ST. JOSEPH
HOSPITAL

CREDENTIALS PROCEDURE MANUAL

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Table of Contents

PART ONE: QUALIFICATIONS FOR MEMBERSHIP

PART TWO: INITIAL APPOINTMENT PROCESS AND PROCEDURES

PART THREE: PROVISIONAL PERIOD

PART FOUR: REAPPOINTMENT PROCESS AND PROCEDURES

PART FIVE: CLINICAL PRIVILEGES

PART SIX: QUESTIONS INVOLVING MEDICAL STAFF MEMBERS

PART SEVEN: OTHER ACTIONS CONCERNING PERSONS HOLDING CURRENT APPOINTMENTS TO THE MEDICAL STAFF

PART EIGHT: REAPPLICATION ADMINISTRATIVE REVOCATION

PART NINE: MODIFICATION OF STAFF STATUS

PART TEN: PHYSICIAN HEALTH

PART ELEVEN: PRACTITIONER PROVIDING CONTRACTUAL SERVICES

PART TWELVE: MEDICO-ADMINISTRATIVE OFFICERS

PART THIRTEEN: PERIOD REVIEW, ADOPTION AND AMENDMENT

PART FOURTEEN: ALLIED HEALTH PROFESSIONALS

PART FIFTEEN: ANCILLARY SERVICES

PART SIXTEEN: EMAIL CREDENTIALING AND PEER REVIEW MATTERS

PART SEVENTEEN: EMERGENCY CREDENTIALING AT TIME OF DISASTER

PART EIGHTEEN: HOSPITAL-AFFILIATED PHYSICIAN EMPLOYEES

PART NINETEEN: USE OF TERMS

PART ONE: QUALIFICATIONS FOR MEMBERSHIP

SECTION A: QUALIFICATIONS

St. Joseph Hospital accepts applications to the Medical Staff from licensed medical and osteopathic physicians, oral surgeons and podiatrists. Other licensed independent practitioners will be permitted to apply for specific clinical privileges as defined in the Allied Health Professionals Policy. Only the Board of Directors may make exceptions to this policy.

SECTION B:

It is St. Joseph Hospital's policy to process applications for appointment to the Medical Staff and requests for privileges only for individuals who meet the following criteria:

PHYSICIANS (MD/DO):

(1) Demonstrate successful graduation from an approved school of medicine or osteopathy; or

(2) Demonstrate certification by the Educational Commission for Foreign Medical Graduates or Fifth Pathway certification; and

(3) Demonstrate successful completion of an ACGME or acceptable equivalent accredited residency training program; and

(4) Current ABMS or AOA certification or an equivalent certification deemed acceptable by the Credentials Committee and Medical Executive Committee, or active participation in the examination process leading to certification or recertification in their primary specialty (board qualified) within the time period of board qualification as specified by each respective specialty board. The burden of proof of board equivalency rests with the potential applicant. In cases where a specialty board does not specify an eligibility time period, the applicant must become certified within five (5) years of completion of training and within three (3) years after lapse of certification in the instance of recertification. Medical Staff members who were appointed and/or privileged as of February 27, 1996, are exempt from the above stated requirement. (Rev 8/10; 12/14)

ORAL SURGEONS (DMD/DDS):

(1) Demonstrate successful graduation from an approved school of dentistry;

(2) Demonstrate successful completion of at least one year in a postgraduate training program accredited by the Commission on Dental Accreditation or by an equivalent professionally recognized accrediting body;

(3) Current ADA certification or an equivalent certification deemed acceptable by the Credentials Committee and Medical Executive Committee, or active participation in the examination process leading to certification within the time period of board qualification as specified by each respective specialty board. The burden of proof of board equivalency rests with the potential applicant. In cases where a specialty board does not specify an eligibility time period, the applicant must become certified within five (5) years of completion of training and within three (3) years after lapse of certification in the instance of recertification. Oral surgeons who were appointed and/or privileged as of February 27, 1996, are exempt from the above stated requirement.

