as otherwise agreed upon by both sides), each party shall provide the other party with its proposed exhibits. All objections to documents or witnesses shall be submitted in writing at least five Days in advance of the pre-hearing conference. The Presiding Officer shall not entertain subsequent objections unless the party offering the objection demonstrates good cause.

(e) Evidence unrelated to the reasons for the recommendation or to the individual's qualifications for appointment or the relevant Clinical Privileges shall be excluded.

7.C.5. Pre-Hearing Conference:

The Presiding Officer shall require the individual and the MEC or their representatives (who may be counsel) to participate in a pre-hearing conference, which shall be held no later than 14 Days prior to the hearing. At the pre-hearing conference, the Presiding Officer shall establish the time to be allotted to each witness's testimony and cross-examination and shall resolve all procedural questions, including any objections to exhibits, witnesses, or the time limitation for the hearing.

7.C.6. Stipulations:

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

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

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

7.D. HEARING PROCEDURES

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

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

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

(2) to introduce exhibits;

(3) to cross-examine any witness on any matter relevant to the issues;

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

(5) to submit proposed findings, conclusions and recommendations to the Hearing Panel as part of the Post-Hearing statement referenced in this Article, following the close of the hearing session(s).

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

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

7.D.2. Record of Hearing:

No recording (audio or video) of the hearing shall be permitted or made. A stenographic reporter shall be present to make a written record of the hearing. The cost of the reporter shall be borne by the Hospital. Copies of the transcript shall be available at the individual's expense. Oral evidence shall be taken only on oath or affirmation administered by any person entitled to notarize documents in this state.

7.D.3. Failure to Appear:

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

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

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

7.D.5. Persons to Be Present:

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

7.D.6. Order of Presentation:

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

7.D.7. Admissibility of Evidence:

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

7.D.8. Post-Hearing Statement:

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

7.D.9. Postponements and Extensions:

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

7.E. HEARING CONCLUSION, DELIBERATIONS, AND RECOMMENDATIONS

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

Consistent with the burden on the individual to demonstrate that he or she satisfies, on a continuing basis, all criteria for initial appointment, reappointment and Clinical Privileges, the Hearing Panel shall recommend in favor of the MEC unless it finds that the individual who requested the hearing has proved, by a preponderance of the evidence, that the recommendation that prompted the hearing was arbitrary, capricious, or not supported by credible evidence.

7.E.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 shall conduct its deliberations outside the presence of any other person except the Presiding Officer. Thereafter, the Hearing Panel shall render a recommendation, accompanied by a report, which shall contain a concise statement of the basis for its recommendation.

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

The Hearing Panel shall deliver its report to the CEO. The CEO shall send by Special Notice a copy of the report to the individual who requested the hearing. The CEO shall also provide a copy of the report to the MEC.

7.F. APPEAL PROCEDURE

7.F.1. Time for Appeal:

(a) Within 10 Days after Notice of the Hearing Panel's recommendation, either party may request an appeal. The request shall be in writing, delivered to the CEO either in person or by certified mail, return receipt requested, and shall include a statement of the reasons for appeal and the specific facts or circumstances which justify further review.

(b) If an appeal is not requested within 10 Days, an appeal is deemed to be waived and the Hearing Panel's report and recommendation shall be forwarded to the Board for final action.

7.F.2. Grounds for Appeal:

The grounds for appeal shall be limited to the following:

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

(b) the recommendations of the Hearing Panel were made arbitrarily or capriciously and/or were not supported by credible evidence.

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

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

7.F.4. Nature of Appellate Review:

(a) The Board may serve as the Review Panel or the Chair of the Board may appoint a Review Panel composed of not less than three persons, either members of the Board or others, including but not limited to reputable persons outside the Hospital, to consider the record upon which the recommendation before it was made and recommend final action to the Board.

References to the Board or the Chair of the Board in this Section 7.F.4 and Section 7.G. shall also be references to a committee of the Board with delegated authority and the chair of such committee.

(b) Each party shall have the right to present a written statement in support of its position on appeal. The party requesting the appeal shall submit a statement first and the other party shall then have ten Days to respond. In its sole discretion, the Review Panel may allow each party or its representative to appear personally and make oral argument not to exceed 30 minutes.

(c) When requested by either party, the Review Panel may, in its discretion, accept additional oral or written evidence subject to the same rights of cross-examination provided at the Hearing Panel proceedings. Such additional evidence shall be accepted only if the Review Panel determines that the party seeking to admit it has demonstrated that it is relevant, new evidence that could not have been

presented at the hearing, or that any opportunity to admit it at the hearing was improperly denied.

7.G. BOARD ACTION

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

(a) Within 30 Days after the Board (i) considers the appeal as a Review Panel, (ii) receives a recommendation from a separate Review Panel, or (iii) receives the Hearing Panel's report and recommendation when no appeal has been requested, the Board shall consider the matter and take final action.

(b) The Board may review any information that it deems relevant, including, but not limited to, the findings and recommendations of the MEC, Hearing Panel, and Review Panel (if applicable). The Board may adopt, modify, or reverse any recommendation that it receives or, in its discretion, refer the matter to any individual or committee for further review and recommendation, or make its own decision based upon the Board's ultimate legal authority for the operation of the Hospital and the quality of care provided.

(c) The Board shall render its final decision in writing, including specific reasons, and shall send Special Notice to the individual. A copy shall also be provided to the MEC for its information.

7.G.2. Further Review:

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

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

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

ARTICLE 8

CONFLICT OF INTEREST GUIDELINES FOR CREDENTIALING, PRIVILEGING, AND PROFESSIONAL PRACTICE EVALUATION ACTIVITIES

8.A.1. General Principles:

(a) All those involved in credentialing, privileging, and Professional Practice Evaluation activities (referred to collectively as "Medical Staff Functions" in this Article) must be sensitive to potential conflicts of interest ("COI") in order to be fair to the individual whose qualifications are under review, to protect the individual with the potential conflict, and to protect the integrity of the review processes.

(b) It is also essential that peers participate in Medical Staff Functions in order for these activities to be meaningful and effective. Therefore, whether and how an individual can participate must be evaluated reasonably, taking into consideration common sense and objective principles of fairness.

(c) A potential conflict of interest depends on the situation and not on the character of the individual. To promote this understanding, any individual with a potential conflict of interest shall be referred to as an "Interested Member."

(d) No Medical Staff Member has a right to compel the disqualification of another Medical Staff Member based on an allegation of conflict of interest. Rather, that determination is within the discretion of the Medical Staff Leaders or Board chair, guided by this Article.

(e) The fact that any Medical Staff Member chooses to refrain from participation, or is excused from participation, in any Medical Staff Function shall not be interpreted as a finding of an actual conflict that inappropriately influenced the review process.

(f) **Appendix A** to this Policy is a chart that outlines the conflict of interest guidelines that are applicable to Medical Staff Functions at the Hospital. The remainder of this Article is intended to supplement **Appendix A** and expand upon the guidelines that are summarized in the chart.

8.A.2. Process for Identifying Conflicts of Interest:

(a) Self-Disclosure. Any individual involved in Medical Staff Functions must disclose all personal conflicts of interest relevant to those activities to the committee chair, the VPMA, or CMO.

(b) Identification by Others. Any individual who is concerned about a potential conflict of interest on the part of any other individual who is involved in Medical Staff Functions should inform the committee chair, the VPMA, or CMO.

(c) Identification by Individual under Review. An individual who is the subject of review during any Medical Staff Functions is obligated to notify the committee chair, the VPMA, or CMO of any known or suspected conflicts of interest by others who are involved in such activities. Any potential conflict of interest that is not raised timely by the individual under review shall be deemed waived.

8.A.3. Implementation of Conflict of Interest Guidelines in **Appendix A**:

This section describes how to implement the Conflict of Interest Guidelines found in **Appendix A** of this Policy:

- Paragraph (a) identifies the three COI situations that require special treatment and rules during the performance of Medical Staff Functions, irrespective of the Interested Member's level of participation in the process (e.g., individual reviewer, PPC member, MEC member);

- Paragraph (b) describes the other common situations that raise COI issues during the performance of Medical Staff Functions; and

- Paragraph (c) describes how to apply the guidelines in **Appendix A** to the common COI situations outlined in (b) at each level of the review processes.

(a) Three COI Situations That Require Special Treatment and Rules, Irrespective of an Interested Member's Level of Participation:

(1) Employment or Contractual Arrangement with the Hospital. Because Medical Staff Functions are performed on behalf of the Hospital, the interests of those who are employed by, or under contract with, the Hospital are aligned with the Hospital's interest in seeing that those activities are performed effectively, efficiently, and lawfully. As such, employment by, or other contractual arrangement with, the Hospital or any of its affiliated entities does not, in and of itself, preclude an Interested Member from participating in Medical Staff Functions.

(2) Self or Family Member. While Interested Members may provide information to other individuals involved in the review process, an Interested Member should not otherwise participate in the review of his or her own application or the Professional Practice Evaluation of the care he or she provided or in any such activities involving an immediate family member (spouse or domestic partner, parent, child, sibling, or in-law).

(3) Relevant Treatment Relationship. As a general rule, an Interested Member who has provided professional health services to a Medical Staff Member whose application or provision of care is under review should not participate in the review process regarding the Medical Staff Member. However, if the patient-Physician relationship has terminated and the review process does not involve the health condition for which the Medical Staff Member sought professional health services, the Interested Member may participate fully in all Medical Staff Functions.

Furthermore, even if a current patient-Physician relationship exists, the Interested Member may provide information to others involved in the review process if:

(i) the information was not obtained through the treatment relationship, or

(ii) the information was obtained through the treatment relationship, but the disclosure was authorized by the Medical Staff Member under review through the execution of a HIPAA-compliant authorization form.

(b) Other Common Situations That Raise COI Issues During the Performance of Medical Staff Functions:

Participation by any Interested Member who is in one of the following situations – as it relates to the Medical Staff Member under review – will be evaluated under the guidelines outlined in Paragraph (c) and **Appendix A**:

(1) Significant Financial Relationship (e.g., when the Interested Member and other Medical Staff Members: are members of a small, single specialty group; maintain a significant referral relationship; are partners in a business venture; or, are individuals practicing in a specialty for which a policy matter – such as clinical privileging criteria – is being considered);

(2) Direct Competitor (e.g., Medical Staff Members in the same specialty, but in different groups);

(3) Close Friendships;

(4) History of Personal Conflict (e.g., former partner, ex-spouse, or where there has been demonstrated animosity);

(5) Personal Involvement in the Care That Is Subject to Review (e.g., where the Interested Member provided care in the case under review, but is not the subject of the review);

(6) Active Involvement in Certain Prior Interventions with the Individual under Review (e.g., where the Interested Member was involved in the development of a prior Performance Improvement Plan or in a disciplinary action involving the individual under review. This situation does not include participation in initial education or Collegial Intervention efforts (e.g., sending an Educational Letter; meeting collegially with a colleague and sending a follow-up letter)); and/or

(7) Formally Raised the Concern about Another Individual (e.g., where the Interested Member's concern triggered the review of another Medical Staff Member, as evidenced by the Interested Member's written report regarding the concern (i.e., sent a written concern to a Medical Staff Officer, the VPMA, or the CMO, or filed a report through the Hospital's electronic reporting system)).

(c) Application of the Guidelines in **Appendix A** to the Performance of Medical Staff Functions:

(1) Individual Reviewers in Credentialing and Professional Practice Evaluation Activities

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

(i) participation in the review of applications for initial and renewed membership and Clinical Privileges (which is subsequently reviewed by the Credentials Committee and/or MEC); and

(ii) participation as a case reviewer in Professional Practice Evaluation activities (which is subsequently reviewed by the Leadership Council, the PPC, the APPC, Investigating Committee, and/or MEC).

(2) Credentials Committee, Leadership Council, Professional Practice Committee Members and Advanced Practice Professionals Committee

As a general rule, an Interested Member may fully participate as a member of the Credentials Committee, Leadership Council, PPC, and APPC because these committees do not possess any disciplinary authority and do not make any final recommendation that could adversely affect the membership or Clinical Privileges of a Medical Staff Member, which is only within the authority of the MEC and Board.

However, the chairs of these committees always have the discretion to recuse an Interested Member if they determine that the Interested

Member's presence or participation would inhibit full and fair discussion of the issue, would skew the recommendation or determination of the committee, or would otherwise be unfair to the Medical Staff Member under review.

(3) Medical Executive Committee

As a general rule, an Interested Member may fully participate as a member of the MEC when it is approving routine and favorable recommendations regarding the granting of initial appointment, reappointments, and Clinical Privileges.

However, an Interested Member should be recused from the MEC when that committee is considering a matter that could result in an adverse professional review action affecting the Medical Staff Membership or Clinical Privileges of a Medical Staff Member. The Interested Member's participation in MEC meetings will be governed by the guidelines regarding recusal that are set forth in **Appendix A**.

(4) Investigating Committees

Once an Investigation has been initiated by the MEC, additional steps to manage conflicts of interest should be taken as a precaution. Therefore, an Interested Member should not be appointed as a member of an investigating committee and should not participate in the committee's deliberations or decision-making, but may be interviewed and provide information if necessary for the committee to conduct a full and thorough Investigation.

(5) Hearing Panel

An Interested Member should not be appointed as a member of a Hearing Panel and should not participate in the Panel's deliberations or decision-making.

(6) Board

As a general rule, an Interested Member may fully participate as a member of the Board when it is approving routine and favorable recommendations regarding the granting of initial appointment, reappointments, and Clinical Privileges.

However, an Interested Member should be recused from the Board when the Board is considering action that will adversely affect Medical Staff Membership or Clinical Privileges of a Medical Staff Member. The

Interested Member's participation in Board meetings will be governed by the guidelines regarding recusal that are set forth in **Appendix A**.

ARTICLE 9

CONFIDENTIALITY AND PEER REVIEW PROTECTION

9.A. CONFIDENTIALITY

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

(1) when the disclosures are to another authorized Medical Staff Member or authorized Hospital employee and are for the purpose of researching, investigating, or otherwise conducting legitimate credentialing and Professional Practice Evaluation activities;

(2) when the disclosures are authorized by a Medical Staff or Hospital policy; or

(3) when the disclosures are authorized, in writing, by the CEO or by legal counsel to the Hospital.

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

9.B. PEER REVIEW PROTECTION

(1) All credentialing and Professional Practice Evaluation activities pursuant to this Policy and related Medical Staff documents are considered to be quality assurance activities under Arizona laws governing peer review and shall be performed by "review committees" in accordance with state law. These committees include, but are not limited to:

(a) all standing and ad hoc Medical Staff and Hospital committees, including, but not limited to, the MEC, the PPC, the APPC, and the Leadership Council;

(b) all departments and sections;

(c) hearing panels;

(d) the Board and its committees; and

(e) any individual acting for or on behalf of any such entity, including but not limited to Department Chairs, Section Chiefs, committee chairs and members, officers of the Medical Staff, the CMO, the VPMA, all Hospital personnel, and experts or consultants retained to assist in peer review activities.

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

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

ARTICLE 10

AMENDMENTS

This Policy may be amended pursuant to Article 9 of the Medical Staff Bylaws.

ARTICLE 11

ADOPTION

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

Medical Staff: _____

Board of Trustees: October 5, 2021

APPENDIX A

CONFLICT OF INTEREST GUIDELINES

Potential Conflicts	Levels of Participation								
			Committee Member						
	Provide Information	PPC or APPC Member (When Conducting Initial Case Review)	Credentials	Leadership Council	PPC/APPC	MEC	Investigating Committee	Hearing Panel	Board
Employment/contract relationship with Hospital	Y	Y	Y	Y	Y	Y	Y	Y	Y
Self or family member	Y	N	R	R	R	R	N	N	R
Relevant treatment relationship*	Y	N	R	R	R	R	N	N	R
Significant financial relationship	Y	Y	Y	Y	Y	R	N	N	R
Direct competitor	Y	Y	Y	Y	Y	R	N	N	R
Close friends	Y	Y	Y	Y	Y	R	N	N	R
History of conflict	Y	Y	Y	Y	Y	R	N	N	R
Provided care in case under review (but not subject of review)	Y	Y	Y	Y	Y	R	N	N	R
Involvement in prior PIP or disciplinary action	Y	Y	Y	Y	Y	R	N	N	R
Formally raised the concern	Y	Y	Y	Y	Y	R	N	N	R

Y – ("Yes") – means the Interested Member may serve in the indicated role; no extra precautions are necessary.

Y – ("Yes, with infrequent but occasional limitations") – means the Interested Member may generally serve in the indicated role. It is legally permissible for Interested Members to serve in these roles because of the check and balance provided by the multiple levels of review and the fact that the Credentials Committee, Leadership Council, PPC, and APPC have no disciplinary authority.

In addition, the Chair of the Credentials Committee, Leadership Council, PPC, or APPC always has the authority and discretion to recuse a member in a particular situation if the Chair determines that the Interested Member's presence would (i) inhibit the full and fair discussion of the issue before the committee, (ii) skew the recommendation or determination of the committee, or (iii) otherwise be unfair to the Practitioner under review.

N – ("No") – means the Interested Member should not serve in the indicated role.

R – ("Recuse") – means the Interested Member should be recused, in accordance with the guidelines on the next page.

RULES FOR RECUSAL	
STEP 1 Confirm the conflict of interest	The Committee Chair or Board Chair should confirm the existence of a conflict of interest relevant to the matter under consideration.
STEP 2 Participation by the Interested Member at the meeting	The Interested Member may participate in any part of the meeting that does not involve the conflict of interest situation. When the matter implicating the conflict of interest is ready for consideration, the Committee Chair or Board Chair will note that the Interested Member will be excused from the meeting prior to the group's deliberation and decision-making. Prior to being excused, the Interested Member may provide information and answer any questions regarding the following: (i) any factual information for which the Interested Member is the original source; (ii) clinical expertise that is relevant to the matter under consideration; (iii) any policies or procedures that are applicable to the committee or Board or are relevant to the matter under consideration; (iv) the Interested Member's prior involvement in the review of the matter at hand (for example, an Investigating Committee member may describe the Investigating Committee's activities and present the Investigating Committee's written report and recommendations to the MEC prior to being excused from the meeting); and (v) how the committee or Board has, in the past, managed issues similar or identical to the matter under consideration.
STEP 3 The Interested Member is excused from the meeting	The Interested Member will then be excused from the meeting (i.e., physically leave the meeting room and/or disconnect from any telephone or other electronic connection) prior to the committee's or Board's deliberation and decision-making.
STEP 4 Record the recusal in the minutes	The recusal should be documented in the minutes of the committee or Board. The minutes should reflect the fact that the Interested Member was excused from the meeting prior to deliberation and decision-making.

TUCSON MEDICAL CENTER
MEDICAL STAFF SERVICES
Tucson, AZ

GUIDELINES
EVALUATING MALPRACTICE JUDGMENTS AND SETTLEMENTS FOR CREDENTIALING AND PRIVILEGING

1. Purpose

The purpose of these guidelines is to provide guidance on how malpractice judgments and settlements will be evaluated for the purpose of credentialing and privileging. The existence of one or more malpractice judgments and/or settlements does not, in itself, suggest a concern about a practitioner's clinical competence or professional communications skills. However, patterns or trends of malpractice judgments and settlements involving unexpected death, serious injury or impairment, should be evaluated to determine if a concern exists.

2. Disclosure

(a) Malpractice judgments and settlements must be disclosed by applicants on the initial application form and on the reapplication form.

(b) Judgments and/or settlements that occur after initial appointment must be disclosed to the Medical Staff Services Office within 10 days of notice to the applicant.

(c) If an applicant fails to disclose the existence of a malpractice judgment or settlement, the Hospital may, in accordance with the Medical Staff Credentials Policy, (i) stop processing the application or, (ii) if appointment has been granted prior to the discovery of a misstatement or omission, appointment and privileges may be deemed to be automatically relinquished.

3. Evaluation of Judgments and Settlements

(a) The Credentials Committee will evaluate malpractice judgments and settlements during the initial appointment and reappointment processes. Additionally, the Credentials Committee will be provided by the applicant notice of judgments and settlements that occur during an appointment term.

(b) The Credentials Committee may request any information it determines is relevant to evaluate malpractice judgments and settlements.

(c) The evaluation of any malpractice judgment or settlement may be limited to information provided by the applicant, or member, and the insurance carrier if the

applicant or member has (i) fewer than three malpractice judgments, settlements or open cases filed against him or her during the last ten years; (ii) judgments or settlements that do not involve an unexpected death or serious injury or impairment; and (iii) no settlement or judgment is in excess of Three Hundred Thousand Dollars ($300,000).

(d) There may be a focused evaluation if the applicant or member has: (i) between three and five malpractice judgments, settlements or open cases filed against him or her during the last ten years; (ii) any judgments or settlements that involves an unexpected death or serious injury or impairment; or (iii) any settlement or judgment in excess of Three Hundred Thousand Dollars ($300,000).

(e) If an initial applicant has five or more malpractice judgments, settlements or open cases that have been filed against him or her during the last ten years, the applicant will be considered ineligible for appointment and clinical privileges to practice at the Hospital, unless a waiver is granted. These guidelines will not apply automatically to existing members of the Medical Staff, but this information will be considered in reviewing the member's continued practice.

(f) It is the obligation of all applicants and members to provide information requested by the Credentials Committee so that malpractice settlements and judgments can be evaluated.

(g) Exceptions may be made to these guidelines for high-risk specialties and high-risk jurisdictions, taking into account factors such as the types of allegations/claims, how recent the claims occurred, etc. If an applicant is seeking an exception to these guidelines, the burden is on the applicant to establish that he or she practices in a high-risk specialty and/or high-risk jurisdiction by pursuing a waiver through Section 2.A.2 of the Medical Staff Credentials Policy.

Approved by:

- Credentials Committee: January 7, 2020
- Medical Executive Committee: February 10, 2020

MEDICAL STAFF BYLAWS, POLICIES, AND RULES AND REGULATIONS OF TUCSON MEDICAL CENTER

POLICY ON ADVANCED PRACTICE AND OTHER HEALTHCARE PROFESSIONALS

Approved by the Board: April 23, 2025

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ARTICLE 1

GENERAL

1.A. DEFINITIONS

Unless otherwise indicated, the capitalized terms used in all of the Medical Staff documents are defined in the Medical Staff Glossary.

1.B. DELEGATION OF FUNCTIONS

(1) When a function under this Policy is to be carried out by a member of the Administrative Team, by a Medical Staff Member, or by a Medical Staff committee, the individual, or the committee through its chair, may delegate performance of the function to a qualified designee who is a Practitioner or Hospital employee (or a committee of such individuals). Any such designee must treat and maintain all credentialing, privileging, and peer review information in a strictly confidential manner and is bound by all other terms, conditions, and requirements of the Medical Staff Bylaws and related policies. In addition, the delegating individual or committee is responsible for ensuring that the designee appropriately performs the function in question. Any documentation created by the designee are records of the committee that is ultimately responsible for the review in a particular matter.

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

1.C. PREROGATIVES AND RESPONSIBILITIES

(1) Advanced Practice and Other Healthcare Professionals described in this Policy may attend meetings of the Medical Staff and of relevant clinical departments and sections, without vote.

(2) The Leadership Council shall appoint one Advanced Practice Professional to the Medical Executive Committee, one to the Credentials Committee, and one to the Professional Practice Committee ("PPC") to provide input and perspectives on issues related to Advanced Practice Professionals. The Chair of the Advanced Practice Professionals Committee shall serve as the Advanced Practice Professional Member of the PPC.

(3) Advanced Practice Professionals and Other Healthcare Professionals may be appointed to serve on other Medical Staff committees, at the discretion of the Leadership Council.

(4) Except for (i) Nurse Practitioners whose clinical privileges include only diabetic care or wound care, or (ii) the Diagnostic Nursing FNP all Advanced Practice Professionals function in the Hospital in collaboration with/under the supervision of a Collaborating/ Supervising Physician appointed to the Medical Staff who is responsible for the activities of the Advanced Practice Professional in the Hospital.

(5) Section 6.A of this Policy addresses the conditions of practice applicable to Advanced Practice Professionals to admit inpatients, to participate in patient consultations, perform inpatient rounds, to participate in the provision of Emergency Department on-call coverage, and to respond to calls from the floor regarding hospitalized patients. In addition, provisions in the Medical Staff Rules and Regulations address any necessary countersignature requirements that may pertain to Collaborating/Supervising Physicians.

(6) MEDICAL TITLE TRANSPARENCY

1) All healthcare professionals must clearly identify their specific role and credentials when introducing themselves to patients and families.

(2) The title" doctor" shall be used in clinical settings and written communications by individuals who hold a current, unrestricted license to practice in Arizona. This includes Doctor of Medicine (MD), Doctor of Osteopathic Medicine (DO), Bachelor of Medicine, Bachelor of Surgery (MBBS), Dentists (DDS), Oral and Maxillofacial Surgeons (DMD), or Doctor of Podiatric Medicine (DPM) and are credentialed to practice within Tucson Medical Center.

(3) Violations of this policy shall be reviewed by the Medical Executive Committee and may result in corrective action.

ARTICLE 2

OVERVIEW OF POLICY

2.A. GENERAL

(1) This Policy addresses those Practitioners who are permitted to provide patient care services in the Hospital and are listed in the Appendices to this Policy.

(2) This Policy sets forth the credentialing process and the general practice parameters for these individuals, as well as guidelines for determining the need for additional categories of Practitioners at the Hospital.

2.B. CATEGORIES OF PRACTITIONERS COVERED BY THIS POLICY

(1) Only those specific categories of Practitioners that have been approved by the Board shall be permitted to practice at the Hospital. All such Practitioners who are addressed in this Policy shall be classified as either Advanced Practice Professionals or Other Healthcare Professionals.

(2) Current listings of the specific categories of Advanced Practice Professionals or Other Healthcare Professionals functioning in the Hospital are attached to this Policy as Appendices A and B, respectively. The Appendices may be modified or supplemented by action of the Board, after receiving the recommendation of the MEC, without the necessity of further amendment of this Policy.

2.C. ADDITIONAL POLICIES

The Board shall adopt a separate credentialing protocol for each category of Practitioner covered by this Policy that it approves to practice in the Hospital. These separate protocols shall supplement this Policy and shall address the specific matters set forth in Section 3.B of this Policy.

ARTICLE 3

GUIDELINES FOR DETERMINING THE NEED FOR NEW CATEGORIES OF ADVANCED PRACTICE AND OTHER HEALTHCARE PROFESSIONALS

3.A. DETERMINATION OF NEED

(1) Whenever an individual in a category that has not been approved by the Board requests Permission to Practice at the Hospital, the Board shall refer the matter to the Credentials Committee or appoint an ad hoc committee to evaluate the need for that particular category of Advanced Practice or Other Healthcare Professional and to make a recommendation to the MEC for its review and recommendation and then to the Board for final action.

(2) As part of the process of determining need, the individual shall be invited to submit information about the nature of the proposed practice, why Hospital access is sought, and the potential benefits to the community by having such services available at the Hospital.

(3) The Credentials Committee or ad hoc committee may consider the following factors when making a recommendation to the MEC and the Board as to the need for the services of this category of Advanced Practice or Other Healthcare Professionals:

(a) the nature of the services that would be offered;

(b) any state license or regulation which outlines the scope of practice that the individual is authorized by law to perform;

(c) any state "non-discrimination" or "any willing provider" laws that would apply to the individual;

(d) the business and patient care objectives of the Hospital, including patient convenience;

(e) the community's needs and whether those needs are currently being met or could be better met if the services offered by the individual were provided at the Hospital;

(f) the type of training that is necessary to perform the services that would be offered and whether there are individuals with more training currently providing those services;

(g) the availability of supplies, equipment, and other necessary Hospital resources;

(h) the need for, and availability of, trained staff to support the services that would be offered; and

(i) the ability to appropriately supervise performance and monitor quality of care.

3.B. DEVELOPMENT OF POLICY

(1) If the Credentials Committee or ad hoc committee determines that there is a need for the particular category of Advanced Practice or Other Healthcare Professionals at the Hospital, the committee shall recommend to the MEC and the Board a separate policy for the pertinent type of Advanced Practice or Other Healthcare Professionals that addresses:

(a) any specific qualifications and/or training that they must possess beyond those set forth in this Policy;

(b) a detailed description of their authorized Clinical Privileges;

(c) any specific conditions that apply to their functioning within the Hospital beyond those set forth in this Policy; and

(d) any Collaboration/Supervision requirements, if applicable.

(2) In developing such policies, the Credentials Committee or ad hoc committee shall consult the appropriate Department Chair and/or Section Chief and consider relevant state law and may contact applicable professional societies or associations. The committee may also recommend to the Board the number of Advanced Practice or Other Healthcare Professionals that are needed in a particular category.

ARTICLE 4

QUALIFICATIONS, CONDITIONS, AND RESPONSIBILITIES

4.A. QUALIFICATIONS

4.A.1. Eligibility Criteria:

To be eligible to apply for initial and continued Permission to Practice at the Hospital, Advanced Practice and Other Healthcare Professionals must:

(a) have a current, unrestricted license, certification, or registration to practice in Arizona that is not subject to probation and have never had a license, certification, or registration to practice revoked, denied, or suspended by any state licensing agency;

(b) where applicable to their practice, have a current, unrestricted DEA registration;

(c) be available on a continuous basis, either personally or by arranging appropriate coverage when unavailable, to respond to the needs of patients in a prompt, efficient, and conscientious manner. ("Appropriate coverage" means coverage by another individual with appropriate specialty-specific Privileges as determined by the Credentials Committee.) Compliance with this eligibility requirement means that the individual must document and certify that he or she is willing and able to:

(1) respond within 20 minutes, via phone, to an initial contact from the Hospital; and

(2) appear in person (or via technology-enabled direct communication and evaluation, i.e., Telemedicine) to attend to a patient within 60 minutes of being requested to do so (or more quickly based upon (i) the acute nature of the patient's condition or (ii) as required for a particular specialty as recommended by the MEC and approved by the Board);

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

(e) have never been convicted of, or entered a plea of guilty or no contest to, Medicare, Medicaid, or other federal or state governmental or private third-party payer fraud or program abuse, nor have been required to pay civil monetary penalties for the same;

(f) have never been, and are not currently, excluded, precluded, or debarred from participation in Medicare, Medicaid, or other federal or state governmental health

care program and have not entered into any Program Integrity Agreement or similar settlement agreement with any such health care program;

(g) have never had Clinical Privileges denied, revoked, suspended, or terminated by any health care facility or health plan for reasons related to clinical competence or professional conduct;

(h) have never relinquished or resigned affiliation or Clinical Privileges at any health care facility during an Investigation or in exchange for not conducting such an Investigation;

(i) have not been convicted of, or entered a plea of guilty or no contest to, (i) any felony; (ii) any misdemeanor relating to controlled substances, illegal drugs, insurance or health care fraud or abuse, child abuse, elder abuse, or violence; (iii) any crime involving moral turpitude or immoral conduct so as to discredit the reputation, character or standing of the Hospital or of any Hospital affiliate or personnel; or (iv) any crime relevant to the provision of medical services or the practice of medicine;

(j) have not been found to have engaged in unprofessional or unethical conduct by any governmental or non-governmental board or professional organization having a right or privilege to pass upon the professional conduct and/or to discipline the individual therefor;

(k) satisfy all additional eligibility qualifications relating to their specific area of practice that may be established by the Hospital;

(l) document compliance with all applicable training and educational protocols that may be adopted by the MEC or required by the Board, including, but not limited to, those involving electronic medical records, computerized Physician order entry ("CPOE"), privacy and security of protected health information, infection control, and patient safety;

(m) document compliance with any health screening requirements (i.e., TB testing, mandatory flu vaccines, and infectious agent exposures);

(n) agree to maintain and regularly monitor a current secure, Hospital e-mail address with the Medical Staff Office (or use any other technology approved by the MEC or the Board), which will be the primary mechanism used to communicate all Medical Staff information to the individual;

(o) provide a valid phone number in order to facilitate Practitioner-to-Practitioner communication (e.g., office or mobile phone number or answering service information); and

(p) if seeking to practice as an Advanced Practice Professional (except for (i) Nurse Practitioners whose clinical privileges include only diabetic care, wound care, or (ii) the Diagnostic Nursing FNP), have a supervision agreement and/or collaborative agreement with a Physician who is appointed to the Medical Staff (the "Collaborating/Supervising Physician").

4.A.2. Waiver of Eligibility Criteria:

(a) Any applicant who does not satisfy one or more of the threshold eligibility criteria outlined above may request that it be waived. The applicant requesting the waiver bears the burden of demonstrating (i) that he/she is otherwise qualified, and (ii) exceptional circumstances exist (e.g., when there is a demonstrated Hospital or Medical Staff need for the services in question). Exceptional circumstances generally do not include situations where a waiver is sought for the convenience of an applicant.

(b) In reviewing the request for a waiver, the Credentials Committee may consider the specific qualifications of the individual in question, input from the relevant Department Chair and Section Chief, and the best interests of the Hospital and the communities it serves. Additionally, the Credentials Committee may, in its discretion, consider the application form and other information supplied by the applicant. The Credentials Committee's recommendation will be forwarded to the MEC. Any recommendation to grant a waiver must include the specific basis for the recommendation.

(c) The MEC will review the recommendation of the Credentials Committee and make a recommendation to the Board regarding whether to grant or deny the request for a waiver. Any recommendation to grant a waiver must include the specific basis for the recommendation.

(d) No individual is entitled to a waiver or to a hearing if the MEC recommends and/or the Board determines not to grant a waiver. A determination that an individual is not entitled to a waiver is not a "denial" of Permission to Practice or Clinical Privileges. Rather, that individual is ineligible to request Permission to Practice or Clinical Privileges. A determination of ineligibility is not a matter that is reportable to either the state board or the National Practitioner Data Bank.

(e) The granting of a waiver in a particular case does not set a precedent for any other individual or group of individuals.

(f) An application form that does not satisfy an eligibility criterion will not be processed until the Board has determined that a waiver should be granted.

(g) If a waiver is granted that does not specifically include a time limitation, the waiver is considered to be permanent and the individual does not have to request a waiver at subsequent recredentialing cycles.

4.A.3. Factors for Evaluation:

The six ACGME general competencies (patient care, medical knowledge, professionalism, system-based practice, practice-based learning, and interpersonal communications) will be evaluated as applicable, as part of a request for Permission to Practice, as reflected in the following factors:

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

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

(c) ability to safely and competently perform the Clinical Privileges requested;

(d) good reputation and character;

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

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

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

Advanced Practice and Other Healthcare Professionals shall not be appointed to the Medical Staff or entitled to the rights, Privileges, and/or prerogatives of Medical Staff appointment.

4.A.5. Non-Discrimination Policy:

No person shall be denied appointment or Clinical Privileges solely on the basis of age, national origin, culture, race, gender, sexual orientation, gender identity, ethnic background, religion, creed, or disability unrelated to the provision of patient care to the extent the individual is otherwise qualified.

4.B. GENERAL CONDITIONS OF PRACTICE

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

As a condition of Permission to Practice at the Hospital, all Advanced Practice and Other Healthcare Professionals shall specifically agree to the following:

(a) to provide continuous and timely quality care to all patients in the Hospital for whom the individual has responsibility;

(b) to abide by all bylaws, rules and regulations, and policies of the Medical Staff and Hospital;

(c) to accept committee assignments and such other reasonable duties and responsibilities as may be assigned;

(d) to maintain and monitor a current personal e-mail address with the Medical Staff Office (or use any other technology approved by the MEC or the Board), which will be the primary mechanism used to communicate all relevant information to the individual;

(e) to provide a valid phone number in order to facilitate Practitioner-to-Practitioner communication (e.g., office or mobile phone number or answering service information);

(f) to inform the Medical Staff Office, in writing or via e-mail, as soon as possible but in all cases within 10 Days, of any change in the individual's status or any change in the information provided on the individual's application form. This information will be provided with or without request, and will include, but not be limited to:

- changes in licensure or certification status, DEA controlled substance authorization, or professional liability insurance coverage;
- adverse changes in professional liability insurance coverage;
- the filing of a professional liability lawsuit against the individual;
- changes in the individual's status at any other hospital or health care entity as a result of peer review activities;
- changes in the individual's employment status at any medical group or hospital as a result of issues related to clinical competence or professional conduct;

- knowledge of a criminal investigation involving the individual, arrest, charge, indictment, conviction, or a plea of guilty or no contest in any criminal matter;

- exclusion or preclusion from participation in Medicare/Medicaid or any sanctions imposed;

- any changes in the individual's ability to safely and competently exercise Clinical Privileges or to perform the duties and responsibilities of Permission to Practice because of health status issues, including, but not limited to, impairment due to addiction, alcohol use, or other similar issue (all of which shall be referred for review under the Practitioner Health Policy);

- any referral to a state board health-related program; and

- any charge of, or arrest for, driving under the influence ("DUI") (which shall be referred for review under the Practitioner Health Policy);

(g) to immediately submit to an appropriate evaluation, which may include diagnostic testing (including, but not limited to, blood and/or urine test) and/or a complete physical, mental, and/or behavioral evaluation, if at least two Medical Staff Leaders (or one Medical Staff Leader and one member of the Administrative team) are concerned with the individual's ability to safely and competently care for patients and request such testing and/or evaluation. The health care professional(s) to perform the testing and/or evaluations will be determined by the Medical Staff Leaders, and the individual will execute all appropriate releases to permit the sharing of information with the Medical Staff Leaders;

(h) to strictly comply with the standards of practice applicable to the functioning of Advanced Practice Professionals in the inpatient hospital setting, as set forth in Section 6.A of this Policy;

(i) to constructively participate in the development, review, and revision of clinical practice and evidence-based medicine protocols pertinent to his or her specialty (including those related to national patient safety initiatives and core measures), and to comply with all such protocols and pathways;

(j) to meet with Medical Staff Leaders and/or Hospital administration upon request, to provide information regarding professional qualifications upon written request, and to participate in collegial efforts as may be requested;

(k) to appear for personal or phone interviews in regard to an application for Permission to Practice as may be requested;

(l) to refrain from illegal fee splitting or other illegal inducements relating to patient referral;

(m) to refrain from assuming responsibility for diagnosis or care of hospitalized patients for which he or she is not qualified or without adequate supervision;

(n) to refrain from deceiving patients as to the individual's status as an Advanced Practice or Other Healthcare Professional and to always wear proper Hospital identification of their name and status;

(o) to seek consultation when appropriate;

(p) to participate in the performance improvement and quality monitoring activities of the Hospital;

(q) to complete, in a timely and legible manner, the medical and other required records, containing all information required by the Hospital, and to utilize the electronic medical record as required;

(r) to cooperate with all utilization oversight activities;

(s) to perform all services and conduct himself/herself at all times in a cooperative and professional manner;

(t) to satisfy applicable continuing education requirements;

(u) to pay any applicable application fees, assessments, and/or fines;

(v) to comply with all applicable training and educational protocols as well as orientation requirements that may be adopted by the MEC or required by the Board, including, but not limited to, those involving electronic medical records, computerized Physician order entry ("CPOE"), the privacy and security of protected health information, infection control, and patient safety; and

(w) that, if there is any misstatement in, or omission from, the application, the Hospital may stop processing the application (or, if Permission to Practice has been granted prior to the discovery of a misstatement or omission, the permission may be deemed to be Automatically Relinquished). In either situation, there shall be no entitlement to the procedural rights provided in this Policy. The individual will be informed in writing of the nature of the misstatement or omission and permitted to provide a written response for the Credentials Committee's consideration. If the determination is made to not process an application or that Permission to Practice and Clinical Privileges should be Automatically Relinquished pursuant to this provision, the individual may not reapply for a period of at least two years.

4.B.2. Burden of Providing Information:

(a) Individuals seeking Permission to Practice or renewal of Permission to Practice shall have the burden of producing information deemed adequate by the Hospital for a proper evaluation of current competence, character, ethics, and other qualifications, and for resolving any doubts about such qualifications.

(b) Individuals seeking permission or renewal of Permission to Practice have the burden of providing evidence that all the statements made and information given on the application are accurate.

(c) Complete Application: An application shall be complete when all questions on the application form have been answered, all supporting documentation has been supplied, all information has been verified from primary sources, and all application fees and applicable fines have been paid. An application shall become incomplete if the need arises for new, additional, or clarifying information at any time during the credentialing process. Any application that continues to be incomplete 30 Days after the individual has been notified of the additional information required shall be deemed to be withdrawn.

(d) It is the responsibility of the individual seeking Permission to Practice or renewal of Permission to Practice to provide a complete application, including adequate responses from references. An incomplete application will not be processed.

4.C. APPLICATION

4.C.1. Information:

(a) The Advanced Practice and Other Healthcare Professionals application forms existing now and as may be revised are incorporated by reference and made a part of this Policy. These applications shall require detailed information concerning the applicant's professional qualifications, including copies of his or her most recent OPPE report, if the applicant has affiliations with other hospitals.

(b) In addition to other information, the applications shall seek the following:

(1) information as to whether the applicant's Clinical Privileges, Permission to Practice, and/or affiliation has ever been voluntarily or involuntarily relinquished, withdrawn, denied, revoked, suspended, reduced, subjected to probationary or other conditions, limited, terminated, or not renewed at any hospital, health care facility, or other organization, or is currently being investigated or challenged;

(2) information as to whether the applicant's license or certification to practice any profession in any state, DEA registration, or any state controlled substance license (if applicable) is or has ever been voluntarily

or involuntarily relinquished, suspended, modified, terminated, restricted, or is currently being investigated or challenged;

(3) information concerning the applicant's professional liability litigation experience and/or any professional misconduct proceedings involving the applicant, in this state or any other state, whether such proceedings are closed or still pending, including the substance of the allegations of such proceedings or actions, the substance of the findings of such proceedings or actions, the ultimate disposition of any such proceedings or actions that have been closed, and any additional information concerning such proceedings or actions as the Credentials Committee, MEC or Board may deem appropriate;

(4) current information regarding the applicant's ability to perform, safely and competently, the Clinical Privileges requested and the duties of Advanced Practice and Other Healthcare Professionals; and

(5) a copy of government-issued photo identification.

(c) The applicant shall sign the application and certify that he or she is able to perform the Clinical Privileges requested and any corresponding responsibilities of his or her Permission to Practice.

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

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

(a) Immunity:

To the fullest extent of the law, the individual releases from any and all liability, extends immunity to, and agrees not to sue the Hospital or the Board, any Medical Staff Member or the Board, their authorized representatives, and third parties who provide information for any matter relating to Permission to Practice, Clinical Privileges, or the individual's qualifications for the same. This immunity covers any actions, recommendations, communications, and/or disclosures involving the individual that are made or taken by the Hospital, its authorized agents, or third parties in the course of quality assurance activities, including credentialing and peer review activities. This immunity also extends to any reports that are made to government regulatory and licensure boards or agencies pursuant to federal or state law.

(b) Authorization to Obtain Information from Third Parties:

The individual specifically authorizes the Hospital, Medical Staff Leaders, and their authorized representatives (1) to consult with any third party who may have

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

(c) Authorization to Release Information to Third Parties:

The individual also authorizes Hospital representatives to release information to (i) the Collaborating/Supervising Physician, (ii) other hospitals, health care facilities, managed care organizations, and their agents when information is requested in order to evaluate his or her professional qualifications for Permission to Practice, Clinical Privileges, and/or participation at the requesting organization/facility, and (iii) government regulatory and licensure boards or agencies pursuant to federal or state law. The disclosure of any such information does not waive any associated privilege and all such disclosures shall be made with the understanding that the receiving entity will only use such information for appropriate purposes.

(d) Authorization to Share Information among TMC Entities:

The individual specifically authorizes the Hospital and its affiliates to make requests and disclosures of quality assurance information pertaining to the individual for the purpose of engaging in quality assurance activities as described in the Hospital's Sharing of Quality Assurance Information Policy.

(e) Procedural Rights:

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

(f) Legal Actions:

If, despite this Section, an individual institutes legal action challenging any credentialing, privileging, peer review, or other action affecting Permission to Practice or Clinical Privileges, or any report that may be made to a regulatory board or agency, and does not prevail, he or she shall reimburse the Hospital and any Medical Staff Member or Board involved in the action for all costs incurred

in defending such legal action, including reasonable attorney's fees, expert witness fees, and lost revenues.

(g) Scope of Section:

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

(1) whether or not Permission to Practice or Clinical Privileges is granted;

(2) throughout the term of any affiliation with the Hospital and thereafter;

(3) should Permission to Practice or Clinical Privileges be denied, revoked, reduced, restricted, suspended, and/or otherwise affected as part of the Hospital's professional review activities;

(4) as applicable, to any third-party inquiries received after the individual leaves the Hospital about his or her tenure at the Hospital; and

(5) as applicable, to any reports that may be made to government regulatory and licensing boards or agencies pursuant to federal or state law.

ARTICLE 5

CREDENTIALING PROCEDURE

5.A. PROCESSING OF INITIAL APPLICATION TO PRACTICE

5.A.1. Request for Application:

(a) Applications for Permission to Practice as an Advanced Practice or Other Healthcare Professional shall be approved by the Board, upon recommendation by the MEC and Credentials Committee.

(b) Any individual requesting an application for Permission to Practice at the Hospital will be sent information that (i) outlines the threshold eligibility criteria for Permission to Practice outlined earlier in this Policy, (ii) outlines the applicable criteria for the Clinical Privileges being sought, and (iii) provides access to the application form.

(c) An individual who is in a category of Advanced Practice and Other Healthcare Professionals that has not been approved by the Board to practice at the Hospital shall be ineligible to receive an application. A determination of ineligibility does not entitle the individual to the procedural rights outlined in Article 8 of this Policy.

5.A.2. Initial Review of Application:

(a) A completed application form with copies of all required documents must be returned to the Medical Staff Office accompanied by any required application fee.

(b) As a preliminary step, the application will be reviewed by the Medical Staff Office to determine that all questions have been answered and that the individual satisfies all threshold criteria. Incomplete applications will not be processed. Individuals who fail to return completed applications or fail to meet the eligibility criteria set forth in Section 4.A.1 of this Policy will be notified that they are not eligible for Permission to Practice at the Hospital and that their application will not be processed. A determination of ineligibility does not entitle an individual to the procedural rights outlined in Article 8 of this Policy, and is not reportable to any state agency or to the National Practitioner Data Bank.

(c) The Medical Staff Office shall oversee the process of gathering and verifying relevant information and confirming that all references and other information or materials deemed pertinent have been received. Once an application is complete, it shall be transmitted, along with all supporting documentation, to the applicable Department Chair and/or Section Chief.

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

(a) Evidence of the applicant's character, professional competence, qualifications, behavior, and ethical standing shall be examined. This information may be contained in the application and obtained from peer references and from other available sources, including individuals at other health care entities where the applicant practiced or trained who may have knowledge about the applicant's education, training, experience, and ability to work with others. The review process described in this Article will also be guided by the Medical Staff's Policy for the Continued Safe Practice of Aging Practitioners.

(b) An interview(s) with the applicant may be conducted. The purpose of the interview is to discuss and review any aspect of the applicant's application, qualifications, and requested Clinical Privileges. This interview may be conducted by a combination of any of the following: the Department Chair, the Section Chief, the Credentials Committee, a Credentials Committee representative, the MEC, the Chief of Staff, the VPMA, the CMO, and/or the CEO. The applicant's Collaborating/ Supervising Physician may also be invited to join.

5.A.4. Department Chair/Section Chief Procedure:

(a) The Medical Staff Office shall transmit the complete application and all supporting materials to the appropriate Department Chair and/or Section Chief based on where the applicant seeks Clinical Privileges. The Department Chair/Section Chief shall prepare a report regarding whether the applicant has satisfied all of the qualifications for Permission to Practice and the Clinical Privileges requested on a form provided by the Medical Staff Office.

(b) As part of the process of making this report, the Department Chair/Section Chief may also confer with subject matter experts within the Hospital (e.g., other Physicians, relevant Hospital department heads, nurse managers).

(c) The Department Chair/Section Chief shall be available to the Credentials Committee, the MEC, and the Board to answer any questions that may be raised with respect to the report and findings of that individual.

(d) In addition to review by the Department Chair/Section Chief, all individuals who are seeking Permission to Practice as advanced practice nurses shall also be evaluated by the Chief Nursing Officer (or designee).

5.A.5. Credentials Committee Procedure:

(a) The Credentials Committee shall review and consider the reports from the appropriate Department Chair/Section Chief and the Chief Nursing Officer (when applicable) and shall make a recommendation to the MEC.

(b) The Credentials Committee may use the expertise of the Department Chair/Section Chief or any member of the department or section, or an outside consultant, if additional information is required regarding the applicant's qualifications.

(c) After determining that an applicant is otherwise qualified for Permission to Practice and Privileges, the Credentials Committee may require the applicant to undergo a physical, mental, and/or behavioral examination by a Physician(s) satisfactory to the Credentials Committee if there is any question about the applicant's ability to perform the Privileges requested. The results of this examination shall be made available to the committee for its consideration. Failure of an applicant to undergo an examination within a reasonable time after being requested to do so in writing by the Credentials Committee shall be considered a voluntary withdrawal of the application and all processing of the application shall cease. The cost of the health assessment will be borne by the applicant.

(d) The Credentials Committee may recommend specific conditions. These conditions may relate to behavior (e.g., personal code of conduct) or to clinical issues (e.g., general consultation requirements, appropriate documentation requirements, proctoring, completion of education requirements). The Credentials Committee may also recommend that Permission to Practice be granted for a period of less than two years in order to permit closer monitoring of an individual's compliance with any conditions.

(e) The Credentials Committee's recommendation will be forwarded to the MEC.

5.A.6. MEC Procedure:

(a) At its next meeting after receipt of the written findings and recommendation of the Credentials Committee, the MEC shall:

(1) adopt the findings and recommendations of the Credentials Committee as its own; or

(2) refer the matter back to the Credentials Committee for further consideration and responses to specific questions raised by the MEC prior to its final recommendation; or

(3) the Credentials Committee may use the expertise of the Department Chair/Section Chief or any member of the department or section, or an outside consultant, if additional information is required regarding the applicant's qualifications.