PODIATRISTS (DPM):

(1) Demonstrate successful graduation from an approved school of podiatry;

(2) Demonstrate successful completion of at least one year in a postgraduate training program accredited by the American Podiatric Medical Association (APMA);

(3) Current APMA or American Board of Multiple Specialties in Podiatry (ABMSP) certification or an equivalent certification deemed acceptable by the Credentials Committee and Medical Executive Committee, or active participation in the examination process leading to certification within the time period of board qualification as specified by each respective specialty board. The burden of proof of board equivalency rests with the potential applicant. In cases where a specialty board does not specify an eligibility time period, the applicant must become certified within five (5) years of completion of training and within three (3) years after lapse of certification in the instance of recertification. Podiatrists who were appointed and/or privileged as of February 27, 1996, are exempt from the above stated requirement. (Rev 4/21/15)

ALL:

(1) Demonstrate current, unrestricted license in the State of New Hampshire to practice medicine, osteopathy, dentistry or podiatry and compliance with any continuing education obligations required under applicable law;

(2) Have a licensure history, which consists of no license revocation or voluntary relinquishment of a license to avoid disciplinary action and no more than one suspension of license in any State in the United States;

(3) Demonstrate current, unrestricted U.S. Drug Enforcement Agency registration, if applicable to the applicant's requested privileges;

(4) Possess and maintain evidence of current malpractice insurance coverage, which covers the scope of clinical privileges requested in the *minimum* amount of $1 million/$ 3 million;

(5) Demonstrate clinical performance and competence with active clinical practice for the last twelve (12) months (residency training acceptable);

(6) Demonstrate evidence of skills to provide a type of service that the Board of Directors has determined to be appropriate for performance within the hospital and for which a need exists;

(7) Provide evidence of appropriate personal qualifications to include a record of applicant's observance of ethical standards including, without limitation:

(a) Abstinence from any participation in fee splitting or other payment, receipt or remuneration with respect to referral or patient service opportunities;

(b) A record of professionally and harmoniously working with others within an institutional setting;

(c) Appropriate written and verbal communication skills;

(d) A record that is free of current Medicare/Medicaid/CHAMPUS sanctions, insurance fraud or abuse or payment of civil money penalties for same or exclusion from such programs (for the past three years);

(e) A record that is free of felony convictions or misdemeanor related to professional practice, reimbursement or controlled substance violations or occurrences that would raise questions of undesirable conduct;

(f) Agreement to practice his/her profession in this Hospital and facilities in accordance with Roman Catholic moral and ethical principles and values enunciated in the Ethical and Religious Directives for Catholic Facilities;

(g) For those practitioners seeking admitting privileges, documentation that covering physicians

have obtained Medical Staff membership and clinical privileges at St. Joseph Hospital or are actively in the process of obtaining such.

(8) Demonstrate his/her background, experience and training, current competence, knowledge, judgment, ability to perform, and technique in his/her specialty for all privileges requested;

(9) Upon request, provide evidence of both physical and mental health that does not impair the fulfillment of his/her responsibilities of Medical Staff membership and/or specific privileges requested by and granted to the applicant.

(10) Be located (office and residence) within the geographic service are of the Hospital, as defined by the Board, close enough to fulfill their Medical Staff responsibilities and to provide timely and continuous care for their patients in the Hospital;

(11) Have never had Medical Staff appointment, clinical privileges, or status as a participating provider denied, revoked, or terminated by any health care facility or health plan for reasons related to clinical competence or professional conduct.

(12) Have never resigned Medical Staff appointment or relinquished privileges during a Medical Staff investigation or in exchange for not conducting such an investigation. (REV 12/13)

PART TWO: INITIAL APPOINTMENT PROCESS AND PROCEDURES

SECTION A: NATURE OF MEDICAL STAFF MEMBERSHIP

Appointment to the Medical Staff of St. Joseph Hospital is a privilege which shall be extended only to physicians, oral surgeons and podiatrists who continuously meet the qualifications, standards and requirements set forth in this manual and the Medical Staff Bylaws. All individuals practicing medicine, oral surgery and podiatry in St. Joseph Hospital, unless excepted by specific provisions of this policy, must first have been appointed to the Medical Staff.