(b) If the recommendation of the MEC is favorable to the applicant, the Committee shall forward its recommendation to the Board.

(c) If the MEC's recommendation is unfavorable and would entitle the applicant to the procedural rights set forth in this Policy, the MEC shall forward its recommendation to the CEO, who shall promptly send Special Notice to the applicant. The CEO shall then hold the application until after the applicant has completed or waived the procedural rights outlined in this Policy.

5.A.7. Board Action:

(a) Expedited Review: The Board (including any committee exercising delegated authority of the Board) may delegate to a sub-committee, consisting of at least two Board members, action on applications if there has been a favorable recommendation from the Credentials Committee and the MEC (or their designees) and there is no evidence of any of the following:

(1) a current or previously successful challenge to any license, certification, or registration;

(2) an involuntary termination, limitation, reduction, denial, or loss of Permission to Practice or Clinical Privileges at any other hospital or other entity; or

(3) an unusual pattern of, or an excessive number of, professional liability actions resulting in a final judgment against the applicant.

Any decision reached by the Board sub-committee to appoint following expedited review shall be effective immediately and shall be forwarded to the Board for ratification at its next meeting.

(b) Board Review: Upon receipt of a recommendation that the applicant be granted Permission to Practice and Clinical Privileges requested, the Board may:

(1) grant the applicant Permission to Practice and Clinical Privileges as recommended; or

(2) refer the matter back to the Credentials Committee or MEC for additional research or information; or

(3) reject or modify the recommendation.

(c) If the Board determines to reject a favorable recommendation, it should first discuss the matter with the Chair of the Credentials Committee and the Chief of Staff. If the Board's determination remains unfavorable to the applicant, the CEO

shall promptly send Special Notice to the applicant that the applicant is entitled to request the procedural rights as outlined in this Policy.

(d) Any final decision by the Board to grant, deny, revise, or revoke Permission to Practice and/or Clinical Privileges will be disseminated to appropriate individuals and, as required, reported to appropriate entities.

5.B. CLINICAL PRIVILEGES

5.B.1. General:

The Clinical Privileges recommended to the Board for Other Healthcare Professionals and Advanced Practice Professionals will be based upon consideration of the following factors:

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

(b) ability to perform the Privileges requested competently and safely;

(c) information resulting from OPPE, FPPE, and performance improvement activities, as applicable;

(d) adequate professional liability insurance coverage for the Clinical Privileges requested;

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

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

(g) any information concerning professional review actions or voluntary or involuntary termination, limitation, reduction, or loss of appointment or Clinical Privileges at another hospital;

(h) Practitioner-specific data as compared to aggregate data, when available;

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

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

5.B.2. FPPE to Confirm Competence and Professionalism:

All new Clinical Privileges for Other Healthcare Professionals and Advanced Practice Professionals, regardless of when they are granted (initial Permission to Practice, renewal of Permission to Practice, or at any time in between), will be subject to FPPE in order to confirm competence. The FPPE process for these situations is outlined in the FPPE Policy to Confirm Practitioner Competence and Professionalism.

5.C. TEMPORARY CLINICAL PRIVILEGES

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

(a) Applicants: Temporary Privileges for an applicant for initial Permission to Practice may be granted by a member of the Administrative Team, upon a favorable recommendation of the Chief of Staff, the Department Chair, the Section Chief and/or the Chair of the Credentials Committee, when an Other Healthcare Professional or Advanced Practice Professional has submitted a completed application and the application is pending review by the Credentials Committee, the MEC and the Board. Prior to temporary Privileges being granted in this situation, the credentialing process must be complete, including, where applicable, verification of current licensure, relevant training or experience, current competence, ability to exercise the Privileges requested, and compliance with criteria, and consideration of information from the National Practitioner Data Bank. In order to be eligible for temporary Privileges, an individual must demonstrate that there are no current or previously successful challenges to his or her licensure or registration and that he or she has not been subject to involuntary termination of membership, or involuntary limitation, reduction, denial, or loss of Clinical Privileges at another health care facility.

(b) Locum Tenens: A member of the Administrative Team, upon recommendation of the Chief of Staff or the relevant Department Chair and/or Section Chief, may grant temporary Privileges to an Other Healthcare Professional or Advanced Practice Professional serving as a locum tenens for an individual who is on vacation, attending an educational seminar, or ill, and/or otherwise needs coverage assistance for a period of time. Prior to temporary Privileges being granted in this situation, the verification process must be complete, including, where applicable, verification of current licensure, relevant training or experience, current competence, ability to exercise the Privileges requested, and compliance with criteria, and consideration of information from the National Practitioner Data Bank. In order to be eligible for temporary Privileges, an individual must demonstrate that there are no current or previously successful challenges to his or her licensure or registration and that he or she has not been subject to involuntary termination of membership, or involuntary limitation, reduction, denial, or loss of Clinical Privileges at another health care facility.

(c) Compliance with Bylaws and Policies: Prior to temporary Privileges being granted, the individual must agree in writing to be bound by all applicable bylaws, rules and regulations, and policies, procedures, and protocols.

(d) Time Frames and Automatic Expiration: Temporary Privileges will be granted for a specific period of time, not to exceed 120 Days, and will expire at the end of the time period for which they are granted.

5.C.2. Withdrawal of Temporary Clinical Privileges:

The CEO, CMO, or VPMA may withdraw temporary Privileges for any reason, at any time, after consulting with the Chief of Staff, the Chair of the Credentials Committee, or the Department Chair and/or Section Chief.

5.D. PROCESSING APPLICATIONS FOR RENEWAL TO PRACTICE

5.D.1. Submission of Application:

(a) The grant of Permission to Practice will be for a period not to exceed two years. A request to renew Clinical Privileges will be considered only upon submission of a completed renewal application.

(b) Approximately four months prior to the date of expiration of an individual's Clinical Privileges, the Medical Staff Office will notify the individual of the date of expiration and provide the individual with a renewal application electronically. A completed renewal application must be returned to the Medical Staff Office accompanied by any reapplication fee within 30 Days.

(c) Failure to submit a complete application at least three months prior to the expiration of the individual's current term may result in automatic expiration of Clinical Privileges at the end of the then current term, unless the application can still be processed in the normal course, without extraordinary effort on the part of the Medical Staff Office and the Medical Staff Leaders.

(d) Once an application for renewal of Clinical Privileges has been completed and submitted, it will be evaluated following the same procedures outlined in this Policy regarding initial applications.

5.D.2. Renewal Process for Other Healthcare Professionals and Advanced Practice Professionals:

(a) The procedures pertaining to an initial request for Clinical Privileges, including eligibility criteria and factors for evaluation, will be applicable in processing requests for renewal for these individuals.

(b) As part of the process for renewal of Clinical Privileges, the following factors will be considered:

(1) an assessment prepared by the applicable Department Chair and/or Section Chief;

(2) an assessment prepared by a peer, if possible;

(3) results of the Hospital's performance improvement and OPPE and FPPE activities, taking into consideration, when applicable, Practitioner-specific information compared to aggregate information concerning other individuals in the same or similar specialty (provided that, other individuals will not be identified);

(4) resolution of any verified complaints received from patients or staff; and

(5) any FPPE activities.

(c) For Advanced Practice Professionals, the following information may also be considered:

(1) an assessment prepared by the Collaborating/Supervising Physician(s); or

(2) an assessment prepared by the applicable Hospital supervisor (i.e., OR Supervisor, Nursing Supervisor).

ARTICLE 6

STANDARDS OF PRACTICE APPLICABLE TO
ADVANCED PRACTICE PROFESSIONALS

6.A. STANDARDS OF PRACTICE FOR THE UTILIZATION OF ADVANCED PRACTICE PROFESSIONALS IN THE HOSPITAL

(1) As a condition of being granted Permission to Practice at the Hospital, all Advanced Practice Professionals specifically agree to abide by the standards of practice set forth in this Section. In addition, as a condition of utilizing the services of Advanced Practice Professionals in the Hospital, all Medical Staff Members who serve as Collaborating/Supervising Physicians to such individuals also specifically agree to abide by the standards set forth in this Section.

(2) The following standards of practice apply to the functioning of Advanced Practice Professionals in the Hospital:

(a) Exercise of Clinical Privileges. Advanced Practice Professionals may exercise those Clinical Privileges as have been granted pursuant to their approved delineation of Clinical Privileges, which delineations specify the requisite levels of Collaboration/Supervision that apply to their Privileges (general, direct, or personal, which terms are defined in this Policy), of which only "personal" supervision requires the actual physical presence of the Collaborating/Supervising Physician.

(b) Admitting Privileges. With the exception of Certified Nurse Midwives, Advanced Practice Professionals are not granted inpatient admitting Privileges and therefore may not admit patients independent of the Collaborating/Supervising Physician. However, an Advanced Practice Professional may write inpatient admission orders on behalf of a Collaborating/Supervising Physician who has inpatient admitting Privileges and may examine the patient, gather data, order tests, and generate other documentation to help facilitate the admission. Any order to admit must be co-signed by the Collaborating/Supervising Physician (e.g., the admitting Physician).

(c) Consultations. Advanced Practice Professionals may perform patient consultations in collaboration with their Collaborating/Supervising Physicians. An Advanced Practice Professional may examine patients, gather data, order tests, and develop an assessment and plan. However, the Collaborating/Supervising Physician must still personally assess the patient and render an opinion in accordance with the time frames set forth in the Medical Staff Rules and Regulations.

(d) Emergency On-Call Coverage. Advanced Practice Professionals may not independently participate in the emergency on-call roster (formally, or informally by agreement with their Collaborating/Supervising Physicians), in lieu of the Collaborating/Supervising Physician. The role that Advanced Practice Providers may play in assisting an On-Call Physician are set forth in the Emergency Department On-Call Policy.

(e) Calls Regarding Collaborating/Supervising Physician's Hospitalized Inpatients. It shall be within the discretion of the Hospital personnel requesting assistance whether it is appropriate to contact an Advanced Practice Professional or the Collaborating/Supervising Physician. Advanced Practice Professionals may not independently respond to calls from the floor or special care units regarding hospitalized inpatients that were specifically directed to the Collaborating/Supervising Physician. The Collaborating/Supervising Physician must personally respond to all calls that have been specifically directed to him or her in a timely manner.

(f) Inpatient Rounds for Attending Physicians. An Advanced Practice Professional is permitted to perform inpatient rounds; however, all inpatients must also be visited by the Collaborating/Supervising Physician (or a designated Physician – either in person or via technology-enabled direct communication and evaluation (i.e., Telemedicine) – whenever medically appropriate.

Exceptions to the above Standards of Practice may be granted by the MEC to an individual in a particular clinical situation, upon demonstration of good cause shown. When the MEC grants such an exception, the committee will follow the same process as set forth in Section 4.A.2 of this Policy.

6.B. OVERSIGHT BY COLLABORATING/SUPERVISING PHYSICIAN

(1) Any activities permitted to be performed at the Hospital by an Advanced Practice Professional shall be performed only in collaboration with or under the supervision or direction of a Collaborating/Supervising Physician, except for (i) Nurse Practitioners whose clinical privileges include only diabetic care, wound care, or (ii) the Diagnostic Nursing FNP.

(2) Except for (i) Nurse Practitioners whose clinical privileges include only diabetic care or wound care, or (ii) the Diagnostic Nursing FNP Advanced Practice Professionals may function in the Hospital only so long as (i) they are supervised by a Collaborating/Supervising Physician who is currently appointed to the Medical Staff, and (ii) they have a current, written supervision or collaboration agreement with the Collaborating/Supervising Physician. In addition, should the Medical Staff appointment or Clinical Privileges of the Collaborating/Supervising Physician be revoked or terminated, the Advanced Practice Professional's Permission to Practice at the Hospital and Clinical Privileges shall be Automatically Relinquished (unless the individual will be supervised by another approved Physician on the Medical Staff).

(3) As a condition of obtaining Clinical Privileges, an Advanced Practice Professional and the Collaborating/Supervising Physician must provide the Hospital with a copy of any written supervision or collaboration agreement that may be required by the state as well as notice of any revisions or modifications that are made to any such agreements between them. This notice must be provided to the Medical Staff Office within three Days of any such change.

(4) The Collaborating/Supervising Physician shall be kept apprised of issues related to clinical competence, performance, and/or professional conduct that involve any Advanced Practice Professional with whom the Collaborating/Supervising Physician has a supervisory or collaborative relationship. Collaborating/Supervising Physicians will specifically be copied on all correspondence that an Advanced Practice Professional receives from Medical Staff leadership regarding the same.

6.C. QUESTIONS REGARDING AUTHORITY OF AN ADVANCED PRACTICE PROFESSIONAL

(1) Should any Medical Staff Member or Hospital employee who is licensed or certified by the state have any question regarding the clinical competence or authority of an Advanced Practice Professional, either to act or to issue instructions outside the physical presence of the Collaborating/Supervising Physician in a particular instance, the Medical Staff Member or Hospital employee shall have the right to require that the Advanced Practice Professional's Collaborating/Supervising Physician validate, either at the time or later, the instructions of the Advanced Practice Professional. Any act or instruction of the Advanced Practice Professional shall be delayed until such time as the Medical Staff Member or Hospital employee can be certain that the act is clearly within the scope of the Advanced Practice Professional's activities as permitted by the Board.

(2) Any question regarding the clinical practice or professional conduct of an Advanced Practice Professional shall be immediately reported to the Chief of Staff, the relevant Department Chair and/or Section Chief, the CMO or the VPMA, who shall undertake such action as may be appropriate under the circumstances. The individual to whom the concern has been reported may also discuss the matter with the Collaborating/Supervising Physician.

6.D. RESPONSIBILITIES OF COLLABORATING/SUPERVISING PHYSICIAN

(1) Physicians who wish to utilize the services of an Advanced Practice Professional in their clinical practice at the Hospital must notify Medical Staff Services of this fact in advance and must ensure that the individual has been appropriately credentialed in accordance with this Policy or with Human Resources policies and procedures before the Advanced Practice Professional participates in any clinical or direct patient care of any kind in the Hospital.

(2) The Collaborating/Supervising Physician will remain responsible for all care provided by the Advanced Practice Professional in the Hospital.

(3) Collaborating/Supervising Physicians who wish to utilize the services of an Advanced Practice Professional in the inpatient setting specifically agree to abide by the standards of practice set forth in Section 6.A above.

(4) The number of Advanced Practice Professionals acting under the supervision of, or in collaboration with, one Collaborating/Supervising Physician, as well as the care they may provide, will be consistent with applicable state statutes and regulations and any other policies adopted by the Hospital. The Collaborating/Supervising Physician will make all appropriate filings with the relevant state board regarding the Collaboration/Supervision and responsibilities of the Advanced Practice Professional, to the extent that such filings are required, and shall provide a copy of the same to Medical Staff Services.

(5) It will be the responsibility of the Collaborating/Supervising Physician to ensure that the Advanced Practice Professional maintains professional liability insurance in amounts required by the Board. The insurance must cover any and all activities of the Advanced Practice Professional in the Hospital. The Collaborating/Supervising Physician will furnish evidence of such coverage to the Hospital. The Advanced Practice Professional will act in the Hospital only while such coverage is in effect.

ARTICLE 7

QUESTIONS INVOLVING PRACTITIONERS

7.A. COLLABORATIVE LEADERSHIP EFFORTS AND PROGRESSIVE STEPS

(1) This Policy encourages the use of Collaborative Leadership Efforts and Progressive Steps by Medical Staff Leaders and Hospital administration, in consultation with Collaborating/Supervising Physicians, to address questions relating to an individual's clinical practice, professional conduct, and/or health. The goal of these efforts is to arrive at voluntary, responsive actions by the individual to resolve questions that have been raised. Medical Staff Leaders and Hospital administration have been authorized by the MEC, the Leadership Council, and the PPC to engage in Collaborative Leadership Efforts and Progressive Steps and all of these activities are undertaken on behalf of these committees as part of their Professional Practice Evaluation functions.

(2) Collaborative Leadership Efforts include activities such as:

(a) informal mentoring, coaching, or counseling of the individual, and, if necessary, the Collaborating/Supervising Physician by a Medical Staff Leader (e.g., advising an individual of policies regarding appropriate behavior, communication issues, emergency call obligations, or the timely and adequate completion of medical records); and

(b) sharing comparative data, including any variations from clinical practice or evidence-based protocols or guidelines, in order to assist the individual with conforming his or her practice to appropriate norms.

There is no expectation that these efforts be documented, though documentation may be created in the discretion of the Medical Staff Leader and maintained in the individual's Confidential File.

(3) Progressive Steps are defined as follows:

(a) addressing minor performance issues through Informational Letters (i.e., a non-punitive, educational tool to help individuals self-correct and improve their performance through feedback);

(b) sending an Educational Letter (i.e., a letter that describes opportunities for improvement and provides specific guidance and suggestions);

(c) facilitating a formal Collegial Intervention (i.e., a planned, face-to-face meeting between an individual and one or more Medical Staff Leaders), which may also include the Collaborating/Supervising Physician, in order

to directly discuss a matter and the steps needed to be taken to resolve it; and

(d) developing a Performance Improvement Plan, which may include a wide variety of tools and techniques that can result in a constructive and successful resolution of the concern.

All Progressive Steps shall be documented in a constructive manner and included in an individual's Confidential File and maintained in a confidential manner consistent with its privileged status. Any written responses to any of these Progressive Steps by the individual shall also be included in the individual's Confidential File.

(4) All of these efforts are fundamental and integral components of the Hospital's Professional Practice Evaluation activities, and are privileged, confidential, and protected in accordance with state law.

(5) Collaborative Leadership Efforts and Progressive Steps are encouraged, but are not mandatory, and shall be within the discretion of the appropriate Medical Staff Leaders and Hospital administration. When a question arises, the Medical Staff Leaders and/or Hospital Administration may:

(a) address it pursuant to the informal leadership efforts and Progressive Steps provisions of this Section;

(b) refer the matter for review in accordance with the Professional Practice Evaluation Policy, Professionalism Policy, Practitioner Health Policy, and/or other relevant policy; or

(c) refer it to the MEC for its review and consideration in accordance with Section 7.D of this Article.

(6) Should any recommendation be made or an action taken that entitles an Advanced Practice Professional to a hearing in accordance with this Policy, the individual is entitled to be accompanied by legal counsel at that hearing. However, Advanced Practice Professionals do not have the right to be accompanied by counsel when the Medical Staff Leaders and Hospital administration are engaged in Collaborative Leadership Efforts or other Progressive Steps. These efforts are intended to resolve issues in a constructive manner and do not involve the formal hearing process. In addition, there shall be no recording (audio or video) or transcript made of any meetings that involve Collaborative Leadership Efforts or Progressive Steps activities.

7.B. PROFESSIONAL PRACTICE EVALUATION ACTIVITIES

Professional Practice Evaluation activities shall be conducted in accordance with the Professional Practice Evaluation Policy, Professionalism Policy, Practitioner Health Policy, and/or other relevant policy. Matters that are not satisfactorily resolved through collegial efforts or through one of these policies shall be referred to the MEC for its review in accordance with Section 7.D below. Such interventions and evaluations, however, are not mandatory prerequisites to MEC review.

7.C. ADMINISTRATIVE SUSPENSION

(1) The Chief of Staff, the relevant Department Chair and/or Section Chief, the Chair of the Credentials Committee, the CMO, the VPMA, the CEO, and the MEC will each have the authority to impose an administrative suspension of all or any portion of the Clinical Privileges of any individual whenever a question has been raised about such individual's clinical care or professional conduct.

(2) An administrative suspension will become effective immediately upon imposition, will immediately be reported in writing to the CEO, the Chief of Staff, the VPMA, and the CMO and will remain in effect unless or until modified by the CEO or the MEC. The imposition of an administrative suspension does not entitle an individual to the procedural rights set forth in Article 8 of this Policy.

(3) Upon receipt of notice of the imposition of an administrative suspension, the CEO and Chief of Staff will promptly forward the matter to the MEC, which will review and consider the question(s) raised and thereafter make a recommendation to the Board.

7.D. INVESTIGATIONS

7.D.1. Initiation of Investigation:

When a question involving clinical competence or professional conduct of an individual is referred to, or raised by, the MEC, the MEC will review the matter and determine whether to conduct an Investigation, to direct the matter to be handled pursuant to another policy, or to proceed in another manner.

7.D.2. Investigative Procedure:

(a) The MEC will either investigate the matter itself, request that the Credentials Committee conduct the Investigation, or appoint an ad hoc committee to conduct the Investigation ("investigating committee"). The investigating committee will not include relatives or financial partners of the individual or, where applicable, the Advanced Practice Professional's Collaborating/Supervising Physician. Whenever the questions raised concern the clinical competence of the individual

under review, the ad hoc committee shall include a peer of the individual (e.g., an individual in a similar discipline).

(b) The investigating committee will have the authority to review relevant documents and interview individuals and will have available to it the full resources of the Medical Staff and the Hospital. The investigating committee may also request written input from, or a meeting with, the Collaborating/Supervising Physician as part of the Investigation process.

(c) The investigating committee will also have the authority to use outside consultants, if needed.

(d) The investigating committee may require a physical, mental, and/or behavioral examination of the individual by a health care professional(s) acceptable to it. The individual being investigated shall execute a release (in a form approved or provided by the investigating committee) allowing (i) the investigating committee (or its representative) to discuss with the health care professional(s) conducting the examination the reasons for the examination; and (ii) the health care professional(s) conducting the examination to discuss and provide documentation of the results of such examination directly to the investigating committee. The cost of such health examination shall be borne by the individual.

(e) The individual will have an opportunity to meet with the investigating committee before it makes its report. Prior to this meeting, the individual will be informed, in writing, of the general questions being investigated. The investigating committee may also ask the individual to provide written responses to specific questions related to the Investigation and/or a written explanation of his or her perspective on the events that led to the Investigation for review by the investigating committee prior to the meeting.

(f) At the meeting, the individual will be invited to discuss, explain, or refute the questions that gave rise to the Investigation. No recording (audio or video) or transcript of the meeting shall be permitted or made. A summary of the interview will be prepared. This meeting is not a hearing, and none of the procedural rules for hearings will apply. The individual being investigated will not have the right to be accompanied by legal counsel at this meeting.

(g) The investigating committee will make a reasonable effort to complete the Investigation and issue its report within 30 Days of the commencement of the Investigation, provided that an outside review is not necessary. When an outside review is necessary, the investigating committee will make a reasonable effort to complete the Investigation and issue its report within 30 Days of receiving the results of the outside review. These time frames are intended to serve only as guidelines.

(h) At the conclusion of the Investigation, the investigating committee will prepare a report with its findings, conclusions, and recommendations.

7.D.3. Recommendation:

(a) The MEC may accept, modify, or reject any recommendation it receives from an ad hoc investigating committee if one was appointed by the MEC. In either case, at the conclusion of the Investigation, the MEC may:

(1) determine that no action is justified;

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

(3) impose conditions for continued Permission to Practice;

(4) impose a requirement for monitoring, proctoring, or consultation;

(5) impose a requirement for additional training or education;

(6) recommend reduction of Clinical Privileges;

(7) recommend suspension of Clinical Privileges for a term;

(8) recommend revocation of Clinical Privileges; or

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

(b) A recommendation by the MEC that would entitle the individual to request a hearing will be forwarded to the CEO, who will promptly inform the individual by Special Notice. The CEO will hold the recommendation until after the individual has completed or waived a hearing and appeal.

(c) If the MEC makes a recommendation that does not entitle the individual to request a hearing, it will take effect immediately and will remain in effect unless modified by the MEC or the Board.

7.E. AUTOMATIC RELINQUISHMENT/ACTIONS

(1) An individual's Clinical Privileges shall be Automatically Relinquished, without entitlement to the procedural rights outlined in this Policy, in the following circumstances:

(a) the individual no longer satisfies any of the threshold eligibility criteria set forth in Section 4.A.1 or any additional threshold credentialing qualifications set forth in the specific Hospital policy relating to his or her discipline;

(b) the individual is arrested, charged, indicted, convicted, or enters a plea of guilty or no contest to any felony; or to any misdemeanor involving (i) controlled substances; (ii) illegal drugs; (iii) Medicare, Medicaid, or insurance or health care fraud or abuse; (iv) child abuse; (v) elder abuse; or (vi) violence against another (DUIs will be reviewed in accordance with the Practitioner Health Policy;

(c) the individual fails to complete medical records as described in the Medical Staff Rules and Regulations;

(d) the individual fails to provide information pertaining to his or her qualifications for Clinical Privileges in response to a written request from the CEO, the Credentials Committee, the Leadership Council, PPC, the APPC, the MEC, or any other committee authorized to request such information;

(e) the individual fails to complete or comply with training or educational requirements that are adopted by the MEC or required by the Board, including, but not limited to, those pertinent to electronic medical records, computerized Physician order entry ("CPOE"), the privacy and security of protected health information, infection control, or patient safety;

(f) the individual fails to attend a special meeting at the request of a Medical Staff Leader to discuss a concern with clinical practice or professional conduct, provided Special Notice of the meeting has been provided at least three Days in advance;

(g) a determination is made that there is no longer a need for the services of a particular discipline or category of Advanced Practice or Other Healthcare Professional;

(h) an Advanced Practice Professional fails, for any reason, to maintain an appropriate relationship with a Collaborating/Supervising Physician as defined in this Policy (except for (i) Nurse Practitioners whose clinical privileges include only diabetic, wound care, or (ii) the Diagnostic Nursing FNP;); or

(i) any individual employed by the Hospital has his or her employment terminated.

(2) Requests for reinstatement.

(a) Requests for reinstatement following the expiration of a license/certification/registration, controlled substance authorization, and/or insurance coverage will be processed by the Medical Staff Office. If any questions or concerns are noted, the Medical Staff Office will refer the matter for further review in accordance with (c) below.

(b) Requests for reinstatement following the relinquishment of Clinical Privileges due to (i) failure to provide requested information, (ii) failure to complete medical records, (iii) failure to complete or comply with training, educational, or orientation requirements, and/or (iv) failure to attend a special meeting shall be reviewed by the Leadership Council Chair. If the Leadership Council Chair recommends favorably on reinstatement, the individual may immediately resume clinical practice. If, however, any questions or concerns are noted, the matter will be referred to the full Leadership Council in accordance with (c) below.

(c) All other requests for reinstatement will be reviewed by the Leadership Council. If the Leadership Council makes 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 MEC, and the Board for ratification. If, however, the Leadership Council has any questions or concerns, those questions will be noted and the reinstatement request will be forwarded to the full Credentials Committee, MEC, and Board for review and recommendation.

7.F. LEAVE OF ABSENCE

(1) An Advanced Practice or Other Healthcare Professional may request a leave of absence by submitting a written request to the Medical Staff Office. The request must state the beginning and ending dates of the leave, which shall not exceed one year, and the reasons for the leave. Except in extraordinary circumstances, this request will be submitted at least 30 Days prior to the anticipated start of the leave. The request must state the beginning and ending dates of the leave, which shall not exceed 12 months, and the reasons for the leave. The CMO and/or VPMA shall determine whether a request for a leave of absence shall be granted.

(2) Except for maternity leaves, individuals must report to the Medical Staff Office any time they are away from patient care responsibilities for longer than 30 Days and the reason for such absence is related to their physical or mental health or otherwise to their ability to care for patients safely and competently. Failure to report such circumstances may trigger an automatic medical leave of absence.

(3) Individuals requesting reinstatement must submit a written summary of their professional activities during the leave, and any other information that may be requested, to the Medical Staff Office. Requests for reinstatement will then be reviewed by the Leadership Council. If the Leadership Council makes a favorable recommendation on reinstatement, the individual may immediately resume practice. This determination will then be forwarded to the Credentials Committee, the MEC, and the Board for ratification. If, however, the Leadership Council has any questions or concerns, those questions will be noted and the reinstatement request will be forwarded to the full Credentials Committee, MEC,

and Board for review and recommendation. In the event the MEC determines to take action that would entitle the individual to the procedural rights set forth in Article 8, the individual will be given Special Notice.

(4) If the leave of absence was for health reasons (except for maternity leaves), the request for reinstatement must be accompanied by a report from the individual's Physician indicating that the individual is physically and/or mentally capable of resuming a hospital practice and safely exercising the Clinical Privileges requested and the reinstatement will be processed in accordance with the Practitioner Health Policy.

(5) If an individual's Permission to Practice and Clinical Privileges are due to expire during the leave, the individual must apply for renewal of practice or his or her Permission to Practice and Clinical Privileges shall lapse at the end of the their current term.

(6) Failure to request renewal of practice from a leave of absence in a timely manner shall be deemed a voluntary resignation of Permission to Practice and Clinical Privileges.

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

ARTICLE 8

PROCEDURAL RIGHTS FOR PRACTITIONERS

8.A. GENERAL

Individuals shall not be entitled to the hearing and appeals procedures set forth in the Medical Staff Credentials Policy. Any and all procedural rights to which these individuals are entitled are set forth in this Article.

8.B. NOTICE OF RIGHTS

(1) In the event a recommendation is made by the MEC that an Other Healthcare Professional or Advanced Practice Professional not be granted Clinical Privileges or that the Privileges previously granted be restricted for a period of more than 30 Days, terminated, or not renewed, the individual will receive Special Notice of the recommendation. The Special Notice will include a general statement of the reasons for the recommendation and will advise the individual that he or she may request a hearing.

(2) The rights and procedures in this Section will also apply if the Board, without a prior adverse recommendation from the MEC, makes a recommendation not to grant Clinical Privileges or that the Privileges previously granted be restricted, terminated, or not renewed. In this instance, all references in this Article to the MEC will be interpreted as a reference to the Board.

(3) If the Other Healthcare Professional or Advanced Practice Professional wants to request a hearing, the request must be in writing, directed to the CEO, within 30 Days after receipt of written notice of the adverse recommendation.

(4) The hearing will be convened as soon as is practical, but no sooner than 30 Days after the notice of the hearing, unless an earlier hearing date has been specifically agreed to by the parties.

8.C. HEARING COMMITTEE

(1) If a request for a hearing is made in a timely manner, the CEO, in conjunction with the Chief of Staff, shall appoint a Hearing Committee composed of up to three individuals (including, but not limited to, individuals appointed to the Medical Staff, other Advanced Practice Professionals, Hospital management, individuals not connected to the Hospital, or any combination of these individuals) and a Presiding Officer, who may be legal counsel to the Hospital. The Hearing Committee shall not include anyone who previously participated in the recommendation, any relatives or practice partners of the Other Healthcare

Professional or Advanced Practice Professional, or any competitors of the affected individual.

(2) As an alternative to the Hearing Committee described in paragraph (a) of this Section, the CEO, in conjunction with the Chief of Staff, may instead appoint a Hearing Officer to perform the functions that would otherwise be carried out by the Hearing Committee. The Hearing Officer shall preferably be an attorney at law. The Hearing Officer may not be in direct economic competition with the individual requesting the hearing and shall not act as a prosecuting officer or as an advocate to either side at the hearing. If the Hearing Officer is an attorney, he or she shall not represent clients who are in direct economic competition with the affected individual. In the event a Hearing Officer is appointed instead of a Hearing Committee, all references in this Article to the Hearing Committee shall be deemed to refer instead to the Hearing Officer, unless the context would clearly otherwise require.

(3) The hearing shall be convened as soon as is practical, but no sooner than 30 Days after the notice of the hearing, unless an earlier hearing date has been specifically agreed to by the parties.

8.D. HEARING PROCESS

(1) No recording (audio or video) of the hearing shall be permitted or made. A written record of the hearing will be maintained by a stenographic reporter or by a recording of the proceedings. Copies of the transcript will be available at the individual's expense.

(2) The hearing will last no more than six hours, with each side being afforded approximately three hours to present its case, in terms of both direct and cross-examination of witnesses.

(3) At the hearing, a representative of the MEC will first present the reasons for the recommendation. The Other Healthcare Professional or Advanced Practice Professional will be invited to present information to refute the reasons for the recommendation.

(4) Both parties will have the right to present witnesses. The Presiding Officer will permit reasonable questioning of such witnesses.

(5) The Other Healthcare Professional or Advanced Practice Professional and the MEC may be represented at the hearing by legal counsel. However, while counsel may be present at the hearing, counsel will not call, examine, or cross-examine witnesses or present the case.

(6) The Other Healthcare Professional or Advanced Practice Professional will have the burden of demonstrating, by clear and convincing evidence, that the

recommendation of the MEC was arbitrary, capricious, or not supported by substantial evidence. The quality of care provided to patients and the smooth operation of the Hospital will be the paramount considerations.

(7) The Other Healthcare Professional or Advanced Practice Professional and the MEC will have the right to prepare a post-hearing memorandum for consideration by the Hearing Committee. The Presiding Officer will establish a reasonable schedule for the submission of such memoranda.

8.E. HEARING COMMITTEE REPORT

(1) Within 20 Days after the conclusion of the proceeding or submission of the post-hearing memoranda, whichever date is later, the Hearing Committee will prepare a written report and recommendation. The Hearing Committee will forward the report and recommendation, along with all supporting information, to the CEO. The CEO will send a copy of the written report and recommendation by Special Notice to the Other Healthcare Professional or Advanced Practice Professional and to the MEC.

(2) Within ten Days after notice of such recommendation, the Other Healthcare Professional or Advanced Practice Professional and/or the MEC may make a written request for an appeal. The request must include a statement of the reasons, including specific facts, which justify an appeal.

(3) The grounds for appeal will be limited to an assertion that there was substantial failure to comply with this Policy during the hearing, so as to deny a fair hearing, and/or that the recommendation of the Hearing Committee was arbitrary, capricious, or not supported by substantial evidence.

(4) The request for an appeal will be delivered to the CEO by Special Notice.

(5) If a written request for appeal is not submitted timely, the appeal is deemed to be waived and the recommendation and supporting information will be forwarded to the Board for final action. If a timely request for appeal is submitted, the CEO will forward the report and recommendation, the supporting information and the request for appeal to the Board. The Chair of the Board will arrange for an appeal.

8.F. APPELLATE REVIEW

(1) An Appellate Review Committee appointed by the Chair of the Board will consider the record upon which the adverse recommendation was made. The Board may serve as the Appellate Review Committee or the Chair of the Board may appoint an Appellate Review Committee composed of not less than three persons, either members of the Board or others, including but not limited to reputable persons outside the Hospital.

(2) New or additional written information that is relevant and could not have been made available to the Hearing Committee may be considered at the discretion of the Appellate Review Committee. This review will be conducted within 30 Days after receiving the request for appeal.

(3) The Other Healthcare Professional or Advanced Practice Professional and the MEC will each have the right to present a written statement on appeal.

(4) At the sole discretion of the Appellate Review Committee, the Other Healthcare Professional or Advanced Practice Professional and a representative of the MEC may also appear personally to discuss their position.

(5) Upon completion of the review, the Appellate Review Committee will provide a report and recommendation to the full Board for action. The Board will then make its final decision based upon the Board's ultimate legal responsibility to grant Privileges and to authorize the performance of clinical activities at the Hospital.

(6) The Other Healthcare Professional or Advanced Practice Professional will receive Special Notice of the Board's action. A copy of the Board's final action will also be sent to the MEC for information.

ARTICLE 9

HOSPITAL EMPLOYEES

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

(B) Except as noted in (A), Hospital-employed Advanced Practice and Other Healthcare Professionals are bound by all of the same conditions and requirements in this Policy that apply to non-Hospital employed Advanced Practice and Other Healthcare Professionals.

(C) A request for Clinical Privileges, on an initial basis or for renewal, submitted by an Other Healthcare Professional or Advanced Practice Professional who is seeking employment or who is employed by the Hospital shall be processed in accordance with the terms of this Policy and the Medical Staff leadership shall determine whether the individual is qualified for the Privileges requested. A report regarding each individual's qualifications shall then be made to Hospital management or Human Resources (as appropriate) to assist the Hospital in making employment decisions.

(D) If a concern about an employed individual's clinical competence or professional conduct originates with the Medical Staff, the concern may be reviewed and addressed in accordance with Articles 7 and 8 of this Policy, after which a report will be provided to Hospital management or Human Resources (as appropriate). This provision does not preclude Hospital management or Human Resources from addressing an issue in accordance with the Hospital's employment policies/manuals or in accordance with the terms of any applicable employment contract.

ARTICLE 10

AMENDMENTS

This Policy may be amended pursuant to Article 9 of the Medical Staff Bylaws.

ARTICLE 11

ADOPTION

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

Medical Staff: _____

Board of Trustees: December 9, 2019

APPENDIX A

Those individuals currently practicing as Advanced Practice Professionals at the Hospital are as follows:

Advanced Practice Nurses as defined by the Arizona Nurse Practice Act, which includes, but is not limited to, Nurse Practitioners, Certified Nurse Midwives, and Certified Registered Nurse Anesthetists

Physician Assistants

APPENDIX B

Those individuals currently practicing as Other Healthcare Professionals at the Hospital are as follows:

Clinical Social Workers

Moonlighting Residents and Fellows

Psychologists

MEDICAL STAFF BYLAWS, POLICIES, AND RULES AND REGULATIONS OF TUCSON MEDICAL CENTER

MEDICAL STAFF RULES AND REGULATIONS

Approved by the Board: October 22, 2025

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ARTICLE I

DEFINITIONS

Unless otherwise indicated, the capitalized terms used in all of the Medical Staff documents are defined in the Medical Staff Glossary.

ARTICLE II

ADMISSIONS,
TREATMENT, AND SERVICES

2.A. ADMISSIONS

(1) A patient may only be admitted to the Hospital, or designated as "observation status," by order of a Practitioner who is granted admitting Privileges.

(2) Except in an emergency, all inpatient medical records will include an admitting diagnosis on the record prior to admission. In the case of an emergency, the admitting diagnosis will be recorded as soon as possible, and no later than ***24 hours*** after admission.

(3) Patients will be admitted based on the following order of priority:

(a) **Emergency** – includes patients in an emergency medical condition or in active labor who require hospitalization.

(b) **Urgent** – includes non-emergency patients whose admission is considered imperative by the Admitting Practitioner.

(c) **Routine Admissions** – includes scheduled elective admissions involving all services.

(4) The Admitting Practitioner will provide the Hospital with any information concerning the patient that is necessary to protect the patient, other patients or Hospital personnel from infection, disease or other harm, and to protect the patient from self-harm.

2.B. ADMISSIONS THROUGH THE EMERGENCY DEPARTMENT

If an Unassigned Patient is evaluated by the Emergency Department and requires admission, the patient will be assigned to the appropriate on-call Physician or admitted to the hospitalist service.

2.C. OBSERVATION STATUS

(1) Observation status is an outpatient status meant to be used as a period of diagnosis and/or treatment prior to or in lieu of an inpatient admission.

(2) All patients placed in observation status must be seen by the Admitting Practitioner or a Responsible Practitioner within the observation period and a history and physical examination completed.

2.D. RESPONSIBILITIES OF PRIMARY TREATING PHYSICIAN

(1) At all times during a patient's hospitalization, the identity of the patient's Primary Treating Physician (or his or her alternate or covering Physician) will be clearly documented in the medical record. Whenever the responsibilities of the Primary Treating Physician are transferred to another Physician outside of his or her established coverage arrangement, a note covering the transfer of responsibility will be entered in the patient's medical record. The Primary Treating Physician will be responsible for verifying the other Physician's acceptance of the transfer and updating the Primary Treating Physician screen in the electronic medical record ("EMR").

(2) If the Primary Treating Physician does not participate in an established coverage arrangement with known alternate coverage and will be unavailable to care for a patient for longer than 24 hours, the Primary Treating Physician will document in the medical record the name of the Medical Staff Member who will be assuming responsibility for the care of the patient during his or her unavailability. The Primary Treating Physician will be responsible for (i) verifying the other Physician's acceptance of the transfer, and (ii) notifying the Medical Staff Office and the Emergency Department, if applicable, of his or her absence and who will cover for him or her.

(3) If the Primary Treating Physician is unavailable and alternate coverage has not been arranged, the relevant Department Chair/Section Chief, the Chief of Staff, the CMO, the VPMA, or the administrator on call will have the authority to call on the on-call Physician in that specialty or any other Medical Staff Member to attend the patient. The Medical Staff Leaders will also confirm the Primary Treating Physician meets the eligibility criteria related to appropriate coverage, as outlined in the Medical Staff Credentials Policy.

2.E. CONTINUED HOSPITALIZATION

(1) The Primary Treating Physician will provide whatever information may be requested with respect to the continued hospitalization of a patient, including:

(a) an adequate record of the reason for continued hospitalization (a simple reconfirmation of the patient's diagnosis is not sufficient);

(b) the estimated period of time the patient will need to remain in the Hospital; and

(c) plans for post-hospital care.

This response will be provided within 24 hours of the request. Failure to comply with this requirement will be reported to the Department Chair/Section Chief and/or the Chief of Staff for review and appropriate action.

(2) If a determination is made that a case does not meet the criteria for continued hospitalization, written notification will be given to the Hospital, the patient, and the Primary Treating Physician. If the matter cannot be appropriately resolved, the Leadership Council will be consulted.

ARTICLE III

MEDICAL RECORDS

3.A. GENERAL

A medical record will be prepared for every individual evaluated and treated at the Hospital. Each Practitioner who is involved in the care of a patient will be responsible for the timely and accurate completion of the portions of the medical record that pertain to the care he or she provides.

3.B. MEDICAL RECORD ENTRIES

3.B.1. Entries:

(a) The following individuals are authorized to document in the medical record:

(1) Admitting Practitioners, Consulting Physicians, and other Responsible Practitioners;

(2) nursing providers, including registered nurses ("RNs");

(3) other licensed or certified health care professionals involved in patient care, including, but not limited to, physical therapists, occupational therapists, respiratory therapists, pharmacists, social workers, and case managers;

(4) other health care providers who have access to the medical record pursuant to their job description (e.g., aides and assistants);

(5) volunteers, such as chaplains, functioning within their approved roles;

(6) residents and students in an approved professional education program who are involved in patient care as part of their education process (e.g., medical and nursing students) if that documentation is reviewed and countersigned by the student's supervisor, who must also be authorized to document in the medical record; and

(7) non-clinical and administrative staff, as appropriate, pursuant to their job description.

(b) Electronic entries will be entered through the EMR and/or Computerized Provider Order Entry ("CPOE") in accordance with Hospital policy.

(c) Handwritten medical record entries will be legibly recorded in blue or black ink whenever the use of paper-based documentation is appropriate (i.e., an emergency

situation or when the EMR or CPOE function is not available) or has been otherwise approved by the Hospital (e.g., documentation of informed consents). Any such written or paper-based entries will be scanned and entered into the patient's EMR in accordance with Hospital policy.

(d) All entries, including handwritten entries, must be timed, dated and signed.

(e) Any entry in the medical record should be clear, concise, and objective. Practitioners should avoid editorializing in the medical record of a patient or entering extraneous comments or criticisms about a patient, a patient's family, or the care provided by other Practitioners or Hospital personnel.

3.B.2. Entries by an Advanced Practice Professional:

(a) With the exception of (i) Certified Nurse Midwives, (ii) Nurse Practitioners whose clinical privileges include only diabetic, wound care, or (iii) the Diagnostic Nursing FNP, Certified Nurse Midwives, the following entries by an Advanced Practice Professional related to inpatients must be countersigned by a Collaborating/Supervising Physician: the order to admit, history and physical examinations, consultations, discharge summaries, and procedure reports.

(b) A countersignature by a Collaborating/Supervising Physician indicates that the Collaborating/Supervising Physician has taken full responsibility for the entry that has been countersigned.

3.B.3. Authentication:

(a) Authentication means to establish authorship by signature or identifiable initials and may include computer entry using unique electronic signatures for entries entered through the EMR or CPOE.

(b) The Practitioner will provide a signed statement attesting that he or she alone will use his or her unique electronic signature code to authenticate documents in accordance with Hospital policy.

(c) If a rubber-stamp signature or an electronic signature code is used to authenticate an order, the individual whose signature the stamp or electronic code represents is accountable for the use of the stamp or the electronic code.

3.B.4. Forms:

All printed forms and templates used for medical record documentation shall be approved by the Health Information Management ("HIM") Department. The EMR will be used for electronic documentation.

3.B.5. Symbols and Abbreviations:

(a) Only standardized terminology, definitions, abbreviations, acronyms, symbols and dose designations will be used. Abbreviations on the unapproved abbreviations and/or symbols list may not be used.

(b) The Medical Staff will periodically review the unapproved abbreviations and/or symbols list and an official record of unapproved abbreviations will be kept on file.

3.B.6. Clarity and Completeness:

All entries in the medical record shall be clear and complete so that other members of the health care team are able to understand the entry and the author's intentions.

3.B.7. Correction of Errors:

When a dictated or electronic entry requires correction, the author shall dictate or enter an electronic addendum to the initial entry. Any error made while entering an order in the CPOE should be corrected by entering another order.

3.B.8. Copying and Pasting:

Copying and pasting from a prior note in the EMR is only permissible when the posted note is properly updated in accordance with the standards outlined in the Professionalism Policy.

3.B.9. Permanent Filing of Medical Records:

A medical record will not be permanently filed until it is completed by the Responsible Practitioner, or it is ordered filed by the Medical Records Department under the direction of the MEC. Except in rare circumstances, and only when approved by the MEC, no Practitioner will be permitted to complete a medical record on an unfamiliar patient in order to permanently file that record.

3.C. OWNERSHIP, RETENTION, AND ACCESS TO RECORDS

3.C.1. Ownership of Records:

Hospital medical records are the property of the Hospital. Original medical records may only be removed from the Hospital in accordance with federal or state laws.

3.C.2. Retention of Records:

Hospital medical records will be retained in accordance with the Hospital's policy on the retention of patient records.

3.C.3. Access to Records:

(a) Information from, or copies of, records may be released only to authorized individuals or entities (i.e., other health care providers) in accordance with federal and state law and the Hospital's Health Insurance Portability and Accountability Act ("HIPAA") policies.

(b) A patient or his or her duly designated representative may receive copies of the patient's completed medical record, or an individual report, pursuant to the Hospital's HIPAA policies.

(c) Access to all medical records of patients will be afforded to Medical Staff Members for bona fide study and research consistent with Hospital policy, applicable federal and state law, and preserving the confidentiality of personal information concerning the individual patients. All such projects will be approved by the Institutional Review Board (IRB).

(d) Subject to the discretion of the Administrative Team, former Medical Staff Members may be permitted access to information from the medical records of their patients covering all periods during which they attended to such patients in the Hospital.

ARTICLE IV

CONTENT AND TIMELINESS OF MEDICAL RECORD DOCUMENTATION

4.A. CONTENT OF MEDICAL RECORD

4.A.1. General Requirements:

All medical records for patients receiving an evaluation or treatment in the Hospital or at an Ambulatory Care Location will document the information outlined in this section, as relevant and appropriate to the patient's care. This documentation will be the joint responsibility of the Responsible Practitioners and the Hospital:

(a) identification data, including the patient's name, sex, address, date of birth, race, ethnicity, and name of authorized representative (if any);

(b) legal status of any patient receiving behavioral health services (i.e., voluntary or involuntary status);

(c) patient's language and communication needs, including preferred language for discussing health care;

(d) evidence of informed consent when required by Hospital policy and, when appropriate, evidence of any known advance directives and/or resuscitation orders (i.e., DNR or AND);

(e) records of communication with the patient regarding care, treatment, and services (e.g., telephone calls or e-mail) and any patient-generated information;

(f) emergency care, treatment, and services provided to the patient before his or her arrival, if any;

(g) admitting history (i.e., date, source and type of admission) and physical examination and conclusions or impressions drawn from the history and physical examination;

(h) allergies and sensitivities;

(i) reason(s) for admission of care, treatment, and services;

(j) diagnosis, diagnostic impression, or symptoms;

(k) goals of the treatment and treatment plan;

(l) diagnostic and therapeutic orders, procedures, tests, and results;

(m) interval notes made by authorized individuals;

(n) medications ordered, prescribed or administered in the Hospital (including the strength, dose, or rate of administration, titration parameter, as applicable, administration devices used, access site or route, known drug allergies, and adverse drug reactions);

(o) consultation reports;

(p) operative procedure reports and/or notes;

(q) any applicable anesthesia evaluations;

(r) response to care, treatment, and services provided;

(s) relevant observations, diagnoses or conditions established during the course of care, treatment, and services;

(t) reassessments and plan of care revisions;

(u) complications, hospital acquired infections, and unfavorable reactions to medications and/or treatments; and

(v) discharge summary with outcome of hospitalization, final diagnosis, discharge plan, discharge planning evaluation, disposition of case, discharge instructions, medications dispensed or prescribed on discharge, and if the patient left against medical advice.

4.A.2. Emergency Care:

In addition to any of the applicable general requirements outlined in Section 4.A.1, the medical records of patients who have received emergency care will contain the information outlined in this section, as relevant and appropriate to the patient's care. This documentation will be the joint responsibility of the Responsible Practitioners and the Hospital:

(a) identification data, including the patient's name, sex, address, date of birth, and name of authorized representative (if any);

(b) patient's language and communication needs, including preferred language for discussing health care;

(c) time and means of arrival;

(d) record of care prior to arrival;

(e) known long-term medications, including current medications, over-the-counter drugs, and herbal preparations;

(f) pertinent history of the injury or illness, including details relative to first aid or emergency care given to the patient prior to his or her arrival at the Emergency Department;

(g) results of the medical screening examination, including significant clinical, laboratory, and radiographic findings;

(h) treatment given, if any;

(i) conclusions at termination of treatment, including final disposition, condition, instructions for follow-up care, and any changes in medications;

(j) if the patient left against medical advice; and

(k) a copy of any information provided to the health care provider or facility providing follow-up care, treatment, or services.

4.A.3. Interval Notes:

(a) Interval notes will be entered by the Primary Treating Physician or his or her covering Practitioner at least every ***calendar Day*** for all hospitalized patients and as needed to reflect changes in the status of a patient in an Ambulatory Care Location.

(b) Interval notes will be understandable, dated, timed, and authenticated. When appropriate, each of the patient's clinical problems should be clearly identified in the interval notes and correlated with specific orders as well as results of tests and treatments.