SECTION B: CONFIDENTIALITY

All processes described in this Section shall be subject to the confidentiality provisions described in Article Nine of the Medical Staff Bylaws.

SECTION C: NO ENTITLEMENT TO APPOINTMENT

No individual shall be entitled to appointment to the Medical Staff or to the exercise of particular clinical privileges in the hospital merely by virtue of the fact that such individual:

(1) Is licensed to practice a profession in this or any other state,

(2) Is a member of any particular professional organization,

(3) Has had in the past, or currently has, Medical Staff appointment or privileges at any hospital or health care facility,

(4) Resides in the geographic service area of the Hospital, or

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

SECTION D: CONDITIONS OF APPOINTMENT

Staff appointments shall be made only if required by the needs of the particular service for which the physician, oral surgeon or podiatrist is eligible, if the applicant has demonstrated an ability to enhance that service through prior training or experience, and if it is anticipated that the activities of the applicant as a member of the staff will represent a positive contribution to the academic and economic well-being of the Hospital.

SECTION E: HOSPITAL NEED AND ABILITY TO ACCOMMODATE

In evaluating the applicant's eligibility for Medical Staff membership and/or clinical privileges, consideration will be given to any policies, plans and objectives formulated by the Board of Directors, including a policy to provide for the delivery of one or more clinical services through the granting of exclusive contracts, the availability of adequate physical, personnel and financial resources and consideration of quality and efficient patient care.

SECTION F: TERM OF APPOINTMENT

All appointments to the Medical Staff and the granting of privileges are for up to a two-year period except for the Emeritus members who shall retain that title without being reappointed.

SECTION G: REQUEST FOR APPLICATION AND APPLICATION PACKET

(1) An individual shall submit a written request for application to St. Joseph Medical Staff noting the reasons for requesting appointment and/or privileges. No practitioner may submit or have more than one application for initial appointment or reappointment at any given time.

(2) Those individuals who meet the threshold criteria for consideration for appointment to the Medical Staff and clinical privileges shall be given an application. Individuals who fail to meet these criteria or refuse to accept the responsibilities of a Medical Staff member shall not be given an application and shall be notified that they are not eligible.

(3) The application packet provided to the prospective applicant shall include:

- Cover letter
- An application for Medical Staff Appointment
- Instructions for completion of the application
- Appropriate delineation of privilege request form(s) and criteria for privileges
- Medical Staff Bylaws, Rules and Regulations and related manuals, or these documents will be made available via the Hospital's website
- Ethical and Religious Directives for Catholic Facilities
- Conditions of Appointment/Release
- Criminal Records Release and Authorization Form
- Immunization and TB Policy
- Mantoux Test Record
- Confidentiality Statement
- Notice Regarding Medicare
- Pharmacy Form
- Application Fee Request
- Patient Bill of Rights
- Request for Photograph for Identification Purposes
- First Choice PHO Release and Invoice

SECTION H: APPLICATION FOR INITIAL APPOINTMENT AND CLINICAL PRIVILEGES

(1) **INFORMATION**

(a) Applications for appointment to the Medical Staff shall be in writing and shall be submitted on forms approved by the Board upon recommendation of the Credentials and Medical Executive Committees. These forms shall be obtained from the Medical Staff Office.

(b) The application shall contain a request for specific clinical privileges desired by the applicant and shall require detailed information concerning the applicant's professional qualifications, including:

1. The names of three physicians, oral surgeons or podiatrists, as appropriate, at least two of whom are not about to be associated with the applicant in professional practice or related to the applicant by blood or marriage, and who have had extensive experience in observing and working with the applicant, and who can provide adequate references pertaining to the applicant's professional competence and character; preferably, at least two such references shall be from a physician, oral surgeon or podiatrist in the same specialty as the applicant; in some circumstances, references from non-physicians may be considered; (Rev 4/14)