4.A.4. History and Physical:

The requirements for histories and physicals, including general documentation and timing requirements, are outlined in Appendix B of the Medical Staff Bylaws.

4.A.5. Consultation Reports:

(a) Consultation reports will be completed in a timely manner and documented in an EMR-generated note or, when the EMR is unavailable, a dictated or legible written note. The consultation report will contain the date and time of the consultation, opinions based on relevant findings and reasons, and recommendations by the Consulting Physician that reflect, when appropriate, an actual examination of the patient and the patient's medical record. A statement, such as "I concur," will not

constitute an acceptable consultation report. The consultation report will be authenticated by the Consulting Physician and made a part of the patient's medical record.

(b) When non-emergency operative procedures are involved, the Consulting Physician's report will be recorded in the patient's medical record prior to the surgical procedure.

4.A.6. Medical Orders:

Medical orders will be entered/written and documented in the medical record in accordance with Article 5 of these Rules and Regulations.

4.A.7. Informed Consent:

Informed consent will be obtained in accordance with the Hospital's Informed Consent Policy and documented in the medical record.

4.A.8. Operative Procedure Reports:

An operative procedure report must be dictated or written in accordance with Article 7 of these Rules and Regulations.

4.A.9. Anesthesia Care Record:

Appropriate notes regarding the anesthesia care provided will be inserted into the patient's medical record on appropriate paper or electronic forms in accordance with Article 8.

4.A.10. Diagnostic Reports:

All diagnostic reports shall be included in the completed medical record. These reports may be filed in the medical record or may appear in an electronic version in the EMR.

4.B. TIMELINESS OF DOCUMENTATION

(1) General Requirements. It is the responsibility of every Practitioner involved in the care of a patient in the Hospital to prepare and complete medical records in a timely fashion in accordance with the specific provisions of these Rules and Regulations and other relevant policies. ***Practitioners must notify the Health Information Management (HIM) Office when out of the office. Absence does not remove the obligation to complete medical records.***

(2) A medical record is considered incomplete when:

(a) the H&P is not documented within ***24 hours*** after admission or registration (but in all cases prior to the procedure).

(b) the results of a medical screening examination are not documented within ***24 hours*** after the conclusion of an Emergency Department visit;

(c) an order, including a verbal order, is not signed within ***72 hours*** of the order;

(d) the full operative procedure report is not documented and entered into the medical record within ***48 hours***;

(e) the discharge summary is not completed within ***72 hours*** of the patient's discharge; or

(f) ***Patient amendment requests are not completed within 7 days of receipt.***

(g) ***CDI and/or coding query responses are not responded to within 48 hours***

(h) any other required patient reports are not entered, written, dictated and/or authenticated within ***72 hours*** of the patient's discharge.

(3) Notification. If a medical record is incomplete, the Practitioner will be notified ***of the delinquency***. The Notice will give the Practitioner seven **(7)** days to complete the medical record ***deficiencies***. In accordance with paragraphs (4) and (5) below, failure to complete the delinquent medical records within seven **(7)** days of the ***delinquency notification*** will ***trigger the progressive steps outlined in Section 4.***

(4) Enforcement. A Practitioner who is notified of delinquent medical records ***and who does not complete the medical record deficiencies within 7 days of said notice will be subject to the following progressive steps outlined below, which will be measured and counted on a calendar year basis:***

(a) The **first time** that a Practitioner's Privileges are relinquished, the Automatic Relinquishment will continue until all of the Practitioner's delinquent medical records have been completed. *

(b) The **second time** that a Practitioner's Privileges are relinquished will result in the matter being referred to the applicable Department Chair or Section Chief, who will offer assistance to the Practitioner in complying with this section of the Rules and Regulations. The Automatic Relinquishment will continue until all of the Practitioner's delinquent medical records have been completed and the Practitioner has met with the Department Chair or Section Chief. *

(c) The **third time** that a Practitioner's Privileges are relinquished will result in a referral to the Leadership Council for review under the Medical Staff Professionalism Policy. The Automatic Relinquishment will continue until all of the Practitioner's delinquent medical records have been completed and the individual has met with the Leadership Council to explain the reasons for the delinquencies. *

(d) A Practitioner who automatically relinquishes his or her Clinical Privileges a **fourth time** indicates his or her inability and/or unwillingness to meet the requirements in these Rules and Regulations. Accordingly, that Practitioner

will automatically resign his or her Medical Staff appointment (or Permission to Practice) and Clinical Privileges and must follow the steps outlined in (5) below if he or she wishes to rejoin the Medical Staff or renew his or her practice as a Licensed Independent Practitioner or an Advanced Practice Professional at the Hospital.

* The Practitioner will have 30 Days to complete each of these steps. Failure to do so will result in the Practitioner's automatic resignation from the Medical Staff (or Permission to Practice) and Clinical Privileges.

(5) Automatic Relinquishment Procedures. In the event that an Automatic Relinquishment occurs, the HIM Department will notify the Practitioner that his or her Clinical Privileges have been relinquished. The Chief of Staff, Emergency Department and nursing will also be notified. The Automatic Relinquishment will take effect immediately and the Practitioner will be responsible for cancelling any cases scheduled at the Hospital and for transferring the care of any patients in the Hospital to a Practitioner who has appropriate Clinical Privileges. However, the Practitioner must complete all scheduled emergency call obligations or arrange for appropriate coverage.

(6) Rejoining the Medical Staff or Renewing Practice as an Advanced Practice Professional After Resignation. Any Practitioner who resigns his or her appointment (or permission to practice) and Clinical Privileges as a result of medical record delinquencies may subsequently apply as an initial applicant, provided that all delinquent medical records have been completed. The individual may not be granted any temporary Privileges while the application is being processed until all records are completed.

(7) Former Practitioners. When a Practitioner no longer practices at the Hospital, and his or her medical records are filed as permanently incomplete, this will be recorded in the Practitioner's Confidential File and divulged in response to any future credentialing inquiry concerning the Practitioner.

(8) Exceptions. Any requests for special exceptions to the above requirements will be submitted by the Practitioner and considered by the MEC.

ARTICLE V

MEDICAL ORDERS

5.A. GENERAL

(1) Orders will be entered directly into the EMR by the ordering Practitioner utilizing the CPOE, except when the use of written or paper-based orders has been approved by the Hospital (e.g., an emergency situation or when the EMR or CPOE function is not available). Written or paper-based orders should be documented on appropriate forms as approved by the Hospital. Any such written or paper-based orders will be transcribed or scanned into the patient's EMR as soon as possible, and no later than the time of discharge.

(2) All orders (including verbal/telephone orders) must be:

(a) dated and timed when documented or initiated;

(b) authenticated by the ordering Practitioner, with the exception of a verbal order which may be countersigned by another Practitioner who is responsible for the care of a patient. Authentication must include the time and date of the authentication*; and

(c) documented clearly and completely. Orders which are improperly entered will not be carried out until they are clarified by the ordering Practitioner and are understood by the appropriate health care provider.

* Orders entered into the EMR are electronically authenticated, dated, and timed.

5.B. ORDERS FOR TESTS AND THERAPIES

(1) Orders for tests and therapies will be accepted, to the extent permitted by their license and Clinical Privileges, only from:

(a) Medical Staff Members;

(b) Advanced Practice Professionals; and

(c) Other Healthcare Professionals.

(2) Orders for "daily" tests will state the number of Days, except as otherwise specified by protocol, and will be reviewed by the ordering Practitioner at the expiration of this time frame unless warranted sooner. At the end of the stated time, any order

that would be automatically discontinued will be reentered in the same format in which it was originally recorded if it is to be continued.

(3) Outpatient orders for physical therapy, rehabilitation, laboratory, radiology, or other diagnostic services may also be ordered by Practitioners who are not affiliated with the Hospital in accordance with Hospital policy.

5.C. ORDERS FOR MEDICATIONS

(1) All medication orders will clearly state the administration times or the time interval between doses and the indications for use when appropriate. Each dose of medication shall be recorded in the medical record of the patient after the medication has been administered. If not specifically prescribed as to time or number of doses, the medications will be controlled by protocols or by automatic stop orders as described in Section 5.G of these Rules and Regulations.

(2) All orders for medications administered to patients will be:

(a) periodically reviewed by the prescriber to assure appropriateness;

(b) reviewed when the patient goes to surgery, is transferred to a different level of care, or when care is transferred to another clinical service; and

(c) reviewed by a Hospital pharmacist before the initial dose of medication is dispensed (except in an emergency when time does not permit). In cases when the medication order is issued when the Hospital pharmacy is "closed" or a Hospital pharmacist is otherwise unavailable, the medication order will be reviewed by the nursing supervisor and then by a Hospital pharmacist as soon thereafter as possible, preferably within 24 hours.

(3) The use of the summary (blanket) orders (e.g., "renew," "repeat," "resume," and "continue") to resume previous medication orders is <u>not</u> acceptable.

(4) All PRN orders (i.e., as necessary medication orders) must be qualified by either specifying time intervals or the limitation of quantity to be given in a 24-hour period. All PRN medications must specify the indications for use. Multiple PRNs for the same indication are prohibited.

(5) Advanced Practice Professionals may be authorized to issue medication orders as specifically delineated in their Clinical Privileges. If required by the Advanced Practice Professional's written supervision/collaboration agreement, any such order will be countersigned in accordance with Section 3.B.2 of these Rules and Regulations.

5.D. VERBAL ORDERS

A verbal order for medications or treatment will be accepted in accordance with Hospital policy. The ordering Practitioner, or another Practitioner who is responsible for the patient's care in the Hospital, will countersign the verbal order within ***72 hours*** after the order was given.

5.E. STANDING ORDERS AND ORDER SETS

(1) The MEC and the Hospital's nursing and pharmacy departments must review and approve any standing orders and order sets (collectively, "standing orders") that permit treatment to be initiated by an individual (for example, a nurse) without a prior specific order from a Physician. All standing orders will identify well-defined clinical scenarios for when the order is to be used.

(2) The MEC will confirm that all approved standing orders are consistent with nationally recognized and evidence-based guidelines. The MEC will also ensure that such standing orders are reviewed at least annually.

(3) If the use of a standing order has been approved by the MEC, treatment may be initiated (i) by a nurse or other authorized individual acting within his or her scope of practice who activates the order; or (ii) when a nurse enters documentation into the medical record that triggers the standing order.

(4) When used, standing orders must be dated, timed, and authenticated promptly in the patient's medical record by the individual who activates the order or by another Responsible Practitioner.

(5) A Physician must authenticate the initiation of each standing order after the fact, with the exception of those for influenza vaccines, which may be administered per Hospital policy after an assessment for contraindications.

5.F. SELF-ADMINISTRATION OF MEDICATIONS

(1) The self-administration of medications (either Hospital-issued or those brought to the Hospital by a patient) will not be permitted unless:

(a) the patient (or the patient's caregiver) has been deemed capable of self-administering the medications;

(b) a Practitioner responsible for the care of the patient has issued an order permitting self-administration;

(c) in the case of a patient's own medications, the medications are visually evaluated in accordance with Section 9.B of these Rules and Regulations; and

(d) the patient's first self-administration is monitored by Medical Staff or nursing staff personnel to determine whether additional instruction is needed on the safe and accurate administration of the medications and to document the administration in the patient's medical record.

(2) The self-administration of medications will be documented in the patient's medical record as reported by the patient (or the patient's caregiver).

(3) All self-administered medications (whether hospital-issued or the patient's own) will be kept secure in accordance with Storage and Access provisions of these Rules and Regulations.

(4) If the patient's own medications brought to the Hospital are not allowed to be self-administered, the patient (or the patient's caregiver) will be informed of that decision and the medications will be maintained in accordance with Section 9.Bof these Rules and Regulations.

5.G. STOP ORDERS

(1) The medication stop order policy shall apply to those medications defined by the Pharmacy and Therapeutics Committee, except for those orders which have:

(a) a specified number of total doses to be administered; or

(b) a specified time period for doses to be administered.

(2) The ordering Practitioner shall be notified in advance of the impending expiration of an order through the patient's medical record.

(3) Drug orders shall not be stopped until there is documented evidence that the ordering Practitioner has been contacted, is aware of the impending expiration of the order, and has had an opportunity to determine if administration of the drug is to be stopped, continued, or altered. Orders may be renewed by telephone.

5.H. ORDERS FOR RADIOLOGY AND DIAGNOSTIC IMAGING SERVICES

(1) Radiology and diagnostic imaging services may only be provided on the order of an individual who has been granted Privileges to order the services by the Hospital or in accordance with the Hospital's policy on accepting orders for outpatient services from Practitioners who are not otherwise affiliated with the Hospital.

(2) Orders for radiology services and diagnostic imaging services must include: (i) the patient's name; (ii) the name of the ordering individual; (iii) the radiological or diagnostic imaging procedure orders; and (iv) the reason for the imaging service.

5.I. ORDERS FOR RESPIRATORY CARE SERVICES

(1) Respiratory care services may be ordered by a qualified and licensed Practitioner who is responsible for the care of the patient, either independently or working in conjunction with a Medical Staff Member.

(2) Orders for respiratory care services must include: (i) the patient's name; (ii) the name and electronic or written signature of the ordering individual; (iii) the type, frequency, and, if applicable, duration of treatment; (iv) the type and dosage of medication and diluents; and (v) the oxygen concentration or oxygen liter flow and method of administration.

5.J. RESUSCITATION ORDERS

(1) Resuscitation orders (e.g., DNR) shall be documented in the patient's medical record by the patient's Responsible Practitioner.

(2) All resuscitation orders should be accompanied by an interval note justifying the appropriateness of such order and documenting discussions with the patient and/or his or her family resulting in this decision.

5.K. DISCHARGE ORDER

Patients shall be discharged in accordance with Article 11.

ARTICLE VI

INPATIENT CONSULTATIONS

6.A. GENERAL

This section of the Medical Staff Rules and Regulations applies to requests for inpatient consultations. Requests for consultations in the Hospital Emergency Department will be governed by the On-Call Physician Responsibilities Policy.

6.B. REQUESTING INPATIENT CONSULTATIONS

(1) Requests for inpatient consultations shall be ordered in the EMR by a Requesting Practitioner and in accordance with the following communication guidelines:

- **Emergent Consults** – For emergent consults (e.g., "stat" or similar terminology), the Requesting Practitioner must be a Physician who personally speaks with the Consulting Physician (face-to-face or by telephone) to provide the patient's clinical history and the specific reason for the emergent consultation.

- **Urgent Consults** – For urgent consults (e.g., "urgent," "today," or similar terminology), the Requesting Practitioner must be a Physician who personally speaks with the Consulting Physician (face-to-face or by telephone) to provide the patient's clinical history and the specific reason for the urgent consultation.

- **Routine Consults** – In addition to entering the reasons for the consultation request in the EMR, the Requesting Practitioner (who may be any member of the requesting care team) will make reasonable attempts to personally contact the Consulting Physician to discuss all routine consultation requests.

(2) Failure by a Requesting Practitioner to follow the communication guidelines described in this Section may be reviewed through the appropriate Medical Staff policy.

6.C. RESPONDING TO CONSULTATION REQUESTS

(1) Any Medical Staff Member can be asked to provide an inpatient consultation within his or her area of expertise. If the Medical Staff Member is reasonably available and accepts the inpatient consultation, he or she will respond to the request either in person or via telephone or technology-enabled direct communication and evaluation (i.e., text or other EMR communication) as allowed by Hospital policy. In either case, a Medical Staff Member who has accepted a consult (i.e., the

Consulting Physician) is expected to respond in accordance with the following patient care guidelines:

(a) **Emergent Consults** – will respond within ***twenty (20) minutes*** of request via telephone or technology-enabled direct communication and otherwise evaluate patient within ***one hour*** of the request, unless the patient's condition requires that the Consulting Physician complete the consultation sooner;

(b) **Urgent Consults** – will respond within ***four hours*** of the request, unless the patient's condition requires that the Consulting Physician complete the consultation sooner;

(c) **Routine Consults** – will respond within ***24 hours*** of the request or within a time frame as agreed upon by the Requesting Practitioner and the Consulting Physician.

If a requested Medical Staff Member is unavailable or otherwise unable to respond to a request for a consultation within the timelines provided above, then the request for a consultation shall be referred to the relevant On-Call Physician under the On-Call Physician Responsibilities Policy, which shall guide emergency consultation requests for both Emergency Department patients as well as hospitalized patients.

(2) The Consulting Physician may ask an Advanced Practice Professional with appropriate Clinical Privileges to see the patient, gather data, order tests, and develop an assessment plan. However, an evaluation by an Advanced Practice Professional will not relieve the Consulting Physician of his or her obligation to personally see the patient within these time frames unless agreed to by the Requesting Practitioner. The Collaborating/ Supervising Physician must still personally see the patient and render an opinion.

(3) When providing an inpatient consult, the Consulting Physician will review the patient's medical record, brief the patient on his or her role in the patient's care, and examine the patient in a manner consistent with the requested consult. Any plan of ongoing involvement by the Consulting Physician will be directly communicated to the Requesting Practitioner through a note in the EMR or by a phone call or text message.

(4) Failure to reasonably respond to a request for an inpatient consultation in a timely and appropriate manner may be referred for review under the appropriate Medical Staff policy (e.g., the Medical Staff Professionalism Policy).

(5) Once the Consulting Physician is involved in the care of the patient, the Requesting Practitioner and Consulting Physician are expected to review the patient's medical record on a regular basis to assure continuity of care until such time as the Consulting Physician has signed off on the case or the patient is discharged. The consulting Physician shall examine the patient and a new consultation note shall be prepared if there is any material change in the patient's condition.

6.D. RECOMMENDED CONSULTATIONS

(1) Consultations are recommended in all cases in which, in the judgment of the Primary Treating Physician:

(a) there is doubt as to the best therapeutic measures to be used;

(b) the diagnosis is obscure after ordinary diagnostic procedures have been completed;

(c) complications are present that may require specific skills of other Practitioners; or

(d) they are indicated for the clinical specialty in admission to special care units.

(2) The Chief of Staff, the CMO, the VPMA, and the appropriate Department Chair/Section Chief shall each also have the right to call in a Consulting Physician where a consultation is determined to be in the patient's best interest.

6.E. MENTAL HEALTH CONSULTATIONS

A mental health consultation and treatment will be requested for and offered to all patients who have engaged in self-destructive behavior (e.g., attempted suicide) or who are determined to be a potential danger to themselves or others. If psychiatric care is recommended, evidence that such care has at least been offered and/or an appropriate referral made will be documented in the patient's medical record.

6.F. SURGICAL CONSULTATIONS

Whenever a consultation (medical or surgical) is requested prior to surgery, a notation from the Consulting Physician, including relevant findings and reasons, must appear in the patient's medical record. If a relevant consultation has not been communicated, surgery and anesthesia will not proceed, unless the surgeon states in writing that an emergency situation exists.

ARTICLE VII

SURGICAL SERVICES

7.A. PRE-PROCEDURAL PROCEDURES

Except in a documented emergency situation, the following will occur before an operative procedure or the administration of anesthesia occurs:

(1) the Operating Physician is in the Hospital;

(2) the Operating Physician will thoroughly document in the medical record:

(a) the provisional diagnosis and the results of any relevant diagnostic tests;

(b) the consent of the patient or his/her legal representative; and

(c) a complete and appropriately updated history and physical examination (or completed short-stay form, as appropriate) prior to transport to the operating room;

(3) the anticipated needs of the patient are assessed to plan for the appropriate level of post-procedural care;

(4) pre-procedural education, treatments, and services are provided according to the plan for care, treatment, and services;

(5) a pre-anesthesia evaluation is performed in accordance with Section 8.B of these Rules and Regulations; and

(6) the procedure site is marked and a "time out" is conducted, as described in the Operative Procedure Site Verification and Time Out Protocol.

7.B. POST-PROCEDURAL PROCEDURES

(1) Post-Operative Interval Note. A brief, post-operative interval note must be entered in the medical record ***immediately*** after an operative procedure and before the patient is transferred to the next level of care by the Operating Physician. The post-operative interval note will include:

(a) the names of the Physician(s) responsible for the patient's care and physician assistants;

(b) the name and description/technique of the procedure(s) performed;

(c) findings, where appropriate, given the nature of the procedure;

(d) estimated blood loss, when applicable or significant;

(e) specimens removed; and

(f) post-operative diagnosis.

A full operative note may substitute for the brief, post-operative note if it is completed and signed immediately following the procedure.

(2) Full Operative Report. The full operative procedure report must be dictated or entered ***within 72 hours*** after an operative procedure. The full operative procedure report shall include:

(a) the patient's name and hospital identification number;

(b) pre- and post-operative diagnoses;

(c) date and time of the procedure;

(d) the name of the Operating Physician(s) and assistant surgeon(s) responsible for the patient's operation;

(e) procedure(s) performed and description/technique of the procedure(s);

(f) description of the specific surgical tasks that were conducted by Practitioners other than the Operating Physician;

(g) findings, where appropriate, given the nature of the procedure;

(h) estimated blood loss, where applicable;

(i) any unusual events or any complications, including blood transfusion reactions and the management of those events;

(j) the type of anesthesia/sedation used;

(k) specimen(s) removed, if any;

(l) prosthetic devices, grafts, tissues, transplants, or devices implanted (if any); and

(m) the signature of the Operating Physician.

7.C. PATHOLOGY REPORTS AND DISPOSITION OF SURGICAL SPECIMENS

(1) All significant surgical specimens removed during an operative procedure shall be properly labeled, packaged in preservative as designated, identified in the operating room or operating suite as to patient and source, and sent to the Hospital pathologist, who will determine the extent of examination necessary for diagnosis. The specimen must be accompanied by pertinent clinical information, including the pre-operative and post-operative surgical diagnoses.

(2) The pathologist will document the receipt of all surgically removed specimens and sign the pathology report, which shall become part of the patient's medical record. The pathology report will be filed in the medical record within ***24 hours*** of completion of the pathology work-up.

(3) The disposition of surgical specimens, whether discarded or submitted to pathology, will be recorded in the operative record.

ARTICLE VIII

ANESTHESIA SERVICES

8.A. GENERAL

(1) Anesthesia may only be administered by the following qualified Practitioners:

(a) an anesthesiologist;

(b) an M.D. or D.O. who has been granted Clinical Privileges to administer certain types of anesthesia in a specific patient care area or for a specific procedure; or

(c) a CRNA who is under the direct supervision of an Anesthesiologist.

(2) "Anesthesia" includes general or regional anesthesia, monitored anesthesia care or deep sedation, including epidurals/spinals and other nerve blocks. "Anesthesia"
(3) does not include topical or local anesthesia or minimal or moderate ("conscious") sedation.

(4) Because it is not always possible to predict how an individual patient will respond to minimal or conscious sedation, a qualified Practitioner with expertise in airway management and advanced life support must be available to return a patient to the originally intended level of sedation when the level of sedation becomes deeper than initially intended.

8.B. PRE-ANESTHESIA PROCEDURES

(1) A pre-anesthesia evaluation will be performed for each patient who receives anesthesia by an individual qualified to administer anesthesia.

(2) The following elements of the pre-anesthesia evaluation must be performed within the ***48 hours*** immediately prior to an inpatient or outpatient surgery or procedure requiring anesthesia services:

(a) a review of the medical history, including anesthesia, drug and allergy history; and

(b) an interview, if possible, preprocedural education, and examination of the patient.

(3) The following additional elements of the pre-anesthesia evaluation may be performed up to 30 Days prior to an inpatient or outpatient surgery or procedure

requiring anesthesia services, but must be reviewed and updated as necessary within ***48 hours*** of the surgery or procedure:

(a) notation of any anesthesia risks according to established standards of practice (e.g., ASA classification of risk);

(b) identification of potential anesthesia problems that may suggest complications or contraindications to the planned procedure (e.g., difficult airway as identified through an airway examination, any ongoing infections, limited intravascular access (e.g., Mallampati scoring));

(c) development of a plan for the patient's anesthesia care (i.e., discussion of risks and benefits, type of medications for induction, post-operative care); and

(d) any additional pre-anesthesia data or information that may be appropriate or applicable (e.g., stress tests, additional specialist consultations).

Per the Centers for Medicare & Medicaid Services Conditions of Participation, under no circumstances may these elements be performed more than 30 Days prior to surgery or a procedure requiring anesthesia services.

(4) The patient will be reevaluated immediately before induction in order to confirm that the patient remains able to proceed with care and treatment.

8.C. MONITORING DURING PROCEDURE

(1) All patients will be monitored during the administration of anesthesia at a level consistent with the potential effect of the anesthesia. Appropriate methods will be used to continuously monitor the patient per current ASA standards.

(2) All relevant events taking place during the induction and maintenance of, and the emergence from, anesthesia will be documented in an intraoperative anesthesia record, including at least the following:

(a) the name and Hospital identification number of the patient;

(b) the name of the Practitioner who administered anesthesia and, as applicable, any supervising Practitioner;

(c) the name, dosage, route, time, and duration of all anesthetic agents;

(d) the technique(s) used and patient position(s), including the insertion or use of any intravascular or airway devices;

(e) the name and amounts of IV fluids, including blood or blood products, if applicable;

(f) time-based documentation of vital signs, as well as oxygenation and ventilation parameters; and

(g) any complications, adverse reactions or problems occurring during anesthesia, including time and description of symptoms, vital signs, treatments rendered, and patient's response to treatment, and the patient's status upon leaving the operating room.

8.D. POST-ANESTHESIA EVALUATIONS

(1) In all cases, a post-anesthesia evaluation will be completed and documented in the patient's medical record by an individual qualified to administer anesthesia no later than 48 hours after the patient has been moved into the designated recovery area.

(2) The post-anesthesia evaluation should not begin until the patient is sufficiently recovered so as to participate in the evaluation, to the extent possible, given the patient's medical condition. If the patient is unable to participate in the evaluation for any reason, the evaluation will be completed within the 48-hour time frame and a notation documenting the reasons for the patient's inability to participate will be made in the medical record (e.g., intubated patient).

(3) The elements of the post-anesthesia evaluation will conform to current standards of anesthesia care, including:

(a) respiratory function, including respiratory rate, airway patency, and oxygen saturation;

(b) cardiovascular function, including pulse rate and blood pressure;

(c) mental status;

(d) temperature;

(e) pain;

(f) nausea and vomiting; and

(g) post-operative hydration status.

(4) Patients will be discharged from the recovery area by a qualified Practitioner according to criteria approved by the American Society of Anesthesiologists ("ASA"), using a post-anesthesia recovery scoring system. Post-operative

documentation will record the patient's discharge from the post-anesthesia care area and record the name of the individual responsible for discharge.

(5) Patients who have received anesthesia in an outpatient setting will be discharged to the company of a responsible, designated adult.

(6) When anesthesia services are performed on an outpatient basis, the patient will be provided with written instructions for follow-up care that include information about how to obtain assistance in the event of post-operative problems. The instructions will be reviewed with the patient or the individual responsible for the patient.

8.E. MINIMAL OR CONSCIOUS SEDATION

All patients receiving minimal or conscious sedation will be monitored and evaluated before, during, and after the procedure by a trained Practitioner in accordance with applicable Hospital policies. However, such procedures are not subject to the requirements regarding pre-anesthesia evaluations, intraoperative anesthesia reports or post-anesthesia evaluations described in this Article.

8.F. DIRECTION OF ANESTHESIA SERVICES

Anesthesia services will be under the direction the Department Chair, who satisfies the Eligibility Criteria as defined in section 3.B of the Bylaws, and who is responsible for the following:

- planning, directing and supervising all activities of the anesthesia service; and
- evaluating the quality and appropriateness of anesthesia patient care.

ARTICLE IX

PHARMACY

9.A. GENERAL RULES

(1) Orders for medications are addressed in the Medical Orders Article.

(2) Adverse medication reactions and errors in administration of medications will be documented in the patient's medical record and reported to the Primary Treating Physician, the director of pharmaceutical services, and, if appropriate, to the Hospital's quality assessment and performance improvement program.

(3) The pharmacy may substitute an alternative equivalent product for a prescribed brand name medication when the alternative is of equal quality and ingredients, and is to be administered for the same purpose and in the same manner.

(4) All medications will be administered in accordance with the Policies and Procedures of the Pharmacy and Therapeutics Committee. A Hospital Formulary shall be developed by the Pharmacy and Therapeutics Committee. All investigational drugs must be reviewed and approved in accordance with the Policies and Procedures of the Institutional Review Committee and shall only be used in full accordance with the Statement of Principles Involved in the Use of Investigational Drugs in Hospitals and all regulations of the Federal Drug Administration.

(5) Information relating to medication interactions, therapy, side effects, toxicology, dosage, indications for use, and routes of administration will be readily available to Medical Staff Members, Advanced Practice Professionals, and other Hospital personnel.

9.B. PATIENT'S OWN MEDICATION

If a patient brings his or her own medications to the Hospital, these medications shall not be administered unless the Primary Treating Physician or the Hospital pharmacy has inspected the medications and labelled it for use in the Hospital. Otherwise, the medications shall be (1) sent home with the patient's personal representative or other person identified by the patient on admission or (2) kept in a secure area such as the Hospital pharmacy for up to 30 Days after the patient's discharge, at which time such medications will be returned to the patient or given to the patient's legal representative. Controlled substances as listed in the Controlled Substances, Drug, Device and Cosmetic Act shall be returned to the patient on discharge unless the Primary Treating Physician states otherwise.

9.C. STORAGE AND ACCESS

(1) In order to facilitate the delivery of safe care, medications and biologicals will be controlled and distributed in accordance with Hospital policy, consistent with federal and state law.

(a) All medications and biologicals will be kept in a secure area, and locked unless under the immediate control of authorized staff.

(b) Medications listed in Schedules II, III, IV, and V of the Comprehensive Drug Abuse Prevention and Control Act of 1970 will be kept locked within a secure area.

(c) Only authorized personnel may have access to locked or secure areas.

(2) Abuses and losses of controlled substances will be reported, in accordance with applicable federal and state laws, to the individual responsible for the pharmaceutical service, and to the CEO.

ARTICLE X

EMERGENCY SERVICES

10.A. GENERAL

Emergency services and care will be provided to any person who comes to the emergency department, as that term is defined in the EMTALA regulations, whenever there are appropriate facilities and qualified personnel available to provide such services or care. Such emergency services and care will be provided without regard to the patient's insurance status, economic status, or ability to pay for medical services.

10.B. MEDICAL SCREENING EXAMINATIONS

(1) Medical screening examinations, within the capability of the Hospital, will be performed on all individuals who come to the Hospital requesting examination or treatment to determine the presence of an emergency medical condition. Qualified Medical Personnel ("QMP") who can perform medical screening examinations within applicable Hospital policies and procedures are defined as:

(a) Emergency Department:

(i) Medical Staff Members with Clinical Privileges in Emergency Medicine;

(ii) other Active Staff members; and

(iii) appropriately credentialed Advanced Practice Professionals.

(b) Labor and Delivery:

(i) Medical Staff Members with OB/GYN Privileges;

(ii) Certified Registered Nurse Midwives with OB Privileges; and

(iii) Registered Nurses who have achieved competency in Labor and Delivery and who have validated skills to provide fetal monitoring and labor assessment.

(2) The results of the medical screening examination must be dictated within ***48 hours*** of the conclusion of an Emergency Department visit.

10.C. EMERGENCY CARE

(1) Any person presenting at the Emergency Department who has not been referred by or is not the patient of a specific Medical Staff Member, and who does not express a desire for the medical services of a particular member, shall be assigned to the hospitalist service or the appropriate Physician on call for Unassigned Patients.

(2) Nothing in this provision shall interfere with the patient's right to request his or her own Physician if such a choice is expressed.

(3) A roster of Medical Staff Members who are on call for primary coverage and specialty consultations will be maintained in accordance with the Medical Staff's Emergency Department On-Call Policy.

10.D. MEDICAL RECORDS FOR PATIENTS RECEIVING EMERGENCY SERVICES

In accordance with Section 4.A.2 of these Medical Staff Rules and Regulations, a medical record will be maintained for patients who have received emergency care at the Hospital.

ARTICLE XI

DISCHARGE PLANNING AND DISCHARGE SUMMARIES

11.A. WHO MAY DISCHARGE

(1) Patients will be discharged only upon the order of the Primary Treating Physician or another Practitioner acting as his or her designee.

(2) At the time of discharge, the discharging Practitioner will review the patient's medical record for completeness, state the principal and secondary diagnoses (if one exists) and authenticate the entry.

(3) Practitioners should follow the Hospital's policy on Patients Leaving Against Medical Advice or Refusing Treatment whenever confronted with a situation in which a patient leaves against medical advice.

11.B. DISCHARGE PLANNING

(1) Discharge planning will be an integral part of the hospitalization of each patient and an assessment will commence as soon as possible after admission. The discharge plan and assessment, which includes an evaluation of the availability of appropriate services to meet the patient's needs after hospitalization, will be documented in the patient's medical record. The Responsible Practitioner is expected to participate and collaborate in the discharge planning process, which includes documentation/updates of the expected discharge date in the EMR throughout the patient's stay.

(2) Discharge planning will include determining the need for continuing care in an acute care setting, treatment, services after discharge or transfer, and services which can be obtained in an outpatient vs. inpatient setting.

11.C. DISCHARGE SUMMARY

(1) A concise discharge summary will be prepared for every patient who is admitted to, or placed in observation at, the Hospital by the Practitioner discharging the patient unless alternative arrangements are made (and are documented in the medical record) with another Practitioner who agrees to assume this responsibility. All discharge summaries will include the following and must be completed as soon as possible and no later than ***72 hours*** after discharge:

(a) reason for hospitalization;

(b) significant findings;

(c) procedures performed and care, treatment, and services provided;

(d) final diagnosis and the patient's condition and disposition at discharge;

(e) information provided to the patient and family, as appropriate;

(f) provisions for follow-up care;

(g) discharge medication reconciliation; and

(h) updated problem list.

(2) A discharge summary is required in any case in which the patient dies in the Hospital, regardless of length of admission. (See 11.D below).

(3) If the discharge summary is prepared by an Advanced Practice Professional, the Primary Treating Physician will authenticate and date the discharge summary to verify its content.

11.D. DEATH SUMMARIES

A death summary shall be completed in the event of an inpatient death, regardless of the length of the patient's stay in the Hospital. The death summary shall include date of admission, admitting and final diagnoses, reason for hospitalization, significant findings, course of treatment, events leading to death, and the date and exact time of death. If the death summary is prepared by an Advanced Practice Professional, the Primary Treating Physician will authenticate and date the death summary to verify its content.

11.E. DISCHARGE OF MINORS AND INCAPACITATED PATIENTS

Any individual who cannot legally consent to his or her own care shall be discharged only to the custody of parents, legal guardian, person standing in loco parentis, or another responsible party unless otherwise directed by the parent or guardian or court of competent jurisdiction. If the parent or guardian directs that discharge be made otherwise, he or she shall so state in writing and the statement shall become a part of the permanent medical record of the patient.

ARTICLE XII

TRANSFERS TO AND FROM OTHER FACILITIES

Transfers to and from other hospitals will be carried out in accordance with the applicable Hospital policy (i.e., Emergency Medical Screen and Patient Transfers (EMTALA) and Patient Transfers to Other Hospitals or Healthcare Facilities).

ARTICLE XIII

HOSPITAL DEATHS AND AUTOPSIES

13.A. DEATH CERTIFICATES

(1) In the event of an inpatient death at the Hospital, the deceased will be pronounced dead by a Physician, a Certified Registered Nurse Practitioner, or a Physician Assistant within a reasonable time frame. Death certificates are the responsibility of a Responsible Practitioner and will be completed within ***24 hours*** of when the certificate is available to the Responsible Practitioner and in accordance with state law.

(2) The body of a deceased patient can be released only with the consent of the parent, legal guardian, or responsible person, and only after an entry has been made in the deceased patient's medical record by the Responsible Practitioner or other designated Medical Staff Member.

(3) A Responsible Practitioner will notify the coroner/medical examiner of any cases considered by law to be a coroner/medical examiner's case.

13.B. AUTOPSIES

(1) The Medical Staff should attempt to secure autopsies in accordance with state and local laws. No autopsy shall be performed without written consent of a relative or legally authorized agent. Such consent must be documented in the medical record.

(2) Authorization for autopsy must be obtained from the parent, legal guardian, or responsible person after the patient's death. A Responsible Practitioner must document in the medical record if permission for an autopsy was granted. If permission is refused by the authorized individual or if, in the opinion of a Physician, an autopsy should not be requested (e.g., the health and welfare of the next of kin or religious proscription), this must be documented in the medical record.

(3) The Primary Treating Physician must be notified when an autopsy is to be performed. All autopsies shall be performed by the Hospital pathologist or by a Practitioner delegated this responsibility by the Hospital pathologist. Provisional anatomic diagnoses shall be recorded on the medical record within two working Days and the complete protocol should be made part of the record within 30 Days after the autopsy.

(4) The Medical Staff shall be actively involved in the assessment of the use of developed criteria for autopsies.

13.C. POTENTIAL ORGAN AND TISSUE DONORS

It is the policy of the Hospital to identify potential organ and tissue donors and to offer the relatives or legally authorized agents of every medically suitable deceased patient, the opportunity to donate. All Practitioners will cooperate fully in this effort.

ARTICLE XIV

MISCELLANEOUS

14.A. ORIENTATION

All new Practitioners will be provided an overview of the Hospital and its operations. As a part of this orientation, the Medical Records Department and nursing service will orient new Practitioners as to their respective areas, detailing those activities and/or procedures that will help new Practitioners in the performance of their duties.

14.B. SELF-TREATMENT AND TREATMENT OF FAMILY MEMBERS, COLLEAGUES, AND CO-WORKERS

14.B.1. Self-Treatment:

(a) Practitioners are strongly discouraged from treating themselves, except in an emergency situation or where no viable alternative treatment is available.

(b) Practitioners should never write prescriptions for controlled substances for themselves.

14.B.2. Guidelines for Treatment of Immediate Family Members, Colleagues, and Co-Workers:

(a) Generally, Practitioners should refrain from the following activities in the Hospital:

(1) admitting or consulting on immediate family members (i.e., a parent, spouse, child, or anyone else residing in the same household); or

(2) being involved in the care of a family member with complex or potentially serious symptoms or diagnoses.

When considering these guidelines, factors such as the availability of other Practitioners to provide the needed care, patient acuity, and the patient's right to direct his/her own medical care should also be considered.

(b) Practitioners should never write prescriptions for controlled substances for family members.

(c) As it relates to colleagues and co-workers in the Hospital, Practitioners should refrain from:

(1) treating any individual without first performing an appropriate assessment and creating a proper medical record; or

(2) writing a prescription for any individual in the absence of a formal Practitioner-patient relationship.

14.C. INFECTION PRECAUTIONS

All Practitioners will abide by Hospital infection control policies.

14.D. HIPAA REQUIREMENTS

All Practitioners will:

(1) adhere to the security and privacy requirements of HIPAA and the Hospital's HIPAA policies, meaning that only a Responsible Practitioner may access, utilize, or disclose protected health information; and

(2) complete any applicable HIPAA compliance and privacy training that is required by the Hospital.

14.E. MEDICAL TITLE TRANSPARENCY

(1) All healthcare professionals must clearly identify their specific role and credentials when introducing themselves to patients and families.

(2) The title" doctor" shall be used in clinical settings and written communications by individuals who holds a current, unrestricted license to practice in Arizona. This includes Doctor of Medicine (MD), Doctor of Osteopathic Medicine (DO), Bachelor of Medicine, Bachelor of Surgery (MBBS), Dentists (DDS), Oral and Maxillofacial Surgeons (DMD), or Doctor of Podiatric Medicine (DPM) and are credentialed to practice within Tucson Medical Center.

(3) Violations of this policy shall be reviewed by the Medical Executive Committee and may result in corrective action.

ARTICLE XV

AMENDMENTS

These Medical Staff Rules and Regulations may be amended pursuant to Article 9 of the Medical Staff Bylaws.

ARTICLE XVI

ADOPTION

These Rules and Regulations are adopted and made effective upon approval of the Board of Directors, superseding and replacing any and all other bylaws, rules and regulations, policies, or manuals of the Medical Staff.

Adopted by the Medical Executive Committee on:

Date: September 11, 2023

Approved by the Board of Directors on:

Date: November 28, 2023

TUCSON MEDICAL CENTER

Flow Chart of Professional Practice Evaluation Process

Events That Trigger a Review
- Specialty-Specific Triggers
- Reported Concerns
- Other (defined in PPE Policy)

Medical Staff Office

1. Consults with CPE Chair, VPMA, CMO, CPE Member, and/or APPC Chair, as necessary, for assistance regarding:
   - A. Appropriate determinations to be made in #2, or
   - B. Identifying appropriate reviewers, e.g.:
     - Case involves CPE Member who would otherwise conduct review;
     - Limited clinical expertise available on staff; or
     - Several CPE Members are needed to review case concurrently, because it involves more than one Practitioner.
2. ***Determinations/Interventions (Report to CPE)***
   - A. No issue — close case
   - B. Send Informational Letter
   - C. Refer case to CPE Member(s), along with appropriate portion of review form completed, or
   - D. Refer to Leadership Council for administratively complex matters as defined in the PPE Policy, including:
     - (i) case requires immediate review,
     - (ii) conduct issues, and
     - (iii) health issues.

2.C

2.D

Assigned Reviewer

1. Complete review form (if requested) or otherwise serve as consultant to CPE Member
2. Forward findings to CPE Member, if applicable

(Discretionary referral)

(Findings)

CPE Member

Duties:

1. If needed, obtain input about case from Assigned Reviewer
2. Complete review form
3. Forward findings to CPE for determination/intervention, or close case in consultation with VPMA, CMO, or CPE Chair

Leadership Council

Duties:

1. Assess and act on any matter requiring immediate review
2. Act on any other individual case or matter that may be referred by the MSO or the CPE
3. Review and address behavioral issues (including failure to cooperate with the utilization review process) pursuant to Medical Staff Professionalism Policy, after triage and review by the Chief of Staff and either VPMA or CMO
4. Review and address health issues pursuant to Practitioner Health Policy

*(If the Practitioner is employed by TMC Healthcare or a qualifying private entity, see **Note 1**.)*

(Clinical Issues)

Committee for Professional Enhancement (CPE)

1. Review determinations from prior levels of review, supplement intervention as deemed necessary
2. For cases referred to CPE for assessment, obtain additional clinical expertise, internal or external, if needed
3. If a matter involves a Practitioner employed by TMC Healthcare or a qualifying private entity, see ***Note 1***
4. ***Determinations/Interventions (guided by Just Culture algorithm)***
   - A. No issue — close case
   - B. Exemplary care – send letter
   - C. Educational Letter
   - D. Collegial Counseling
   - E. Performance Enhancement Plan (PEP Options for Clinical Issues)
   - F. Refer to Leadership Council
   - G. Refer to MEC

(Obtain input before any intervention)

Notice of PEP — ***Acceptance of PEP***

Practitioner Whose Care Is Under Review

Referral for review under Professional Staff Credentials Policy, if questions or concerns cannot be resolved by CPE

MEC

Possible determinations same as for CPE. as well as those outlined in Professional Staff Credentials Policy

Referral for review under Professional Staff Credentials Policy, if questions or concerns cannot be resolved by Leadership Council

Possible SYSTEM ISSUES identified at any level shall be referred to the appropriate Medical Center department and reported to the CPE, which shall monitor the issue until resolved.

Any CPE Member, APPC, the Leadership Council, or the CPE may refer a case for review during an EDUCATIONAL SESSION or request that the LESSONS LEARNED from the case be otherwise disseminated, after the review process for an individual Practitioner has been completed.

Note 1: If the Practitioner involved is employed by TMC Healthcare ("Employer"), the CPE or Leadership Council may notify a TMC Healthcare representative with employment responsibilities of the review and request assistance in addressing the matter. If the Practitioner is employed by a qualifying private entity (also referred to as "Employer"), the CPE or Leadership Council may notify the peer review committee within the Employer and request assistance in addressing the matter. In each situation, a representative of the Employer may be invited to attend meetings of the CPE or Leadership Council, participate in discussions and deliberations, and participate in any interventions that may be deemed necessary. *(See Section 1.D*

(definition of Employer) and Sections 5.C, 5.F, and 6.N of Policy for additional guidance.)

TUCSON MEDICAL CENTER

PROFESSIONAL PRACTICE EVALUATION POLICY (PEER REVIEW)

Approved by the Board: January 21, 2020

PROFESSIONAL PRACTICE EVALUATION POLICY (PEER REVIEW)

TABLE OF CONTENTS

PROFESSIONAL PRACTICE EVALUATION POLICY (PEER REVIEW)

1. OBJECTIVES, SCOPE OF POLICY AND DEFINITIONS

1.A ***Objectives.*** The primary objectives of the Professional Practice Evaluation ("PPE") process of Tucson Medical Center (the "Hospital") are to:

(1) Establish a positive, educational approach to performance issues and a culture of continuous improvement for individual Practitioners, which includes:

(a) fairly, effectively, and efficiently evaluating the care being provided by Practitioners, comparing it to established patient care protocols and benchmarks whenever possible; and

(b) providing constructive feedback, education, and performance improvement assistance to Practitioners regarding the quality, appropriateness, and safety of the care they provide;

(2) Effectively disseminate lessons learned and promote education sessions so that all Practitioners in a relevant specialty area will benefit from the PPE process and also participate in the culture of continuous improvement; and

(3) Promote the identification and resolution of system process issues that may adversely affect the quality and safety of care being provided to patients (e.g., protocol or policy revisions that are necessary; addressing patient handoff breakdowns or communication problems).

1.B ***Scope of Policy.***

(1) The Hospital's PPE process includes several related but distinct components:

(a) The PPE process described in this Policy is used when questions or concerns are raised about a Practitioner's clinical performance. This process has traditionally been referred to as "peer review."

(b) The process used to confirm an individual's competence to exercise newly granted privileges is described in the FPPE Policy to Confirm Practitioner Competence and Professionalism (New Members/New Privileges).

(c) The process used to evaluate a Practitioner's competence on an ongoing basis is described in the Ongoing Professional Practice Evaluation (OPPE) Policy.

(d) Concerns regarding a Practitioner's professional conduct or health status shall be reviewed in accordance with the Medical Staff Professionalism Policy or Practitioner Health Policy, respectively.

(e) If a matter involves both clinical and behavioral concerns, the Chairs of the Leadership Council and the Committee for Performance Enhancement ("CPE") shall coordinate the reviews. The behavioral concerns may either be:

(i) addressed by the Leadership Council pursuant to the Professionalism Policy, with a report to the CPE; or

(ii) addressed by the CPE pursuant to this Policy, with the provisions in the Professionalism Policy being used for guidance.

(2) This Policy applies to all Practitioners who provide patient care services at the Hospital.

1.C ***Definitions and Acronyms.***

(1) Definitions of capitalized terms used in this Policy are included in the Medical Staff Glossary.

(2) Acronyms used in this Policy are:

APPC	Advanced Practice Professionals Committee
FPPE	Focused Professional Practice Evaluation
MEC	Medical Executive Committee
OPPE	Ongoing Professional Practice Evaluation
PEP	Performance Enhancement Plan
CPE	Committee for Performance Enhancement
PPE	Professional Practice Evaluation (Peer Review)

2. STEP-BY-STEP REVIEW PROCESS. The process for PPE when questions or concerns are raised is outlined in **Appendix A** to this Policy ("Flowchart of Professional Practice Evaluation Process and CPE Case Review Algorithm"). This Section describes each step in that process.

2.A ***Cases to Be Reviewed.*** Cases or issues shall be identified for review through specialty-specific triggers that are approved by the CPE, reported concerns from Practitioners and Hospital personnel, and other means as set forth in **Appendix B** ("PPE Triggers That Prompt the PPE Review Process") to this Policy.

2.B ***Follow-up with Individuals Who Report Concerns.*** The Medical Staff Office, Chief Medical Officer ("CMO"), or Vice President Medical Affairs ("VPMA") shall follow up with individuals who report concerns, either verbally or by sending a letter. Guidance for such follow-up communication is included in **Appendix B** ("PPE Triggers That Prompt the PPE Review Process") to this Policy. A sample ***Response to Reported Concerns*** is included in the ***PPE Manual***.

2.C ***Medical Staff Office.***

(1) ***Fact-Finding.*** All cases or issues identified for review shall be referred to the Medical Staff Office, which will log the matter in some manner that facilitates the subsequent tracking and analysis of the case (e.g., a confidential database or spreadsheet). The Medical Staff Office will review, as necessary, the following:

(a) the medical record;

(b) interviews with, and information from, Hospital employees, Practitioners, patients, family, visitors, and others who may have relevant information. For Practitioner-specific concerns referred for review under this Policy from the serious safety event, sentinel event, or other review process, interviews and other fact-finding will be coordinated, to the extent possible, with such other review process to avoid redundancy and duplication of effort;

(c) other relevant documentation; and

(d) the Practitioner's professional practice evaluation history.

(2) ***Review and Determination.*** The Medical Staff Office shall consult with the appropriate CPE Member, APPC Chair, CPE Chair, CMO, or VPMA if there is any uncertainty about the proper disposition or review process for a case. The Medical Staff Office will then:

(a) determine that no further review is required and close the case (with such determinations being reviewed by the CPE as set forth in Section 2.H of this Policy);

(b) send an Informational Letter as described in **Appendix C** ("Options to Address Clinical Concerns") to this Policy and **Appendix D** ("Performance Issues That Trigger Informational Letters"). A sample ***Informational Letter*** is included in the ***PPE Manual***; or

(c) determine that further review is required.

(3) ***Preparation of Case for Further Review.*** The Medical Staff Office shall prepare cases that require further review. Preparation of the case may include, as appropriate, the following:

(a) completion of the appropriate portions of the applicable case review form (case review forms are contained in the ***PPE Manual***);

(b) as needed, modifying the case review form to reflect specialty-specific issues, as may be directed by a CPE Member, APPC Chair, CPE Chair, CMO or VPMA;

(c) preparation of a time line or summary of the care provided;

(d) identification of relevant patient care protocols or guidelines; and

(e) identification of relevant literature.

(4) ***Referral of Case for Further Review.***

(a) ***Referrals to Leadership Council.*** Cases shall be referred to the Leadership Council if they involve:

(1) a concern for which immediate or expedited review is needed;

(2) professional conduct;

(3) a Practitioner health issue;

(4) a refusal to cooperate with utilization oversight activities; or

(5) a concern for which the Medical Staff Office, in consultation with a CPE Member, APPC Chair, CPE Chair, CMO or VPMA, determines that review by the Leadership Council would be appropriate.

(b) ***Referrals to the CPE.***

(1) If a Performance Enhancement Plan is currently in effect, the Medical Staff Office will consult with the CPE Chair to determine if the case should be referred directly to the CPE.

(2) If a case involves care provided by both a Practitioner and an APP who works with the Practitioner, the case will be referred directly to the CPE.

(c) ***Referral to CPE Member or APPC Member.*** Except as noted in (d), all other cases shall be referred to the appropriate CPE Member or APPC Member, as applicable.

(d) ***Referrals Involving Certain Complex Cases.*** If a case involves:

(1) Practitioners from two or more specialties or Departments;

(2) the CPE Member or APPC Member who would otherwise be expected to review the case; or

(3) a matter for which necessary clinical expertise is not available on the Medical Staff,

the Medical Staff Office will consult with the CPE Chair, APPC Chair, CMO, or VPMA regarding referral of the case. In these situations, it may be determined that two or more CPE members review the case and complete assessments simultaneously, that an Assigned Reviewer complete the review, or that an external review be obtained.

2.D ***CPE Member or APPC Member.***

(1) ***Review.*** When a matter is referred to a CPE Member or APPC Member, they shall either:

(a) review the case and complete the ***CPE Member Case Review Form*** or the ***APPC Member Case Review Form***, copies of which are included in the ***PPE Manual***; or

(b) assign the review to an Assigned Reviewer, who shall evaluate the care provided, complete the ***AR Case Review Form***, and report his or her findings back to the CPE Member or APPC Member. The ***AR Case Review Form*** is contained in the ***PPE Manual***.

In all cases, the CPE Member or APPC Member remains responsible for completing the appropriate portions of the ***CPE Member Case Review Form*** or the ***APPC Member Case Review Form***, as applicable.

(2) ***Determinations.*** The CPE Member or APPC Member may:

(a) in consultation with the CMO, VPMA, or CPE Chair, determine that no further review or action is required; or

(b) report their findings to the CPE for determination.

2.E ***Committee for Performance Enhancement.***

(1) ***Review of Prior Determinations.*** The CPE shall review reports from all cases where it was determined that no further review or action was required. If the CPE has concerns about any such determination, it may direct that further information be obtained about the case and a report be made to the CPE for its review and action, or the CPE may take action based on the information already provided to it.

(2) ***Cases Referred to the CPE for Further Review.***

(a) ***Review.*** The CPE shall consider the review forms, supporting documentation, and recommendations for all cases referred to it.

(b) ***Information Sharing with Employer.*** If the Practitioner involved is an Employed Practitioner, the CPE may notify the Employer of the review and obtain its assistance in addressing the matter. In such case, a representative of the Employer may be invited to attend meetings of the CPE and participate in its deliberations and interventions. Additional guidance on this process is set forth in **Appendix F** ("Information Sharing with Employer") to this Policy.

(c) ***Case Presentation at CPE Meeting.*** The CPE Member or APPC Member responsible for the initial assessment (or any assigned reviewer), the APPC Chair, or the CPE Chair shall present the case to the CPE using the guidance in the ***Case Review Algorithm*** in **Appendix A**.

(d) ***Determination if Additional Expertise is Required.*** Based on the case presentation, the CPE shall determine whether any additional clinical expertise is needed to adequately identify and address concerns raised in the case. If additional clinical expertise is needed, the CPE may:

(i) invite a specialist with the appropriate clinical expertise to attend a CPE meeting as a guest, without vote, to assist the CPE in its review of issues, determinations, and interventions;

(ii) assign the review to any Practitioner on the Medical Staff with the appropriate clinical expertise, with a report of the assessment back to the CPE; or

(iii) arrange for an external review in accordance with **Appendix H** ("Other Provisions That Govern the PPE Process") to this Policy.

(e) ***Input from Practitioner.*** If the CPE has any questions or concerns about the care provided by the Practitioner, the CPE shall obtain input from the Practitioner prior to making any final determinations or findings. The process for obtaining input is set forth in **Appendix G** ("Obtaining Input from the Practitioner") to this Policy and a sample ***Request for Input*** letter is in the ***PPE Manual***.

(f) ***Determinations and Interventions.*** The CPE shall deliberate using the guidance in the ***Case Review Algorithm*** in **Appendix A**. Based on its review of all information obtained, including input from the Practitioner, the CPE may:

(i) determine that no further review or action is required;

(ii) determine that exemplary care was provided and send a letter recognizing the Practitioner's efforts;

(iii) review additional cases or data related to the Practitioner to better understand any potential concerns;

(iv) send an Educational Letter as described in **Appendix C** ("Options to Address Clinical Concerns") to this Policy. A sample ***Educational Letter*** is included in the ***PPE Manual***;

(v) conduct or facilitate a Collegial Intervention as described in **Appendix C** ("Options to Address Clinical Concerns") to this Policy. A sample ***Collegial Intervention Checklist*** and ***Follow-Up Letter to Collegial Intervention*** are included in the ***PPE Manual***;

(vi) develop a Performance Enhancement Plan as described in **Appendix C** ("Options to Address Clinical Concerns") and **Appendix E** ("Performance Enhancement Plan Options – Implementation Issues Checklist") to this Policy. A ***PEP Template Letter*** is included in the ***PPE Manual***;

(vii) refer the matter to the Leadership Council; or

(viii) refer the matter to the Medical Executive Committee.

2.F ***Leadership Council.*** The Leadership Council is primarily responsible for addressing issues of professional conduct and health in accordance with the Professionalism Policy and the Practitioner Health Policy. However, with respect to clinical performance issues, the Leadership Council will review (i) any matter that requires immediate or expedited review given the seriousness of the issue and

(ii) any other matter that may be referred to it by the Medical Staff Office or the CPE. In reviewing and acting on these clinical matters, the Leadership Council will utilize the principles set forth in this Policy as well as any direction provided by the CPE, and will have the authority to send Educational Letters, conduct Collegial Interventions, and refer matters to the CPE or MEC.

2.G ***Time Frames for Review.***

(1) ***General.*** The time frames specified in this Section are provided only as guidelines. However, all participants in the process shall use their best efforts to adhere to these guidelines, with the goal of completing reviews, from initial identification to final disposition, within 90 days.

(2) ***Assigned Reviewers.*** Assigned Reviewers are expected to submit completed review forms to, or consult with, the CPE Member, APPC Member, or the CPE, depending on who assigned the review, within 14 calendar days of the review being assigned.

(3) ***CPE Members and APPC Member.*** CPE Members and ACPC Members are expected to complete their reviews prior to the next CPE meeting, provided that they have at least 14 days to complete the review.

(4) ***External Reviewers*.** If an external review is sought pursuant to **Appendix H** ("Other Provisions That Govern the PPE Process") to this Policy, those involved will use their best efforts to take the steps needed to have the report returned within 30 days of the decision to seek the external review (e.g., by ensuring that relevant information is provided promptly to the external reviewer, and that the contract with the external reviewer includes an appropriate deadline for the review).

2.H ***No Further Review or Action Required.*** If, at any point in this process, a determination is made that there are no clinical issues or concerns presented in the case that require further review or action, the matter shall be closed. A report of this determination shall be made to the CPE. If information was sought from the Practitioner involved, the Practitioner shall also be notified of the determination.

2.I ***Referral to the Medical Executive Committee.***

(a) ***Referral by the CPE or the Leadership Council.*** The CPE (or the Leadership Council, if involved) may refer a matter to the Medical Executive Committee if:

(i) it determines that a PEP may not be adequate to address the issues identified;

(ii) the individual refuses to participate in a PEP developed by the CPE;

(iii) the Practitioner fails to abide by a PEP; or

(iv) the Practitioner fails to make reasonable and sufficient progress toward completing a PEP.

(b) ***Pursuant to the Medical Staff Credentials Policy.*** This Policy outlines collegial and progressive steps that can be taken to address clinical concerns about a Practitioner. However, a single incident or pattern of care may be of such concern that more significant action is required. Therefore, nothing in this Policy precludes an immediate referral of a matter to the Medical Executive Committee pursuant to the Medical Staff Credentials Policy when deemed necessary under the circumstances.

3. ADDITIONAL REQUIREMENTS AND GENERAL PRINCIPLES GOVERNING THE PPE PROCESS

(a) The Appendices to this Policy contain: (1) additional requirements that expand upon specific steps outlined in this Policy; and (2) general principles that govern the implementation of this Policy.

(b) Each Appendix to this Policy is a binding and integral part of the Policy. The placement of a provision in an Appendix rather than in the body of the Policy is a drafting convention to facilitate comprehension of the primary PPE review process and has no effect on the validity or enforceability of any provision in an Appendix.

Adopted by the Medical Executive Committee on _____, 2019.

Adopted by the Board on January 21, 2020.

APPENDICES

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APPENDIX B

PPE TRIGGERS THAT PROMPT THE PPE REVIEW PROCESS

The PPE process set forth in this Policy may be triggered by any of the following events:

1. ***Specialty-Specific Triggers.*** Each Department shall identify adverse outcomes, clinical occurrences, or complications that will trigger PPE. The MEC will approve these triggers, and review them periodically to evaluate their effectiveness. Any trigger that the MEC determines is not useful will be discontinued and will no longer lead to an automatic review under this Policy.

2. ***Reported Concerns.***

   (a) ***Reported Concerns from Practitioners or Hospital Employees.*** Any Practitioner or Hospital employee may report to the Medical Staff Office concerns related to the safety or quality of care provided to a patient by an individual Practitioner, which shall be reviewed through the process outlined in the PPE Policy.

   (b) ***Follow-up with Individual Who Filed Report.*** The Medical Staff Office, CMO, or VPMA shall follow up with individuals who file a report by:

      (1) Thanking them for reporting the matter and participating in the Hospital's culture of safety and quality care;

      (2) Informing them that:

         (i) The matter will be reviewed in accordance with this Policy and that they may be contacted for additional information;

         (ii) Due to confidentiality requirements under state law, it is important that they maintain confidentiality and only discuss the matter with individuals who are a formal part of the review process and not with colleagues or co-workers;

         (iii) Due to these same confidentiality requirements, the Hospital is not permitted to disclose the outcome of the review to them, but they can be assured that a thorough review will be conducted; and

         (iv) No retaliation is permitted against any individual who raises a concern and they should immediately report any retaliation or any other incidents of inappropriate conduct.

A sample ***Response to Reported Concerns*** is included in the ***PPE Manual*** and can be used as a script for a verbal discussion with the individual who reported the concern or sent as a letter.

(c) ***Anonymous Reports.*** Practitioners and employees may report concerns anonymously, but all individuals are encouraged to identify themselves when making a report. This identification promotes an effective review of the concern because it permits the Medical Staff Office to contact the reporter for additional information, if necessary.

(d) ***Unsubstantiated Reports or False Reports.*** If a report cannot be substantiated, or is determined to be without merit, the matter shall be closed as requiring no further review. False reports will be grounds for disciplinary action. False reports by Practitioners will be referred to the Leadership Council. False reports by Hospital employees will be referred to human resources.

(e) ***Self-Reporting.*** Practitioners are encouraged to self-report their cases that involve either a specialty-specific trigger or other PPE review trigger or that they believe would be an appropriate subject for an educational session as described in **Appendix H** of the PPE Policy ("Other Provisions That Govern the PPE Process"). Self-reported cases will be reviewed as outlined in this Policy. A notation will be made that the case was self-reported.

3. ***Other PPE Triggers.*** In addition to specialty-specific triggers and reported concerns, other events that may trigger PPE include, but are not limited to, the following:

(a) Identification by a Medical Staff committee or work group of a clinical trend or specific case or cases that require further review. The review and deliberations of such a committee or work group and any documentation prepared are confidential peer review information and shall be used and disclosed only as set forth in this Policy;

(b) Patient complaints that are referred by the patient representative and that require further review, as determined by the Medical Staff Office (in consultation with the CPE Chair, CMO, or VPMA);

(c) Cases identified as quality risks that are referred to the CPE process by the risk management department. (***NOTE:*** As described in Section 8 of **Appendix H** of this Policy ("Other Provisions That Govern the PPE Process"), Confidential Information that is subsequently generated pursuant to this PPE Policy may not be documented in risk management files or disclosed as part of any risk management activities);

(d) Unresolved issues of medical necessity referred through the Utilization Management Committee, Case Management Department, Compliance Officer, or otherwise;

(e) Referrals from a serious safety event or sentinel event review team involving an individual Practitioner's clinical performance;

(f) A Department Chair's determination that ongoing professional practice evaluation ("OPPE") data reveal a practice pattern or trend that requires further review as described in the OPPE Policy; and

(g) When a threshold number of Informational Letters is reached or a trend of noncompliance is otherwise identified with: (i) Medical Staff Rules and Regulations or other policies; or (ii) adopted clinical protocols, order sets or pathways, or other quality measures.

APPENDIX C

OPTIONS TO ADDRESS CLINICAL CONCERNS

This Policy encourages the use of Collaborative Leadership Efforts and Progressive Steps by Medical Staff Leaders and the Administrative Team to address questions relating to an individual's clinical practice. The goal of these efforts is to arrive at voluntary, responsive actions by the individual to constructively resolve questions that have been raised.

1. Collaborative Leadership Efforts

This Policy encourages the use of Collaborative Leadership Efforts by Medical Staff Leaders to address performance issues that may arise from time to time, but which are ***not*** reported to, or identified by, the Medical Staff Office for more formal review under this Policy. Such efforts may include, but are not limited to, informal discussions, mentoring, counseling, and sharing of comparative data. All such efforts are part of the Hospital's confidential performance improvement and professional practice evaluation activities.

There is no expectation that input from a Practitioner be obtained prior to Collaborative Leadership Efforts or that these efforts be documented, though documentation may be created in the discretion of the Medical Staff Leader and maintained in the Practitioner's confidential file.

2. Progressive Steps

For matters that ***are*** reported to, or identified by, the Medical Staff Office and reviewed under the PPE Policy, Medical Staff Leaders will generally use Progressive Steps to address any performance issues that may be identified. Progressive Steps include Informational Letters, Educational Letters, Collegial Interventions, and Performance Enhancement Plans, as described in this Appendix.

The goal of all Progressive Steps is to arrive at voluntary, responsive actions by the Practitioner. All such efforts are part of the Hospital's confidential performance improvement and professional practice evaluation activities.

Progressive Steps are encouraged, but are not mandatory. Nothing in this Policy prevents the immediate referral of a matter for review under the Medical Staff Credentials Policy or other applicable policy.

3. Informational Letter

(a) ***General.*** Minor performance issues can be successfully addressed through Informational Letters. Informational Letters are intended to be interventions that simply make a Practitioner aware of an expectation or requirement. They are non-punitive, educational tools to help Practitioners self-correct and improve their

performance through timely feedback. A sample ***Informational Letter*** is included in the ***PPE Manual***.

(b) ***When an Informational Letter May be Sent.***

(1) The CPE will prepare a list of objective occurrences for which an Informational Letter is appropriate. The list may be modified by the CPE at any time, without the need for approval by the Medical Executive Committee or Board. However, notice of any revisions shall be provided by the CPE to the Medical Executive Committee and the Medical Staff.

(2) The types of performance issues that may be addressed via Informational Letters include, but are not limited to, noncompliance with:

(A) specific provisions of the Medical Staff Rules and Regulations or Hospital or Medical Staff policies;

(B) an adopted protocol, without appropriate documentation in the medical record as to the reasons for not following the protocol;

(C) core or other quality measures; or

(D) care management/utilization management requirements.

(3) **Appendix D** ("Performance Issues that Trigger Informational Letters") sets forth the current issues that will trigger an Informational Letter. Notwithstanding this, nothing in the PPE Policy prohibits any authorized individual or committee from forgoing the use of an Informational Letter and responding to a particular incident in some other manner as warranted by the circumstances.

(c) ***Preparation of Informational Letter.*** The Medical Staff Office shall prepare an Informational Letter reminding the Practitioner of the applicable requirement and offering assistance to the Practitioner in complying with it. A copy of the Informational Letter shall be placed in the Practitioner's confidential file. It shall be considered in the reappointment process and in the assessment of the Practitioner's competence to exercise the clinical privileges granted.

Informational Letters may be signed by: A Department Chair, the CPE Chair, CMO or VPMA. Individuals named in the preceding sentence shall be copied on any Informational Letter that they do not personally sign.

(d) ***Further Review of Informational Letter Concerns.*** A matter shall be subject to review by the CPE if: (i) the threshold number of Informational Letters to address a particular type of situation is reached, as identified in advance by the CPE; or

(ii) a trend of noncompliance is otherwise identified based on the overall number of Informational Letters sent to a Practitioner or other relevant factors.

4. **Educational Letter**

An Educational Letter may be sent to the Practitioner that describes the opportunities for improvement that were identified in the care reviewed and offers specific recommendations for future practice. A copy of the letter will be included in the Practitioner's file along with any response that he or she would like to offer. A sample ***Educational Letter*** is included in the ***PPE Manual***.

Educational Letters may be sent by: The Leadership Council or CPE. The Department Chair and CPE will be informed of the substance of any Educational Letter that is sent to a Practitioner and may contact the Medical Staff Office to review a copy of the letter.

5. **Collegial Intervention**

Collegial Intervention means a formal, planned, face-to-face discussion between the Practitioner and one or more Medical Staff Leaders. Collegial Intervention only occurs after a Practitioner has had an opportunity to provide input regarding a concern, and the Medical Staff Leaders then determine that a Collegial Intervention will successfully resolve an issue. If the Collegial Intervention results from a matter that has been reported to the Medical Staff Office and reviewed through applicable Policy, it shall be followed by a letter that summarizes the discussion and, when applicable, the expectations regarding the Practitioner's future practice in the Hospital. A copy of the follow-up letter will be included in the Practitioner's file along with any response that the Practitioner would like to offer. (In contrast to conducting a "Collegial Intervention," see the description of "Collaborative Leadership Efforts" in Section 1 of this Appendix.) A sample ***Collegial Intervention Checklist*** to help prepare for such a meeting and a ***Follow-Up Letter to Collegial Intervention*** are included in the ***PPE Manual***.

A Collegial Intervention may be personally conducted by: One or more members of the CPE or the CPE may facilitate a Collegial Intervention by one or more designees. The Department Chair shall be informed of the substance of any collegial intervention and the follow-up letter, regardless of who conducts or facilitates it, and may contact the Medical Staff Office to review a copy of the follow-up letter.

6. **Performance Enhancement Plan ("PEP")**

(a) ***General.*** The CPE may determine it is necessary to develop a PEP for the Practitioner to bring about sustained improvement in the individual's practice. To the extent possible, a PEP shall be for a defined time period or for a defined number of cases. The plan should specify how the Practitioner's compliance with, and results of, the PEP will be monitored. One or more members of the CPE should personally discuss the PEP with the Practitioner to help ensure a shared and clear understanding of the elements of the PEP. The PEP will also be presented in

writing, with a copy being placed in the Practitioner's file, along with any statement the Practitioner may like to offer. A ***PEP Template Letter*** is included in the ***PPE Manual***.

(b) ***Input.*** As deemed appropriate by the CPE, the Practitioner may have an opportunity to provide input into the development and implementation of the PEP. The Department Chair may also be asked for input regarding the PEP, and shall assist in implementation of the PEP as may be requested by the CPE.

(c) ***Voluntary Nature of PEPs.*** If a Practitioner agrees to participate in a PEP developed by the CPE, such agreement will be documented in writing. If a Practitioner disagrees with the need for a PEP developed by the CPE, the Practitioner is under no obligation to participate in the PEP. In such case, the CPE cannot compel the Practitioner to agree with the PEP. Instead, the CPE will refer the matter to the Medical Executive Committee for its independent review and action pursuant to the Medical Staff Credentials Policy. A sample ***Referral to MEC When PEP Not Accepted*** is included in the ***PPE Manual***.

(d) ***Ongoing Assessment of PEP Results.***

(1) The CPE will keep all PEPs on its agenda and periodically assess them so it can determine whether any modifications to the PEP are appropriate. Such modifications may include, but are not limited to, additional education, monitoring requirements, or a decision that the elements of the PEP have been satisfied and no additional action is needed. The CPE will obtain input from the Practitioner before making any modification to a PEP other than a determination that the elements of the PEP have been satisfied.

(2) Assessment of the PEP by the CPE will continue until the CPE determines that either: (i) concerns about the Practitioner's practice have been adequately addressed; or (ii) the Practitioner is not making reasonable progress toward completion of the PEP in a timely manner, in which case the CPE shall refer the matter to the Medical Executive Committee for its independent review pursuant to the Medical Staff Credentials Policy. A sample ***Referral to MEC When PEP Not Completed*** is included in the ***PPE Manual***.

(3) The CPE will communicate with the Practitioner: (i) periodically regarding the Practitioner's progress under the PEP; and (ii) prior to any referral of the matter to the Medical Executive Committee.

(e) ***PEPs Not Disciplinary.*** PEPs are part of the Hospital's performance improvement and professional practice evaluation/peer review process. PEPs are not disciplinary in nature. Because a PEP is recommended by a non-disciplinary committee that has no authority to restrict privileges and is voluntarily accepted by the Practitioner,

the PEP is not reportable to the National Practitioner Data Bank or any state licensing board.

(f) ***Participation in PEPs by Partners.*** Consistent with the conflict of interest guidelines set forth in the Credentials Policy and this Policy, partners and other individuals who are affiliated in practice with the Practitioner may participate in PEPs through chart review and monitoring, proctoring, and providing second opinions when deemed appropriate by the CPE. In any such instance, these individuals shall comply with the standard procedures that apply to all other individuals who participate in the PPE process, such as the use of approved Hospital forms and the requirements related to confidentiality. To the extent possible, individuals who are not partners or affiliated in practice with the Practitioner will also be sought to perform these functions, consistent with the conflict of interest guidelines in this Policy.

(g) ***PEP Options*.** A PEP may include, but is not limited to, the interventions in this section (used individually or in combination). Additional detailed guidance regarding each of these PEP options is set forth in **Appendix E** ("Performance Enhancement Plan Options – Implementation Issues Checklist").

(1) ***Additional Education/CME*** which means that, within a specified period of time, the Practitioner must arrange for education or CME of a duration and type specified by the CPE. The educational activity/program may be chosen by the CPE or by the Practitioner, but must be approved by the CPE. If necessary, the Practitioner may be asked to voluntarily refrain from exercising all or some of his or her clinical privileges or may be granted an educational leave of absence while undertaking such additional education.

(2) ***Prospective Monitoring*** which means that a certain number of the Practitioner's future cases of a particular type will be subject to a focused review (e.g., review of the next 10 similar cases performed or managed by the Practitioner). This PEP can be used independently to encourage improvement by conducting a focused review of performance with feedback to the Practitioner. More frequently, it is used in combination with other PEP elements to assess and monitor whether clinical performance has been improved.

(3) ***Indicators Checklist*** which means that the Practitioner must (i) research the medical literature or government publications; (ii) identify evidence-based guidelines that address when a test or procedure is medically-indicated; and (iii) prepare a checklist, flowchart, or similar document that can be used to document in the medical record the medical necessity and appropriateness of a test or procedure for a specific patient.

(4) ***Second Opinions/Consultations*** which means that before the Practitioner proceeds with a particular treatment plan or procedure, the Practitioner must

obtain a second opinion or consultation from a Medical Staff member approved by the CPE. If there is any disagreement about the proper course of treatment, the Practitioner must discuss the matter further with individuals identified by the CPE before proceeding further. The Practitioner providing the second opinion/consultation must generally complete a Second Opinion/Consultation Report form for each case, which shall be reviewed by the CPE. A Sample ***Letter to Physicians Providing Second Opinions/Consultations*** and a ***Second Opinion Consultation/Worksheet*** are included in the ***PPE Manual***.

(5) ***Concurrent Proctoring/Observation*** which means that a certain number of the Practitioner's future cases of a particular type (e.g., the Practitioner's next five vascular cases or the Practitioner's next five cases managing a particular medical condition) must be personally proctored (observed) by a Medical Staff member approved by the CPE, or by an appropriately credentialed individual from outside of the Medical Staff approved by the CPE. Proctors are intended to be observers who neither supervise the Practitioner nor direct the care of the patient, but they are authorized to intervene in a patient's care whenever that may be in a patient's best interests. To ensure such observation is effective, the proctor must be present during the relevant portions of the operative procedure or must personally assess the patient and be available throughout the course of medical treatment. The proctor will generally complete an appropriate review form, which shall be reviewed by the CPE. Because concurrent proctoring is recommended by a non-disciplinary committee that has no authority to restrict privileges and is voluntarily accepted by the Practitioner, a PEP that includes proctoring as described in this subsection is not reportable to the National Practitioner Data Bank or any state licensing board. A sample ***Letter to Physicians Who Will Serve as Proctor*** is included in the ***PPE Manual***.

(6) ***Participation in a Formal Evaluation/Assessment Program*** which means that, within a specified period of time, the Practitioner must enroll in a program approved by the CPE that is designed to assess whether there are any opportunities for improvement in the Practitioner's clinical practice. The Practitioner must complete the assessment program within a specified time period established by the CPE. The Practitioner is responsible for all costs associated with the program, unless the CPE determines otherwise. The Practitioner must execute a release to allow the CPE to communicate information to, and receive information from, the selected assessment program. If necessary, the Practitioner may be asked to voluntarily refrain from exercising all or some of his or her clinical privileges or may be granted an educational leave of absence while undertaking such formal assessment. A sample ***Authorization and Release for Disclosure of Confidential Information*** is included in the ***PPE Manual***.

(7) ***Additional Training*** which means that, within a specified period of time, the Practitioner must complete additional training in a program approved by the CPE to address any identified opportunities for improvement in his or her practice. This training may be accomplished by participation in simulation activities, mini-fellowship programs, or refreshers at the residency program from which a Practitioner graduated. The Practitioner is responsible for all costs associated with the training, unless the CPE determines otherwise. The Practitioner must execute a release to allow the CPE to communicate information to, and receive information from, the selected program. The director of the training program or appropriate supervisor must provide an assessment and evaluation of the Practitioner's current competence, skill, judgment and technique, when requested by the CPE. If necessary, the Practitioner may be asked to voluntarily refrain from exercising all or some of his or her clinical privileges or may be granted an educational leave of absence while undertaking such additional training.

(8) ***Educational Leave of Absence or Determination to Voluntarily Refrain from Practicing during the PPE Process*** which means that the Practitioner voluntarily agrees to a leave of absence ("LOA") or to temporarily refrain from some or all clinical practice while the PPE process continues. During the LOA or the period of refraining, a further assessment of the issues will be conducted or the Practitioner will complete an education/training program of a duration and type specified by the CPE.

(9) ***Other*** elements not specifically listed may be included in a PEP. The CPE has wide latitude to tailor PEPs to the specific concerns identified, always with the objective of helping the Practitioner to improve his or her clinical practice and to protect patients.

APPENDIX D

PERFORMANCE ISSUES THAT TRIGGER INFORMATIONAL LETTERS

This Appendix lists specific performance issues that can be successfully addressed by Practitioners via Informational Letters as described in **Appendix C** of this Policy ("Options to Address Clinical Concerns"), rather than a more formal review. More formal review is required only if a pattern is established as indicated below.

Department	Performance Issue	Location (including section number) in which requirement is identified (e.g., Rules and Regulations) or date on which performance issue was adopted by PPC/MEC	Number of occurrences that trigger first Informational Letter being sent (*NOTE*: Each subsequent occurrence triggers an additional Informational Letter until threshold for review under PPE Policy is reached)	Number of Informational Letters that trigger review under PPE Policy

APPENDIX E

PERFORMANCE ENHANCEMENT PLAN OPTIONS

IMPLEMENTATION ISSUES CHECKLIST

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Note: The Implementation Issues Checklists in this Appendix may be used by the CPE to effectuate Performance Enhancement Plans ("PEPs") that are developed in accordance with **Appendix C** ("Options to Address Clinical Concerns"). Checklists may be used individually or in combination with one another, depending on the nature of the PEP.

A copy of a completed Checklist may be provided to the Practitioner who is subject to the PEP, so that the CPE and the Practitioner have a shared and clear understanding of the elements of the PEP. While Checklists may serve as helpful guidance to the CPE and the Practitioner, there is no requirement that they be used. Failure to use a Checklist or to answer one or more questions on a Checklist will not affect the validity of a PEP. The committee conducting the review may opt to use the Checklist as a working document in developing a PEP and then discard the Checklist at any time.

PEP OPTION	IMPLEMENTATION ISSUES
Additional Education/CME ***(Wide range of options)***	***Scope of Additional Education/CME*** ❑ Be specific – what type? _____ _____ ❑ Number of hours: _____ ❑ Acceptable programs include: _____ _____ ❑ CPE approval required before Practitioner enrolls. ❑ Program approved: _____ ❑ Date of approval: _____ ❑ Time frames ❑ Practitioner must enroll by: _____ ❑ CME must be completed by: _____ ❑ Who pays for the CME/course? ❑ Practitioner subject to PEP ❑ Medical Staff ❑ Hospital ❑ Combination: _____ ❑ Documentation of completion must be submitted to CPE. _____ _____ ❑ Date submitted: _____ ***Additional Safeguards*** ❑ Will the individual be asked to voluntarily refrain from exercising relevant clinical privileges until completion of additional education? ❑ Yes ❑ No _____ _____ ***Follow-Up*** ❑ After CME has been completed, how will monitoring be done to be sure that concerns have been addressed/practice has improved? (Focused prospective monitoring? Proctoring?) _____ _____

PEP OPTION	IMPLEMENTATION ISSUES
Prospective Monitoring ***(100% focused review of next X cases (e.g., obstetrical cases, laparoscopic surgery))***	***Scope of Monitoring*** ❑ How many cases are subject to review? _____ ❑ What types of cases are subject to review? _____ _____ ❑ Based on Practitioner's practice patterns, estimated time for completion of monitoring? _____ ❑ Does monitoring include more than review of medical record? ❑ Yes ❑ No If yes, what else does it include? _____ _____ ❑ Review to be done: ❑ Post-discharge ❑ During admission ❑ Review to be done by: ❑ Medical Staff Office ❑ Department Chair ❑ CMO or VPMA ❑ Other: _____ _____ ❑ Must Practitioner notify reviewer of cases subject to requirement? ❑ Yes ❑ No Other options? _____ _____ ***Documentation of Review*** ❑ Case Review Form ❑ Specific form developed for this review ❑ General summary by reviewer ❑ Other: _____ _____ ***Results of Monitoring*** ❑ Who will review results of monitoring with Practitioner? _____ ❑ After each case ❑ After total # of cases subject to review (unless sooner discussions are necessary based on case findings)

PEP OPTION	IMPLEMENTATION ISSUES
Indicators Checklist ***(Research the medical literature, identify evidence-based guidelines addressing when a test or procedure is medically indicated, and develop a Checklist that can be included in the medical record to document medical necessity and appropriateness.)***	***Completion of the Checklists*** ❑ Checklists will be developed for the following procedures (in order of priority, if more than one): _____ _____ ❑ The Practitioner will consult with the following subject matter experts in developing the Checklists: _____ _____ ❑ The following CPE member will serve as the point of contact to assist the Practitioner with questions about the Checklists: _____ _____ ❑ The first draft of the Checklists will be submitted to the CPE by: _____ _____ ❑ The CPE will submit the Checklists to the following individuals/ committees for their review and comment, prior to final approval by the CPE: _____ ❑ The target date for final completion of the Checklists is: _____ ***Additional Safeguards*** ❑ Until the Checklists have been approved, what steps will be taken to monitor the medical necessity/appropriateness of the Practitioner's tests/procedures? _____ _____ ❑ Will the individual be asked to voluntarily refrain from exercising relevant clinical privileges until the Checklists have been approved? ❑ Yes ❑ No _____ _____ ***Follow-Up*** ❑ Once Checklists are completed and being used to document medical necessity/appropriateness of the Practitioner's procedures/tests for individual patients, describe the monitoring of completed Checklists that will occur (who will monitor, how often, and who will discuss with Practitioner): _____ _____

PEP OPTION	IMPLEMENTATION ISSUES
Second Opinions/ Consultations ***(Before the Practitioner proceeds with a particular treatment plan or procedure, he or she obtains a second opinion or consultation.)*** ***(This is not a "restriction" of privileges that triggers a hearing and reporting, if implemented as set forth in the Policy (i.e., recommended by a non-disciplinary committee with no authority to restrict privileges and voluntarily accepted by the Practitioner.))***	***Scope of Second Opinions/Consultations*** ❑ What types of cases are subject to the second opinions/consultations? _____ _____ ❑ How many cases are subject to the second opinions/consultations? _____ _____ ❑ Based on practice patterns, estimated time to complete the second opinions/consultations? _____ _____ ❑ Must consultant evaluate patient in person prior to treatment/ procedure? ❑ Yes ❑ No _____ _____ ***Responsibilities of Practitioner*** ❑ Notify consultant when applicable patient is admitted or procedure is scheduled and ensure that all information necessary to provide consultation is available in the medical record (H&P, results of diagnostic tests, etc.). _____ _____ ❑ What time frame for notice to consultant is practical and reasonable (e.g., two days prior to scheduled, elective procedure)? _____ _____ ❑ If consultant must evaluate patient prior to treatment, inform patient that consultant will be reviewing medical record and will examine patient. _____ _____ ❑ If consultant must evaluate patient prior to treatment, include general progress note in medical record noting that consultant examined patient and discussed findings with Practitioner. _____ _____ ❑ Discuss proposed treatment/procedure with consultant. _____ _____

PEP OPTION	IMPLEMENTATION ISSUES
Second Opinions/ Consultations ***(Before the Practitioner proceeds with a particular treatment plan or procedure, he or she obtains a second opinion or consultation.)*** ***(This is not a "restriction" of privileges that triggers a hearing and reporting, if implemented as set forth in the Policy (i.e., recommended by a non-disciplinary committee with no authority to restrict privileges and voluntarily accepted by the Practitioner.))*** ***(cont'd.)***	***Qualifications of Consultant*** ❑ Consultant must have clinical privileges in _____. ❑ Possible candidates include: _____ _____ _____ ❑ The following individuals agreed to act as consultants and were approved by the CPE on: _____ (date) _____ _____ _____ _____ ***Responsibilities of Consultant (****Information provided by CPE; include discussion of legal protections for consultant.****)*** ❑ Review medical record prior to treatment or procedure. _____ _____ ❑ Evaluate patient prior to treatment or procedure, if applicable. _____ _____ ❑ Discuss proposed treatment/procedure with physician. _____ _____ ❑ Complete Second Opinion/Consultation Form and submit to Medical Staff Office *(not for inclusion in the medical record)*. _____ _____ ***Disagreement Regarding Proposed Treatment/Procedure*** If consultant and physician disagree regarding proposed treatment/procedure, consultant notifies one of the following so that an immediate meeting can be scheduled to resolve the disagreement: ❑ CMO or VPMA ❑ Chief of Staff ❑ CPE Chair ❑ Department Chair ❑ Other: _____ _____ _____

PEP OPTION	IMPLEMENTATION ISSUES
Second Opinions/ Consultations ***(Before the Practitioner proceeds with a particular treatment plan or procedure, he or she obtains a second opinion or consultation.)*** ***(This is not a "restriction" of privileges that triggers a hearing and reporting, if implemented as set forth in the Policy (i.e., recommended by a non-disciplinary committee with no authority to restrict privileges and voluntarily accepted by the Practitioner.))*** ***(cont'd.)***	***Compensation for Consultant*** *(consultant cannot bill for consultation)* ❑ No compensation ❑ Compensation by: ❑ Practitioner subject to PEP ❑ Medical Staff ❑ Hospital ❑ Combination _____ _____ ***Results of Second Opinion/Consultations*** ❑ Who will review results of second opinions/consultations with Practitioner? _____ ❑ After each case ❑ After total # of cases subject to review (unless sooner discussions are necessary based on case findings) ❑ Include consultants' reports in Practitioner's quality file. ***Additional Safeguards*** ❑ Will Practitioner be removed from some/all on-call responsibilities until the second opinions/consultations are completed? ❑ Yes ❑ No _____ _____

PEP OPTION	IMPLEMENTATION ISSUES
Concurrent Proctoring/Observation ***(A certain number of the Practitioner's future cases of a particular type (e.g., vascular cases, management of diabetic patients) must be directly observed.)*** ***(This is not a "restriction" of privileges that triggers a hearing and reporting, if implemented as set forth in the Policy (i.e., recommended by a non-disciplinary committee with no authority to restrict privileges and voluntarily accepted by the Practitioner.))***	***Scope of Proctoring*** ❑ What types of cases are subject to proctoring? _____ _____ ❑ How many cases are subject to proctoring? _____ _____ ***Time Frames*** ❑ Based on practice patterns, estimated time to complete the proctoring? _____ _____ ***Responsibilities of Practitioner*** ❑ Notify proctor when applicable patient is admitted or procedure is scheduled and ensure that all information necessary for proctor to evaluate case is available in the medical record (H&P; results of diagnostic tests, etc.). _____ _____ ❑ What time frame for notice to proctor is practical and reasonable (e.g., two days prior to scheduled, elective procedure)? _____ _____ ❑ ***Procedures***: Inform patient that proctor will be present during procedure and may examine patient, and document patient's consent on informed consent form. _____ _____ ❑ ***Medical***: If proctor will personally assess patient, discuss with patient prior to proctor's examination. _____ _____ ❑ Include general progress note in medical record noting that proctor examined patient and discussed findings with Practitioner, *if applicable*. _____ _____ ❑ Agree that proctor has authority to participate in procedures in an emergency. _____ _____ ❑ Discuss treatment/procedure with proctor. _____ _____

PEP OPTION	IMPLEMENTATION ISSUES
Concurrent Proctoring/Observation ***(A certain number of the Practitioner's future cases of a particular type (e.g., vascular cases, management of diabetic patients) must be directly observed.)*** ***(This is not a "restriction" of privileges that triggers a hearing and reporting, if implemented as set forth in the Policy (i.e., recommended by a non-disciplinary committee with no authority to restrict privileges and voluntarily accepted by the Practitioner.))*** ***(cont'd.)***	***Qualifications of Proctor*** *(CPE must approve)* ❑ Proctor must have clinical privileges in _____. *(If proctor is not a member of the Medical Staff, credential and grant temporary privileges.)* ❑ Possible candidates include: _____ _____ _____ ❑ The following individuals agreed to act as proctors and were approved by the CPE on _____: (date) _____ _____ _____ _____ ***Responsibilities of Proctor*** *(information provided by CPE; include discussion of legal protections for proctor)* ❑ Review medical record and: ❑ ***Procedure***: Be present for the relevant portions of the procedure and be available post-op if complications arise. ❑ ***Medical***: Be available during course of treatment to discuss treatment plan, orders, lab results, discharge planning, etc., and personally assess patient, if necessary. ❑ Participate in care if necessary to protect patient and document such participation appropriately in medical record. ❑ Discuss treatment plan/procedure with Practitioner. _____ _____ ❑ Document review as indicated below and submit to Medical Staff Office. ***Documentation of Review*** *(not for inclusion in the medical record)* ❑ Case Review Form ❑ Specific form developed for this PEP ❑ Other: _____

PEP OPTION	IMPLEMENTATION ISSUES
Concurrent Proctoring/Observation ***(A certain number of the Practitioner's future cases of a particular type (e.g., vascular cases, management of diabetic patients) must be directly observed.)*** ***(This is not a "restriction" of privileges that triggers a hearing and reporting, if implemented as set forth in the Policy (i.e., recommended by a non-disciplinary committee with no authority to restrict privileges and voluntarily accepted by the Practitioner.))*** ***(cont'd.)***	***Compensation for Proctor*** *(proctor cannot bill for review of medical record or assessment of patient and cannot act as first assistant)* ❑ No compensation ❑ Compensation by: ❑ Practitioner subject to PEP ❑ Medical Staff ❑ Hospital ❑ Combination ***Results of Proctoring*** ❑ Who will review results of proctoring with Practitioner? ❑ After each case ❑ After total # of cases subject to review (unless sooner discussions are necessary based on case findings) ❑ Include proctor reports in Practitioner's quality file ***Additional Safeguards*** ❑ Will Practitioner be removed from some/all on-call responsibilities until proctoring is completed? ❑ Yes ❑ No

PEP OPTION	IMPLEMENTATION ISSUES
Formal Evaluation/ Assessment Program ***(Onsite multiple-day programs that may include formal testing, simulated patient encounters, chart review.)***	***Scope of Formal Evaluation/Assessment Program*** ❑ Acceptable programs include: _____ _____ ❑ CPE approval required before Practitioner enrolls ❑ Program approved: _____ ❑ Date of approval: _____ ❑ Who pays for the evaluation/assessment? ❑ Practitioner subject to PEP ❑ Medical Staff ❑ Hospital ❑ Combination: _____ ***Practitioner's Responsibilities*** ❑ Sign release allowing CPE to provide information to program (if necessary) and program to provide report of assessment and evaluation to CPE. _____ _____ ❑ Enroll in program by: _____ ❑ Complete program by: _____ ***Additional Safeguards*** ❑ Will the individual be asked to voluntarily refrain from exercising relevant clinical privileges until completion of evaluation/assessment program? ❑ Yes ❑ No _____ _____ ❑ Will Practitioner be removed from some/all on-call responsibilities until completion of evaluation/assessment program? ❑ Yes ❑ No _____ _____ ***Follow-Up*** ❑ Based on results of assessment, what additional interventions are necessary, if any? _____ _____ ❑ How will monitoring after assessment program/any additional interventions be conducted to be sure that concerns have been addressed/practice has improved? (Focused prospective review? Proctoring?) _____ _____

PEP OPTION	IMPLEMENTATION ISSUES
Additional Training ***(Wide range of options from hands-on CME to simulation to repeat of residency or fellowship.)***	***Scope of Additional Training*** ❑ Be specific – what type? _____ _____ ❑ Acceptable programs include: _____ _____ ❑ CPE approval required before Practitioner enrolls. ❑ Program approved: _____ ❑ Date of approval: _____ ❑ Who pays for the training? ❑ Practitioner subject to PEP ❑ Medical Staff ❑ Hospital ❑ Combination: _____ ***Practitioner's Responsibilities*** ❑ Sign release allowing CPE to provide information to training program (if necessary) and program to provide detailed evaluation/assessment to CPE before resuming practice. ❑ Enroll in program by: _____ ❑ Complete program by: _____ ***Additional Safeguards*** ❑ Will the individual be asked to voluntarily refrain from exercising relevant clinical privileges until completion of additional training? ❑ Yes ❑ No _____ _____ ❑ Will Practitioner be removed from some/all on-call responsibilities until completion of additional training? ❑ Yes ❑ No _____ _____ ❑ Will LOA be used for the additional training? ❑ Yes ❑ No _____ _____ ***Follow-Up*** ❑ After additional training is completed, how will monitoring be conducted to be sure that concerns have been addressed/practice has improved? (Focused prospective review? Proctoring?) _____ _____

PEP OPTION	IMPLEMENTATION ISSUES
Educational Leave of Absence or Determination to Voluntarily Refrain from Practicing during the PPE Process	❑ Who may grant a formal LOA (if applicable)? *(Review Bylaws)* _____ _____ ❑ Will the individual be asked to voluntarily refrain from exercising relevant clinical privileges while the PPE process continues? ❑ Yes ❑ No _____ _____ ❑ Specify the conditions for reinstatement from the LOA or for the resumption of practice following the decision to voluntarily refrain: _____ _____ ❑ What happens if the Practitioner agrees to LOA or to voluntarily refrain, but: ❑ does not return to practice at the Hospital? Will this be considered resignation in return for not conducting an investigation and thus be reportable? ❑ Yes ❑ No ❑ moves practice across town? Must Practitioner notify other Hospital of educational leave of absence or the determination to voluntarily refrain from practicing? ❑ Yes ❑ No _____ _____

PEP OPTION	IMPLEMENTATION ISSUES
"Other" ***Wide latitude to utilize other ideas as part of PEP, tailored to specific concerns.*** ***Examples:*** • ***Participate in an educational session at section or Department meeting and assess colleagues' approach to case.*** • ***Study issue and present grand rounds.*** • ***Design and use informed consent forms approved by CPE.*** • ***Design and use indication forms approved by CPE.*** • ***Limit inpatient census.*** • ***Limit number of procedures in any one day/block schedule.*** • ***No elective procedures to be performed after _ p.m.*** • ***All patient rounds done by certain time of day – timely orders, tests, length of stay concerns.*** • ***Personally see each patient prior to procedure (rather than using PA or APRN).*** • ***Personally round on patients – cannot rely solely on PA or APRN.*** • ***Utilize individuals from other specialties to assist in PEPs (e.g., cardiologist experiencing difficulties with TEE technical complications mentored by anesthesiologists).***	

APPENDIX F

INFORMATION SHARING WITH EMPLOYER

1. ***Scope.*** This Appendix applies when the Practitioner subject to a review is an Employed Practitioner.

2. ***Information Sharing.***

   (a) If the Practitioner involved is employed by TMC Healthcare, the Leadership Council or CPE may notify an appropriate TMC Healthcare representative with employment responsibilities of the review and request assistance in addressing the matter. If the Practitioner is employed by a qualifying private entity, the Leadership Council or CPE may notify the peer review committee within that entity and request assistance in addressing the matter.

   (b) The Leadership Council and CPE will generally notify the Employer when, in the committee's discretion, the concern being reviewed is more significant. By way of example and not limitation, the CPE may choose to not notify the Employer of a matter that is likely to result in an Educational Letter, but may choose to notify the Employer of a concern that may lead to a Performance Enhancement Plan involving second opinions or proctoring.

   (c) If the Employer is notified, a representative of the Employer may be invited to attend meetings of the committee conducting the review, participate in discussions and deliberations, and participate in any interventions that may be deemed necessary.

   (d) This Appendix is intended to supplement, not replace, any applicable Bylaw provision, policy, agreement, or application form pertaining to the sharing of PPE/peer review information among the Hospital, Hospital-related entities, and private entities.

3. ***Documentation and Confidentiality.*** The purpose of notifying an Employer of a review pursuant to this Appendix is to improve the quality of patient care. Accordingly, any information or documentation that is disclosed to the Employer or created for purposes of the review must be maintained in a confidential manner in accordance with its privileged status under the state peer review protection law. Such information should ***not*** be maintained in the employment or personnel file of the Practitioner, but rather in the Practitioner's peer review-protected file at the Hospital or at the Employer.

APPENDIX G

OBTAINING INPUT FROM THE PRACTITIONER

1. ***Input by Practitioner.***

   (a) Practitioners will be requested to provide meaningful input into the review of the care they have provided. This is an essential element of a transparent and constructive review process.

   (b) If any questions or concerns are identified by the CPE or Leadership Council about the care provided in a case under review, the Practitioner will be notified of the questions or concerns and offered an opportunity to provide input prior to the review being completed and any final determination made. The notice to the Practitioner shall include a time frame for the Practitioner to provide the requested input. Sample ***Requests for Input*** are included in the ***PPE Manual***.

   (c) No Educational Letter, Collegial Intervention, or Performance Enhancement Plan shall be implemented until the Practitioner is first notified of the specific concerns identified and given an opportunity to provide input as described in this Section. Prior notice and an opportunity to provide input are *not required* before an Informational Letter is sent to a Practitioner.

2. ***Manner of Providing Input.***

   (a) The Practitioner shall provide input through a written description and explanation of the care provided, responding to any specific questions posed in the correspondence to the Practitioner (e.g., email or letter).

   (b) Upon the request of either the Practitioner or the committee conducting the review, the Practitioner may also provide input by meeting with appropriate individuals (as determined by the committee conducting the review) to discuss the issues.

   (c) As part of a request for input pursuant to the PPE Policy, the committee requesting input may ask the Practitioner to provide a copy of, or access to, medical records from the Practitioner's office. Failure to provide such copies or access will be viewed as a failure to provide requested input.

   (d) Individual members of the CPE or Leadership Council should not engage in separate discussions with a Practitioner regarding the review of a case unless the committee in question has asked the individual committee member to speak with the Practitioner on its behalf. Similarly, unless formally requested to do so, Practitioners may not provide verbal input to a member of the Medical Staff Office or to any other individual and ask that individual to relay that verbal input to an individual or committee involved in the review. The goal of these requirements is to ensure that all individuals and committees involved in the review process receive

the same, accurate information. Practitioners must also refrain from any discussions or lobbying with other Medical Staff members or Board members outside the authorized review process outlined in the PPE Policy.

(e) Correspondence sent to the Practitioner pursuant to the PPE Policy shall be placed in the Practitioner's confidential file. The Practitioner shall be permitted to respond in writing, and the Practitioner's response shall also be kept in the confidential file.

3. ***Sharing Identity of Any Individual Reporting a Concern.***

(a) ***General Rule.*** Since the PPE Policy does not involve disciplinary action or "restrictions" of privileges, the specific identity of any individual reporting a concern or otherwise providing information about a matter (the "reporter") generally will not be disclosed to the Practitioner.

(b) ***Exceptions.***

(1) ***Consent.*** The identity of the reporter may be disclosed to the Practitioner if the reporter specifically consents to the disclosure (with the reporter being reassured that he or she will be protected from retaliation).

(2) ***Medical Staff Hearing.*** The identity of the reporter shall be disclosed to the Practitioner if information provided by the reporter is used to support an adverse professional review action that results in a Medical Staff hearing.