2. The names and complete addresses of the chairs of each department of any and all hospitals or other institutions at which the applicant has worked or trained. If the number of hospitals the applicant has worked in is great or if a number of years have passed since the applicant worked at a particular institution, the Credentials and Medical Executive Committee and the Board may take into consideration such factors;

3. Information as to whether the applicant's Medical Staff appointment or clinical privileges have ever been voluntarily or involuntarily relinquished, withdrawn, limited, denied, revoked, suspended, subjected to probationary or other conditions, reduced, or not renewed at any other hospital or health care facility;

4. Information as to whether the applicant has ever voluntarily or involuntarily withdrawn his/her application for appointment, reappointment and clinical privileges, or resigned from the Medical Staff before final decision by a hospital's or health care facility's governing board;

5. Information as to whether the applicant's membership in local, state or national medical societies, or license to practice any profession in any state, or narcotic license has ever been suspended, modified, voluntarily or involuntarily relinquished or terminated;

6. Information as to whether the applicant has currently in force professional liability insurance coverage, the name of the insurance company, as well as the amount and classification of such coverage and whether said insurance covers the clinical procedures for which the applicant is seeking clinical privileges;

7. Information as to whether the applicant has ever been named as a defendant in a criminal action and/or convicted of a crime, with details about any such instance;

8. A consent to the release of information from his present and past malpractice insurance carriers and a directive to all such carriers to notify the hospital of any change in insurance status;

9. Information concerning the applicant's professional litigation experience, specifically information concerning final judgments or settlements: (i) the substance of the allegations, (ii) the findings, (iii) the ultimate disposition, and (iv) any additional information concerning such proceedings or actions as the Credentials or Medical Executive Committees deem appropriate;

10. A request for the specific clinical privileges desired by the applicant;
11. Current information on the applicant's physical or mental health as it pertains to the applicant's ability to perform the clinical privileges requested;

12. Information concerning any professional misconduct proceedings and any malpractice actions involving the applicant in this state or any other state, whether such proceedings are closed or still pending;

13. Information concerning the suspension or termination, for any period of time, of the right or privilege to participate in Medicare, Medicaid, any other government sponsored program, or any private or public medical insurance program, and information as to whether the applicant is currently under investigation;

14. A complete chronological listing of the applicant's professional and educational appointments, employment, or positions;

15. Information on the citizenship and/or visa status of the applicant;

16. The applicant's signature, a copy of a government-issued photo ID and a signed identification attestation form. The applicant must appear before one of the following designated ID inspectors: The Medical Staff Office, Department Chairman, or Member of the Credentials Committee. The designee will then sign the attestation form on behalf of the applicant for the credentials file;

17. Such other information as the Board, Medical Executive or Credentials Committees may require.

The history of malpractice verdicts and the settlement of malpractice claims, as well as pending claims, will be evaluated as a criterion for appointment, reappointment and the granting of clinical privileges. However, the mere presence of verdicts, settlements or claims shall not, in and of themselves, be sufficient to deny appointment or particular clinical privileges. The evaluation shall consider the extent to which verdicts, settlements or claims evidence a pattern of care that raises questions concerning the individual's clinical competence, or whether a verdict, settlement or claim in and of itself, represents such deviation from standard medical practice as to raise overall questions regarding the applicant's clinical competence, skill in the particular privilege or general behavior.

SECTION I: BASIC RESPONSIBILITIES AND REQUIREMENTS FOR APPLICANTS AND APPOINTEES

As a condition of consideration of an application for Medical Staff appointment or reappointment, and as a condition of continued Medical Staff appointment, if granted, every applicant and appointee shall specifically agree to the following:

(1) To provide appropriate continuous and timely care and supervision to all patients within the Hospital for whom the individual has responsibility;

(2) To abide by all bylaws, policies, and rules and regulations of the Medical Staff and Hospital as shall be in force during the time the individual is appointed to the Medical Staff, including the Confidentiality Policy;

(3) To accept committee assignments and such other reasonable Medical Staff duties and responsibilities as shall be assigned;

(4) To provide with or without request, new or updated information to the CEO or designee, as it occurs, that is pertinent to any question on the application form;