(c) ***Practitioner Guessing the Identity of Reporter.*** This section does not prevent notification to a Practitioner about a concern that has been raised even if the description of the concern would allow the Practitioner to guess the identity of the reporter (e.g., where the reporter and the Practitioner were the only two people present when an incident occurred). In such case, the person or committee conducting the review will not confirm the identity of the reporter, and will pay particular attention to reminding the Practitioner to avoid any action that could be perceived as retaliation.

(d) ***Retaliation Prohibited.*** Retaliation by the Practitioner against anyone who is believed to have reported a concern or otherwise provided information about a matter is inappropriate conduct and will be addressed by the Leadership Council through the Professionalism Policy.

4. ***Failure to Provide Requested Input.***

(a) ***Failure to Provide Written Input.*** If the Practitioner fails to provide written input requested by the CPE or Leadership Council within the time frame specified in the request, the Practitioner will be required to meet with the Leadership Council. The purpose of the meeting is to discuss the Practitioner's obligation to participate in the review process, permit the Practitioner to explain why the information was not

provided, and inform the Practitioner of the consequences of continuing to not provide the information. Failure of the Practitioner to either:

(1) meet with the Leadership Council and persuade it that the requested written input is not necessary; or

(2) provide the requested written input prior to the meeting

will result in the automatic relinquishment of the Practitioner's clinical privileges. Such automatic relinquishment will continue until the Practitioner either meets with the Leadership Council and persuades it that the written information is not necessary or provides the requested written information. The Chair of the Leadership Council may determine that written information provided by the Practitioner is responsive to the Leadership Council's request and that automatic relinquishment will therefore not occur (or that such relinquishment will end if it has already commenced).

(b) ***Failure to Attend Meeting.*** If the CPE or the Leadership Council requests that the Practitioner attend a meeting with it or a designated individual to provide verbal input and the Practitioner fails or refuses to attend such a meeting, the Practitioner's clinical privileges will be automatically relinquished until the meeting occurs.

(c) ***When Temporary Automatic Relinquishment Becomes Automatic Resignation from Staff.*** If the Practitioner fails to (i) meet with the CPE or the Leadership Council or (ii) provide the requested information within thirty (30) days of the automatic relinquishment, the Practitioner's Medical Staff membership and clinical privileges will be deemed to have been automatically resigned. (See the definition of Automatic Relinquishment/Resignation in the Medical Staff Glossary for additional information and guidance.)

(d) ***Extensions for Good Cause***. Automatic relinquishment or resignation as described in this Appendix will not occur if the Practitioner's failure to provide written input or meet with the Leadership Council or CPE is due to the Practitioner's absence (e.g., a planned vacation, attendance at a conference, etc.), illness, family emergency or other cause beyond the Practitioner's control. In such case, the Leadership Council or CPE will establish reasonable deadlines depending on the circumstances.

(e) ***Automatic Relinquishment and Automatic Resignation Not Reportable***. The automatic relinquishment or resignation of appointment and/or clinical privileges described in this Appendix are administrative actions that occur by operation of this Policy. They are not professional review actions that must be reported to the National Practitioner Data Bank or to any state licensing board or agency, nor do they entitle the Practitioner to a hearing or appeal.

APPENDIX H

OTHER PROVISIONS THAT GOVERN THE PPE PROCESS

This Appendix contains various other provisions that govern aspects of the PPE review process. Specifically, this Appendix contains guidance regarding the following matters:

1	Incomplete Medical Records for Cases Being Reviewed During PPE Process
2	Approved PPE Process Forms and Letters
3	External Reviews
4	Findings and Recommendations Supported by Evidence-Based Research/Clinical Protocols or Guidelines
5	System Process Issues
6	Tracking of Reviews
7	Educational Sessions/Dissemination of Educational Information
8	Confidentiality Requirements
9	Supervising Physicians and Advanced Practice Professionals
10	Legal Protection for Reviewers
11	Delegation of Functions
12	No Legal Counsel or Recordings During Collegial Meetings
13	Professional Practice Evaluation Reports
14	Conflict of Interest Guidelines

1. ***Incomplete Medical Records for Cases Being Reviewed During PPE Process.*** One of the objectives of the PPE Policy is to review matters and provide feedback to Practitioners in a timely manner. Therefore, if a matter referred for review involves a medical record that is incomplete (whether in the hospital or office), the Medical Staff Office shall notify the Practitioner that the case has been referred for evaluation and that the medical record must be completed within 10 days.

   If the medical record is not completed within 10 days, the Practitioner will be required to meet with the Leadership Council to explain why the medical record was not completed. Failure of the individual to either:

   (i) meet with the Leadership Council and convince it that the medical record is not relevant to the review; or

   (ii) complete the medical record in question prior to that meeting,

will result in the automatic relinquishment of the Practitioner's clinical privileges until the medical record is completed. If the Practitioner fails to complete the medical record within thirty (30) days of the automatic relinquishment, the Practitioner's Medical Staff membership and clinical privileges will be deemed to have been automatically resigned. (See the definition of Automatic Relinquishment/Resignation in the Medical Staff Glossary for additional information.)

The 10-day time frame set forth in this section applies only to medical records that are necessary for a review being conducted pursuant to the PPE Policy. The time frame set forth in this section supersedes any other time frames for the completion of medical records as may be set forth in the Medical Staff Bylaws, Rules and Regulations, or other policy.

2. ***Approved PPE Process Forms and Letters.*** The CPE shall approve forms and template letters necessary to implement the PPE Policy. Such documents shall be developed and maintained by the Medical Staff Office, unless the CPE directs that another office or individual develop and maintain specific PPE documents. Individuals performing a function pursuant to the PPE Policy shall use the document currently approved by the CPE for that function.

3. ***External Reviews.*** An external review may be appropriate if:

   (a) There are ambiguous or conflicting findings by internal reviewers;

   (b) The clinical expertise needed to conduct a review is not available on the Medical Staff; or

   (c) An outside review is advisable to prevent allegations of bias, even if unfounded.

   Obtaining an external review is within the discretion of the Leadership Council or CPE, acting in consultation with the Chief Executive Officer, CMO or VPMA. No Practitioner has the right to demand that the Hospital obtain an external review in any particular circumstance.

   Those arranging for an external review shall first seek to identify an appropriate expert who is already affiliated with TMC Healthcare. If a decision is made to obtain an external review, the Practitioner involved shall be notified of that decision and the nature of the external review. Upon completion of the external review, the Practitioner shall be provided a copy of the reviewer's report. The report of the external reviewer is a record of the committee that requested it, and will be maintained in a confidential manner as described in this Policy. A sample ***Letter Agreement with External Review Entity, Letter Agreement with External Reviewer – Individual*** and ***Letter to External Reviewer Enclosing Information for Review*** are included in the ***PPE Manual***.

4. ***Findings and Recommendations Supported by Evidence-Based Research/Clinical Protocols or Guidelines.*** Whenever possible, the findings of reviewers and the CPE shall be supported by evidence-based research, clinical protocols, or guidelines.

5. ***System Process Issues.*** Quality of care and patient safety depend on many factors in addition to Practitioner performance. If system processes or procedures that may have adversely affected, or could adversely affect, outcomes or patient safety are identified through the process outlined in this Policy, the issue shall be referred to the appropriate Hospital department or committee and/or the Medical Staff Office. The referral shall be reported to the CPE and will stay on the CPE's agenda until it determines, based on reports from the Hospital department or individuals charged with addressing the system issue, that the issue has been resolved. A sample ***Memo to Hospital Department Regarding System Issue*** is included in the ***PPE Manual***.

6. ***Tracking of Reviews.*** The Medical Staff Office shall track the processing and disposition of matters reviewed pursuant to the PPE Policy. CPE Members, the APPC Member, and CPE shall promptly notify the Medical Staff Office of their determinations, interventions, and referrals.

7. ***Educational Sessions/Dissemination of Educational Information.***

   (a) ***General Principles.***

      (1) Educational sessions as described in this section, as well as the dissemination of educational information through other mechanisms, are integral parts of the peer review process and assist Practitioners in continuously improving the quality and safety of the care they provide. These activities will be conducted in a manner consistent with their confidential and privileged status under the Arizona peer review protection law and any other applicable federal or state law.

      (2) Cases that reflect exemplary care, unusual clinical facts, or would be of educational value for any other reason, shall be referred to the appropriate Department Chair for discussion during an educational session or for the dissemination of "lessons learned" in some other manner.

      (3) Medical Staff members, residents, medical students, and appropriate Hospital personnel are encouraged to participate in educational sessions to assess and continuously improve the care they provide.

      (4) Educational sessions may also serve as a triage mechanism for the review process set forth in the PPE Policy in certain circumstances. If any case is identified in an educational session that:

         (i) may raise questions or concerns with the clinical practice or professional conduct of an individual Practitioner; and

(ii) has not already been reviewed as part of the process set forth in the PPE Policy,

the case should be referred for review in accordance with the PPE Policy to evaluate whether the potential concern has merit, and to address any concerns that exist. Following the conclusion of that review process, the case may be referred back to the Department Chair for purposes of conducting an educational session as described in this section.

(b) ***Rules for Educational Sessions.***

(1) For purposes of this section, "educational sessions" include morbidity and mortality conferences, and any other session conducted in a manner designed to promote quality assessment and improvement.

(2) Educational sessions will be supported and facilitated by the Medical Staff Office, whenever possible.

(3) Any Practitioner whose care of a patient will be reviewed in a session shall be notified at least seven days prior to the educational session. Such Practitioners shall be encouraged to attend and participate in the discussion.

(4) Information identifying specific Practitioners shall be removed prior to any presentation, unless the Practitioner requests otherwise or it is impossible to de-identify the information.

(5) All individuals who attend routine educational sessions that occur in designated specialty areas shall sign a Confidentiality Agreement annually.

(6) All attendees at an educational session will also be required to sign a confidentiality reminder for each session (e.g., as part of the sign-in process). In addition, a confidentiality reminder should be made verbally at the beginning of each session.

(7) Minutes are not required to be kept for educational sessions, but each session will have a standardized agenda that includes:

- a header in large, bold print identifying the agenda as a "Confidential Peer Review Document," and a reference to the Arizona peer review statute (including the citation of the statute);
- the date of the educational session;
- cases reviewed (i.e., medical record numbers); and

- participants involved.

All such agendas shall be filed securely in confidential Medical Staff Office files. A sample ***Request for Educational Session/Dissemination of Lessons Learned, Sign-In Sheet for Educational Session,*** and ***Documentation of Educational Session*** are included in the ***PPE Manual***.

8. ***Confidentiality Requirements.*** Maintaining confidentiality is a fundamental and essential element of an effective professional practice evaluation process.

(a) ***Documentation.*** All documentation that is prepared in accordance with the PPE Policy shall be maintained in appropriate Medical Staff files. This documentation shall be accessible to Hospital personnel and Medical Staff Leaders and committees having responsibility for credentialing and professional practice evaluation functions, and to those assisting them in those tasks. All such information shall otherwise be deemed confidential and kept from disclosure or discovery to the fullest extent permitted by Arizona or federal law.

(b) ***Risk Management.*** Information that is generated pursuant to this PPE Policy may not be documented in risk management files or disclosed as part of any risk management activities.

(c) ***Participants in the PPE Process.*** All individuals involved in the PPE process (Medical Staff and Hospital employees) will maintain the confidentiality of the process. All such individuals shall sign an appropriate Confidentiality Agreement. Violations of this provision by Practitioners will be reviewed under the Medical Staff Professionalism Policy. Violations by Hospital employees will be referred to human resources. Sample ***Confidentiality Agreements*** are included in the ***PPE Manual***.

(d) ***Practitioner Under Review.*** The Practitioner under review must also maintain all information related to the review in a strictly confidential manner, as required by Arizona law. The Practitioner may not disclose information to, or discuss it with, anyone outside of the review process set forth in this Policy without first obtaining the permission of the Leadership Council, except for any legal counsel who may be advising the Practitioner. Violations of this provision will be reviewed under the Medical Staff Professionalism Policy.

(e) ***PPE Communications.*** Communications among those participating in the PPE process, including communications with the reviewers and the individual Practitioner involved, shall be conducted in a manner reasonably calculated to assure privacy.

(1) Telephone and in-person conversations shall take place in private at appropriate times and locations to minimize the risk of a breach of confidentiality (e.g., conversations should not be held in Hospital hallways).

(2) Hospital e-mail may be used to communicate between individuals participating in the professional practice evaluation process, including with those reviewing a case and with the Practitioner whose care is being reviewed. E-mail should not be sent to non-hospital accounts unless the e-mail merely directs recipients to check their Hospital e-mail. Notwithstanding this subsection, e-mail should not be utilized to present a PEP to a Practitioner. As noted previously in this Policy, one or more members of the CPE should personally discuss the PEP with the Practitioner and present a copy to the Practitioner in person.

(3) All e-mails should include a standard convention, such as "Confidential PPE/Peer Review Communication" in the subject line. All documents (whether paper or electronic) should be conspicuously marked with the notation "Confidential PPE/Peer Review" or words to that effect. However, failure to mark documents in this manner shall not be viewed as an indication that the document is not privileged.

(4) Before any correspondence is sent to a Practitioner whose care is being reviewed (whether paper or electronic), a text message or e-mail may be sent or a phone call may be attempted as a courtesy to alert the Practitioner that the correspondence is being sent and how it will be sent. The intent of any such text message or phone call is to make the Practitioner aware of the correspondence and avoid any deadline being missed. Whenever such a text message or phone call is utilized, a notation to that effect should be made on the copy of the applicable correspondence maintained in the Practitioner's confidential file or in another peer review database.

(5) If it is necessary to e-mail medical records or other documents containing a patient's protected health information, Hospital policies governing compliance with the HIPAA Security Rule shall be followed.

9. ***Supervising Physicians and Advanced Practice Professionals.*** An appropriate supervising or collaborating physician shall be kept apprised of any concerns that are reviewed pursuant to this Policy involving an Advanced Practice Professional with whom the physician has a supervisory or collaborative relationship. Without limiting the foregoing, the supervising or collaborating physician will be copied on all correspondence that an Advanced Practice Professional is sent under the PPE Policy and may be invited to participate in any meetings or interventions. The supervising or collaborating physician shall maintain in a confidential manner all information related to reviews under the PPE Policy.

10. ***Legal Protection for Reviewers.*** It is the intention of the Hospital and the Medical Staff that the PPE process outlined in the PPE Policy be considered patient safety, professional review, peer review, and quality assurance activity within the meaning of the Patient Safety Quality Improvement Act of 2005, the federal Health Care Quality Improvement Act of

1986, and Arizona law. In addition to the protections offered to individuals involved in review activities under those laws, such individuals shall be indemnified and covered under the Hospital's general liability and/or directors' and officers' insurance policies when they act within the scope of their duties as outlined in the PPE Policy and function on behalf of the Hospital.

11. ***Delegation of Functions.*** When a function under the PPE Policy is to be carried out by a member of the Administrative Team, by a Medical Staff Member, or by a Medical Staff committee, the individual, or the committee through its chair, may delegate performance of the function to a qualified designee who is a Practitioner or Hospital employee (or a committee of such individuals). Any such designee must treat and maintain all information in a strictly confidential manner and is bound by all other terms, conditions, and requirements of the PPE Policy. In addition, the delegating individual or committee is responsible for ensuring that the designee appropriately performs the function in question. Any documentation created by the designee are records of the committee that is ultimately responsible for the review in a particular matter.

12. ***No Legal Counsel or Recordings During Collegial Meetings.***

(a) To promote the collegial and educational objectives of this Policy, all discussions and meetings with a Practitioner shall generally involve only the Practitioner and the appropriate Medical Staff Leaders and Hospital personnel. No counsel representing the Practitioner or the Medical Staff or the Hospital shall attend any of these meetings. In their discretion, Medical Staff Leaders may permit a Practitioner to invite another Practitioner to the meeting. In such case, the invited Practitioner may not participate in the discussion or in any way serve as an advocate for the Practitioner under review, must sign a Confidentiality Agreement, and may be required to leave the meeting at any time.

(b) No recording (audio or video) of a meeting shall be permitted or made. In their discretion, Medical Staff Leaders may require that smart phones, iPads, and similar devices be left outside the meeting room.

13. ***Professional Practice Evaluation Reports.***

(a) ***Practitioner Professional Practice Evaluation History Reports.*** A Practitioner history report showing all cases that have been reviewed for a Practitioner within the past two years and their dispositions shall be generated for each Practitioner for consideration and evaluation by the appropriate Department Chair and the Credentials Committee in the reappointment process. A sample ***Practitioner History Report*** is included in the ***PPE Manual***.

(b) ***Reports to Medical Executive Committee and Board.*** The Medical Staff Office shall prepare reports at least annually showing the aggregate number of cases reviewed through the PPE process and the dispositions of those matters. A sample ***PPE Activity Summary Report*** is included in the ***PPE Manual***.

(c) ***Reports on Request.*** The Medical Staff Office shall prepare reports as requested by the Leadership Council, Department Chair, CPE, Medical Executive Committee, Administrative Team, or the Board.

14. ***Conflict of Interest Guidelines.*** To protect the integrity of the review process, all those involved must be sensitive to potential conflicts of interest. It is also important to recognize that effective peer review involves "peers" and that the CPE does not make any recommendations that would adversely affect the clinical privileges of a Practitioner (which is only within the authority of the Medical Executive Committee). As such, the Conflict of Interest Guidelines outlined in the Medical Staff Credentials Policy shall be used in assessing and resolving any potential conflicts of interest that may arise under this Policy. Those conflict of interest guidelines are summarized on the following two pages.

CONFLICT OF INTEREST GUIDELINES

Potential Conflicts	Levels of Participation								
			Committee Member						
	Provide Information	CPE or APPC Member (When Conducting Initial Case Review)	Credentials	Leadership Council	CPE/ APPC	MEC	Investigating Committee	Hearing Panel	Board
Employment/contract relationship with Hospital	Y	Y	Y	Y	Y	Y	Y	Y	Y
Self or family member	Y	N	R	R	R	R	N	N	R
Relevant treatment relationship*	Y	N	R	R	R	R	N	N	R
Significant financial relationship	Y	Y	Y	Y	Y	R	N	N	R
Direct competitor	Y	Y	Y	Y	Y	R	N	N	R
Close friends	Y	Y	Y	Y	Y	R	N	N	R
History of conflict	Y	Y	Y	Y	Y	R	N	N	R
Provided care in case under review (but not subject of review)	Y	Y	Y	Y	Y	R	N	N	R
Involvement in prior PEP or disciplinary action	Y	Y	Y	Y	Y	R	N	N	R
Formally raised the concern	Y	Y	Y	Y	Y	R	N	N	R

Y – ("Yes") – means the Interested Member may serve in the indicated role; no extra precautions are necessary.

Y – ("Yes, with infrequent but occasional limitations") – means the Interested Member may generally serve in the indicated role. It is legally permissible for Interested Members to serve in these roles because of the check and balance provided by the multiple levels of review and the fact that the Credentials Committee, Leadership Council, CPE and APPC have no disciplinary authority.

In addition, the Chair of the Credentials Committee, Leadership Council, CPE or APPC always has the authority and discretion to recuse a member in a particular situation if the Chair determines that the Interested Member's presence would (i) inhibit the full and fair discussion of the issue before the committee, (ii) skew the recommendation or determination of the committee, or (iii) otherwise be unfair to the Practitioner under review.

N – ("No") – means the Interested Member should not serve in the indicated role.

R – ("Recuse") – means the Interested Member should be recused, in accordance with the guidelines on the next page.

RULES FOR RECUSAL	
STEP 1 Confirm the conflict of interest	The Committee Chair or Board Chair should confirm the existence of a conflict of interest relevant to the matter under consideration.
STEP 2 Participation by the Interested Member at the meeting	The Interested Member may participate in any part of the meeting that does not involve the conflict of interest situation. When the matter implicating the conflict of interest is ready for consideration, the Committee Chair or Board Chair will note that the Interested Member will be excused from the meeting prior to the group's deliberation and decision-making. Prior to being excused, the Interested Member may provide information and answer any questions regarding the following: (i) any factual information for which the Interested Member is the original source; (ii) clinical expertise that is relevant to the matter under consideration; (iii) any policies or procedures that are applicable to the committee or Board or are relevant to the matter under consideration; (iv) the Interested Member's prior involvement in the review of the matter at hand (for example, an Investigating Committee member may describe the Investigating Committee's activities and present the Investigating Committee's written report and recommendations to the MEC prior to being excused from the meeting); and (v) how the committee or Board has, in the past, managed issues similar or identical to the matter under consideration.
STEP 3 The Interested Member is excused from the meeting	The Interested Member will then be excused from the meeting (i.e., physically leave the meeting room and/or disconnect from any telephone or other electronic connection) prior to the committee's or Board's deliberation and decision-making.
STEP 4 Record the recusal in the minutes	The recusal should be documented in the minutes of the committee or Board. The minutes should reflect the fact that the Interested Member was excused from the meeting prior to deliberation and decision-making.

TUCSON MEDICAL CENTER

Sharing Of Quality Assurance Information

POLICY:

Tucson Medical Center ("TMC") and its affiliates establish the following policy to request or disclose Quality Assurance Information (as defined below) from other Health Care Entities (as defined below) for the sole purpose of engaging in Quality Assurance Activities (as defined below).

This Policy does not authorize or condone any disclosures of Quality Assurance Information for any purpose other than engaging in Quality Assurance Activities.

PURPOSE:

To permit and encourage sharing of Quality Assurance Information among and between TMC, its Affiliates (as defined below), and other Health Care Entities as appropriate and as limited by this Policy, to the fullest extent permitted by law while retaining privilege and confidentiality in accordance with A.R.S. §§ 36-2401 *et seq*., 36-445 *et seq*., and other applicable law.

PROCEDURE:

1. Definitions:

1.1. "Affiliate" or "Affiliates" for purposes of this Policy means (i) any Health Care Entity owned, controlled, or under common control with TMC (ii) any Provider who is employed by TMC or any Affiliate of TMC, and (iii) any Provider who is an active member of TMC's Professional Staff.

1.2. "Quality Assurance Information" or "QAI" means information in oral, written or digital form that is submitted to, prepared for or by or considered by a Health Care Entity for or in the course of Quality Assurance Activities, including the record of the Health Care Entity's actions and proceedings.

1.3. "Quality Assurance Activities" means activities or proceedings of a Health Care Entity:

(a) That are established for the purposes of reducing morbidity and mortality and for improving the quality of health care or encouraging proper utilization of health care services and facilities through the review of the qualifications, professional practices, training, experience, patient care, conduct, processes or data of licensed health care providers.

(b) That follow a process adopted by the Health Care Entity that includes written standards and criteria.

1.4. "Health Care Entity" or "Provider" means any of the following:

(a) A licensed health care provider, which includes a person or institution that is licensed or certified by this state to provide health care, medical services, nursing services or other health-related services.

(b) An entity that provides health care services through one or more licensed health care

providers.

(c) An entity that contracts to provide or pays for health care services.

(d) A professional organization of licensed health care providers.

(e) A utilization or quality control peer review organization.

(f) A state health care provider.

(g) A component of the statewide emergency medical services and trauma system.

(h) A qualifying community health center as defined in A.R.S. Section 36-2907.06.

(i) A committee or other organizational structure of a Health Care Entity.

1.5. "Disclosing Provider" means a Health Care Entity that discloses QAI under this policy.

1.6. "Requesting Provider" means a Health Care Entity that requests the disclosure of QAI under this policy.

1.7. "PHI" means protected health information protected under the Health Insurance Portability and Accountability Act (HIPAA).

2. Sharing of Quality Assurance Information.

TMC may use and disclose QAI for its internal operations, including quality assurance, patient safety, utilization review, credentialing and peer review activities without the need to complete the QAI Request Form; and any other use, disclosure or request for TMC's QAI must be approved in writing by TMC's Patient Safety Officer or his/her authorized designee.

2.1. TMC may request QAI (as a Requesting Provider) from a Health Care Entity or Provider as follows:

(a) Only TMC's CEO, COO, CMO, CNO, CLO, Patient Safety Officer or their authorized designees may request QAI from other Health Care entities.

(b) All requests must be made in writing utilizing TMC's Quality Assurance Information Request Form.

2.2. Any request for TMC's QAI should be directed to TMC's Patient Safety Officer ("PSO") for approval. The PSO will forward the request to TMC's Chief Compliance Officer ("CCO") who will determine if the Requesting Provider needs to execute a business associate agreement ("BAA") before releasing TMC's QAI in accordance with this Policy.

2.3. TMC's Medical Executive Committee has approved the sharing of TMC's Quality Assurance information in accordance with this Policy.

2.4. TMC and its Affiliates may disclose QAI to, or request the disclosure of QAI from, other Health Care Entities only for the purpose of conducting Quality Assurance Activities, including but not limited to joint Quality Assurance Activities.

3. Confidentiality and Privilege. QAI received from a Disclosing Provider shall be kept confidential, and shall not be disclosed subject to subpoena or order to produce except in proceedings before the appropriate state licensing or certifying agency, or in actions by a licensed health care provider against the Requesting Provider arising from the discipline of the licensed health care provider or the refusal, termination, suspension or limitation of privileges.

4. Handling of PHI. Before disclosing QAI, TMC as Disclosing Provider shall determine whether the QAI includes PHI.

4.1. TMC may disclose QAI that includes PHI to a Requesting Provider which is an Affiliate of TMC.

4.2. TMC may disclose QAI that includes PHI to a Requesting Provider for purposes of assisting TMC with its Quality Assurance Activities, provided that the Requesting Provider agrees to keep the PHI confidential. TMC's CCO will determine if the Requesting Provider needs to execute a BAA prior to disclosing any QAI that includes PHI. .

4.3. If the Requesting Provider is neither an Affiliate nor a business associate of TMC, the Patient Safety Officer, in consultation with TMC's CCO, shall that ensure that patient identifying information is removed from the QAI before disclosure.

5. Statements. All QAI exchanged in accordance with this policy shall be labeled as "**Privileged and Confidential Quality Assurance Information**" and shall be accompanied by the following statement:

> "The attached information is privileged and confidential Quality Assurance Information, and may be used solely to conduct Quality Assurance Activities, under state statutes. Disclosure of all or any part of the attached information is not subject to discovery by subpoena or otherwise, nor may it be introduced into evidence in any administrative or judicial proceeding except as required or permitted by law. The recipient is responsible for maintaining the confidentiality of the attached information."

Originating/Reviewing Source: Chief Legal Officer Approval Source: Medical Executive Committee
Supersedes: 08/20/2016

Tucson Medical Center
Quality Assurance Information Request Form

Requesting Provider: _____

Disclosing Provider: _____

Date of Request: _____

Description of the Quality Assurance Information being requested:

The licensed health care provider(s) to which the requested information relates:

The purpose of the request:

The Requesting Provider represents and promises as follows:

(a) The requested Quality Assurance Information will be used solely for the Requesting Provider's Quality Assurance Activities, and that the Requesting Provider's Quality Assurance Activities meet the definition set forth in the Tucson Medical Center policy on Sharing of Quality Assurance Information (the "Policy").

(b) The Requesting Provider has received a copy of the Policy, and agrees to comply with Policy as it applies to the Requesting Provider.

(c) The Requesting Provider shall maintain the Quality Assurance Information that it receives from the Disclosing Provider confidentially in accordance with the Policy.

(d) The Requesting Provider agrees to maintain confidential the Quality Assurance Information, including any protected health information as defined by the HIPAA Privacy Rule (hereinafter "Confidential Information"), provided by the Disclosing Provider, and shall not further disclose the Confidential Information to any third party (other than its attorneys or independent consultants engaged to assist it with its Quality Assurance Activities pursuant to the written quality assurance process adopted by the Requesting Provider that includes written standards and criteria) without the written consent of the Disclosing Provider. The Requesting Provider shall immediately notify the Disclosing Provider of any request to disclose Quality Assurance Information, including but not limited to a subpoena or order to produce, in order to provide the Disclosing Provider with an opportunity to object to or otherwise resist such request.

(e) The Requesting Provider shall comply all applicable law relating to the Quality Assurance Information, including but not limited to A.R.S. Sections 36-2402 and 36-2403.

Signature of authorized official of Requesting Provider:

_____

TUCSON MEDICAL CENTER

FPPE POLICY
TO CONFIRM PRACTITIONER COMPETENCE AND PROFESSIONALISM

(NEW MEMBERS/NEW PRIVILEGES)

Approved by the Board: January 21, 2020

FPPE POLICY TO CONFIRM PRACTITIONER COMPETENCE AND PROFESSIONALISM

(NEW MEMBERS/NEW PRIVILEGES)

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FPPE POLICY TO CONFIRM
PRACTITIONER COMPETENCE AND PROFESSIONALISM

(NEW MEMBERS/NEW PRIVILEGES)

1. ***Scope of Policy.*** All Practitioners who are granted clinical privileges at Tucson Medical Center (the "Hospital") are subject to focused professional practice evaluation ("FPPE") to confirm their:

   (a) clinical competence to exercise the clinical privileges that have been granted to them; and

   (b) professionalism, which includes (i) the ability to work with others in a professional manner that promotes quality and safety; and (ii) the ability to satisfy all other responsibilities of Practitioners who are granted clinical privileges at the Hospital (i.e., "citizenship" responsibilities).

2. ***Definitions.*** Definitions of capitalized terms used in this Policy are included in the Medical Staff Glossary.

3. ***FPPE Clinical Activity Requirements.***

   3.A ***Development of Clinical Activity Requirements.*** Each Department will recommend the following FPPE clinical activity requirements:

      (1) ***For New Practitioners:***

         (a) the number and types of procedures or cases that will be reviewed to confirm a new Practitioner's competence to exercise the core and special privileges in his or her specialty;

         (b) how those reviews are to be documented; and

         (c) the expected time frame in which the evaluation will be completed (generally six months); and

      (2) ***For Practitioners with Existing Clinical Privileges Who Are Requesting New Privileges:***

         (a) the number and types of procedures or cases that must be reviewed to confirm a Practitioner's competence to exercise a new privilege that is granted during a term of appointment or at reappointment;

         (b) how those reviews are to be documented; and

(c) the expected time frame in which the review will be completed (generally six months).

In developing such recommendations, Departments should attempt to identify "index" procedures or cases that will demonstrate a Practitioner's competence to perform a bundle of privileges (i.e., the skills required to perform the index procedure or case are the same skills required to perform privileges in the bundle). Departments may consult with the Medical Staff Office, the Chair of the Professional Practice Committee ("PPC"), the Chief Medical Officer ("CMO") or the Vice President Medical Affairs ("VPMA"). The FPPE clinical activity requirements shall be reviewed by the Credentials Committee and approved by the Medical Executive Committee. They shall be reviewed periodically by the Departments to ensure their continued effectiveness.

3.B ***Gathering FPPE Data.***

(1) ***Mechanism for FPPE Review.***

(a) ***Data to Be Reviewed.*** The FPPE clinical activity requirements will utilize at least one of the following review mechanisms to confirm competence:

(i) retrospective chart review by internal or external reviewers;

(ii) concurrent proctoring or direct observation of procedures or patient care practices; and/or

(iii) discussion with other individuals also involved in the care of the Practitioner's patients.

Review of available Ongoing Professional Practice Evaluation ("OPPE") data and other quality data may also be used to confirm competence.

(b) ***Selection of Cases.*** The Medical Staff Office, the CMO, or the VPMA will select the specific cases to be evaluated and the individuals who will be asked to provide information about the Practitioner, with the goal being an effective and fair review process. To that end, cases should be selected randomly or in a deliberate manner that ensures a representative sample is reviewed. Generally, FPPE should not be conducted on the first "x" cases because of the possible selection bias that may result. Practitioners shall notify the Medical Staff Office, CMO, VPMA, or FPPE Reviewers when cases subject to review are scheduled or have been completed.

(c) ***Cooperation of Practitioner.*** Practitioners are required to cooperate with the data gathering outlined in this Policy. For example, if cases are to be proctored the Practitioner must promptly notify the proctor when cases are scheduled.

(2) ***FPPE Reviewers.*** Practitioners who have completed the FPPE process described in this Policy and who hold applicable clinical privileges are obliged to provide a reasonable amount of service as a FPPE reviewer through chart review, proctoring, direct observations, and/or discussions with others involved in the patient's care. Reviewers will be assigned by the Department Chair. If no qualified Practitioners are available, the Department Chair shall consult with the Leadership Council regarding the need for an external review. FPPE reviewers act on behalf of, and their work product is a record of, the Credentials Committee and Medical Executive Committee.

(3) ***Partners as FPPE Reviewers.*** Consistent with the conflict of interest guidelines set forth in the Credentials Policy, partners and other individuals who are affiliated in practice with a Practitioner may participate in the FPPE process for new members/new privileges described in this Policy through chart review, proctoring, direct observations, and/or discussions with others involved in the patient's care. Such individuals shall comply with the standard procedures that apply to all other individuals who participate in the FPPE process, such as the use of Hospital forms and the requirements related to confidentiality.

4. ***FPPE for Professionalism.*** In addition to assessing clinical competence, the FPPE process for new Practitioners will also assess the Practitioner's professionalism based on the following criteria:

(a) cooperation with the FPPE clinical activity requirements for the Practitioner's specialty and the monitoring process described in this Policy;

(b) compliance with the Medical Staff Professionalism Policy, including appropriate interactions with nursing, other Hospital personnel, the Practitioner's colleagues, and patients and their families;

(c) compliance with medical record documentation requirements, including those related to use of CPOE and the EHR;

(d) timeliness and quality of response to consultation and ED call requests;

(e) completion of any orientation program requirements (e.g., patient safety modules; EHR training);

(f) patient satisfaction scores; and

(g) compliance with protocols that have been adopted by the Medical Staff or the Practitioner's Department.

The Leadership Council may recommend that these criteria for professionalism be modified or expanded, with such modifications or expansions being reviewed and approved by the Credentials Committee and Medical Executive Committee.

5. ***Notice of FPPE Requirements.*** When notified that a request for privileges has been granted, Practitioners shall be informed of the relevant FPPE clinical activity requirements and of their responsibility to cooperate in satisfying those requirements. New applicants will also be informed that the FPPE process will be used to assess their professionalism, as described above. The Credentials Committee and Medical Executive Committee may modify the FPPE requirements for a particular applicant if the applicant's credentials indicate that additional or different FPPE may be required.

6. ***Review of FPPE Results.***

6.A ***Review by Medical Staff Office.***

(1) Information gathered for purposes of FPPE shall be reported to the Medical Staff Office, which shall compile the information and prepare it for subsequent review by FPPE reviewers, Department Chairs, the Credentials Committee and the Medical Executive Committee.

(2) If any information gathered for FPPE suggests that a concern may exist that requires expedited review, the FPPE reviewer and/or the Medical Staff Office shall notify the Chairpersons of the Credentials Committee and the Leadership Council, who shall determine whether a concern exists such that the matter should be referred for processing under the Professional Practice Evaluation Policy (Peer Review), the Professionalism Policy, or the Credentials Policy.

(3) The Medical Staff Office shall determine whether any of a Practitioner's cases or activities have been reviewed pursuant to the Professional Practice Evaluation Policy (Peer Review) or the Medical Staff Professionalism Policy. If so, a summary of these matters shall be included with the Practitioner's FPPE results.

6.B ***Review by the Department Chair.***

(1) At the conclusion of the expected time frame for completion of the FPPE, the relevant Department Chair shall review the results of a Practitioner's FPPE and provide a report to the Credentials Committee. The report shall address whether:

(a) the Practitioner fulfilled all the clinical activity requirements;

(b) the results of the FPPE confirmed the Practitioner's clinical competence;

(c) the results of the FPPE confirmed the Practitioner's professionalism; and/or

(d) additional FPPE is required to make an appropriate determination regarding clinical competence and/or professionalism.

(2) In addition, the Department Chair may engage in a collegial discussion with a Practitioner where the FPPE indicates that competence and professionalism are confirmed, but where there is nonetheless an opportunity for the Practitioner to improve upon an aspect of his/her clinical care or citizenship responsibilities.

6.C ***Review by Credentials Committee.*** Based on the Department Chair's assessment and report, and its own review of the FPPE results and all other relevant information, the Credentials Committee will make one of the following recommendations to the Medical Executive Committee:

(1) ***Competence and Professionalism Are Confirmed.*** The FPPE process has confirmed clinical competence and professionalism, and no changes to clinical privileges or the Practitioner's conditions of practice are necessary;

(2) ***Extend FPPE Due to Questions.*** Some questions exist and additional FPPE is needed to confirm clinical competence and/or professionalism, what additional FPPE is needed, and the time frame for it;

(3) ***Extend FPPE Due to Inactivity.*** The time period for FPPE should be extended for six months because the individual did not fulfill the FPPE clinical activity requirements, thus preventing an adequate assessment of the individual's clinical competence or professionalism. Although exceptions may be made for certain low volume Practitioners based on a need for services in their specialties or coverage requirements, generally the time frame for initial FPPE shall not extend beyond 12 total months after the initial granting of privileges;

(4) ***Performance Improvement Plan or Other Intervention is Necessary.*** Some concerns exist about the Practitioner's competence to exercise some or all of the clinical privileges granted or the Practitioner's professionalism, and the details of the Performance Improvement Plan (or other intervention) that should be pursued with the Practitioner in order to adequately address the concerns. Prior to making such a recommendation to the Medical Executive Committee, the Credentials Committee will obtain the input of

the Practitioner as set forth in Section 6.E of this Policy. In developing a proposed Performance Improvement Plan or other intervention, the Credentials Committee may also request input or assistance from the PPC (for clinical issues) or the Leadership Council (for behavioral issues);

(5) ***Change to Privileges or Membership is Necessary.*** More significant concerns exist about a Practitioner and the changes that should be made to the Practitioner's clinical privileges or membership (e.g., mandatory concurring consultation requirement imposed; suspension; revocation), subject to the procedural rights outlined in the Credentials Policy. Prior to making such a recommendation to the Medical Executive Committee, the Credentials Committee will obtain the input of the Practitioner as set forth in Section 6.E of this Policy; or

(6) ***Transfer to Membership-Only Staff Category or the Automatic Relinquishment of Certain Privileges Due to Inactivity.*** The individual shall either: (i) be transferred to a membership-only staff category for failure to meet FPPE clinical activity requirements for all privileges, or (ii) automatically relinquish specific clinical privileges for which the individual failed to meet the applicable requirements. Exceptions may be granted based on a need for services in the Practitioner's specialty or coverage requirements. Such transfer or automatic relinquishment shall not entitle the Practitioner to the hearing and appeal rights outlined in the Credentials Policy.

6.D ***Review by Medical Executive Committee.*** At its next regular meeting after receipt of the written findings and recommendation of the Credentials Committee, the Medical Executive Committee shall:

(1) adopt the findings and recommendation of the Credentials Committee as its own;

(2) refer the matter back to the Credentials Committee for further consideration and responses to specific questions raised by the Medical Executive Committee prior to its final recommendation; or

(3) state its reasons in its report and recommendation, along with supporting information, for its disagreement with the Credentials Committee's recommendation.

As needed, the Medical Executive Committee may obtain additional input from the Practitioner as set forth in Section 6.E of this Policy before making a decision. If the recommendation of the Medical Executive Committee would entitle the Practitioner to request a hearing pursuant to the Credentials Policy, the Medical Executive Committee shall forward its recommendation to the Chief Executive Officer, who shall proceed as set forth in the Credentials Policy.

6.E ***Input by Practitioner.***

(1) ***General.*** The Practitioner shall provide input in writing, responding to any specific questions posed in the request. Upon the request of either the Practitioner or the committee conducting the review, the Practitioner may also provide input by meeting with appropriate individuals to discuss the issues. The committee requesting input may ask the Practitioner to provide a copy of, or access to, medical records from the Practitioner's office. Failure to provide such copies or access will be viewed as a failure to provide requested input.

(2) ***Failure to Provide Written Input.*** If the Practitioner fails to provide written input within the time frame specified in the request, the Practitioner will be required to meet with the Leadership Council. The purpose of the meeting is to discuss the Practitioner's obligation to participate in the review process, permit the Practitioner to explain why the written input was not provided, and inform the Practitioner of the consequences of continuing to not provide the information. Failure of the Practitioner to either:

(i) meet with the Leadership Council and persuade it that the written input was not necessary; or

(ii) provide the requested written input prior to the date of that meeting

will result in the automatic relinquishment of the Practitioner's clinical privileges. Such automatic relinquishment will continue until the Practitioner either meets with the Leadership Council and persuades it that the written information is not necessary or provides the requested written information.

(3) ***Failure to Meet with Committee.*** If the committee conducting the review requests that the Practitioner attend a meeting with it or a designated individual to provide verbal input and the Practitioner fails or refuses to attend such a meeting, the Practitioner's clinical privileges will be automatically relinquished until the meeting occurs.

(4) ***Automatic Resignation.*** If the Practitioner fails to provide written input or meet with a committee conducting the review within thirty (30) days of an automatic relinquishment, the Practitioner's Medical Staff membership and clinical privileges will be automatically resigned.

6.F ***Decision Not an Adverse Action.*** A decision that a Practitioner will be transferred to a membership-only staff category or will automatically relinquish his or her clinical privileges for failure to satisfy clinical activity requirements is not an

adverse action that must be reported to the National Practitioner Data Bank or any state licensing board.

6.G ***Future Application for Privileges.*** A Practitioner who is transferred to a membership-only staff category or who automatically relinquishes certain privileges will be ineligible to apply for the clinical privileges in question for two years from the date of the transfer or automatic relinquishment.

Adopted by the Medical Executive Committee on _____, 2019.

Adopted by the Board on January 21, 2020.

APPENDIX A

[Insert flowchart of FPPE process to confirm practitioner competence and professionalism.]

TUCSON MEDICAL CENTER

ONGOING PROFESSIONAL PRACTICE EVALUATION POLICY (OPPE)

Approved by the Board: January 21, 2020

ONGOING PROFESSIONAL PRACTICE EVALUATION POLICY (OPPE)

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ONGOING PROFESSIONAL PRACTICE EVALUATION POLICY (OPPE)

1. ***Scope of Policy.*** All Practitioners who provide patient care services at Tucson Medical Center (the "Hospital") are subject to ongoing professional practice evaluation ("OPPE").

2. ***Definitions.*** Definitions of capitalized terms used in this Policy are included in the Medical Staff Glossary.

3. ***OPPE Data to Be Collected.***

   3.A ***Department Data Elements.*** Each Department, in consultation with the Medical Staff Office, Chief Medical Officer ("CMO"), and Vice President Medical Affairs ("VPMA"), shall determine the OPPE data to be collected for each Practitioner in the Department and, where appropriate, the expected parameters of performance for each data element. Depending on the size of the Department, data elements may be identified for Sections within the Department. All Department data elements and parameters shall be approved by the Professional Practice Committee ("PPC").

   3.B ***Data Elements for All Practitioners.*** The PPC shall establish OPPE data elements that are relevant to all Practitioners irrespective of Department and, where appropriate, the expected parameters of performance for each data element.

   3.C ***Guidelines.*** The following guidelines will be used in determining the OPPE data elements to be collected:

      (1) quality and performance improvement department representatives shall be consulted to inform and support the assessment process;

      (2) medical informatics/information technology department representatives shall be consulted to determine the available information system capabilities;

      (3) for Department OPPE elements, the type of data that would reasonably be expected to reflect clinically significant issues for the specialties within the Department shall be considered; and

      (4) when possible, the expected parameters of performance shall be based on relevant clinical literature.

4. ***OPPE Reports.***

   4.A ***Frequency and Content.*** An OPPE report for each Practitioner shall be prepared at least every nine months. A copy shall be placed in the Practitioner's file and considered in the reappointment process and in the assessment of the Practitioner's

competence to exercise the clinical privileges granted. A Practitioner's OPPE report may include:

(1) the Practitioner's activity during the OPPE period (i.e., numbers of procedures, admissions, and consults);

(2) clinical performance as measured by the approved Department and other OPPE data elements;

(3) the number of Informational Letters sent pursuant to the Professional Practice Evaluation Policy (Peer Review) (Informational Letters are a non-punitive, educational tool to help improve Practitioner performance through the use of timely feedback);

(4) the number of cases reviewed pursuant to the Professional Practice Evaluation Policy (Peer Review) and the dispositions of those cases; and

(5) the number of complaints addressed pursuant to the Medical Staff Professionalism Policy and the disposition of those matters.

4.B ***Review by Medical Staff Office.***

(1) ***Initial Review.*** The Medical Staff Office will review each OPPE report. As needed, the Medical Staff Office will consult with the CMO, VPMA or a Medical Staff Leader in making the determinations set forth in this section.

(2) ***Data Within Expected Parameters of Performance/No Concerns.***

(a) If the OPPE report reveals that the Practitioner's data is within, or exceeds, expected performance parameters and no other issues or concerns are noted, the Medical Staff Office shall provide a copy of the report to the Practitioner or notify the Practitioner how to access the report. The Medical Staff Office shall also indicate that the report is being provided solely for the Practitioner's information and use in his or her patient care activities and that no response and no further review are necessary at that time.

(b) The Medical Staff Office shall provide a summary report to the applicable Department Chair of these determinations. If the data reflect exceptional care, the Medical Staff Office should notify the Department Chair, who is encouraged to acknowledge the Practitioner's efforts.

(3) ***No Activity/Insufficient Volume.*** If the OPPE report indicates that the Practitioner has had no activity, or has clearly had insufficient volume at the Hospital to generate meaningful data, the Medical Staff Office shall file the

report in the Practitioner's quality file. In such case, review of the OPPE report by the Department Chair is not required, but the Department Chair shall receive a summary report of these determinations.

(4) ***Data Not Within Expected Parameters of Performance or Raises Questions.*** If performance is not within expected parameters or raises any questions, the Medical Staff Office shall:

(a) provide a copy of the report to the Department Chair; and

(b) provide a copy of the report to the Practitioner or notify the Practitioner how to access it and indicate that it has been forwarded to the Department Chair for review. The Practitioner will also be informed that the Department Chair will contact the Practitioner if he or she determines that any response or further review is required.

4.C ***Review by Department Chair.*** When an OPPE report is forwarded to the Department Chair, he or she may review the underlying cases that make up the data or other relevant information and shall make one of the following determinations:

(1) ***Acceptable Performance.*** The data do not reflect a pattern or issue regarding the Practitioner's performance that requires further review. In such case, the Department Chair shall document his or her findings and include them in the Practitioner's file along with the OPPE report.

(2) ***Exceptional Performance.*** The data indicate that the Practitioner's performance has been exceptional, in which case the Department Chair is encouraged to acknowledge the Practitioner's efforts.

(3) ***Review OPPE Report with Practitioner/Collegial Intervention.*** The data reflect an issue or concern with the Practitioner's performance, but the issue or concern is not so significant that further review is necessary under the Professional Practice Evaluation Policy (Peer Review) or the Medical Staff Professionalism Policy. In such case, the Department Chair shall obtain the Practitioner's input and then, if warranted, conduct a collegial intervention with the Practitioner. Any such collegial meeting should be documented via a follow-up letter to the Practitioner, with such documentation being included in the Practitioner's file along with the OPPE report.

(4) ***Forward for Review under Other Applicable Policy.*** The data reflect a pattern or issue regarding the Practitioner's performance that requires further review. In such case, the Department Chair shall notify the Medical Staff Office, who shall log the report and proceed in accordance with the Professional Practice Evaluation Policy (Peer Review), the Medical Staff Professionalism Policy, or the Policy on Review of Concerns Related to Utilization, as applicable.

(5) ***Insufficient Volume.*** The data reflect insufficient activity at the Hospital to evaluate the Practitioner's practice, in which case the Department Chair shall document this conclusion so that the OPPE report is properly evaluated as part of any application for reappointment submitted by the Practitioner. At reappointment, procedures set forth in the Credentials Policy for obtaining information from low-volume practitioners shall be followed.

OPPE reports involving a Department Chair will be reviewed by the Medical Staff President (or designee).

Adopted by the Medical Executive Committee on _____, 2019.

Adopted by the Board on January 21, 2020.

APPENDIX A

[Insert flowchart of OPPE process.]

TUCSON MEDICAL CENTER

POLICY ON PRACTITIONER ACCESS TO CONFIDENTIAL FILES

Approved by the Board: January 21, 2020

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POLICY ON PRACTITIONER ACCESS

TO CONFIDENTIAL FILES

1. SCOPE OF POLICY, DEFINITIONS, AND GENERAL PRINCIPLES

1.A ***Scope of Policy.*** This Policy applies to all Confidential Files maintained by Tucson Medical Center (the "Hospital").

1.B ***Definitions.*** Definitions of capitalized terms used in this Policy are included in the Medica Glossary.

1.C ***General Principles.***

(1) ***General Rules Regarding Access to Confidential Files by a Practitioner.***

(a) ***Hospital Record.*** The Confidential File is a confidential and proprietary business record of the Hospital. As such, access to the Confidential File is governed by this Policy.

(b) ***Review and Note-Taking.*** Subject to the rules set forth in this Policy, Practitioners may review and make notes of information in their Confidential File.

(c) ***Copying***. Practitioners may not copy, digitally image, or otherwise record any information from their Confidential File. Smart phones and other devices capable of copying or making digital images of information must remain with PPE Specialists while a Practitioner reviews documents. Except as otherwise set forth in this Policy, PPE Specialists may provide copies or summaries to the Practitioner only with the written permission of the Chief Medical Officer ("CMO") or Vice President Medical Affairs ("VPMA").

(d) ***Documents Previously Sent to the Practitioner.*** Upon the request of a Practitioner, the Medical Staff Office may copy and provide to the

Practitioner any routine or sensitive documents contained in the Confidential File that: (i) had previously been sent by the Practitioner to the Hospital, or (ii) had previously been sent by the Hospital to the Practitioner. The written permission of the CMO/VPMA is not required for the Medical Staff Office to make or disclose such copies.

(e) ***Alterations and Deletions.*** Practitioners may not alter or delete any information in their Confidential File. As described in Section 1.C(2) below, Practitioners may submit a request to the CMO/VPMA to alter or delete information in their Confidential File that is factually inaccurate.

(f) ***Logistics of Review.*** The format (e.g., paper or electronic), location, and other conditions relating to a Practitioner's review of the Confidential File will be determined by the CMO/VPMA, using the provisions of this Policy for guidance. The review will generally occur in the Medical Staff Office or other location where the Confidential File is maintained, with a PPE Specialist available to provide assistance as needed. The Confidential File may not be removed from the Hospital without the written permission of the CMO/VPMA.

(g) ***Medical Staff Hearings.*** Notwithstanding any other provision in this Policy, a Practitioner shall be entitled to a non-redacted copy of any document that was used as the basis for an adverse professional review action that entitles the Practitioner to a Medical Staff hearing, subject to any rules set forth in the Medical Staff Bylaws, Credentials Policy, or related policies.

(2) ***Alterations and Deletions at the Request of the Practitioner.***

(a) Practitioners may submit a request to the CMO/VPMA to alter or delete information in their Confidential File.

(b) The CMO/VPMA shall make the alteration or deletion only if the Leadership Council determines that the information in question is factually inaccurate. By way of example and not limitation, information is factually inaccurate if it pertains to the wrong individual (e.g., a Practitioner with the same name) or if it reflects an error in calculation (e.g., improper calculation of infection or complication rates).

(c) Reported concerns regarding a Practitioner's clinical performance or behavior shall not be deleted simply because the applicable committee decides that the care provided was appropriate or the behavior did not warrant an intervention. Similarly, information shall not be altered or deleted simply because it is old or reflects an opinion with which the Practitioner disagrees.

(d) Any request by a Practitioner to alter or delete information will be maintained in the Confidential File, regardless of whether the request is granted.

(3) ***Disputes.*** Any dispute regarding access to information in a Practitioner's Confidential File shall be resolved by the CMO/VPMA and the Chief of Staff, after discussing the matter with the Practitioner.

(4) ***Request from Attorney or Threatened/Pending Legal Action.*** Hospital counsel shall be consulted if a request for access is received from a Practitioner's attorney or if legal action is otherwise threatened or pending.

(5) ***Documentation Added to Confidential File.*** A copy of all communications sent to a Practitioner regarding credentialing, privileging, or PPE/peer review matters shall be included in the Practitioner's Confidential File. Practitioners may respond in writing to any such communications and the Practitioner's response shall be maintained in the Practitioner's Confidential File along with the original communication.

(6) ***Non-Retaliation.*** Practitioners may not retaliate against any individual for: (i) providing information; or (ii) otherwise being involved in the collection or review of any information that is included in a Confidential File.

(7) ***Confidentiality.*** Consistent with the confidential and privileged status of the Confidential File under Arizona law, a Practitioner may not disclose or discuss information from the Confidential File except as follows: (i) to other Practitioners and/or Hospital employees who are directly involved in credentialing, privileging, and peer review activities concerning the Practitioner, and/or (ii) to any legal counsel who may be advising the Practitioner. The Practitioner may not share or discuss information from the Confidential File with any other individual without first obtaining the express written permission of the Leadership Council or CMO/VPMA.

(8) ***Former Practitioners and Non-Privileged Practitioners.*** Individuals who no longer have clinical privileges or Medical Staff appointment at the Hospital, or who have never been granted clinical privileges, are not entitled to access their Confidential File as set forth in this Policy. However, the Hospital may disclose information from the Confidential File directly to other health care providers, health plans or other organizations where the Practitioner is applying for privileges, participating status, employment or other affiliation if the Practitioner signs an authorization and release from liability form acceptable to the Hospital.

(9) ***Delegation of Functions.*** When a function under the PPE Policy is to be carried out by a member of the Administrative Team, by a Medical Staff Member, or by a Medical Staff committee, the individual, or the committee through its chair, may delegate performance of the function to a qualified designee who is a Practitioner or Hospital employee (or a committee of such individuals). Any such designee must treat and maintain all information in a strictly confidential manner and is bound by all other terms, conditions, and requirements of the PPE Policy. In addition, the delegating individual or committee is responsible for ensuring that the designee appropriately performs the function in question. Any documentation created by the designee are records of the committee that is ultimately responsible for the review in a particular matter.

(10) ***Violations.*** Violations of this Policy constitute unprofessional conduct. Such violations include, but are not limited to, copying, making digital images of, altering, or deleting information from the Confidential File, retaliating against those who are believed to have submitted information, or disclosing confidential information. Violations by Practitioners who maintain appointment or clinical privileges will be reviewed pursuant to the Medical Staff Professionalism Policy. Violations by individuals without appointment or privileges may result in a report to the applicable state licensing board.

2. LEVELS OF ACCESS

2.A *Routine Credentialing, Privileging, and PPE/Peer Review Documents.*

(1) ***Definition.*** The following are routine credentialing, privileging, and PPE/peer review documents ("routine documents"):

(a) applications for appointment, reappointment, clinical privileges, or permission to practice, and requested changes in staff status or clinical privileges, with all attachments;

(b) information gathered in the course of verifying education, training, experience, and similar information included on applications for appointment, reappointment, permission to practice, clinical privileges, or changes in staff status (however, this does not include information obtained from references or other third parties who provide the information with an expectation of confidentiality, as described in Section 2.B below);

(c) quality profiles, Ongoing Professional Practice Evaluation ("OPPE") reports, or other quality data reports;

(d) Informational Letters prepared in accordance with the Professional Practice Evaluation Policy;

(e) routine correspondence between the Hospital and the Practitioner; and

(f) routine affiliation verifications.

(2) ***Access to Routine Documents.*** A Practitioner shall be permitted to review routine documents subject to the rules set forth in Section 1.C above. Practitioners must schedule a specific time to review routine documents, providing at least three (3) business days advance notice so the Medical Staff Office and/or CMO/VPMA can properly prepare the documents.

2.B ***Sensitive Credentialing, Privileging, and PPE/Peer Review Documents.***

(1) ***Definition.*** Any document that is not a routine document as defined above is a sensitive credentialing, privileging, and PPE/peer review document ("sensitive document"). Sensitive documents include, but are not limited to, the following:

(a) reported concerns or incident reports concerning the Practitioner submitted by Hospital employees or other Practitioners;

(b) evaluations or reports completed as part of the credentialing and privileging processes by Department Chairs and other internal reviewers;

(c) documentation created pursuant to the FPPE Policy to Confirm Practitioner Competence and Professionalism;

(d) evaluations or reports completed as part of the PPE/peer review process by internal reviewers, proctors, monitors, or external reviewers;

(e) non-routine affiliation verifications, and all peer references;

(f) e-mails and other electronic communication, memos to file, correspondence, notes and other documents that reflect the deliberative process of Medical Staff Leaders and Hospital personnel related to credentialing, privileging, or PPE/peer review. Such documents are sensitive because Medical Staff Leaders and Hospital personnel must be willing to engage in open, candid discussions about sensitive issues and explore all available options to effectively and constructively resolve concerns;

(g) correspondence between the Practitioner and the Hospital related to the PPE/peer review process;

(h) reports and minutes of peer review committees pertaining to the Practitioner;

(i) correspondence from references and other third parties, including, but not limited to, letters of reference, confidential evaluation forms, and other documents prepared by external sources concerning the Practitioner's training, clinical practice, professional competence, conduct, or health;

(j) notations of telephone conversations concerning the Practitioner's qualifications with references and other third parties, including date of conversation, identification of parties to the conversation, and information received and/or discussed;

(k) correspondence setting forth formal Credentials Committee, Leadership Council, Professional Practice Committee ("PPC"), or Medical Executive Committee action, including, but not limited to, letters of guidance or education, follow-up letters to collegial intervention discussions, letters of warning, or reprimand, consultation requirements, Performance Improvement Plans, or final adverse actions following completion or waiver of a hearing and appeal;

(l) all documentation in the Practitioner's confidential health file, including reported concerns related to health, Health Status Assessment Forms and related evaluations of a Practitioner's health; and

(m) results of queries to the National Practitioner Data Bank.

If there is any doubt about whether a document is routine or sensitive, it shall be treated as sensitive.

(2) ***Access to Sensitive Documents.***

(a) As a condition of being granted access to sensitive documents, the Practitioner must:

(i) provide at least seven (7) business days' advance notice so the sensitive documents can be properly prepared for review, as described in this Section;

(ii) sign the Request to Access Confidential File form set forth as **Appendix A** to this Policy; and

(iii) schedule a specific time to review the file when a Medical Staff Leader or the CMO/VPMA will be available to answer any questions raised by the Practitioner during his/her review.

(b) The Medical Staff Office and CMO/VPMA will determine the manner in which sensitive documents will be made available to the Practitioner, subject to the following rules:

(i) Except for correspondence that has already been exchanged with a Practitioner, a sensitive document will be summarized or redacted by the CMO/VPMA or the Medical Staff Office so that

the identity of any individual who prepared or submitted the document, or who provided information relevant to the matter, can no longer be ascertained.

(ii) In determining which option to use – summary or redaction – the CMO/VPMA or the Medical Staff Office should consider the number of documents that would need to be redacted, the resources needed to complete the redactions, and the probability that an individual who prepared or submitted the document could be identified despite the redactions.

(iii) The Practitioner shall not be told the identity of any individual who prepared or submitted a sensitive document, unless:

(A) the individual specifically consents to the disclosure; or

(B) information provided by the individual is used to support an adverse professional review action that results in a Medical Staff hearing.

(iv) Any summaries of sensitive documents that may be prepared should provide sufficient information to permit a Practitioner to understand:

(A) the nature of the document;

(B) the date it was prepared;

(C) the purpose for which it was prepared;

(D) who prepared it (in general terms, without revealing the person's identity); and

(E) the general nature of the comments in the document.

Adopted by the Medical Executive Committee on _____, 2019.

Adopted by the Board on January 21, 2020.

APPENDIX A

REQUEST TO ACCESS CONFIDENTIAL FILE

I have asked to review information from my confidential Medical Staff file. I understand that the Hospital and Medical Staff Leaders need to take appropriate steps to maintain the confidentiality of this information under Arizona and federal law, as well as to ensure a professional, non-threatening environment for all who work and practice at the Hospital. Accordingly, as a condition to reviewing this information, I agree to the following:

1. My access to my confidential Medical Staff file is governed by the ***Policy on Practitioner Access to Confidential Files*** (the "Policy"). I understand that, pursuant to the Policy, I may not copy, digitally image, or otherwise record any information from the file. I will leave my smart phone or similar electronic device capable of copying or making digital images with the Medical Staff Office while I review information in my file. Also, I may not alter or delete any information in my file. Instead, I may request the Hospital to alter or delete factually inaccurate information pursuant to the process set forth in the Policy.

2. I will maintain all information that I review in a ***strictly confidential*** manner. Specifically, I will not disclose or discuss this information ***except*** to the following individuals: (i) my physician colleagues and/or Hospital employees who are directly involved in credentialing, privileging, and peer review activities concerning me, and/or (ii) any legal counsel who may be advising me. I will not share or discuss this information with any other individual without first obtaining the express written permission of the Leadership Council, Chief Medical Officer ("CMO") or Vice President Medical Affairs ("CMO/VPMA").

3. I understand that this information is being provided to me as part of the Medical Staff's and Hospital's policy of attempting to utilize collegial intervention and progressive steps, where possible, to address any questions or concerns that may arise with my practice. In addition to discussing these matters directly with the Medical Staff and Hospital leadership, I understand that I may also prepare a written response and that this response will be maintained in my file.

4. I understand that the Hospital and the Medical Staff have a responsibility to provide a safe, non-threatening workplace for my physician colleagues and for Hospital employees. I therefore agree that:

    (a) ***I will <u>not discuss</u> the information that I review from my file with any individual who I believe may have provided the information*** because even well-intentioned conversations

with such individuals can be perceived as intimidating. ***Accordingly, I understand that any such discussions will be viewed as retaliation and a violation of the Medical Staff Professionalism Policy.***

(b) ***I will <u>not engage</u> in any other retaliatory or abusive conduct with respect to these individuals.*** This means that I will not confront, ostracize, discriminate against, or otherwise mistreat any such individual with respect to any information that the individual may have provided.

5. I understand that any violation of the Policy constitutes unprofessional conduct. Such violations include, but are not limited to, copying, altering, or deleting information from the Confidential File, retaliating against those who I believe may have submitted information in the File, or disclosing information from the File. Any such violations will be reviewed pursuant to the Medical Staff Professionalism Policy. *[As applicable: If I do not maintain appointment or clinical privileges at the Hospital, any violation of the Policy may result in a report to the applicable state licensing board.]*

By signing this Agreement, I understand that I am ***<u>not waiving</u>*** any of the rights or privileges afforded me under the Medical Staff Bylaws and related documents. I also remain free to raise legitimate concerns regarding the care being provided, or the conduct being exhibited, by a nurse or other Hospital employee, another physician, or the Hospital itself. ***<u>However, like everyone else, I must use the established and confidential Medical Staff and administrative channels in order to register any such concerns</u>.*** These channels are part of the Hospital's ongoing performance improvement and peer review activities, and permit the appropriate Medical Staff or Hospital leadership to fully review and assess the matter and take action to address the issue, as may be necessary.

_____ _____

[Name] [Date]

Note: This form shall be retained in the Practitioner's confidential file. A copy shall be provided to the Practitioner for reference.

TUCSON MEDICAL CENTER

POLICY ON
REVIEW OF CONCERNS
RELATED TO UTILIZATION

Approved by the Board: January 21, 2020

POLICY ON
REVIEW OF CONCERNS RELATED TO UTILIZATION

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POLICY ON
REVIEW OF CONCERNS RELATED TO UTILIZATION

1. POLICY, PURPOSES, AND DEFINITIONS

1.A ***Policy.*** It is the policy of Tucson Medical Center (the "Hospital") to provide quality and safe care in an effective and efficient manner, so that limited resources may benefit as many patients as possible.

1.B ***Purposes.*** This Policy is intended to supplement and be used in conjunction with the Hospital's Utilization Review Plan, Professional Practice Evaluation Policy ("PPE Policy"), and Medical Staff Professionalism Policy. This Policy has two primary purposes:

(1) ***Clarify the Role of the Utilization Management Committee ("UMC") in Managing Performance Issues.*** This Policy describes how the UMC will use collegial and educational efforts to:

(a) assist Practitioners in successfully addressing concerns that may be identified regarding the medical necessity of admissions, lengths of stay, and observation services; and

(b) promote a positive, educational approach to utilization and a culture of continuous improvement surrounding these issues.

(2) ***Integrate and coordinate the efforts of the UMC with the Medical Staff Peer Review/Professional Practice Evaluation ("PPE") Process.*** Specifically, this Policy describes how:

(a) concerns regarding the medical necessity of procedures and diagnostic tests are to be immediately referred for review through the PPE Policy;

(b) other utilization concerns that have not been successfully resolved by the UMC are also referred for review through the PPE Policy; and

(c) concerns regarding unprofessional conduct within the utilization process (e.g., refusal of a Practitioner to cooperate with utilization review activities) are referred for review under the Professionalism Policy.

1.C ***Definitions.*** Definitions for capitalized terms used in this Policy are set forth in the ***Medical Staff Glossary***.

2. IDENTIFICATION OF CONCERNS RELATED TO UTILIZATION

2.A ***Review of Data.*** The UMC will review data to identify potential utilization concerns involving Practitioners.

2.B ***Reported Concerns.*** Practitioners or Hospital employees may report potential utilization concerns to the Medical Staff Office, a Medical Staff Leader, or a member of the UMC. All such reports will be forwarded to the Chair of the UMC. The Chair of the UMC will follow up with the individual who raised the concern in a manner consistent with Article 2 of the PPE Policy (i.e., thanking the individual for raising the concern, informing the individual that the matter will be reviewed but that the results of the review cannot be disclosed due to confidentiality requirements, and informing the individual that retaliation is not permitted against anyone who raises a concern about utilization).

3. MEDICAL NECESSITY CONCERNS REGARDING PROCEDURES, DIAGNOSTIC TESTS, OR PROFESSIONAL SERVICES – REFER FOR REVIEW UNDER THE PPE POLICY

3.A ***Referral.*** Any concern that a Practitioner may be performing unnecessary procedures or diagnostic tests or providing unnecessary professional services, either reported to the UMC by a Practitioner or Hospital employee or identified by the UMC during its review activities, shall be referred for review under the PPE Policy. These issues generally require specialty-specific clinical expertise to assess, and that expertise can most effectively be obtained through the PPE process.

3.B ***Feedback to UMC.*** If a concern about medical necessity is reviewed by the Committee for Professional Enhancement ("CPE") through the PPE Policy (either as a result of a referral from the UMC or via the PPC's own review), the CPE will notify the UMC of any utilization issues that should be monitored with respect to the Practitioner's ongoing practice. The CPE will also share information related to any "lessons learned" from medical necessity reviews that may be useful to the UMC's activities.

4. UTILIZATION CONCERNS REGARDING ADMISSIONS AND LENGTHS OF STAY

4.A ***Review by UMC.***

(1) If, based on its own review of data or referral from another source, the UMC determines that a Practitioner appears to be engaging in a pattern of:

(a) unnecessary admissions,

(b) unnecessary use of outpatient status with observation services, or

(c) practices that result in inappropriate lengths of stay,

it shall address the issue as outlined in this Section 4.

(2) If, at any time during its review, the UMC identifies a possible concern about the Practitioner's clinical competence that is not primarily related to utilization (e.g., concerns about poor operative technique or the use of inappropriate medications), the UMC shall refer the matter for review under the PPE Policy.

4.B ***Notice to Practitioner.*** The Practitioner shall be notified in writing of the general nature of the UMC's concerns and asked to attend a meeting to discuss the concerns. The Practitioner may also be requested to submit written information regarding the resource utilization issue prior to the meeting.

4.C ***Meeting with Practitioner.***

(1) The meeting with the Practitioner shall be held within ten days of the written notice of the concerns. The meeting may involve the entire UMC or one or more members. The relevant Department Chair shall be invited to attend. If the UMC determines that the issue may be related to practice patterns of the Practitioner's group, other members of the group may also be asked to attend.

(2) In order to promote the collegial and educational objectives of this Policy, all discussions and meetings with a Practitioner shall involve only the Practitioner and UMC members. No counsel representing the Practitioner or the UMC shall attend any of these meetings, and no recording (audio or video) shall be permitted or made.

4.D ***Failure to Attend Meeting or Provide Input.***

(1) If the Practitioner fails to attend the meeting with UMC members or provide written input as requested, the Practitioner shall be required to meet with the Leadership Council. The purpose of the meeting with the Leadership Council is to discuss the Practitioner's obligation to participate in the review process, permit the Practitioner to explain why the information was not provided, and inform the Practitioner of the consequences of continuing to not provide the information. Failure of the Practitioner to either:

(a) meet with the Leadership Council and persuade it that the requested written input is not necessary; or

(b) provide the requested written input to the UMC prior to the meeting with the Leadership Council

will result in the automatic relinquishment of the Practitioner's clinical privileges. Such automatic relinquishment will continue until the Practitioner either meets with the Leadership Council and persuades it that the written input is not necessary or provides the requested written information to the UMC. Any member of the UMC may determine that the information provided by the Practitioner is sufficient such that the automatic relinquishment will no longer be in effect.

(2) If the Practitioner fails to meet with the Leadership Council or provide any requested input within 30 days of the automatic relinquishment, the Practitioner's Medical Staff membership and clinical privileges will be deemed to have been automatically resigned.

(3) The automatic relinquishment or resignation of appointment and/or clinical privileges described in this section are administrative actions that occur by operation of this Policy. They are not professional review actions that must be reported to the National Practitioner Data Bank or to any state licensing board or agency, nor do they entitle the Practitioner to a hearing or appeal.

4.E ***Collegial and Educational Interventions to Address Utilization Concerns.*** If, based on its review and any information or input provided by the Practitioner, the UMC determines that a pattern of unnecessary admissions, use of outpatient status with observation services, or lengths of stay has occurred, the UMC may take one or more of the following actions:

(1) ***Educational Letter.*** The UMC may send a letter of education and guidance to the Practitioner that identifies utilization goals and suggests measures by which to achieve those goals. The UMC may then monitor the Practitioner's utilization practices as necessary, depending on the circumstances. A sample ***Educational Letter*** is included in the ***PPE Manual.***

(2) ***Collegial Intervention.*** The UMC may engage in a face-to-face collegial meeting with the Practitioner to discuss utilization issues, which intervention is then documented in a follow-up letter to the Practitioner. A sample ***Collegial Intervention Checklist*** and ***Follow-Up Letter to Collegial Intervention*** are included in the ***PPE Manual.***

(3) ***Periodic Meetings.*** The UMC may require the Practitioner to meet periodically with one or more members of the UMC for specific case review and analysis.

(4) ***Work with Case Managers, Physician Advisors, or Others.*** The UMC may require the Practitioner to meet and/or work directly with Case Managers, Physician Advisors of the Care Management Department, external physician advisors, or other physicians to better manage utilization issues.

4.F ***Referral for Review by CPE under PPE Policy.*** The UMC shall refer a matter for review by the CPE under the PPE Policy when:

(1) A Practitioner continues to engage in a pattern of inappropriate utilization despite the UMC's collegial and educational efforts at intervention; or

(2) The UMC determines that a Performance Improvement Plan should be developed by the CPE to address the utilization issues identified. The UMC may recommend elements of a Performance Improvement Plan that it believes should be included (e.g., specific CME activities, second opinions, etc.).

5. PROFESSIONALISM CONCERNS – REFER FOR REVIEW UNDER PROFESSIONALISM POLICY

(1) All individuals who practice within the Hospital are expected to cooperate with the review process described in this Policy. Without limiting the foregoing, all individuals are expected to respond in a timely manner to requests for information (whether written, oral, or electronic) by the Care Management Department, Physician Advisors (internal or external), or UMC members. This includes returning phone calls, providing written information, and attending meetings when requested to do so.

(2) A Practitioner's failure to cooperate with the UMC's request for information or to attend a meeting will be addressed in accordance with Section 4.D above.

(3) A Practitioner's failure to cooperate with the utilization review process in any other manner will be referred to the Leadership Council for review under the Medical Staff Professionalism Policy (e.g., refusal to communicate with Physician Advisors; failure to provide information requested by Case Managers).

6. OTHER PROVISIONS APPLICABLE TO THIS POLICY

6.A ***Confidentiality and Documentation.*** Maintaining confidentiality is a fundamental and essential element of the review process described in this Policy. All information generated pursuant to this Policy in any form – written, verbal or electronic – will be maintained in a confidential manner in accordance with the Arizona peer review protection law. As noted in the applicable Arizona statute, "[a]ll proceedings, records and materials prepared in connection with the activities of a health care utilization committee are confidential and are not subject to discovery…" Ariz. Rev. Stat. Ann. §36-441. Documentation prepared pursuant to this Policy will be maintained in peer reviewed-protected Medical Staff or quality files. To the extent applicable, the confidentiality requirements set forth in

the PPE Policy will be used for guidance with respect to activities conducted under this Policy.

6.B ***Legal Protection for Reviewers.*** It is the intention of the Hospital and the Medical Staff that the process outlined in this Policy be considered patient safety, professional review, peer review, and quality assurance activity within the meaning of the Patient Safety Quality Improvement Act of 2005, the federal Health Care Quality Improvement Act of 1986, and Arizona law. In addition to the protections offered to individuals involved in review activities under those laws, such individuals shall be indemnified and covered under the general liability insurance policies of the Hospital when they act within the scope of their duties as outlined in this Policy and function on behalf of the Hospital.

6.C ***Delegation of Functions.*** When a function under the PPE Policy is to be carried out by a member of the Administrative Team, by a Medical Staff Member, or by a Medical Staff committee, the individual, or the committee through its chair, may delegate performance of the function to a qualified designee who is a Practitioner or Hospital employee (or a committee of such individuals). Any such designee must treat and maintain all information in a strictly confidential manner and is bound by all other terms, conditions, and requirements of the PPE Policy. In addition, the delegating individual or committee is responsible for ensuring that the designee appropriately performs the function in question. Any documentation created by the designee are records of the committee that is ultimately responsible for the review in a particular matter.

Adopted by the Medical Executive Committee on _____, 2019.

Adopted by the Board on January 21, 2020.

TUCSON MEDICAL CENTER

PRACTITIONER HEALTH POLICY MANUAL

This Practitioner Health Policy Manual may be used to assist with implementation of the Practitioner Health Policy. Documents in this Manual should be tailored, as needed, to reflect the unique circumstances of a particular review.

While the documents in this Manual are intended as helpful guidance, there is no requirement that they be used. Failure to use any specific document will not affect the validity of a review.

Approved by the Board: January 21, 2020

PRACTITIONER HEALTH POLICY MANUAL

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HEALTH ISSUE REPORTING FORM

Instructions: Please use this form to report actions by a Practitioner that could indicate the Practitioner is experiencing a health problem. You are not responsible for identifying the possible cause of the Practitioner's actions. You are only asked to report what you observed. Please submit the completed form to the Hospital Medical Staff Office. The Medical Staff strives to work with Practitioners in a collegial manner to address health problems in a supportive manner.

PRACTITIONER INFORMATION

Name of Practitioner: _____

DATE, TIME, AND LOCATION OF OBSERVED ACTIONS

Date and time:

Location:

Range of dates if your concerns are not limited to one particular date:
_____/_____/20_____ to _____/_____/20_____

OBSERVED ACTIONS *[please check all boxes that apply]*

- ❑ Disoriented
- ❑ Thick, slurred speech
- ❑ Poor motor coordination
- ❑ Sleepiness
- ❑ Rounding at unusual times
- ❑ Dilated pupils
- ❑ Flushed face, head or neck
- ❑ Significant changes in personality
- ❑ Unable to perform routine tasks
- ❑ Unusual forgetfulness
- ❑ Difficult to contact
- ❑ Missed appointments
- ❑ Unexplained absences
- ❑ Unexplained frequent illness
- ❑ Unexplained accidents or injuries
- ❑ Hand tremor
- ❑ Odor of alcohol on breath
- ❑ Extremely nervous
- ❑ Unusually talkative
- ❑ Profuse sweating
- ❑ Uncoordinated walking
- ❑ Poor perception of time or distance
- ❑ Use of alcohol or illegal drugs at hospital
- ❑ Unkempt appearance
- ❑ Mood changes
- ❑ Deterioration of personal hygiene
- ❑ Neglect of patients or duties
- ❑ Other: _____

_____

_____

[Please attach additional sheets as needed]

OTHER WITNESSES

Names of other Practitioners or Hospital employees who may have witnessed these behaviors:

_____

Names of any other persons who witnessed these behaviors (e.g., patients, visitors, family members):

_____

CONTACT INFORMATION	
Your name:	Department:
Phone #:	Date this form completed:
E-mail address:	

Note: Your report will be treated with the utmost confidentiality and your identity will not be disclosed to the Practitioner in question unless you consent or in the unlikely event that the Medical Staff's collegial efforts to assist the Practitioner are unsuccessful and a hearing results. In any event, as part of our culture of safety and quality care, no retaliation is permitted against you for reporting this matter. This means that the Practitioner at issue may not approach you directly to discuss this matter or engage in any abusive or unprofessional conduct directed at you. If you believe that you have been subjected to any retaliation as a result of raising these concerns, please report that immediately to your supervisor, the Chief of Staff, or another Medical Staff leader.

RESPONSE TO INDIVIDUAL WHO REPORTED CONCERNS*

Dear _____:

Thank you for reporting your concerns. We appreciate your participation in our efforts to promote and maintain a culture of safety and quality care at our Hospital.

Your concerns will be reviewed in accordance with the Practitioner Health Policy. We will contact you if we need additional information.

Because your report may involve confidential matters under Arizona law, it is important that you maintain confidentiality and only discuss this matter with individuals who are a formal part of the review process and not with colleagues or co-workers. Due to these same confidentiality requirements, we may not be permitted to inform you of the specific outcome of the review. However, please be assured that your report will be fully reviewed and appropriate steps will be taken to address the matter.

Your report will be treated with the utmost confidentiality. Your identity will not be disclosed to the subject of the report unless:

(a) you consent; or

(b) information provided by you is later used to support an adverse professional review action that results in a Medical Staff hearing (which is an extremely rare occurrence).

In any event, as part of our culture of safety and quality care, no retaliation is permitted against you for reporting this matter. This means that the individual who is the subject of your report may not approach you directly to discuss this matter or engage in any abusive or inappropriate conduct directed at you. If you believe that you have been subjected to any retaliation as a result of raising these concerns, please report that immediately to your supervisor, the CMO, VPMA, or any Medical Staff Officer.

Once again, thank you for bringing your concerns to our attention. If you have any questions or wish to discuss this matter further, please do not hesitate to call me at _____.

Sincerely,

Representative of Medical Staff Office, CMO or VPMA

* ***As an alternative to sending a letter or e-mail, the content of this letter may be used as talking points to respond verbally to the individual who reported a potential Health Issue.***

SAMPLE SUMMARY HEALTH REPORT FOR USE AT REAPPOINTMENT

CONFIDENTIAL PEER REVIEW DOCUMENT

To: Credentials Committee, MEC, and Board of Trustees

From: Leadership Council

Date: _____

Re: Summary Health Report/Reappointment of _____ M.D./D.O.

This summary health report is submitted pursuant to the Practitioner Health Policy of Tucson Medical Center.

During the past appointment cycle, the Leadership Council has worked with _____ (the "Practitioner") to address a Health Issue.

The Leadership Council conducted its review according to the detailed procedures set forth in the Practitioner Health Policy. The Leadership Council obtained input from the Practitioner, gathered information from witnesses, and evaluated the results of a health assessment of the Practitioner. The Practitioner cooperated fully with the review process.

[Choose only <u>one</u> of the following two italicized paragraphs:]
The Leadership Council has determined that the Practitioner's Health Issue does <u>not</u> prevent the Practitioner from safely exercising his/her clinical privileges. *Moreover, the Leadership Council does not believe it is necessary for any conditions to be placed on the Practitioner's practice.* ***<u>OR</u>***

The Leadership Council has determined that the Practitioner's Health Issue does <u>not</u> prevent the Practitioner from safely exercising his/her clinical privileges. *The Practitioner is voluntarily complying with certain conditions developed by the Leadership Council to ensure patient safety. The Leadership Council will continue to work with the Practitioner to address and monitor the Health Issue. The Leadership Council recommends that the Practitioner's reappointment be conditioned on the Practitioner's continued cooperation with the Leadership Council.*

Pursuant to the Practitioner Health Policy, if any member of the Credentials Committee, Medical Executive Committee or Board of Trustees has any question about the Practitioner's ability to safely practice, that member should feel free to contact a member of the Leadership Council to discuss the matter further or attend a meeting of the Leadership Council to discuss the issue. The Leadership Council is comprised of: _____. If additional information is necessary after such conversation, the Practitioner's confidential health file may be reviewed in the Medical Staff Office.

INTERVIEW TOOL (SCRIPT AND QUESTIONS)

SCRIPT FOR INTRODUCTORY STATEMENTS

Instructions: Prior to the interview, the following information should be provided to each individual who is interviewed.

1. A concern about a Practitioner's health is being reviewed under the Practitioner Health Policy. We would like to speak with you because you *[raised the concern]* **or** *[may have relevant information]*.

2. Any information you provide will be treated with the utmost confidentiality. It will not be shared with anyone outside the Hospital's peer review process. Also, Hospital policy states that your identity will generally not be disclosed to the Practitioner whose health is being reviewed except in extremely rare situations (for example, a Medical Staff hearing).

3. As part of our culture of safety and quality care, no retaliation is permitted against you for *[reporting this matter]* **or** *[providing information about this matter]*. This means that the Practitioner under review may not approach you to discuss this matter or engage in any abusive or inappropriate conduct directed at you. If you believe you have been retaliated against, please report immediately to your supervisor or any Medical Staff Leader.

4. The state peer review protection law requires the Hospital to maintain any information related to this review in a ***strictly confidential*** manner and we may not be able to inform you of the outcome of the review. But, if you have any questions about this review process following this interview, please direct them to the Chief of Staff, Chief Medical Officer, Vice President Medical Affairs, or the Medical Staff Office.

SAMPLE INTERVIEW QUESTIONS

Note: The following questions are intended to elicit basic information about an incident. These questions may be modified as appropriate, and should be supplemented with additional questions that specifically pertain to the health matter being reviewed.

1. What was the date of the incident?

2. What time did the incident occur?

3. Where did the incident occur?

4. What is the name of the Practitioner in question?

5. Who was involved? What are their titles and duties?

6. What happened? What did you see and hear?

7. Are you aware of any attempts that were made to address this behavior with the Practitioner when it occurred?

8. Are there any notes or other documentation regarding the incident(s)?

9. Was a patient or a patient's family member directly or indirectly involved in the event? If so, name and medical record number.

10. Did you tell anyone about the incident?

    a. Whom did you tell?

    b. When and where did you tell them?

    c. What did you tell them?

11. How did you react to this incident at the time?

12. Did you experience or witness any retaliation or threatened retaliation by the Practitioner?

13. How do you think this incident affected patient care generally, Hospital operations, the work of your team, or your ability to do your job?

14. Have other incidents occurred, either before or after this incident? ***[If yes, repeat above questions for each incident.]***

15. Do you have any other information we should know about this matter? Please contact me if you recall or learn something new after we are finished talking.

TALKING POINTS
FOR MEETING WITH PRACTITIONER
ABOUT HEALTH ISSUE

- ***Thank you*** for meeting with us. These types of meetings are difficult for all of us, and we appreciate your cooperation and professionalism.

- ***Reason for Meeting.*** Our reason for requesting this meeting is that we have concerns about your health status based on _____ *[briefly summarize basis for concern, but without revealing identity of anyone who provided information]*.

- ***Not Disciplinary.*** This is not a disciplinary meeting. This is a meeting regarding a Health Issue with a colleague.

- ***Input from Practitioner.*** Please give us your perspective on the concerns that have been raised. Do you feel you have been experiencing any Health Issues that could put you or your patients at risk?

- ***Evaluation Requested [if applicable].*** We are asking you to obtain an assessment from an appropriate specialist who is acceptable to the Leadership Council. It is in everyone's best interest, especially yours, for this to occur as soon as possible. We will be happy to work with you to identify an appropriate person or entity to perform the assessment. *[Optional: We contacted the state Physician Health Program ("PHP") – without identifying you – to find out the resources that are available and the time frames involved in order to facilitate our discussions and expedite this process. We will be happy to work with you to have the assessment performed expeditiously.]*

- ***HIPAA and Other Forms [if applicable].*** Once an appropriate evaluator is identified to conduct the assessment, we will provide you the HIPAA-compliant authorization forms and releases you will need to sign to facilitate the evaluation process. *[These forms are included as part of the Practitioner Health Policy Manual.]*

- ***Voluntary and Temporary Agreement Not to Practice.*** Until the assessment can be completed, we need to make sure that we protect you and patients. To that end, while we recognize the difficulty and inconvenience involved, we would like you to voluntarily refrain from exercising your clinical privileges until the evaluation is complete. Is there anything we can do to help you accomplish this? *[The Practitioner may work with partners for coverage, take a couple of weeks of vacation, take an LOA, etc.]*

- ***Other Practice Sites (affiliated and non-affiliated).*** We know you also practice at other sites. Based on the concerns identified above, it would be important for both you and your patients to take the same voluntary safeguards at those sites as well. How do you think we can accomplish that in the same spirit of cooperation*?*

- ***Not Reportable to State Licensing Board or NPDB.*** Please understand that your agreement to temporarily refrain from practicing is not considered a suspension or disciplinary action, and it is not something that needs to be reported to the state licensing board or the National Practitioner Data Bank. The same is true regarding your agreement to obtain an evaluation of your health. However, if you decide you do not want to be evaluated, we would have to consider whether a report to the state licensing board is required.

- ***Confidentiality.*** We will treat this matter in the most highly confidential manner possible, as required by our policies and the state peer review protection law. We understand how sensitive this issue is, and we certainly intend to proceed accordingly. Any communication about this matter will be the minimum necessary to accomplish your voluntary agreement. *[**If applicable – modify as needed**: However, please recognize that pursuant to the Information Sharing Policy and our Practitioner Health Policy, we may keep your employer informed of the status of this review. Our goal is to protect patients, and to have a more effective review process by coordinating our efforts with those of your employer.]*

- ***Non-Retaliation.*** While we do not expect it at all, as a courtesy to you, we want to make sure that you avoid any type of action that could be viewed as retaliation against any individual who you believe may have expressed a concern or provided information in this matter. As such, please avoid discussing this matter with any such individual, because even well-intentioned conversations can be perceived as intimidating. Any questions or concerns or additional information that you wish to provide should be given to one of us.

- ***Thank you.*** We understand what a difficult and uncomfortable situation this is, and we want to thank you again for your professionalism and cooperation.

***ADDITIONAL INFORMATION TO PLAN FOR THE MEETING*:**

1. If the Practitioner refuses to obtain an assessment, the refusal will result in the "automatic relinquishment" of clinical privileges until an assessment is obtained. See **Appendix D** of the Practitioner Health Policy ("Automatic Relinquishment/Resignation for Refusal to Provide Information or Meet with the Leadership Council"). As noted above, refusal to obtain an assessment may also make a matter reportable to the state licensing board – consult with Hospital counsel.

2. If the Practitioner refuses to voluntarily and temporarily refrain from exercising privileges as requested pending completion of an evaluation, a "precautionary suspension" could be imposed. However, that would be the last option. The best approach is to explain to the Practitioner why it is in his or her best interest to voluntarily refrain from practicing while the matter is reviewed.

EMPLOYED PRACTITIONER ROUTING FORM

***Note**: The purpose of this form is to document which of the following two review processes will be used when a Health Issue is being evaluated for an Employed Practitioner: (1) the Medical Staff process as set forth in the Practitioner Health Policy; or (2) the policies or employment contract of the Employer. See **Appendix E** to the Practitioner Health Policy ("Employed Practitioner Triage Process") for additional information and requirements.*

Name of Practitioner: _____

Entity that Employs the Practitioner: _____

Representative(s) of Employer involved in routing discussion: _____

_____

Medical Staff Leader(s) involved in routing discussion: _____

_____

A decision was made that:

- ❑ The process outlined in the ***Practitioner Health Policy*** will be used to review the Health Issue, with input and participation by the Employer.
- ❑ ***The Employer's policies and/or employment contract*** will be used to review the Health Issue.

Comments: _____

_____

_____

_____

Signature of individual completing form

_____

Date

CONFIDENTIAL PEER REVIEW DOCUMENT

CONSENT FOR DISCLOSURE OF INFORMATION
AND
RELEASE FROM LIABILITY

I hereby authorize Tucson Medical Center and its Leadership Council, Medical Executive Committee, and Medical Staff Leaders (the "Hospital") to provide _____ *[the facility or individual performing the health assessment]* (the "Evaluator") all information, written and oral, relevant to an evaluation of my health status.

I understand that the purpose of this Authorization and Release is to allow the Evaluator to conduct a full and complete evaluation of my health status so that the Hospital can determine if I am able to care for patients safely and competently.

I also understand that the information being disclosed is protected by the state peer review law and that the Hospital, the Evaluator and others involved in the peer review process are required to maintain the confidentiality of peer review information pursuant to that law.

I release from any and all liability, and agree not to sue, the Hospital, any of its officers, directors, or employees, any physician on the Hospital's Medical Staff, or any authorized representative of the Hospital, for any matter arising out of their release of information to the Evaluator.

I also release from any and all liability, and agree not to sue, the Evaluator or any of its officers, directors, employees, or authorized representatives for any matter arising out of the Evaluator's provision of an evaluation of my health status to the Hospital.

_____ _____

Date Signature of Practitioner

_____

Printed Name

CONFIDENTIAL PEER REVIEW DOCUMENT

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I hereby authorize _____ *[the facility or individual performing the health assessment]* (the "Evaluator") to provide all information, both written and oral, relevant to an assessment of my health status and my ability to safely practice, to Tucson Medical Center and its Leadership Council, Medical Executive Committee, and Medical Staff Leaders (the "Hospital"). The information to be released includes, but is not limited to, answers to the questions on the attached Health Status Assessment Form, along with the following (as applicable):

1. my current health condition;

2. whether I am continuing to receive medical treatment and, if so, the treatment plan;

3. whether I am continuing to participate in a substance abuse rehabilitation program or an after-care program, and whether I am in compliance with all aspects of the program;

4. to what extent, if any, my behavior and clinical practice need to be monitored;

5. whether I am capable of resuming clinical practice and providing continuous, competent care to patients as requested; and

6. any conditions that are necessary for me to safely exercise my clinical privileges.

I understand that the purpose of this Authorization is to allow the Hospital to obtain information that is relevant to my qualifications for Medical Staff appointment and clinical privileges, including, but not limited to, my ability to care for patients safely and competently and to relate cooperatively with others in the Hospital.

I understand that the willingness of the Evaluator to conduct this assessment or provide treatment does not depend on my signing this Authorization.

OR

Since the Hospital is paying for the health assessment and/or treatment and has conditioned payment for the assessment and/or treatment on receipt of a report, the Evaluator may refuse to conduct the assessment or provide treatment if I refuse to sign this Authorization.

I understand that my health information is protected by a federal law known as the HIPAA Privacy Rule and may not be disclosed by the Evaluator without this Authorization. Once my health information is disclosed to the Hospital pursuant to this Authorization, the HIPAA Privacy Rule may no longer apply to the information. However, in that case, the Hospital would nonetheless be prohibited by the state peer review protection law from disclosing health information it received

about me to anyone outside of its confidential review process. In addition, if the information in question relates to my treatment at a federally-assisted drug or alcohol treatment facility, federal law would also prevent the Hospital from disclosing that information without me signing a separate Authorization form to do so.

I understand that I may revoke this Authorization at any time, in writing, except to the extent that the Evaluator has already relied upon it in making a disclosure to the Hospital. My written revocation will become effective when the Evaluator has knowledge of it.

This Authorization expires when my Medical Staff appointment and clinical privileges at the Hospital end. Once this Authorization has expired, the Evaluator may no longer use or disclose my health information for the purpose listed in this Authorization, unless I sign a new Authorization form.

Date	Signature of Practitioner
	Printed Name

CONFIDENTIAL PEER REVIEW DOCUMENT

HEALTH STATUS ASSESSMENT FORM

Please respond to the following questions based upon your assessment of the current health status of _____ (the "Practitioner"). If additional space is required, please attach a separate sheet.

CURRENT HEALTH STATUS	YES	NO
1. Does the Practitioner have any medical, psychiatric, or emotional conditions that could affect his/her ability to exercise safely the clinical privileges set forth on the attached list and/or to perform the duties of Medical Staff appointment, including response to emergency call? If "yes," please provide the diagnosis and prognosis: _____ _____ _____	❑	❑
2. Is the Practitioner continuing to receive medical treatment for any conditions identified in Question 1? If "yes," please describe treatment plan: _____ _____ _____	❑	❑
3. Has the Practitioner been prescribed or is the Practitioner currently taking any medication that may affect the Practitioner's ability to practice? If "yes," please specify medications and any side effects: _____ _____ _____	❑	❑
4. Is the Practitioner currently under any limitations concerning activities or workload? If "yes," please specify: _____ _____ _____	❑	❑

SUBSTANCE ABUSE/AFTER-CARE PROGRAM *(If the Practitioner is participating in a substance abuse or after-care program, please also answer the questions in this section.)*	**YES**	**NO**
1. Please specifically describe the substance abuse rehabilitation or after-care program: _____ _____		
2. Is the Practitioner in compliance with all aspects of the program? If "no," please explain: _____ _____ _____	❑	❑
CONDITIONS, RESTRICTIONS, AND ACCOMMODATIONS	**YES**	**NO**
1. Does the Practitioner's behavior and/or clinical practice need to be monitored? If "yes," please describe: _____ _____ _____	❑	❑
2. In your opinion, are any conditions or restrictions on the Practitioner's clinical privileges or other accommodations necessary to permit the Practitioner to exercise privileges safely and/or to fulfill Medical Staff responsibilities appropriately? If "yes," please describe such restrictions, conditions, or accommodations: _____ _____	❑	❑
3. In your opinion, is the Practitioner capable of resuming clinical practice and providing continuous, competent care to patients as requested? If "no," please explain: _____ _____ _____	❑	❑

_____ _____

Date Signature of Evaluating Practitioner

CONFIDENTIAL PEER REVIEW DOCUMENT

AUTHORIZATION FOR REDISCLOSURE OF DRUG/ALCOHOL TREATMENT INFORMATION

In the course of credentialing and peer review activities, Tucson Medical Center and its Leadership Council, Medical Executive Committee, and Medical Staff Leaders (the "Hospital") have received information about me from _____, a federally assisted drug or alcohol treatment program governed by 42 C.F.R. Part 2 (the "Program").

I hereby authorize the Hospital to redisclose to _____ (the "Receiving Entity") and _____, its point of contact for credentialing and peer review purposes, any and all information the Hospital received from the Program regarding my treatment. This includes, but is not limited to, any written report or correspondence from the Program, notes to file regarding verbal conversations between the Program and the Hospital, and the contents of any verbal conversations between the Program and the Hospital.

I understand that the purpose of the disclosure of this information is to allow the Receiving Entity to _____ *[Describe the purpose of the disclosure, such as "allow the Receiving Entity to evaluate my health status and my ability to safely practice medicine."]*

I understand that I may revoke this Authorization at any time, in writing, except to the extent that the Hospital has already relied upon it in making a disclosure to the Receiving Entity. My written revocation will become effective when the Hospital has knowledge of it.

This Authorization expires when my Medical Staff appointment and clinical privileges at the Hospital end. Once this Authorization has expired, the Hospital may no longer disclose the information described above unless I sign a new Authorization form.

I understand that this Authorization is governed by 42 C.F.R. §2.31. I also understand that the Receiving Entity is prohibited from further disclosing my information unless I sign a separate authorization form.

_____ _____

Date Signature of Practitioner

_____

Printed Name

TUCSON MEDICAL CENTER

PRACTITIONER HEALTH POLICY

Approved by the Board: October 5, 2021

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PRACTITIONER HEALTH POLICY

1. POLICY, DEFINITIONS, AND DELEGATION OF FUNCTIONS

1.A ***Policy and Scope.***

(1) Tucson Medical Center (the "Hospital") is committed to providing safe, quality care, which can be compromised if a Practitioner is suffering from a Health Issue that is not appropriately addressed. The Hospital is also committed to assisting Practitioners in addressing Health Issues so they may practice safely and competently.

(2) This Policy applies to all Practitioners who provide patient care services at the Hospital.

1.B ***Definitions of Health Issue and Other Terms.***

(1) A "Health Issue" is any physical, mental, or emotional condition that could adversely affect a Practitioner's ability to practice safely and competently. Examples of Health Issues are set forth in **Appendix A** to this Policy ("Examples of Health Issues").

(2) Definitions for other capitalized terms used in this Policy are set forth in the ***Professional Staff Glossary***.

1.C ***Delegation of Functions.*** When a function under the PPE Policy is to be carried out by a member of the Administrative Team, by a Professional Staff Member, or by a Professional Staff committee, the individual, or the committee through its chair, may delegate performance of the function to a qualified designee who is a Practitioner or Hospital employee (or a committee of such individuals). Any such designee must treat and maintain all information in a strictly confidential manner and is bound by all other terms, conditions, and requirements of the PPE Policy. In addition, the delegating individual or committee is responsible for ensuring that the designee appropriately performs the function in question. Any documentation created by the designee are records of the committee that is ultimately responsible for the review in a particular matter.

2. REPORTS OF POTENTIAL HEALTH ISSUES

2.A ***Duty to Self-Report.***

(1) ***General Duty.*** Practitioners who have a Health Issue are required to report it to the Chief of Staff, Chief Medical Officer ("CMO"), Vice President Medical Affairs ("VPMA"), or another Professional Staff Leader.

(2) ***Exception.*** The duty to self-report does not apply to:

(a) A Health Issue that will be fully resolved before the Practitioner next exercises his or her clinical privileges; or

(b) A Health Issue that was evaluated as part of a Practitioner's application for appointment or reappointment to the Professional Staff.

2.B ***Reports of Suspected Health Issues by Others.***

(1) ***General.*** Any Practitioner or Hospital employee who is concerned that a Practitioner may be practicing with a Health Issue shall report the concern to the Chief of Staff, CMO, VPMA, or another Professional Staff Leader.

(2) ***Reporting Form.*** A form that may be used to report potential Health Issues is set forth in the ***Practitioner Health Policy Manual***. The form outlines warning signs to facilitate the objective reporting of these issues.

(3) ***Anonymous Reports.*** Practitioners and employees may report concerns anonymously. However, all individuals are encouraged to identify themselves when making a report so that Professional Staff Office may contact the reporter for additional information, if necessary.

(4) ***Reports by Those in Treatment Relationships.*** A Practitioner who becomes aware of a Health Issue affecting another Practitioner as a result of his or her treatment relationship with that Practitioner is not expected to report the Health Issue internally pursuant to this Policy. However, the treating Practitioner should encourage the Practitioner to self-report the issue to the extent required by Section 2.A of this Policy.

In addition, the treating Practitioner should consider whether a mandatory report is required under Arizona law to the applicable licensing board or any other state agency. If the treating Practitioner believes a mandatory report is necessary pursuant to Arizona law, he or she should notify the Practitioner and encourage the Practitioner to self-report prior to making the mandatory report. The treating Practitioner may consult with the CMO or VPMA for assistance and resources in such matters, but should not disclose to the CMO or VPMA information that identifies the Practitioner.

2.C ***Follow-up with Individual Who Filed Report.*** The Professional Staff Office, CMO, or VPMA shall follow up with individuals who file a report as set forth in **Appendix B** to this Policy ("Response to Individual Who Reported Concerns"). A ***Response to Reported Concerns*** letter that may be used for this purpose is included in the ***Practitioner Health Policy Manual***.

2.D ***Logging of Reports, Creation of Confidential Health File, and Notification to Leadership Council.*** The Professional Staff Office will log any report of a Health Issue and create a Confidential Health File that is maintained separately from the credentials or quality files (however, the existence of the Confidential Health File will be noted in the credentials or quality file). See **Appendix C** to this Policy ("Confidential Health Files/Reappointment Process") for more information on Confidential Health Files. The Leadership Council will be notified of any report of a suspected Health Issue.

3. RESPONSE TO IMMEDIATE THREATS

3.A ***Scope of Section.*** This section applies if a potential Health Issue is reported that raises immediate concerns because either:

(1) The Practitioner is providing services at the Hospital at that time; or

(2) The Practitioner is expected to provide services in the very near future such that the Leadership Council would not have time to meet prior to the Practitioner's provision of services.

By way of example and not limitation, this section applies if a Practitioner seems disoriented or is demonstrating other cognitive difficulties while rounding on patients, or is suspected of being under the influence of drugs or alcohol immediately prior to commencing a surgical procedure.

3.B ***Assessment of Immediate Threat.*** If a report suggests that a Practitioner may have a Health Issue that poses an immediate threat to patients or others, the Chief of Staff, CMO, VPMA or another Professional Staff Leader shall immediately and personally assess the Practitioner. The Practitioner may be required to submit to a blood, hair, or urine test, or other appropriate physical or cognitive evaluation, to determine his or her ability to safely practice. Failure of the Practitioner to undergo such testing upon request will result in the automatic relinquishment of the Practitioner's clinical privileges pending Leadership Council review of the matter. See **Appendix D** to this Policy ("Automatic Relinquishment/Resignation for Refusal to Provide Information or Meet with the Leadership Council") for additional information on the Automatic Relinquishment of privileges.

3.C ***Protection of Patients and Others.*** If the individual who assesses the Practitioner believes the Practitioner may have a Health Issue and that action is necessary to protect patients and others, the Practitioner should be asked to voluntarily refrain from exercising his or her clinical privileges or agree to conditions on his or her practice while the matter is being reviewed. Such a request may be made to the Practitioner either before or after any tests or evaluations regarding the Practitioner have been completed.

(1) ***Agreement to Voluntarily Refrain.*** If the Practitioner agrees to voluntarily refrain from exercising his or her privileges, the Chief of Staff may assign the Practitioner's patients to another individual with appropriate clinical privileges or to the appropriate Practitioner on the Emergency Department call roster. Affected patients shall be informed that the Practitioner is unable to proceed with their care due to an emergency situation. Any wishes expressed by patients regarding a covering Practitioner will be respected to the extent possible. The Practitioner's agreement to voluntarily refrain is not reportable to the National Practitioner Data Bank or state licensing board. Such agreements should be documented in a letter or other correspondence to the Practitioner that is maintained in the Practitioner's Confidential Health File.

(2) ***Other Action.*** If the Practitioner will not agree to voluntarily refrain from exercising his or her privileges, an individual authorized by the Professional Staff Credentials Policy to impose a precautionary suspension will consider whether a precautionary suspension or some other measure is necessary as a safeguard while the Health Issue is assessed.

3.D ***Referral to Leadership Council.*** Following the immediate response described above, the matter shall be referred to the Leadership Council for review pursuant to this Policy.

4. LEADERSHIP COUNCIL REVIEW

4.A ***Employed Practitioner Triage Process.*** If a report involves an Employed Practitioner, Professional Staff Leaders will consult with appropriate representatives of the Employer and then determine whether the matter will be reviewed pursuant to this Policy or pursuant to the policies of the Employer. See **Appendix E** to this Policy ("Employed Practitioner Triage Process") for additional information regarding this triage process. Also, an ***Employed Practitioner Routing Form*** that may be used to document these decisions is included in the ***Practitioner Health Policy Manual***.

4.B ***Individuals Participating in Review/Additional Clinical Expertise.*** If the Leadership Council determines that it would be necessary or helpful in addressing the reported concern, it may consult with or include in the review a relevant subject matter expert (e.g., an addictionologist, neuropsychologist, or psychiatrist). Any individual who participates in a review is an integral part of the Hospital's review process, and shall be governed by the same responsibilities and legal protections (e.g., confidentiality, indemnification, etc.) that apply to other participants in the process.

4.C ***Additional Fact-Finding.*** The Leadership Council may review any documentation relevant to the Health Issue. It may also meet with the individual who initially reported the concern and any other individual who may have relevant information.

The ***Practitioner Health Policy Manual*** contains an ***Interview Tool (Script and Questions)*** that may be used for interviews, along with sample interview questions.

4.D ***Meeting with Practitioner.*** If the Leadership Council believes that a Practitioner may have a Health Issue, the Leadership Council shall meet with the Practitioner. At this meeting, the Practitioner will be advised of the nature of the concern, asked to provide input, and informed of the Leadership Council's recommendations. The ***Practitioner Health Policy Manual*** includes ***Talking Points for Meeting with Practitioner About Health Issue*** that may be used to help the Leadership Council prepare for and conduct such meetings.

4.E ***Practitioner's Refusal to Obtain Assessment.*** If a Practitioner refuses to obtain a health assessment that is recommended by the Leadership Council or provide the results to the Leadership Council, the process outlined in **Appendix D** of this Policy ("Automatic Relinquishment/Resignation for Refusal to Provide Information or Meet with the Leadership Council") will be followed.

5. INTERIM SAFEGUARDS PENDING COMPLETION OF ASSESSMENT

If a Practitioner agrees to obtain an assessment, the Leadership Council may also recommend that the Practitioner voluntarily take one or more of the following actions while the assessment is pending:

(a) Agree to specific conditions on his or her practice, which could include obtaining assistance from other Practitioners during patient care activities;

(b) Refrain from exercising some or all privileges at the Hospital and at other practice locations as may be appropriate; or

(c) Take a leave of absence.

If a Practitioner does not agree to take a temporary voluntary action recommended by the Leadership Council while the assessment is pending, an individual authorized by the Professional Staff Credentials Policy to impose a precautionary suspension will consider whether a precautionary suspension or some other measure is necessary as a safeguard while the Health Issue is assessed.

6. ASSESSMENT OF HEALTH STATUS

6.A ***General.*** The Leadership Council may require the Practitioner to undergo a physical, mental, cognitive, or other examination or other assessment by an appropriate clinician. It may also ask the Practitioner to provide a letter from his or her treating physician confirming the Practitioner's ability to safely and competently practice, and authorize the treating physician to meet or speak with the Leadership Council.

6.B ***Person to Conduct Assessment.*** The Leadership Council shall select the health care professional or organization to perform any examination, testing, or evaluation, but may seek input from the Practitioner. More than one health care professional or organization may be asked to perform an examination, test, or evaluation, and this may occur either concurrently or serially (e.g., a substance abuse assessment following a positive drug screen). The Practitioner shall be responsible for any costs associated with obtaining this information.

6.C ***Forms.*** The ***Practitioner Health Policy Manual*** includes the following forms, which should be used when implementing the provisions of this Section:

(1) ***Consent for Disclosure of Information and Release from Liability*** (authorizing the Hospital to release information to the health care professional or organization conducting the evaluation);

(2) ***Authorization for Release of Protected Health Information*** (authorizing the health care professional or organization conducting the evaluation to disclose information about the Practitioner to the Leadership Council; and

(3) ***Health Status Assessment Form*** (to document the results of an evaluation).

7. REINSTATEMENT/RESUMING PRACTICE

7.A ***Request for Reinstatement from Leave of Absence or to Resume Practicing.***

(1) ***Leave of Absence.*** If a Practitioner was granted a formal leave of absence to participate in a treatment program or otherwise address a Health Issue, the Practitioner must apply for reinstatement of privileges using the process set forth in the Professional Staff Credentials Policy.

(2) ***Agreement to Refrain Without Formal Leave of Absence.*** In all other circumstances where the Practitioner refrained from practicing (e.g., voluntary agreement between Practitioner and Leadership Council; Practitioner was absent from Professional Staff duties while participating in a treatment program or otherwise addressing a Health Issue), the Practitioner must submit a written request to the Leadership Council and receive written permission to resume exercising his or her clinical privileges.

7.B ***Additional Information.*** Before acting on a Practitioner's request for clearance to apply for reinstatement or to resume practicing, the Leadership Council may request any additional information or documentation that it believes is necessary to evaluate the Practitioner's ability to safely and competently exercise clinical privileges. This may include requiring the Practitioner to undergo a health assessment conducted by a physician or entity chosen by the Leadership Council in

order to obtain a second opinion on the Practitioner's ability to practice safely and competently.

7.C ***Determination by Leadership Council.***

(1) If the Leadership Council determines that the Practitioner is capable of practicing safely and competently without conditions, this decision will be documented. The Practitioner may then: (i) proceed with the reinstatement process outlined in the Professional Staff Credentials Policy, if a leave of absence was taken; or (ii) resume practicing, if no leave of absence was taken.

(2) If the Leadership Council determines that conditions should be placed on a Practitioner's practice as a condition of reinstatement or resuming practice, it will consult with the Practitioner in developing any necessary conditions.

8. CONDITIONS OF CONTINUED PRACTICE

8.A ***General.*** The Leadership Council may ask the Practitioner to agree to comply with certain conditions in order to receive clearance to apply for reinstatement of privileges from a leave of absence or to otherwise resume practicing. Examples of such conditions of continued practice are included in **Appendix F** ("Examples of Conditions of Continued Practice").

8.B ***Refusal to Agree to Conditions*.** If the Practitioner does not agree to conditions requested pursuant to the prior paragraph, the matter will be referred to the Medical Executive Committee for its independent review under the Professional Staff Credentials Policy.

8.C ***Reasonable Accommodations.*** Reasonable accommodations may be made consistent with Hospital policy to assist the Practitioner in resuming his or her practice. Examples of reasonable accommodations include, but are not limited to, providing assistive technology or equipment or removing architectural barriers. The Leadership Council will consult with Hospital executive personnel to determine whether reasonable accommodations are feasible.

8.D ***Voluntary Agreement Not a "Restriction."*** A Practitioner's voluntary agreement to conditions similar to those set forth in **Appendix F** ("Examples of Conditions of Continued Practice") generally does not result in a "restriction" of that Practitioner's privileges. Accordingly, such a voluntary agreement generally does not require a report to the National Practitioner Data Bank ("NPDB") or to any state licensing board or other government agency, nor would it entitle a Practitioner to a hearing under the Professional Staff Credentials Policy. However, the Leadership Council will assess each situation independently. If there is concern in a given situation that a condition may be reportable to the NPDB or a state licensing board

or agency, the Leadership Council will consult with Hospital counsel and communicate with the Practitioner about the matter.

9. ADDITIONAL REQUIREMENTS AND GENERAL PRINCIPLES GOVERNING THE HEALTH ISSUE REVIEW PROCESS

(a) The Appendices to this Policy contain: (1) additional requirements that expand upon specific steps outlined in this Policy; and (2) general principles that govern the implementation of this Policy.

(b) Each Appendix to this Policy is a binding and integral part of the Policy. The placement of a provision in an Appendix rather than in the body of the Policy is a drafting convention to facilitate comprehension of the primary PPE review process and has no effect on the validity or enforceability of any provision in an Appendix.

(c) A flowchart that outlines the review process described in this Policy is included as **Appendix H** to this Policy ("Flowchart of Review Process for Practitioner Health Issues").

Adopted by the Medical Executive Committee on _____, 2019.

Adopted by the Board on January 21, 2020.

APPENDICES

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APPENDIX A

EXAMPLES OF HEALTH ISSUES

Health Issues may include, but are not limited to, the following:

1. Substance or alcohol abuse;

2. Use of any medication, whether prescription or over-the-counter, that can affect alertness, judgment, or cognitive function (such as, but not limited to, the use of pain or anti-anxiety medication following surgery, and including medically prescribed marijuana);

3. Any temporary or ongoing mental health concern, including, but not limited to, bipolar disorders or disorders caused by a major family event (e.g., death of spouse or child, divorce) or a major job-related event (e.g., death or significant injury to patient);

4. Carotid, vertebral, or other brain artery surgery or intervention;

5. Chemotherapy with a drug known to effect neurotoxicity (brain) or to have cardiac or neurotoxicity (peripheral nerves);

6. Radiation therapy to head;

7. Medical condition (e.g., stroke or Parkinson's disease), injury, or surgery resulting in temporary or permanent loss of fine motor control or sensory loss;

8. Shoulder surgery, brachial plexus surgery, hand or carpal tunnel surgery for a surgeon;

9. A back injury impacting ability to stand in the OR or other procedure lab;

10. Major surgery;

11. Infectious/contagious disease that could compromise patient safety or jeopardize other health care workers; and

12. Any form of diagnosed dementia (e.g., Alzheimer's disease, Lewy body dementia), or other cognitive impairment.

APPENDIX B

RESPONSE TO INDIVIDUAL WHO REPORTED CONCERNS

The Professional Staff Office, CMO or VPMA should follow up with individuals who file a report regarding a Health Issue by:

1. Thanking them for reporting the matter and participating in the Hospital's culture of safety and quality care;

2. Informing them that:

    (a) The matter will be reviewed in accordance with this Policy and that they may be contacted for additional information;

    (b) Due to confidentiality requirements under state law, it is important that they maintain confidentiality and only discuss the matter with individuals who are a formal part of the review process and not with colleagues or co-workers;

    (c) Due to these same confidentiality requirements, the Hospital is not permitted to disclose the outcome of the review to them, but they can be assured that a thorough review will be conducted; and

    (d) No retaliation is permitted against any individual who raises a concern and they should immediately report any retaliation or any other incidents of inappropriate conduct.

A sample ***Response to Reported Concerns*** is included in the ***Practitioner Health Policy Manual*** and can be used as a script for a verbal discussion with the individual who reported the concern or sent as a letter.

APPENDIX C

CONFIDENTIAL HEALTH FILES/REAPPOINTMENT PROCESS

1. ***Creation of Confidential Health File.*** Reports of potential Health Issues and documentation received or created pursuant to this Policy shall be included in the Practitioner's Confidential Health File, which shall be maintained by the Professional Staff Office as a separate file and shall not be included in the credentials file or the quality file.

2. ***Information Reviewed at Reappointment.***

   (a) The information reviewed by those involved in the reappointment process will not routinely include all the documentation in a Practitioner's Confidential Health File. Instead, the process set forth in this subsection will be followed.

   (b) When a reappointment application is received from an individual who has a Health Issue that is currently being reviewed or monitored by the Leadership Council, or that has been reviewed and resolved in the past reappointment cycle, the Professional Staff Office shall contact the Leadership Council.

   (c) The Leadership Council will prepare a Confidential Summary Health Report to the Credentials Committee. The Summary Health Report shall be included in the credentials file, and will be reviewed by the Credentials Committee only after the Credentials Committee has determined that the applicant is otherwise qualified for clinical privileges.

   (d) The Leadership Council's Summary Health Report will state that it is actively monitoring, or has monitored in the past reappointment cycle, a Health Issue involving the Practitioner. It will not contain details or specifics regarding the Health Issue. The Summary Health Report will also include a recommendation regarding the Practitioner's ability to perform the duties of Professional Staff membership and safely exercise clinical privileges. A ***Sample Summary Health Report*** is included in the ***Practitioner Health Policy Manual***.

   (e) If the Credentials Committee, Medical Executive Committee, or Board of Trustees, or any of their members, has any questions about the Summary Health Report or the Practitioner's ability to safely practice, a representative of the committee or Board will either discuss the issue with a member of the Leadership Council or attend a meeting of the Leadership Council to discuss the issue. If the committee, Board or relevant individual still believes additional information is necessary, they may review the Practitioner's Confidential Health File in the Professional Staff Office.

APPENDIX D

AUTOMATIC RELINQUISHMENT/RESIGNATION FOR REFUSAL TO PROVIDE INFORMATION OR MEET WITH THE LEADERSHIP COUNCIL

1. If a Practitioner refuses to undergo testing or an assessment when there are immediate concerns about patient safety as described in Section 3, the refusal will result in the immediate and automatic relinquishment of the Practitioner's clinical privileges pending the Leadership Council's review of the matter.

2. If a Practitioner fails or refuses to:

   (a) obtain a health assessment or provide the results to the Leadership Council;

   (b) provide other information requested by the Leadership Council; or

   (c) meet with the Leadership Council or other specified individuals when requested to do so in accordance with this Policy,

   the Practitioner will be required to meet with the Leadership Council to discuss why the health assessment was not obtained, the requested information (including the results of a health assessment) was not provided, or the meeting was not attended. Failure of the Practitioner to either:

   (i) meet with the Leadership Council and persuade it that the health assessment, requested information or meeting is not necessary; or

   (ii) provide the requested information prior to the date of the Leadership Council meeting,

   will result in the automatic relinquishment of the Practitioner's clinical privileges until the Practitioner either provides the requested information or attends the original meeting as requested.

3. If the Practitioner fails to meet with or provide information requested by the Leadership Council within thirty (30) days of the automatic relinquishment, the Practitioner's Professional Staff membership and clinical privileges will be deemed to have been automatically resigned.

4. Generally, the automatic relinquishment or resignation of appointment and/or clinical privileges described in this Appendix are administrative actions that occur by operation of this Policy. They are not professional review actions that must be reported to the NPDB or to any state licensing board or agency, nor do they entitle the Practitioner to a hearing or appeal.

5. Notwithstanding the foregoing, if the Leadership Council or Medical Executive Committee determines that a Practitioner's refusal to provide information or attend a meeting is a deliberate attempt to avoid review of a Health Issue, the Practitioner's action may be viewed as a resignation to avoid an investigation, and is thus reportable to the NPDB and a state licensing board or agency. Hospital counsel shall be consulted in making such determinations.

APPENDIX E

EMPLOYED PRACTITIONER TRIAGE PROCESS

If the Practitioner involved is an Employed Practitioner (as defined in the ***Professional Staff Glossary***), Professional Staff Leaders will consult with appropriate representatives of the Employer (as defined below) and then determine which of the following two processes will be used for the review:

1. If the matter will be reviewed using the Professional Staff process as set forth in the Practitioner Health Policy, an appropriate representative of the Employer will be invited to attend relevant portions of committee meetings involving the Practitioner, as well as participate in any interventions that may be necessary following the review. The chair of the Leadership Council may recuse the representative of the Employer during any deliberations or vote on a matter. Documentation from the Professional Staff process should not be maintained in the employment or personnel file of the Practitioner, but rather in the Practitioner's peer review-protected file at the Hospital or at the Employer; or

2. If the matter will be reviewed by the Employer pursuant to its policies and/or the relevant contract:

    (a) The Professional Staff process shall be held in temporary abeyance and the Leadership Council notified;

    (b) The Professional Staff Office will assist the Employer with witness interviews, document review, data compilation, and similar fact-finding. Documentation of such fact-finding will be maintained in the Practitioner's confidential Professional Staff peer review/quality file consistent with the state peer review statute, but the Employer will be permitted access to such documentation as needed to fulfill its operational and legal responsibilities;

    (c) The Leadership Council will be kept informed of the progress and outcome of the review by the Employer; and

    (d) The Leadership Council may choose, at any time and in its sole discretion, that the matter shall also be reviewed pursuant to the Practitioner Health Policy. However, neither such a review by the Leadership Council nor any other provision of the Practitioner Health Policy shall be interpreted to affect the right of the Employer to take any action authorized by the relevant contract with the Practitioner.

3. For purposes of this Section, an "appropriate representative of the Employer" includes TMC Healthcare representatives with employment responsibilities if TMC Healthcare is the Employer or a peer review committee within the Employer (if the Employer is a qualifying private entity).

An ***Employed Practitioner Routing Form*** that may be used to document the decision as to which review process to use is included in the ***Practitioner Health Policy Manual***.

APPENDIX F

EXAMPLES OF CONDITIONS OF CONTINUED PRACTICE

As set forth in Section 8 of the Practitioner Health Policy, the Leadership Council may ask the Practitioner to agree to comply with certain conditions to receive clearance to apply for reinstatement of privileges from a leave of absence or to otherwise resume practicing. By way of example and not of limitation, such conditions may include:

1. ***Coverage.*** The Practitioner may be asked to identify at least one Practitioner who is informed of the Health Issue and is willing to assume responsibility for the care of his or her patients in the event of the Practitioner's inability or unavailability.

2. ***Changes in Practice.*** The Practitioner may be asked to make certain changes to his or her practice, such as changing the frequency and/or schedule with which the Practitioner takes call, limiting inpatient census to a manageable number, or beginning elective procedures prior to a certain time of day.

3. ***Ongoing Monitoring.*** The Practitioner's exercise of clinical privileges may be monitored. The monitor shall be appointed by the Leadership Council. The nature of the monitoring shall be determined by the Leadership Council.

4. ***Periodic Reports of Health Status.*** If the Practitioner is continuing to receive medical treatment or to participate in a substance abuse rehabilitation or after-care program, the Leadership Council may ask the Practitioner to agree to submit periodic reports from his or her treating physician or the substance abuse rehabilitation/after-care program. If applicable, reports regarding compliance with the conditions outlined in an agreement with the Arizona Physician's Health Program may also be obtained. The nature and frequency of these reports will be determined on a case-by-case basis depending on the Health Issue.

5. ***Random Alcohol or Drug Screens.*** A Practitioner who has undergone treatment for substance abuse may be asked to submit to random alcohol or drug screening tests at the request of any member of the Leadership Council.

APPENDIX G

OTHER PROVISIONS THAT GOVERN THE HEALTH ISSUE REVIEW PROCESS

This Appendix contains various other provisions that govern aspects of the professionalism review process. Specifically, this Appendix contains guidance regarding the following matters:

1	Confidentiality Requirements
2	Health Issues Identified During Credentialing Process
3	Immediate Referrals to Medical Executive Committee
4	No Legal Counsel or Recordings During Collegial Meetings
5	Identity of Individual(s) Who Report a Health Issue
6	Supervising Physicians and Advanced Practice Professionals
7	Peer Review Protection
8	Required Reporting; Contact with Law Enforcement Authorities or Governmental Agencies
9	Redisclosure of Drug/Alcohol Treatment Information
10	Requests for Information Concerning Practitioner with a Health Issue
11	Educational Materials

1. ***Confidentiality Requirements.*** Maintaining confidentiality is a fundamental and essential element of an effective professional practice evaluation process.

   (a) ***Documentation.*** All documentation that is prepared in accordance with the ***Practitioner Health Policy*** shall be maintained in appropriate Professional Staff files. This documentation shall be accessible to Hospital personnel and Professional Staff Leaders and committees having responsibility for credentialing and professional practice evaluation functions, and to those assisting them in those tasks. All such information shall otherwise be deemed confidential and kept from disclosure or discovery to the fullest extent permitted by Arizona and federal law.

   (b) ***Participants in the Review Process.*** All individuals involved in the review process (Professional Staff and Hospital employees) will maintain the confidentiality of the process. All such individuals shall sign an appropriate Confidentiality Agreement (sample agreements are included in the ***Practitioner Health Policy Manual***). Violations of this provision by Practitioners will be reviewed under the Professional Staff Professionalism Policy. Violations by Hospital employees will be referred to human resources.

2. ***Health Issues Identified During Credentialing Process.*** A Health Issue that is identified during the credentialing process shall be addressed pursuant to the Professional Staff Credentials Policy. If a determination is made that the Practitioner is qualified for appointment and privileges, but has a Health Issue that should be monitored or treated, the matter shall be referred to the Leadership Council for ongoing monitoring or oversight of treatment pursuant to the Practitioner Health Policy.

3. ***Immediate Referrals to Medical Executive Committee.*** Nothing in this Policy precludes immediate referral to the Medical Executive Committee or the elimination of any particular step in the Policy if necessary, to address a situation that may compromise patient care and safety. Similarly, nothing in this Policy precludes referral of a matter to the Medical Executive Committee if a Practitioner fails to abide by the Practitioner Health Policy or any agreement reached with the Leadership Council (for example, conditions of continued practice).

4. ***No Legal Counsel or Recordings During Collegial Meetings.***

   (a) To promote the collegial and educational objectives of this Policy, all discussions and meetings with a Practitioner shall generally involve only the Practitioner and the appropriate Professional Staff Leaders and Hospital personnel. No counsel representing the Practitioner or the Professional Staff or the Hospital shall attend any of these meetings. In their discretion, Professional Staff Leaders may permit a Practitioner to invite another Practitioner to the meeting. In such case, the invited Practitioner may not participate in the discussion or in any way serve as an advocate for the Practitioner under review, must sign a Confidentiality Agreement, and may be required to leave the meeting at any time.

   (b) No recording (audio or video) of a meeting shall be permitted or made. In their discretion, Professional Staff Leaders may require that smart phones, iPads, and similar devices be left outside the meeting room.

5. ***Identity of Individual(s) Who Report a Health Issue.***

   (a) ***General Rule.*** Since the Practitioner Health Policy does not involve disciplinary action or "restrictions" of privileges, the specific identity of the individual reporting a concern or otherwise providing information about a matter (the "reporter") generally will not be disclosed to the Practitioner.

   (b) ***Exceptions.***

      (i) ***Consent.*** The Leadership Council may, in its discretion, disclose the identity of the reporter to the Practitioner if the reporter specifically consents to the disclosure (with the reporter being reassured that he or she will be protected from retaliation).

(ii) ***Professional Staff Hearing.*** The identity of the reporter shall be disclosed to the Practitioner if information provided by the reporter is used to support an adverse professional review action that results in a Professional Staff hearing.

(c) ***Practitioner Guessing the Identity of Reporter.*** This section does not prohibit the Leadership Council from notifying a Practitioner about a Health Issue concern that has been raised even if the description of the concern would allow the Practitioner to guess the identity of the reporter (e.g., where the reporter and the Practitioner were the only two people present when an incident occurred). In such case, the Leadership Council will not confirm the identity of the reporter, and will pay particular attention to reminding the Practitioner to avoid any action that could be perceived as retaliation.

6. ***Supervising Physicians and Advanced Practice Professionals.*** An appropriate supervising or collaborating physician shall be kept apprised of any concerns that are reviewed pursuant to this Policy involving an Advanced Practice Professional with which the physician has a supervisory or collaborative relationship. Without limiting the foregoing, the supervising or collaborating physician will be copied on all correspondence that an Advanced Practice Professional is sent under the PPE Policy and may be invited to participate in any meetings or interventions. The supervising or collaborating physician shall maintain in a confidential manner all information related to reviews under this Policy.

7. ***Peer Review Protection.*** All minutes, reports, recommendations, communications, and actions made or taken pursuant to the Practitioner Health Policy are intended to be covered by the provisions of the Health Care Quality Improvement Act of 1986, 42 U.S.C.A. 11101 et seq., and Arizona laws governing peer review. Furthermore, the committees or individuals charged with making reports, findings, recommendations or investigations pursuant to the Practitioner Health Policy shall be considered to be acting on behalf of the Hospital and the Board of Trustees when engaged in such professional review activities and thus are "professional review bodies" as that term is defined in the Health Care Quality Improvement Act.

8. ***Required Reporting; Contact with Law Enforcement Authorities or Governmental Agencies.*** The Hospital Chief Executive Officer ("CEO") shall file reports with the appropriate Arizona licensing board or the NPDB, as may be required by applicable statutes or regulations. In addition, if at any time it becomes apparent that a particular matter cannot be handled internally, or jeopardizes the safety of the Practitioner or others, the CEO, CMO, VPMA, Chief of Staff, or the Hospital's counsel may contact law enforcement authorities or other governmental agencies.

9. ***Redisclosure of Drug/Alcohol Treatment Information.*** In the course of addressing a Health Issue pursuant to the Practitioner Health Policy, the Hospital may receive written or verbal information about the treatment of a Practitioner from a federally assisted drug or alcohol abuse program as defined by 42 C.F.R. Part 2. The Hospital may not redisclose such information without a signed authorization from the Practitioner. An ***Authorization***

for Redisclosure of Drug/Alcohol Treatment Information that may be used for this purpose is included in the ***Practitioner Health Policy Manual***.

10. ***Requests for Information Concerning Practitioner with a Health Issue.*** All reference requests or other requests for information concerning a Practitioner with a Health Issue shall be forwarded to the CMO, VPMA, Chief of Staff, or CEO for response.

11. ***Educational Materials.*** The Leadership Council shall recommend to the Medical Executive Committee educational materials that address Practitioner Health Issues and emphasize prevention, identification, diagnosis, and treatment of Health Issues. This Policy and any educational materials approved by the Medical Executive Committee shall be made available to Practitioners and Hospital personnel. In addition, the Medical Executive Committee shall periodically include information regarding illness and impairment recognition issues in CME activities.

APPENDIX H

Flowchart of Review Process for Practitioner Health Issues

TUCSON MEDICAL CENTER

MEDICAL STAFF PROFESSIONALISM POLICY

Approved by the Board: January 21, 2020

MEDICAL STAFF
PROFESSIONALISM POLICY

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MEDICAL STAFF
PROFESSIONALISM POLICY

1. POLICY, DEFINITIONS, AND DELEGATION OF FUNCTIONS

1.A. ***Policy.*** Collegiality, collaboration and professionalism are essential for the provision of safe and competent patient care. Accordingly, all Practitioners at Tucson Medical Center (the "Hospital") must treat others with respect, courtesy, and dignity, and must conduct themselves in a professional and cooperative manner.

1.B Definitions of Unprofessional Conduct, Identity-Based Harassment, and Other Terms.

(1) Unprofessional Conduct is conduct that is inconsistent with the ethical obligations of health care professionals or that adversely affects the health care team's ability to work effectively. Unprofessional Conduct includes behavior that has a negative effect on morale, concentration, collaboration, and communication and includes Identity-Based Harassment. Definitions and examples of Unprofessional Conduct and Identity-Based Harassment are included in **Appendix A** to this Policy ("Definitions of Unprofessional Conduct and Identity-Based Harassment").

(2) Definitions of other capitalized terms used in this Policy are set forth in the ***Medical Staff Glossary***.

1.C ***Delegation of Functions.*** When a function under the PPE Policy is to be carried out by a member of the Administrative Team, by a Medical Staff Member, or by a Medical Staff committee, the individual, or the committee through its chair, may delegate performance of the function to a qualified designee who is a Practitioner or Hospital employee (or a committee of such individuals). Any such designee must treat and maintain all information in a strictly confidential manner and is bound by all other terms, conditions, and requirements of the PPE Policy. In addition, the delegating individual or committee is responsible for ensuring that the designee appropriately performs the function in question. Any documentation created by the designee are records of the committee that is ultimately responsible for the review in a particular matter.

2. REPORTS OF UNPROFESSIONAL CONDUCT

2.A Reports.

(1) Hospital employees or Practitioners who observe, or are subjected to, Unprofessional Conduct by a Practitioner shall report the incident in a timely manner by submitting a completed Professional Conduct Reporting

Form to the Medical Staff Office or through some other approved Hospital reporting mechanism. A ***Professional Conduct Reporting Form*** is included in the ***Professionalism Policy Manual***.

(2) Any individual receiving such a report will forward it to the Medical Staff Office, which will log the report in a confidential peer review database.

(3) The Medical Staff Office shall work with the relevant Department Chair or Section Chief to conduct an initial assessment and triage of the reported concern.

(4) Unless the initial assessment indicates that Unprofessional Conduct did not occur, the Medical Staff Office will forward reports to the Chief of Staff and to the Chief Medical Officer ("CMO") or Vice President Medical Affairs ("VPMA"). Reports shall also be forwarded to the Chief Nursing Officer if helpful to addressing the issue.

2.B ***Follow-up with Individual Who Filed Report.*** The Medical Staff Office, CMO or VPMA shall follow up with individuals who file a report. Guidance for such follow-up communication is included in **Appendix B** to this Policy ("Response to Individual Who Reported Concerns").

3. INFORMAL RESOLUTION OF MINOR CONCERNS

3.A ***Criteria for Informal Resolution.*** A matter that has been reported for review under this Policy and that has not been dismissed pursuant to the triage process described in Section 2.A(4) may be resolved informally, without the need for further review by the Leadership Council, if the Chief of Staff, along with the CMO or VPMA, determine that: (1) the reported concern is minor in nature; and
(2) there is no history or pattern with the Practitioner in question.

3.B ***Procedure for Informal Resolution.*** For matters that qualify for informal resolution, the Chief of Staff, CMO or VPMA will speak with the Practitioner about the reported concern and either:

(1) dismiss the matter altogether (if the behavior does not appear to constitute Unprofessional Conduct as defined in this Policy after discussions with the Practitioner); or

(2) make the Practitioner aware of the concern and counsel the Practitioner. In these situations, the individual performing the counseling may follow up with a brief note to the Practitioner memorializing the conversation.

An ***Informal Resolution Documentation Form*** that may be used to document these informal resolutions is included in the ***Professionalism Policy Manual***.

3.C ***Delegation and Reports***. As set forth in Section 1.C ("Delegation of Functions"), the Chief of Staff, CMO or VPMA may direct that the functions described in this Section 3 be performed by a designee such as a Department Chair, Section Chief, Medical Director, Nurse Director, Nurse Manager, or other qualified individual. When such delegation occurs:

(1) the Chief of Staff, CMO or VPMA shall notify the Medical Staff Office that the function has been delegated to another individual;

(2) the individual who has been delegated authority to perform the function shall report to the Medical Staff Office information necessary to allow the Medical Staff Office to track the process, such as the name of the Practitioner involved, the manner in which the matter was informally resolved, and the date it was resolved; and

(3) the individual who performed the function shall notify the individual who delegated the task when it has been completed.

3.D ***Reports to Leadership Council.*** The Medical Staff Office will provide to the Leadership Council periodic reports of matters that have been informally resolved under this section to allow for oversight of the process and consistency.

4. PROCEDURE WHEN CONCERNS ARE MORE SIGNIFICANT OR A PATTERN HAS DEVELOPED

The steps set forth below apply to reported concerns about behavior that involve: (1) more serious allegations; or (2) a pattern of behavior.

4.A ***Employed Practitioner Triage Process.*** If the report involves an Employed Practitioner, Medical Staff Leaders will consult with appropriate representatives of the Employer and then determine whether the matter will be reviewed pursuant to this Policy or pursuant to the policies of the Employer. See **Appendix C** to this Policy ("Employed Practitioner Triage Process") for additional information regarding this triage process. Also, an ***Employed Practitioner Routing Form*** that may be used to document these decisions is included in the ***Professionalism Policy Manual***.

4.B ***Preliminary Notification to Practitioner.*** For reviews conducted under this Policy, the Chief of Staff, CMO, or VPMA should notify the Practitioner that a concern has been raised and that the matter is being reviewed. Generally, this preliminary communication should occur via a brief telephone call or a personal discussion as soon as practical. The Practitioner should be notified that he or she will be invited to provide input regarding the matter if the facts underlying the incident are determined to be credible, but that he or she is also free to submit input at any time. The Practitioner should also be reminded to avoid any action

that could be perceived as retaliation (including any attempt to discuss the matter with an individual who the Practitioner believes may have raised the concern or provided information about it). ***Instructions for Providing a Preliminary Notification*** and a ***Form*** that may be used to document the preliminary notification are included in the ***Professionalism Policy Manual***.

4.C ***Fact-Finding.*** The Medical Staff Office, Chief of Staff, CMO, and/or VPMA shall interview witnesses or others who were involved in the incident and gather any other necessary documentation or information (e.g., interviews with core leaders or nurse/area leaders) needed to assess the reported concern. An ***Interview Tool: Script, Questions and Guidance*** that may be used for such interviews is included in the ***Professionalism Policy Manual***.

4.D Determination by Chief of Staff and CMO/VPMA.

(1) ***Report Not Credible, No Further Action Required.*** Following the interviews and fact-finding, the Chief of Staff, acting with the CMO or VPMA, may determine that a reported concern is not credible or does not raise issues that need to be addressed pursuant to this Policy. In either case, the matter will be closed, and the Practitioner and Leadership Council will be notified of this determination.

(2) ***Report Credible, Further Review Required.*** The Chief of Staff, acting with the CMO or VPMA, may determine that a matter is credible and should be reviewed further in accordance with this Policy. In such case, input will be obtained from the Practitioner as set forth in **Appendix D** ("Obtaining Input from the Practitioner") and the matter shall be referred to the Leadership Council. The Medical Staff Office shall prepare a summary report of the matter for review by the Leadership Council and provide the Leadership Council with all supporting documentation.

5. LEADERSHIP COUNCIL PROCEDURE

5.A ***Initial Review.*** The Leadership Council shall review the summary prepared by the Medical Staff Office and all supporting documentation, including the response from the Practitioner. If necessary, the Leadership Council may also meet with the individual who submitted the report and/or any witnesses to the incident.

5.B ***Meeting Between Practitioner and Leadership Council.*** A meeting may be held between the Practitioner and the Leadership Council to discuss the circumstances further and obtain more facts if either the Leadership Council or the Practitioner believes that such a meeting would be helpful prior to the Leadership Council concluding its review and making a determination. The ***Professionalism Policy Manual*** contains an ***Interview Tool: Script, Questions and Guidance*** that may be used for a meeting with the Practitioner. In its discretion, the Leadership

Council may designate one or more committee members to attend the meeting rather than the full committee, regardless of who requested the meeting. The Leadership Council may also obtain additional written input from the Practitioner using the process set forth in **Appendix D** to this Policy ("Obtaining Input from the Practitioner").

5.C ***Refusal to Provide Information or Meet with Leadership Council.*** A Practitioner who refuses to provide information or meet with the Leadership Council will be deemed to have automatically relinquished his or her clinical privileges as set forth in **Appendix E** to this Policy ("Automatic Relinquishment for Refusal to Provide Information or Meet with Leadership Council").

5.D Leadership Council Determination and/or Intervention.

(1) ***Options.*** After its review of all relevant information, including input from the Practitioner, the Leadership Council may:

(a) determine that no further review or action is required;

(b) send the Practitioner an Educational Letter, providing guidance and counsel;

(c) engage in a formal Collegial Intervention with the Practitioner and provide education and coaching (a ***Collegial Intervention Checklist*** and ***Follow-Up Letter to Collegial Intervention*** may be found in the ***Professionalism Policy Manual***);

(d) develop a Performance Improvement Plan for Conduct ("PIP"), as described in **Appendix F** to this Policy ("Performance Improvement Plans for Conduct"); or

(e) refer the matter to the Medical Executive Committee.

(2) ***Voluntary Nature of PIPs.*** If a Practitioner agrees to participate in a PIP developed by the Leadership Council, such agreement will be documented in writing. If a Practitioner disagrees with the need for a PIP developed by the Leadership Council, the Practitioner is under no obligation to participate in the PIP. In such case, the Leadership Council cannot compel the Practitioner to agree with the PIP. Instead, the Leadership Council will refer the matter to the Medical Executive Committee for its independent review and action pursuant to the Medical Staff Credentials Policy.

(3) ***Leadership Council Review Not an Investigation.*** A review conducted by the Leadership Council or by any individual pursuant to this Policy shall not constitute an investigation. As set forth in the Medical Staff

Credentials Policy, only the Medical Executive Committee has the authority to commence an investigation.

5.E ***Additional Reports of Unprofessional Conduct.*** If additional reports of Unprofessional Conduct are received concerning a Practitioner, the Leadership Council may continue to use the collegial and progressive steps outlined in this Policy as long as it believes that there is a reasonable likelihood that those efforts will resolve the concerns.

5.F ***Determination to Address Concerns through Practitioner Health Policy.*** The Leadership Council may determine to address the conduct concerns through the Practitioner Health Policy if it believes that there may be a legitimate, underlying health issue that is causing the concerns and the review process outlined in the Practitioner Health Policy is more likely to resolve the concerns.

6. REFERRAL TO THE MEDICAL EXECUTIVE COMMITTEE

6.A ***Referral to the Medical Executive Committee.*** At any point, the Leadership Council may refer the matter to the Medical Executive Committee for review and action because:

(1) the Practitioner refuses to participate in a Performance Improvement Plan developed by the Leadership Council;

(2) the Performance Improvement Plan options for conduct were unsuccessful; or

(3) the Leadership Council otherwise determines that Medical Executive Committee review is required.

The Medical Executive Committee shall be fully apprised of the actions taken previously by the Leadership Council to address the concerns. When it makes such a referral, the Leadership Council may also suggest a recommended course of action.

6.B ***Medical Executive Committee Review.*** The Medical Executive Committee shall review the matter and take appropriate action in accordance with the Medical Staff Credentials Policy. These actions include, but are not limited to, Collegial Intervention efforts, development of a Performance Improvement Plan, commencement of an investigation, a short-term suspension, a long-term suspension, and/or a recommendation to revoke appointment and clinical privileges, subject to any procedural rights as set forth in the Medical Staff Credentials Policy.

7. REVIEW OF REPORTS OF IDENTITY-BASED HARASSMENT

7.A ***Definition.*** A detailed definition of Identity-Based Harassment is included in **Appendix A** ("Definitions of Unprofessional Conduct and Identity-Based Harassment").

7.B ***Review Process for Identity-Based Harassment Concerns and Agreements to Voluntarily Refrain from Clinical Activities During Review.*** All reports of potential Identity-Based Harassment will be reviewed by the Leadership Council in the same manner as set forth above. In addition, while a Practitioner may be asked to voluntarily refrain from exercising clinical privilege pending the review of any behavioral matter under this Policy if appropriate, particular attention will be paid to whether it is necessary to utilize such a temporizing safeguard while an allegation of Identity-Based Harassment is being reviewed.

7.C ***Personal Meeting and Letter of Admonition and Warning.*** Because of the unique legal implications surrounding Identity-Based Harassment, a single confirmed incident requires the actions set forth in this section. Two or more members of the Leadership Council shall personally meet with the Practitioner to discuss the incident. If the Practitioner acknowledges the seriousness of the matter and agrees that there will be no repeat of such conduct, the meeting shall be followed with a formal letter of admonition and warning to be placed in the Practitioner's confidential file. This letter shall also set forth any additional actions or conditions imposed on the Practitioner's continued practice in the Hospital as a result of the meeting.

7.D ***Performance Improvement Plan.*** In addition to the letter of admonition and warning, concerns about Identity-Based Harassment may also be addressed by a Performance Improvement Plan for conduct as described in this Policy.

7.E ***Referral to Medical Executive Committee.*** The matter shall be immediately referred to the Medical Executive Committee if:

(1) the Practitioner refuses to acknowledge the concern, does not recognize the seriousness of it, or will not agree that there will be no repeat of such conduct; or

(2) there are confirmed reports of retaliation or further incidents of Identity-Based Harassment, after the Practitioner agreed there would be no further improper conduct.

The Medical Executive Committee shall conduct its review in accordance with the Medical Staff Credentials Policy. Such referral shall not preclude other action under applicable Human Resources policies.

8. ADDITIONAL REQUIREMENTS AND GENERAL PRINCIPLES GOVERNING THE PROFESSIONALISM REVIEW PROCESS

(a) The Appendices to this Policy contain: (1) additional requirements that expand upon specific steps outlined in this Policy; and (2) general principles that govern the implementation of this Policy.

(b) Each Appendix to this Policy is a binding and integral part of the Policy. The placement of a provision in an Appendix rather than in the body of the Policy is a drafting convention to facilitate comprehension of the primary PPE review process and has no effect on the validity or enforceability of any provision in an Appendix.

(c) A flowchart that outlines the review process described in this Policy is included as **Appendix H** to this Policy ("Flowchart of Review Process for Concerns Regarding Professional Conduct").

Adopted by the Medical Executive Committee:_____, 2019.

Adopted by the Board on January 21, 2020.

APPENDICES

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APPENDIX A

DEFINITIONS OF UNPROFESSIONAL CONDUCT AND IDENTITY-BASED HARASSMENT

1. ***Unprofessional Conduct.*** Unprofessional Conduct is conduct that is inconsistent with the ethical obligations of health care professionals or that adversely affects the health care team's ability to work effectively. Unprofessional Conduct includes behavior that has a negative effect on morale, concentration, collaboration, and communication.

   (a) To aid in both the education of Practitioners and the enforcement of this Policy, examples of "Unprofessional Conduct" include, but are not limited to:

      (1) abusive or threatening language directed at patients, nurses, students, volunteers, visitors, Hospital personnel, or Practitioners (e.g., belittling, berating, and/or non-constructive criticism that intimidates, undermines confidence, or implies stupidity or incompetence);

      (2) degrading, demeaning, or condescending comments regarding patients, families, nurses, Practitioners, Hospital personnel, or the Hospital;

      (3) refusal or failure to answer questions, or return phone calls or pages in a timely manner as defined in the Medical Staff Credentials Policy documents or other applicable policies;

      (4) intentional misrepresentation to Hospital administration, Medical Staff Leaders, other Practitioners, or their representatives, in an attempt to gain a personal benefit or to avoid responsibility for an action taken;

      (5) offensive language (which may include profanity or similar language) while in the Hospital and/or while speaking with patients, nurses, or other Hospital personnel;

      (6) retaliating against any individual who may have reported a quality and/or behavior concern about a Practitioner, provided information related to such a matter, or otherwise been involved in the professional practice evaluation/peer review process in any way (this means a Practitioner may not, under any circumstances, discuss the matter with any such individual, nor may the Practitioner engage in any other retaliatory or abusive conduct such as confronting, ostracizing, or discriminating against such individual);

      (7) unprofessional physical contact with another individual or other aggressive behavior that is threatening or intimidating;

(8) throwing an object of any kind, including but not limited to any medical/surgical instrument or supply;

(9) repeatedly failing to maintain and renew in a timely manner all credentials required by the Medical Staff Credentials Policy;

(10) derogatory comments about the quality of care being provided by the Hospital, another Practitioner, or any other individual outside of appropriate Medical Staff and/or Hospital administrative channels;

(11) unprofessional medical record entries impugning the quality of care being provided by the Hospital, Practitioners, or any other individual, or criticizing the Hospital or the Hospital's policies or processes, or accreditation and regulatory requirements;

(12) imposing idiosyncratic requirements on Hospital staff that have no impact on improved patient care, but serve only to burden the Hospital or Hospital employees with "special" techniques and procedures;

(13) altering or falsifying any medical record entry or hospital document (including, but not limited to, incorrectly dating or timing an entry or document to give the impression it was completed prior to when it was actually completed);

(14) completing medical record entries based on a template without considering the care actually provided to the patient, or using the "copy and paste" or "pull forward" functions of the medical record to populate fields without verifying that the information is accurate for the patient in question;

(15) refusal or failure to use or use properly documentation technology (e.g., CPOE, EHR, and other approved technology);

(16) unprofessional access, use, disclosure, or release of confidential patient information;

(17) audio, video, or digital recording that is not consented to by others present, including patients and other members of the care team;

(18) use of social media in a manner that involves Unprofessional Conduct as defined in this Policy or other Medical Staff or Hospital policies;

(19) disruption of hospital operations, hospital or Medical Staff committees, or departmental affairs;

(20) refusal to abide by Medical Staff requirements as delineated in this Policy, the Medical Staff Credentials Policy, Rules and Regulations, or other Medical Staff policies (including, but not limited to, emergency call issues, response times, medical recordkeeping, other patient care responsibilities, failure to participate on assigned committees, failure to cooperate with utilization oversight activities, and an unwillingness to work cooperatively and harmoniously with other members of the Medical Staff and Hospital employees); and/or

(21) engaging in Identity-Based Harassment as described in Section 2 of this Appendix.

(b) This Policy is not intended to interfere with a Practitioner's ability to express, in a professional manner and in an appropriate forum:

(1) opinions on any topic that are contrary to opinions held by other Practitioners, Medical Staff Leaders, or the Hospital Administrative Team;

(2) disagreement with any Medical Staff or Hospital Bylaws, policies, procedures, proposals, or decisions; or

(3) constructive criticism of the care provided by any Practitioner, nurse, or other Hospital personnel.

2 Identity-Based Harassment.

(a) Identity-Based Harassment is verbal or physical conduct that:

(1) is unwelcome and offensive to an individual who is subjected to it or who witnesses it;

(2) could be considered harassment from the objective standpoint of a "reasonable person"; and

(3) is covered by state or federal laws governing discrimination. Identity- based harassment includes, but is not limited to, sexual harassment and racial, ethnic, or religious discrimination.

(b) Depending on the circumstances, any of the examples of Unprofessional Conduct described in this Policy may also qualify as Identity-Based Harassment. Additional examples of Identity-Based Harassment include, but are not limited to, the following:

(1) ***Verbal:*** innuendoes, epithets, derogatory slurs, off-color jokes, propositions, graphic commentaries, threats, and suggestive or insulting sounds;

(2) ***Visual/Non-Verbal:*** derogatory posters, cartoons, or drawings; suggestive objects or pictures; leering; and obscene gestures;

(3) ***Physical:*** unwanted physical contact, including touching, interference with an individual's normal work movement, and assault;

(4) ***Quid Pro Quo:*** suggesting that submission to an unwelcome sexual advance will lead to a positive employment action or avoid a negative employment action; and

(5) ***Retaliation:*** retaliating or threatening retaliation as a result of an individual's complaint regarding harassment.

(c) Tests and standards used by courts to determine if conduct violates federal or state law (e.g., Title VII of the Civil Rights Act) are not dispositive in determining whether conduct is "Unprofessional Conduct" for purposes of this Policy. Instead, the standard set forth in this section shall govern, as interpreted by the Leadership Council, Medical Executive Committee, and/or Board of Directors. The intent of this provision is to create higher expectations for professional behavior than the minimum required by federal and state law.

APPENDIX B

RESPONSE TO INDIVIDUAL WHO REPORTED CONCERNS

The Medical Staff Office, CMO or VPMA should follow up with individuals who file a report regarding a professionalism issue by:

(1) Thanking them for reporting the matter and participating in the Hospital's culture of safety and quality care; and

(2) Informing them that:

(a) The matter will be reviewed in accordance with the Professionalism Policy and that they may be contacted for additional information;

(b) Due to confidentiality requirements under state law, it is important that they maintain confidentiality and only discuss the matter with individuals who are a formal part of the review process and not with colleagues or coworkers;

(c) Due to these same confidentiality requirements, the Hospital is not permitted to disclose the outcome of the review to them, but they can be assured that a thorough review will be conducted; and

(d) No retaliation is permitted against any individual who raises a concern and they should immediately report any retaliation or any other incidents of inappropriate conduct.

A sample ***Response to Reported Concerns*** is included in the ***Professionalism Policy Manual*** and can be used as a script for a verbal discussion with the individual who reported the concern or sent as a letter.

APPENDIX C

EMPLOYED PRACTITIONER TRIAGE PROCESS

If the Practitioner involved is an Employed Practitioner (as defined in the ***Medical Staff Glossary***), Medical Staff Leaders will consult with appropriate representatives of the Employer and then determine which of the following two processes will be used for the review.

(1) If the matter will be reviewed using the Medical Staff process as set forth in the Professionalism Policy, an appropriate representative of the Employer (as defined below) will be invited to attend relevant portions of committee meetings involving the Practitioner, as well as participate in any interventions that may be necessary following the review. The chair of the Leadership Council may recuse the representative of the Employer during any deliberations or vote on a matter. Documentation from the Medical Staff process should not be maintained in the employment or personnel file of the Practitioner, but rather in the Practitioner's peer review-protected file at the Hospital or at the Employer; or

(2) If the matter will be reviewed by the Employer pursuant to its policies and/or the relevant contract:

(a) The Medical Staff process shall be held in temporary abeyance and the Leadership Council notified;

(b) The Medical Staff Office will assist the Employer with witness interviews, document review, data compilation, and similar fact-finding. Documentation of such fact-finding will be maintained in the Practitioner's confidential Medical Staff peer review/quality file consistent with the state peer review statute, but the Employer will be permitted access to such documentation as needed to fulfill its operational and legal responsibilities;

(c) The Leadership Council will be kept informed of the progress and outcome of the review by the Employer; and

(d) The Leadership Council may choose, at any time and in its sole discretion, that the matter shall also be reviewed pursuant to the Professionalism Policy (regardless of the outcome reached by the Employer). However, neither such a review by the Leadership Council nor any other provision of this Policy shall be interpreted to affect the right of the Employer to take any action authorized by the relevant contract with the Practitioner.

(3) For purposes of this Section, an "appropriate representative of the Employer" includes TMC Healthcare representatives with employment responsibilities if TMC Healthcare is the Employer or a peer review committee within the Employer (if the Employer is a qualifying private entity).

An ***Employed Practitioner Routing Form*** that may be used to document the decision as to which review process to use is included in the ***Professionalism Policy Manual***.

APPENDIX D

OBTAINING INPUT FROM THE PRACTITIONER

(1) ***General.*** When input is to be obtained under this Policy, the Chief of Staff, CMO, VPMA, or Leadership Council will provide details of the concern (but not a copy of the report) to the Practitioner and ask the Practitioner to provide a written explanation of what occurred and his or her perspective on the incident. The ***Professionalism Policy Manual*** includes a sample ***Letter to the Practitioner Requesting Input*** which may be used for this purpose.

(2) Identity of Reporter.

(a) ***General Rule.*** Since the Professionalism Policy does not involve disciplinary action or "restrictions" of privileges, the specific identity of the individual reporting a concern or otherwise providing information about a matter (the "reporter") generally will not be disclosed to the Practitioner.

(b) Exceptions.

(1) ***Consent.*** The Leadership Council may, in its discretion, disclose the identity of the reporter to the Practitioner if the reporter specifically consents to the disclosure (with the reporter being reassured that he or she will be protected from retaliation).

(2) ***Medical Staff Hearing.*** The identity of the reporter shall be disclosed to the Practitioner if information provided by the reporter is used to support an adverse professional review action that results in a Medical Staff hearing.

(c) ***Practitioner Guessing the Identity of Reporter.*** This Policy does not prohibit notification to a Practitioner about a concern that has been raised even if the description of the concern would allow the Practitioner to guess the identity of the reporter (e.g., where the reporter and the Practitioner were the only two people present when an incident occurred). In such case, the identity of the reporter will not be confirmed and those involved in the review will pay particular attention to reminding the Practitioner to avoid any action that could be perceived as retaliation.

(3) Reminder of Practitioner's Obligations. The Chief of Staff, CMO, VPMA, or Leadership Council will remind the Practitioner of the obligations set forth in this Policy (such as confidentiality and non-retaliation) as part of seeking his or her input. The sample ***Letter to the Practitioner Requesting Input*** in the ***Professionalism Policy Manual*** addresses these issues. If concerns about confidentiality and non-retaliation are more significant, the Practitioner may be required to sign a ***Confidentiality and***

Non-Retaliation Agreement (a copy of which is included in the ***Professionalism Policy Manual***) prior to providing detailed information regarding the concern to the Practitioner.

(4) ***Discussions Outside Committee Meetings.*** Practitioners and individual members of the Leadership Council should not engage in separate discussions of a matter unless the Leadership Council has asked the individual committee member to speak with the Practitioner on its behalf. Similarly, unless formally requested to do so, Practitioners may not provide verbal input to a member of the Medical Staff Office or to any other individual and ask him or her to relay that verbal input to the Leadership Council. The goal of this requirement is to ensure that all individuals and committees involved in the review process receive the same, accurate information.

APPENDIX E

AUTOMATIC RELINQUISHMENT FOR REFUSAL TO PROVIDE INFORMATION OR MEET WITH LEADERSHIP COUNCIL

(1) ***Failure to Provide Written Input.*** If the Practitioner fails or refuses to provide written input in response to a request for information sent by the Leadership Council, the Practitioner will be required to meet with the Leadership Council. The purpose of the meeting is to discuss the Practitioner's obligation to participate in the review process, permit the Practitioner to explain why the information was not provided, and inform the Practitioner of the consequences of continuing to not provide the information. Failure of the Practitioner to either:

(a) meet with the Leadership Council and persuade it that the requested information is not necessary; or

(b) provide the requested written information prior to the meeting

will result in the automatic relinquishment of the Practitioner's clinical privileges. Such automatic relinquishment will continue until the Practitioner either meets with the Leadership Council and persuades it that the written information is not necessary or provides the requested written information. Any member of the Leadership Council may determine that written information provided by the Practitioner is responsive to the Leadership Council's request and that automatic relinquishment will therefore not occur (or that such relinquishment will end if it has already commenced).

(2) ***Failure to Attend Meeting.*** If the Leadership Council requests that the Practitioner attend a meeting with it or a designated individual for any reason (e.g., to obtain the Practitioner's verbal input, participate in a Collegial Intervention, etc.) and the Practitioner fails or refuses to attend such a meeting, the Practitioner's clinical privileges will be automatically relinquished until the meeting occurs.

(3) ***When Temporary Automatic Relinquishment Becomes Automatic Resignation from Staff.*** If the Practitioner fails to meet with the Leadership Council or provide requested input within thirty (30) days of the automatic relinquishment, the Practitioner's Medical Staff membership and clinical privileges will be deemed to have been automatically resigned.

(4) ***Extensions for Good Cause***. Automatic relinquishment or resignation as described in this Appendix will not occur if the Practitioner's failure to provide written input or meet with the Leadership Council is due to the Practitioner's absence (e.g., a planned vacation, attendance at a conference, etc.), illness, family emergency or other cause beyond the Practitioner's control. In such case, the Leadership Council will establish reasonable deadlines depending on the circumstances.

(5) ***Automatic Relinquishment and Automatic Resignation Not Reportable.*** The automatic relinquishment or resignation of appointment and/or clinical privileges described in this Appendix are administrative actions that occur by operation of this Policy. They are not professional review actions that must be reported to the National Practitioner Data Bank or to any state licensing board or agency, nor do they entitle the Practitioner to a hearing or appeal.

APPENDIX F

PERFORMANCE IMPROVEMENT PLANS FOR CONDUCT

(1) ***General.*** The Leadership Council may determine it is necessary to develop a Performance Improvement Plan ("PIP") for the Practitioner. One or more members of the Leadership Council should personally discuss the PIP with the Practitioner to help ensure a shared and clear understanding of the elements of the PIP. The PIP will also be presented in writing, with a copy being placed in the Practitioner's file, along with any statement the Practitioner would like to offer.

(2) ***PIP Options.*** A PIP for conduct may include, but is not limited to, one or more of the actions in this Appendix. None of these actions entitles the Practitioner to a hearing or appeal as described in the Medical Staff Credentials Policy, nor do they require that reports be made to any state licensing board or the National Practitioner Data Bank. The ***Professionalism Manual Policy*** includes a ***Performance Improvement Plan Options for Conduct – Implementation Issues Checklist*** that may be used to assist with implementation of the following PIP options.

(a) ***Meeting with Designated Group.*** The Practitioner may be required to meet with a designated group (including the PPC, another Medical Staff committee, or an ad hoc group) to discuss the concerns with the Practitioner's conduct and the need to modify the conduct. An ad hoc group may include any combination of current or past Medical Staff Leaders, Hospital leaders, outside consultants, and/or the Board Chair or other Board members if the Leadership Council determines that Board member involvement is reasonably likely to impress upon the Practitioner involved the seriousness of the matter and the necessity for the Practitioner's conduct to improve. A letter outlining the discussion and expectations for conduct shall be sent to the Practitioner after the meeting;

(b) ***Periodic Meetings with Medical Staff Leaders or Mentors.*** The Practitioner may be required to meet periodically with one or more Medical Staff Leaders or a mentor designated by the Leadership Council. The purpose of these meetings is to provide input and updates on the Practitioner's performance, as well as to offer assistance and support with any challenging issues the Practitioner may be encountering;

(c) ***Review of Literature Concerning the Connection Between Behavior and Patient Safety.*** The Leadership Council may require the Practitioner to review selected literature concerning the established connection between behavior and patient care and safety and then provide a report to the Leadership Council summarizing the information reviewed and how it can be applied to the individual's practice;

(d) ***Behavior Modification Course.*** The Leadership Council may require the Practitioner to complete a behavior modification course that is acceptable to the Leadership Council; and/or

(e) ***Personal Code of Conduct.*** The Leadership Council may develop a "personal" code of conduct for the Practitioner, make continued appointment and clinical privileges contingent on the Practitioner's adherence to it, and outline the specific consequences of the Practitioner's failure to abide by it; and/or

(f) ***Other.*** Elements not specifically listed above may be included in a PIP. The Leadership Council has wide latitude to tailor PIPs to the specific concerns identified, always with the objective of helping the Practitioner to improve his or her performance and to protect patients and staff.

APPENDIX G

OTHER PROVISIONS THAT GOVERN THE PROFESSIONALISM REVIEW PROCESS

This Appendix contains various other provisions that govern aspects of the professionalism review process. Specifically, this Appendix contains guidance regarding the following matters:

1	Confidentiality Requirements
2	Immediate Referrals to Medical Executive Committee
3	Coordination with Other Policies That Govern Professional Conduct
4	No Legal Counsel or Recordings During Collegial Meetings
5	Education Regarding Appropriate Professional Behavior
6	Letters Placed in Practitioner's Confidential File
7	When Both Clinical and Behavioral Concerns Are at Issue
8	Supervising Physicians and Advanced Practice Professionals

1. ***Confidentiality Requirements.*** Maintaining confidentiality is a fundamental and essential element of an effective professional practice evaluation process.

   (a) ***Documentation.*** All documentation that is prepared in accordance with this Policy shall be maintained in appropriate Medical Staff files. This documentation shall be accessible to Hospital personnel and Medical Staff Leaders and committees having responsibility for credentialing and professional practice evaluation functions, and to those assisting them in those tasks. All such information shall otherwise be deemed confidential and kept from disclosure or discovery to the fullest extent permitted by Arizona and federal law.

   (b) ***Participants in the Review Process.*** All individuals involved in the review process (Medical Staff and Hospital employees) will maintain the confidentiality of the process. All such individuals shall sign an appropriate Confidentiality Agreement (sample ***Confidentiality Agreements*** are included in the ***Professionalism Policy Manual***). Violations of this provision by Practitioners will be reviewed under the Professionalism Policy. Violations by Hospital employees will be referred to human resources.

   (c) ***Practitioner Under Review.*** The Practitioner under review must maintain all information related to the review in a strictly confidential manner, as required by Arizona law. The Practitioner may not disclose information to, or discuss it with, anyone outside of the review process set forth in the Professionalism Policy without first obtaining the permission of the Leadership Council, except for any

legal counsel who may be advising the Practitioner. Violations of this provision will be reviewed under the Professionalism Policy.

2. ***Immediate Referrals to Medical Executive Committee.*** The Professionalism Policy outlines collegial and progressive steps (e.g., counseling, warnings, meetings, and behavior modification education) that can be taken to address concerns about Unprofessional Conduct by Practitioners. However, a single incident of Unprofessional Conduct or a pattern of Unprofessional Conduct may be of such concern that more significant action is required. Therefore, nothing in the Professionalism Policy precludes an immediate referral of a matter being addressed through the Policy to the Medical Executive Committee or the elimination of any particular step in the Policy.

3. ***Coordination with Other Policies That Govern Professional Conduct.*** If a report of unprofessional behavior involves an issue that is also governed by another Hospital policy that governs professional conduct (including, but not limited to, alleged violations of the Hospital's HIPAA or corporate compliance policies by a Practitioner), the Chief of Staff, CMO or VPMA will notify the person or committee responsible for that other policy of the substance of the report. Efforts will be made to coordinate the review that occurs under this Policy with the review under such other policy. For example, individuals responsible for such other policies (such as the Hospital's HIPAA Privacy Officer or Corporate Compliance Officer) may be invited to take part in the witness interviews described in the Professionalism Policy or may discuss the matter with the Leadership Council or its representatives.

4. ***No Legal Counsel or Recordings During Collegial Meetings.***

(a) To promote the collegial and educational objectives of the Professionalism Policy, all discussions and meetings with a Practitioner shall generally involve only the Practitioner and the appropriate Medical Staff Leaders and Hospital personnel. No counsel representing the Practitioner or the Professional Staff or the Hospital shall attend any of these meetings. In their discretion, Medical Staff Leaders may permit a Practitioner to invite another Practitioner to the meeting. In such case, the invited Practitioner may not participate in the discussion or in any way serve as an advocate for the Practitioner under review, must sign a Confidentiality Agreement, and may be required to leave the meeting at any time.

(b) No recording (audio or video) of a meeting shall be permitted or made. In their discretion, Medical Staff Leaders may require that smart phones, iPads, and similar devices be left outside the meeting room.

5. ***Education Regarding Appropriate Professional Behavior.*** Medical Staff and Hospital leaders shall educate all Practitioners regarding appropriate professional behavior, make employees and other personnel aware of this Policy, and shall encourage the prompt reporting of Unprofessional Conduct.

6. ***Letters Placed in Practitioner's Confidential File.*** Copies of letters sent to the Practitioner as part of the efforts to address the Practitioner's conduct shall be placed in the Practitioner's confidential file. The Practitioner shall be given an opportunity to respond in writing, and the Practitioner's response shall also be kept in the Practitioner's confidential file.

7. ***When Both Clinical and Behavioral Concerns Are at Issue.*** If a matter involves both clinical and behavioral concerns, the Chairs of the Leadership Council and PPC shall coordinate the reviews. The behavioral concerns may either be:

   (a) addressed by the Leadership Council pursuant to the Professionalism Policy, with a report to the PPC; or

   (b) addressed by the PPC as part of its review under the Professional Practice Evaluation Policy, using the provisions in this Policy for guidance.

8. ***Supervising Physicians and Advanced Practice Professionals.*** An appropriate supervising or collaborating physician shall be kept apprised of any concerns that are reviewed pursuant to this Policy involving an Advanced Practice Professional with which the physician has a supervisory or collaborative relationship. Without limiting the foregoing, the supervising or collaborating physician will be copied on all correspondence that an Advanced Practice Professional is sent under the PPE Policy and may be invited to participate in any meetings or interventions. The supervising or collaborating physician shall maintain in a confidential manner all information related to reviews under this Policy.

APPENDIX H

FLOWCHART OF REVIEW PROCESS FOR CONCERNS REGARDING PROFESSIONAL CONDUCT

TUCSON MEDICAL CENTER

PROFESSIONALISM POLICY MANUAL

This Professionalism Policy Manual may be used to assist with implementation of the Medical Staff Professionalism Policy. Documents in this Manual should be tailored, as needed, to reflect the unique circumstances of a particular review.

While the documents in this Manual are intended as helpful guidance, there is no requirement that they be used. Failure to use any specific document will not affect the validity of a review.

Approved by the Board: January 21, 2020

PROFESSIONALISM POLICY MANUAL

TABLE OF CONTENTS

PROFESSIONAL CONDUCT REPORTING FORM

For Use by Employees and Practitioners

Instructions: Please use this form to report all incidents of unprofessional conduct and unprofessional behavior. Attach additional sheets if necessary. Please provide the following information as ***specifically*** and as ***objectively*** as possible and submit the completed form to the Hospital Medical Staff Office.

DATE, TIME, AND LOCATION OF INCIDENT		
Date of incident:	Time of incident:	a.m. p.m.
Location of incident:		
Range of dates if your concerns are not limited to one particular event: _____/_____/20_____ to _____/_____/20_____		
PRACTITIONER INFORMATION		
Name of Practitioner exhibiting unprofessional professional conduct: _____		
PATIENT INFORMATION		
Was a patient directly or indirectly involved in the event?	**Yes** ❑ **No** ❑	Medical Record # _____
Patient's Last Name: _____	Patient's First Name: _____	
DESCRIPTION OF INCIDENT		
Describe what happened as *specifically* and *objectively* as possible [attach additional pages if necessary]: _____ _____ _____		
OTHER INDIVIDUALS INVOLVED/WITNESSES		
Name(s) of other Practitioner(s) and/or Hospital employee(s) who witnessed this event: _____ _____ _____ _____		
Name(s) of any other person(s) who were involved in or witnessed this event (e.g., visitors; family members, representatives): _____ _____ _____ _____		

EFFECT OF CONDUCT		
How do you think this behavior affected patient care, Hospital operations, your work, or your team members' work? _____ _____ _____		
	Yes	**No**
Did you experience or witness any retaliation or threatened retaliation by the Practitioner?	❑	❑
If yes, please explain: _____ _____ _____		
RESPONSE TO CONDUCT	**Yes**	**No**
Are you aware of any attempts that were made to address this behavior with the Practitioner when it occurred?	❑	❑
If yes, please explain and indicate by whom: _____ _____ _____		

CONTACT INFORMATION	
Your name:	Department:
Phone #:	Date this form completed:
E-mail address:	

Note: Your report will be treated with the utmost confidentiality. Your identity will not be disclosed to the subject of the report unless: (a) you consent; or (b) information provided by you is later used to support an adverse professional review action that results in a Medical Staff hearing (which is an extremely rare occurrence). In any event, as part of our culture of safety and quality care, no retaliation is permitted against you for reporting this matter. This means that the Practitioner at issue may not approach you directly to discuss this matter or engage in any abusive or unprofessional conduct directed at you. If you believe that you have been subjected to any retaliation as a result of raising these concerns, please report that immediately to your supervisor, the Chief of Staff, or another Medical Staff leader.

RESPONSE TO INDIVIDUAL WHO REPORTED CONCERNS*

Dear _____:

Thank you for reporting your concerns. We appreciate your participation in our efforts to promote and maintain a culture of safety and quality care at our Hospital.

Your concerns will be reviewed in accordance with the Medical Staff Professionalism Policy or other applicable policy. We will contact you if we need additional information.

Because your report may involve confidential matters under Arizona law, it is important that you maintain confidentiality and only discuss this matter with individuals who are a formal part of the review process and not with colleagues or co-workers. Due to these same confidentiality requirements, we may not be permitted to inform you of the specific outcome of the review. However, please be assured that your report will be fully reviewed and appropriate steps will be taken to address the matter.

Your report will be treated with the utmost confidentiality. Your identity will not be disclosed to the subject of the report unless:

(a) you consent; or

(b) information provided by you is later used to support an adverse professional review action that results in a Medical Staff hearing (which is an extremely rare occurrence).

In any event, as part of our culture of safety and quality care, no retaliation is permitted against you for reporting this matter. This means that the individual who is the subject of your report may not approach you directly to discuss this matter or engage in any abusive or unprofessional conduct directed at you. If you believe that you have been subjected to any retaliation as a result of raising these concerns, please report it immediately to your supervisor, any Medical Staff Officer, the CMO or the VPMA.

Once again, thank you for bringing your concerns to our attention. If you have any questions or wish to discuss this matter further, please do not hesitate to call me at _____.

Sincerely,

Medical Staff Office Representative, CMO or VPMA

* ***As an alternative to sending a letter or e-mail, the content of this letter may be used as talking points to respond verbally to the individual who reported a concern regarding conduct.***

INFORMAL RESOLUTION OF MINOR CONCERNS DOCUMENTATION FORM

CONFIDENTIAL PEER REVIEW DOCUMENT

This form may be used to document when informal resolution is used to address minor concerns pursuant to Section 3 of the Professionalism Policy.

Practitioner under review: _____

Department: _____

1. The initial triage decision was that (please ***check only one***):

   ❑ ***Additional fact-finding*** was needed to determine if the reported concern was credible and further action was necessary. Preliminary notification will be provided to the Practitioner that a concern has been raised (see **Section 4.B** of Professionalism Policy) and additional fact-finding will occur (see **Section 4.C** of the Professionalism Policy).

   ❑ ***Informal resolution was appropriate*** because the allegations as reported, even if true, did not rise to the level that further review under this Policy was necessary because: (1) the concern was minor in nature; and (2) there was no history or pattern with the Practitioner in question.

2. ***If informal resolution was selected:***

   (a) The matter was discussed with the Practitioner.

   Date of conversation: _____

   (b) The following decision was made (please ***check only one***):

   ❑ The matter was ***dismissed*** because, based on input provided by the Practitioner during the conversation and other available information, the concern was not credible or the behavior did not appear to be Unprofessional Conduct under the Policy; or

   ❑ The Practitioner was made aware of the concern raised and was ***counseled***.

   (c) ***If the Practitioner was counseled***, the matter was documented as follows:

   ❑ A brief note was sent to the Practitioner and included in the Practitioner's file; and/or

❑ The following comments made to the Practitioner provide additional documentation and should be included in the Practitioner's file:

_____

_____

_____

_____

_____
Names and titles of individuals participating in informal resolution

_____
Signature of individual completing form

_____
Date

EMPLOYED PRACTITIONER ROUTING FORM

***Note**: The purpose of this form is to document which of the following two review processes will be used when a behavioral concern is raised about a Practitioner who is employed by an "Employer" as that term is defined in the Professionalism Policy: (1) the Medical Staff process as set forth in this Professionalism Policy; or (2) the policies or employment contract of the Employer. See Section 4.A of the Professionalism Policy for additional information and requirements.*

Name of Practitioner: _____

Entity that Employs the Practitioner: _____

Representative(s) of Employing Entity involved in routing discussion: _____

_____

Medical Staff Leader(s) involved in routing discussion: _____

_____

A decision was made that:

- ☐ The process outlined in the ***Medical Staff Professionalism Policy*** will be used to review the behavioral concern, with input and participation by the Employer.
- ☐ ***The Employer's policies and/or employment contract*** will be used to review the behavioral concern.

Comments: _____

_____

_____

_____

Signature of individual completing form

_____

Date

PRELIMINARY NOTIFICATION TO PRACTITIONER WHEN CONCERNS ARE MORE SIGNIFICANT OR A PATTERN HAS DEVELOPED
(Instructions and Script)

I. PREPARATION PRIOR TO CONVERSATION BY INDIVIDUAL PROVIDING PRELIMINARY NOTIFICATION

1. Review Section 4.B of the Professionalism Policy (dealing with preliminary notification to the Practitioner).

2. Decide whether to provide preliminary notification in person (preferred) or over the telephone. *E-mail is strongly discouraged*.

3. If the Chief of Staff, CMO or VPMA is not able to provide preliminary notification in a timely manner, the Professionalism Policy permits delegation of this function to a qualified designee.

4. Be cognizant that no information should be provided to the Practitioner during the discussion that would identify anyone who filed the complaint or provided information about the matter.

5. Be prepared to document any information the Practitioner provides about the incident in question on the Preliminary Notification Form, which is to be completed as soon as the notification is provided.

6. Review and revise, as necessary, the general script for the conversation, which follows.

II. GENERAL SCRIPT FOR CONVERSATION WITH PRACTITIONER

1. Notify the Practitioner that a concern about professionalism has been raised and that the purpose of this conversation is to provide a **BRIEF PRELIMINARY** notification to the Practitioner, in accordance with the Professionalism Policy.

2. Inform the Practitioner that the matter is being reviewed and summarize how the review process works/next steps. Offer to provide the Practitioner with a copy of the Professionalism Policy.

3. Explain that the Practitioner will be given details of the concern and asked to provide his or her perspective on the incident prior to the Leadership Council taking any further action. However, the Practitioner is also free to submit input at any time, if the Practitioner would like to do so.

4. Remind the Practitioner to avoid any action that could be perceived as **RETALIATION**. This includes speaking with anyone who the Practitioner

believes may have raised the concern or provided information about the matter, because even well-intentioned conversations can be perceived as intimidating.

5. Remind the Practitioner of the crucial importance of **CONFIDENTIALITY** to avoid waiving the protections offered by the state peer review protection law.

After the conversation, complete the Preliminary Notification Form that is set forth on the next page and include it in the Practitioner's Confidential File.

PRELIMINARY NOTIFICATION FORM WHEN CONCERNS ARE MORE SIGNIFICANT OR A PATTERN HAS DEVELOPED
(Form for Documentation)

(to be completed by individual providing preliminary notification)

Practitioner: _____

Department: _____

Date of Conversation: _____

Approximate Time of Conversation: _____

Did this conversation occur in person or via telephone call?	❑ In person	❑ Telephone
Was the script outlined in the "Instruction" form substantially followed during the discussion?	❑ Yes	❑ No
Was the Practitioner advised not to retaliate?	❑ Yes	❑ No
Was the Practitioner advised of confidentiality requirements?	❑ Yes	❑ No

Additional comments/summary of any information provided by the Practitioner:

_____

_____

_____

_____

_____
Name and Title

_____
Signature

INTERVIEW TOOL:
SCRIPT, QUESTIONS AND GUIDANCE

I. SCRIPT FOR INTRODUCTORY STATEMENTS

Instructions: Prior to the interview, the following information should be provided to each individual who is interviewed.

1. A concern about a Practitioner's behavior is being reviewed under the Hospital's Professionalism Policy. We would like to speak with you because you *[raised the concern]* **or** *[may have relevant information]*.

2. Any information you provide will be treated with the utmost confidentiality. It will not be shared with anyone outside the Hospital's peer review process. Also, Hospital policy states that your identity will generally not be disclosed to the Practitioner whose behavior is being reviewed except in extremely rare situations (for example, a Medical Staff hearing).

3. As part of our culture of safety and quality care, no retaliation is permitted against you for *[reporting this matter]* **or** *[providing information about this matter]*. This means that the Practitioner under review may not approach you to discuss this matter or engage in any abusive or unprofessional conduct directed at you. If you believe you have been retaliated against, please report immediately to your supervisor or any Medical Staff Leader.

4. The Arizona peer review protection law requires the Hospital to maintain any information related to this review in a ***strictly confidential*** manner, so we may not be able to inform you of the outcome of the review. However, if you have any questions about this review process following the interview, please direct them to the Chief of Staff, CMO, VPMA or Medical Staff Office.

II. SAMPLE INTERVIEW QUESTIONS

Note: The following questions are intended to elicit basic information about an incident. These questions may be modified as appropriate, and should be supplemented with additional questions that specifically pertain to the incident being reviewed.

1. What was the date of the incident?

2. What time did the incident occur?

3. Where did the incident occur?

4. What is the name of the Practitioner who behaved unprofessionally?

5. Who else was involved or witnessed this event? What are their titles and duties?

6. What happened? What did you see and hear?

7. Are you aware of any attempts that were made to address this behavior with the Practitioner when it occurred?

8. Are there any notes or other documentation regarding the incident(s)?

9. Was a patient or a patient's family member directly or indirectly involved in the event? If so, name and medical record number.

10. Did you tell anyone about the incident?

    a. Whom did you tell?

    b. When and where did you tell them?

    c. What did you tell them?

11. How did you react to this incident at the time?

12. Did you experience or witness any retaliation or threatened retaliation by the Practitioner?

13. How do you think this incident affected patient care generally, Hospital operations, the work of your team, or your ability to do your job?

14. Have other incidents occurred, either before or after this incident? ***[If yes, repeat above questions for each incident.]***

15. How would you like to see the situation resolved?

16. Do you have any other information we should know about this matter? Please contact me if you recall or learn something new after we are finished talking.

COVER LETTER TO PRACTITIONER SEEKING INPUT

VIA HAND DELIVERY

[Date]

[Name]
[Address]

Re: Information Related to Behavioral Concerns

Dear _____:

As you know from our recent conversation, concerns have been raised about your professional conduct at Tucson Medical Center (the "Hospital"). As part of the review process, the Leadership Council would like you to be fully aware of the relevant issues and have an opportunity to respond to them. *Accordingly, enclosed is information that summarizes the concerns that have been raised. [**Alternatively**: Accordingly, the following is a summary of the concerns that have been raised as well as several questions relating to these circumstances (list specific questions, if any)]*: _____.

The Leadership Council would appreciate your perspective on these issues and any other information that you believe would be helpful to our review. Please provide your written response to me by _____ ***[date]***, so that it may be considered by the Leadership Council at its next meeting.

Your participation and input into these issues are essential as we attempt to achieve our goal of having a timely, fair, and constructive review process. ***Please recognize that if you do not respond to this request for written input prior to the date set forth above, a process will commence (as set forth in the Professionalism Policy) that will result in the automatic relinquishment of your clinical privileges until the information is provided***. We trust this will not occur, and look forward to your good faith participation in the review.

Once the Leadership Council reviews your written input, it will decide whether it believes a meeting with you would be helpful to discuss this matter further. If so, we will contact you to arrange a meeting. If the Leadership Council believes a meeting is not necessary but you would nonetheless like to meet with the Council, you are welcome to meet with us at the next scheduled meeting of the Leadership Council.

Finally, the Leadership Council has an obligation to ensure that all peer review information such as this is maintained in a confidential manner. The Leadership Council also has an obligation to maintain a professional, non-threatening environment for all who work and practice at the

Hospital. Accordingly, as a courtesy, we wanted to remind you of the following obligations that apply to all Medical Staff members, as set forth in the Medical Staff Professionalism Policy:

(1) Like the Leadership Council, you must maintain all information related to this review in a strictly confidential manner, as required by Arizona law. Specifically, you may not disclose this information to, or discuss it with, anyone ***except*** the following individuals without first obtaining the written permission of the Hospital: (i) the Leadership Council or its designees, or (ii) any legal counsel who may be advising you.

(2) You may not retaliate against anyone who you believe may have raised a concern about you, provided information regarding this matter, or otherwise been involved in the review process. ***This means that you may not, under any circumstances, discuss this matter with any such individual, because even well-intentioned conversations can be perceived as intimidating. Nor may you engage in any other retaliatory or abusive conduct such as confronting, ostracizing, or discriminating against such individual.***

Please recognize that any retaliation by you, as described in the previous paragraph, is a very serious matter and will be grounds for referral for an independent review under the Medical Staff Professionalism Policy.

Thank you for your anticipated cooperation with our review process. We look forward to an expeditious and constructive resolution of this matter. Please don't hesitate to contact me if you have any questions.

Sincerely,

PPE Specialists, Chief of Staff, CMO or VPMA

Enclosure (if applicable)

CONFIDENTIALITY AND NON-RETALIATION AGREEMENT

Concerns have been raised about my professional conduct at Tucson Medical Center (the "Hospital"). As part of the review process, the Leadership Council would like me to be fully aware of the concerns. It would also like me to provide my perspective and any response I believe may be appropriate.

However, the Leadership Council also wants to take appropriate steps to maintain the confidentiality of the information under Arizona and federal law, as well as to ensure a professional, non-threatening environment for all who work and practice at the Hospital. Accordingly, I agree to the following:

1. I will maintain all information that I review in a ***strictly confidential*** manner. Specifically, I will not disclose or discuss this information ***except*** to the following individuals: (i) the Leadership Council or its designees; or (ii) any legal counsel who may be advising me. I will not share or discuss this information with any other individual without first obtaining the express written permission of the Leadership Council, CMO or VPMA.

2. I understand that this information is being provided to me as part of the Medical Staff's and Hospital's policy of attempting to utilize collegial intervention and progressive steps, where possible, to address any questions or concerns that may arise with my practice. In addition to discussing these matters directly with the Medical Staff and Hospital leadership, I understand that I may also prepare a written response and that this response will be maintained in my file.

3. I understand that the Hospital and the Medical Staff have a responsibility to provide a safe, non-threatening workplace for my physician colleagues and for Hospital employees. I therefore agree that:

   (a) ***I will <u>not discuss</u> the information that I review from my file with any individual who I believe may have provided the information*** because even well-intentioned conversations with such individuals can be perceived as intimidating. ***Accordingly, I understand that any such discussions will be viewed as retaliation and a violation of the Medical Staff Professionalism Policy.***

   (b) ***I will <u>not engage</u> in any other retaliatory or abusive conduct with respect to these individuals.*** This means that I will not confront, ostracize, discriminate against, or otherwise mistreat any such individual with respect to any information that the individual may have provided.

4. I understand that any retaliation by me, as described in the previous paragraph, is a very serious matter, constitutes unprofessional conduct, and cannot be tolerated. Any such conduct by me will represent independent grounds for review pursuant to the Medical Staff Professionalism Policy.

By signing this Agreement, I understand that I am ***not waiving*** any of the rights or privileges afforded me under the Medical Staff Bylaws and related documents. I also remain free to raise legitimate concerns regarding the care being provided, or the conduct being exhibited, by a nurse or other Hospital employee, another physician, or the Hospital itself. ***However, like everyone else, I must use the established and confidential Medical Staff and administrative channels in order to register any such concerns.*** These channels are part of the Hospital's ongoing performance improvement and peer review activities, and permit the appropriate Medical Staff or Hospital leadership to fully review and address the issue, as may be necessary.

_____ _____

_____, M.D./D.O. Date

Note: This form shall be retained in the Practitioner's confidential file. A copy shall be provided to the Practitioner for reference.

COLLEGIAL INTERVENTION CHECKLIST

This checklist is a tool to be used by physician leaders when planning, conducting, and following up on an effective collegial intervention. It is intended to be used after the following steps have been taken:

(1) The initial fact-finding regarding the question or concern has been completed;

(2) The Practitioner has been given an opportunity to provide input regarding the issue raised, in accordance with the procedure outlined in the Medical Staff Professionalism Policy; and

(3) The Medical Staff leaders have decided that a collegial intervention with the Practitioner is the appropriate intervention to address the issue, taking into account the severity of the incident, the Practitioner's history and personality, and all other relevant factors.

I. INITIAL CONSIDERATIONS

- ❑ Determine the participants to meet with the Practitioner.

  (Note: If the issue involves an Employed Practitioner as defined in Section 3 of the Professionalism Policy, consider including a representative of the employer.)

- ❑ Ask all participants to sign a Confidentiality Agreement if they have not done so within the past 12 months.

- ❑ Assemble necessary data/documentation (e.g., comparative quality data, relevant provisions of bylaws, rules and regulations, or policies, Practitioner's history).

- ❑ Schedule a pre-planning meeting with participants.

II. CONTENT OF THE DISCUSSION WITH THE PRACTITIONER, TO BE DEVELOPED IN ADVANCE OF MEETING

- ❑ Determine desired outcome/objective of the discussion.

- ❑ List talking points and which participant will discuss each point.

- ❑ Anticipate likely points or perspective that will be offered by the Practitioner and determine the response to each.

- ❑ Determine how the Practitioner's future practice/conduct will be monitored (e.g., through standard reported concerns process, OPPE reports, focused monitoring efforts such as periodic interviews with hospital personnel or chart review).

- ❑ Prepare draft of follow-up letter to be sent to the Practitioner after meeting. See additional guidance regarding content of letter in Section IV below. *(Generally, it is a best practice to prepare an initial draft of the letter in advance of the meeting since it aids in the preparation process. The letter is then revised, as necessary, following the meeting.)*

III. NOTICE OF MEETING PROVIDED TO PRACTITIONER

- ❑ Determine who will draft the notice letter.
- ❑ Determine who will sign the notice letter.
- ❑ Determine method of delivery. *(Hand delivery preferred.)*
- ❑ Include notice of date, time, and location of meeting.
- ❑ Include as necessary:
  - ❑ no attorneys allowed at meeting, as it is intended to be a collegial meeting between peers;
  - ❑ whether non-attorney colleague may accompany Practitioner to be an observer (and, if so, the colleague must sign a Confidentiality Agreement);
  - ❑ no audio or video recording allowed at meeting, due to confidential nature of the peer review process; and
  - ❑ whether failure of the Practitioner to appear will result in automatic relinquishment of privileges. *(Check applicable governing policy.)*

IV. FOLLOW-UP LETTER TO PRACTITIONER

- ❑ Determine who will draft the follow-up letter.
- ❑ Determine who will review/who will sign the follow-up letter.
- ❑ Determine method of delivery. *(Hand delivery preferred.)*
- ❑ Ensure letter has appropriate tone (professional and firm, yet encouraging and supportive; not emotional or threatening).
- ❑ Ensure letter includes the following:
  - ❑ summary of reason for meeting (i.e., nature of concern);
  - ❑ Practitioner's history of similar incidents, if applicable;

- ❑ summary of discussion;
- ❑ citation/quote of relevant bylaws or policy provisions, if applicable;
- ❑ expectations for Practitioner's future conduct/practice;
- ❑ consequences of failure to meet expectations (appropriate to include if there is a pattern of concerns, and it is required if the matter under review involves sexual harassment concerns);
- ❑ reiteration of how future conduct/practice will be monitored, if applicable;
- ❑ reminder that no retaliation is permitted toward anyone who may have raised a concern or participated in review, if applicable; and
- ❑ notice that Practitioner may provide response for inclusion in confidential file.

❑ Include a copy of follow-up letter in the Practitioner's confidential file.

❑ Share a copy of follow-up letter with the Practitioner's Department Chair.

FOLLOW-UP LETTER TO COLLEGIAL INTERVENTION

CONFIDENTIAL PEER REVIEW DOCUMENT

[Date]

[Name of Practitioner]
[Address]

Re: Follow-Up to Meeting

Dear _____:

Thank you for meeting today with *[_____], [_____],* and me. These meetings can be difficult for all of us and we very much appreciate your cooperation and your professionalism.

The purpose of this letter is to briefly follow up on our discussion regarding *[list issues discussed, e.g., "concerns that have been raised regarding your interactions with other Medical Staff members and Hospital employees" or "your pattern of failing to follow the protocols relating to diabetes care"].*

[Optional paragraph where more supportive approach is appropriate: *We first want to reiterate that we value your significant contributions to the Hospital. Our meeting was intended to be helpful and constructive. Its purpose was to collegially discuss our concerns, and have you work with us to modify your conduct/practice so that the issues can be successfully resolved.]*

[Optional paragraph where firmer approach is necessary: *As you know, the purpose of our meeting was to inform you of the Medical Staff leadership's serious concerns regarding _____. The Medical Staff leadership believes that these issues, which have developed into a pattern over time, have now escalated to a more serious level.]*

Insert paragraphs regarding the following, as applicable.

- *Summarize discussion of issues;*
- *Note the Practitioner's history of similar incidents, if applicable;*
- *Citation/quote of relevant bylaws or policy provisions, if applicable;*
- *Reiterate any action/changes in practice that may have been agreed to by Practitioner during the meeting (short of a formal Performance Improvement Plan);*
- *Outline the consequences of failing to meet expectations (appropriate to include if there is a pattern or concerns; required if the matter under review involves sexual harassment); and*
- *Reiterate how future conduct/practice will be monitored, if applicable.*

*[**Optional paragraph to address retaliation**: As we hope you understand, it is our responsibility to provide a safe, non-threatening workplace for Hospital employees and other Medical Staff members. Therefore, please avoid any action that could be perceived as retaliatory or threatening to anyone who you believe may have been involved in this matter. Specifically, it is essential that you not attempt to discuss this matter with any individual who you believe may have reported a concern, provided information, or participated in the review. Regardless of your intent, such conversations could be viewed as retaliatory by such individuals. Accordingly, any further discussions or additional information that you may have about the matters we discussed during our meeting must be directed to the Medical Staff leadership.]*

*[**Optional paragraph to counsel Practitioner to improve behavior:** Teamwork and open communications are essential to quality care. Accordingly, as a leader of the health care team, you must set the example by striving to maintain a professional demeanor at all times. This is not simply a question of avoiding hurt feelings. Instead, professionalism and respectful interactions are necessary to promote quality care. The Joint Commission, the courts, and articles throughout the medical literature all recognize that the best hospital care is provided by teams that work together in a collegial manner. The expectations for conduct in the Hospital are reflected in the Medical Staff Professionalism Policy, a copy of which is enclosed for your convenience.]*

We hope this letter is helpful to you. No response from you is required at this time.

Thank you again for your cooperation. Please let me know if we can provide any further assistance to you in addressing this matter.

Sincerely,

[Individual who participated in collegial intervention]

PERFORMANCE IMPROVEMENT PLAN OPTIONS FOR CONDUCT

IMPLEMENTATION ISSUES CHECKLIST

(For use by the Leadership Council and Medical Executive Committee)

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Note: The Implementation Issues Checklists in this Appendix may be used by the Leadership Council and Medical Executive Committee in developing and monitoring Performance Improvement Plans ("PIPs"). Checklists may be used individually or in combination with one another, depending on the nature of the PIP.

A copy of a completed Checklist may be provided to the Practitioner who is subject to the PIP, so that the Leadership Council/Medical Executive Committee and the Practitioner have a shared and clear understanding of the elements of the PIP.

While Checklists may serve as helpful guidance, there is no requirement that they be used. Failure to use a Checklist or to answer one or more questions on a Checklist will not affect the validity of a PIP. The committee conducting the review may opt to use the Checklist as a working document in developing a PIP and then discard the Checklist at any time.

PIP OPTION	IMPLEMENTATION ISSUES
Meeting with Designated Group	***Who Should Meet with Practitioner?*** ❑ Medical Staff committee: _____ ❑ Other designated ad hoc group (may include Board Chair or other Board members), including: _____ ❑ May Practitioner bring a colleague (<u>not</u> legal counsel) to the meeting? ❑ Yes ❑ No Is pre-meeting to plan intervention necessary? ❑ Yes ❑ No If yes, where and when: _____ _____ ***Scheduling Meeting with Practitioner*** ❑ Date of meeting: _____ ❑ Time of meeting: _____ ❑ Location of meeting: _____ ***Notice of Meeting*** ❑ Notice of meeting sent by: ❑ Chief of Staff ❑ CMO ❑ VPMA ❑ Hospital CEO ❑ Other: _____ ❑ Practitioner notified that this is a peer review meeting with colleagues, therefore: ❑ No attorneys allowed at the meeting ❑ No audio or video recording of meeting ❑ Does notice state that failure to appear results in automatic relinquishment of clinical privileges? ❑ Yes ❑ No ***Method of Delivery*** ❑ In person/hand-delivered (preferred) ❑ Certified mail, return receipt requested ❑ Other: _____ ***Documentation*** ❑ If not already provided, will documentation/substance of reports regarding unprofessional conduct be shared before or during meeting? ❑ Yes ❑ No ❑ If yes, has Practitioner been provided a cover letter or agreement explaining his/her obligation to maintain the confidentiality of the information and not to retaliate against any individual who may have reported? ❑ Yes ❑ No ***Follow-Up*** ❑ Monitor for additional incidents ❑ Through standard reported concerns process ❑ More focused (e.g., interviews with Hospital personnel or Medical Staff Leaders at regular intervals): _____

PIP OPTION	IMPLEMENTATION ISSUES
Behavior Modification Course	***Scope of Behavior Modification Course*** ❑ Acceptable programs include: _____ _____ ❑ Leadership Council or Medical Executive Committee approval required before Practitioner enrolls: ❑ Program approved: _____ ❑ Date of approval: _____ ❑ Who pays for the behavior modification course? ❑ Practitioner subject to PIP ❑ Medical Staff ❑ Hospital ❑ Combination _____ ❑ Time Frame ❑ Practitioner must enroll by: _____ Date ❑ Program must be completed by: _____ Date ***Practitioner's Responsibilities*** ❑ Sign release allowing Leadership Council or Medical Executive Committee to provide information to the behavior modification course (if necessary) and allowing the course to provide a report to Leadership Council or Medical Executive Committee _____ _____ ❑ Practitioner must submit ❑ Documentation of successful completion signed by course director ❑ Other: _____ _____ ***Follow-Up*** ❑ Monitor for additional incidents ❑ Through standard reported concerns process ❑ More focused (e.g., interviews with Hospital personnel or Medical Staff Leaders at regular intervals): _____

PIP OPTION	IMPLEMENTATION ISSUES
Personal Code of Conduct ***(Conditional Continued Appointment/ Conditional Reappointment)***	***Drafting/Contents of Personal Code of Conduct*** ❑ Who will draft the Personal Code of Conduct? ❑ Chief of Staff ❑ CMO ❑ VPMA ❑ Hospital CEO ❑ Legal Counsel ❑ Other: _____ ❑ Practitioner informed that he/she may provide response for inclusion in file. ❑ Copy of personal code of conduct included in Practitioner's credentials/ quality file. ❑ Is Practitioner required to agree in writing to abide by the personal code of conduct? ❑ Yes ❑ No If yes, written agreement to abide by personal code of conduct received on: _____ Date ❑ Does the personal code of conduct describe the following consequences of a confirmed violation? ❑ Yes ❑ No ***Consequence of first violation (e.g., final warning):*** _____ _____ ❑ Practitioner notified of possible violation on: _____ Date ❑ Practitioner provided opportunity for input on: _____ Date ❑ Violation confirmed on: _____ Date ***Consequence of second violation (e.g., short-term suspension):*** _____ ❑ Practitioner notified of possible violation on: _____ Date ❑ Practitioner provided opportunity for input on: _____ Date ❑ Violation confirmed on: _____ Date

PIP OPTION	IMPLEMENTATION ISSUES
Personal Code of Conduct ***(Conditional Continued Appointment/ Conditional Reappointment)*** ***(cont'd.)***	***Consequence of third violation (e.g., recommendation for disciplinary action, perhaps limited hearing):*** _____ _____ ❑ Practitioner notified of possible violation on: _____ Date ❑ Practitioner provided opportunity for input on: _____ Date ❑ Violation confirmed on: _____ Date ***Review/Signature*** ❑ Who must review and approve the letter outlining the personal code of conduct? ❑ Chief of Staff ❑ CMO ❑ VPMA ❑ Full Leadership Council ❑ MEC ❑ Other Individuals: _____ ❑ Who signs/sends the letter outlining the personal code of conduct? ❑ Chief of Staff ❑ CMO ❑ VPMA ❑ Hospital CEO ❑ Other: _____ ***Method of Delivery*** ❑ In person/hand-delivered (preferred) ❑ Certified mail, return receipt requested ❑ Other: _____ ***Follow-Up*** ❑ Monitor for additional incidents ❑ Through standard reported concerns process ❑ More focused (e.g., interviews with Hospital personnel or Medical Staff Leaders at regular intervals): _____

PIP OPTION	IMPLEMENTATION ISSUES
"Other" ***Wide latitude to utilize other ideas as part of PIP, tailored to specific concerns*** ***Examples:*** • ***Practitioner must have a chaperone;*** • ***Practitioner must attend CME for communication issues;*** • ***Practitioner must study and present grand rounds on behavior/ patient safety connection;*** • ***Practitioner required to apologize in writing (letter must be approved before it is sent) or in person accompanied by appropriate Medical Staff leader.***	

CONFIDENTIALITY AGREEMENT
MEDICAL STAFF LEADER

As a member of the Medical Staff who is involved in professional practice evaluation activities at Tucson Medical Center (the "Hospital"), I recognize that I will have access to sensitive and confidential credentialing and peer review information regarding other Practitioners on the Medical Staff.

I understand the vital importance of maintaining all such information, and any discussions and deliberations regarding it, in ***strict confidence***. I therefore agree to make no disclosure of this confidential information outside of appropriate meetings, except in the following very limited circumstances:

(1) when the disclosure is to another authorized member of the Medical Staff or authorized employee of the Hospital and is for the purpose of conducting legitimate Medical Staff affairs (any such disclosures shall be made only in a private setting); or

(2) when the disclosure has been authorized, in writing, by the Hospital Chief Executive Officer, Chief Medical Officer, Vice President Medical Affairs, or Chief of Staff.

I understand that my breach of this Agreement may not only compromise my own interests, but also the interests of the Hospital and my colleagues on the Medical Staff. Therefore, in the event of such a breach, I understand that my actions may result in:

(1) dismissal from a committee assignment and/or removal from participation in peer review activities;

(2) loss of available legal protections (including loss of indemnification for any litigation costs and expenses);

(3) disciplinary action as deemed appropriate by the Medical Executive Committee pursuant to the Medical Staff Bylaws; and/or

(4) other appropriate legal action.

_____
Signature

_____ _____
Date Printed Name

CONFIDENTIALITY AGREEMENT
HOSPITAL EMPLOYEE

As an employee of _____ (the "Hospital") who is involved in professional practice evaluation activities, I recognize that I will have access to sensitive and confidential credentialing and peer review information regarding Practitioners on the Medical Staff.

I understand the vital importance of maintaining all such information, and any discussions and deliberations regarding it, in ***strict confidence***. I therefore agree to make no disclosure of this confidential information outside of appropriate meetings, except in the following very limited circumstances:

(1) when the disclosure is to an authorized member of the Medical Staff or another authorized employee of the Hospital and is for the purpose of conducting legitimate Medical Staff affairs (any such disclosure shall be made only in a private setting); or

(2) when the disclosure has been authorized, in writing, by the Hospital's Chief Executive Officer, Chief Medical Officer, Vice President Medical Affairs, or Chief of Staff.

I understand that my breach of this Agreement may compromise the interests of the Hospital and its Medical Staff. Therefore, in the event of such a breach, I understand that my actions may result in:

(1) dismissal from a committee or job assignment;

(2) loss of available legal protections (including loss of indemnification for any litigation costs and expenses);

(3) termination of my employment; and/or

(4) other appropriate legal action.

_____
Signature

_____ _____
Date Printed Name