(5) To provide proof of immunization from Hepatitis B, Rubeola and Varicella, and Rubella, or submit appropriate waiver, and proof of compliance with PPD requirements, per the Medical Staff General Rules and Regulations. (REV 5/09)

(6) To attest that s/he has had an opportunity to read a copy of the Bylaws of the Hospital, this Credentials Procedures Manual, and the Bylaws, rules and regulations of the Medical Staff as are in force at the time of application, and that s/he has agreed to be bound by the terms thereof in all matters relating to consideration of the application without regard to whether or not appointment to the Medical Staff and/or clinical privileges are granted;

(7) To appear, if requested, for personal interviews in regard to the application;

(8) That any misrepresentation or misstatement in, or omission from the application, whether intentional or not, shall constitute cause for immediate cessation of the processing of the application and no further processing shall occur. In the event that an appointment has been granted prior to the discovery of such misrepresentation, misstatement or omission, such discovery may be deemed to constitute automatic relinquishment of clinical privileges and Medical Staff appointment. In either situation, there shall be no entitlement to any hearing or appeal rights as set forth in this policy;

(9) To provide to the CEO or designee updated information requested on the original application and subsequent re-applications or privilege request forms. To provide CEO or designee notification in writing within ten (10) days of occurrence concerning:

- Voluntary or involuntary relinquishment of medical staff membership or clinical privileges at any hospital or health care facility,
- Voluntary or involuntary limitation, suspension, reduction, or loss of clinical privileges at any other hospital or health care facility,
- Involvement in any liability actions which include at a minimum, settlements made or final judgments involving the individual,
- Voluntary or involuntary cancellation of professional liability insurance,

- Previously successful or currently pending challenges to any licensure or registration or voluntary relinquishment of such license or registration/DEA registration,

- Medicare/Medicaid sanctions including both current and pending investigations and challenges, conviction for fraud or any other offense related to a federal program,

- Voluntary or involuntary participation in a chemical dependency rehabilitation program,

- Any current criminal charges pending including traffic offenses classified as misdemeanors or felonies,

- Any convictions of felonies and/or misdemeanors,

- Removal from a managed care organization's panel for reasons of quality of care or unprofessional conduct;

(10) To use the Hospital and its facilities sufficiently to allow the Hospital through assessment by appropriate Medical Staff committees and department chairs, to evaluate in a continuing manner the current competence of the appointee;

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

(12) To refrain from delegating responsibility for diagnoses or care of hospitalized patients to any individual who is not qualified to undertake this responsibility or who is not adequately supervised;

(13) To refrain from deceiving patients as to the identity of an operating surgeon or any other individual providing treatment or services;

(14) To seek consultation whenever necessary;

(15) To promptly notify the CEO or designee, and the Medical Staff President of any change in eligibility for payments by third-party payers or for participation in Medicare, including any sanctions imposed or recommended by the federal Department of Health and Human Services, and/or the receipt of a PRO citation and/or quality denial letter concerning alleged quality problems in patient care;

(16) To participate in the monitoring and evaluation activities of clinical departments;

(17) To complete in a timely manner, the medical and other required records for all patients as required by the Medical Staff bylaws, Rules and Regulations, this Credentials Procedures Manual and other applicable policies of the Hospital and the Medical Staff;

(18) To work cooperatively and professionally with Medical Staff appointees, Medical Staff leadership, hospital management, non-physician clinical practitioners, nurses and other hospital personnel;

(19) To promptly pay any applicable Medical Staff application fees, dues and assessments;

(20) To participate in continuing education programs relevant to the privileges granted;

(21) To appropriately satisfy the continuing medical education requirements for Medical Staff appointees and New Hampshire State medical licensing board;

(22) To abide by generally recognized ethical principles applicable to the applicant's or appointee's profession;

(23) Consents to hospital and Medical Staff representatives' inspection of all records and documents that may be material to an evaluation of his/her professional qualifications and competence to carry out the clinical privileges requested, of his/her physical and mental health status and of his/her professional and ethical qualifications;

(24) To agree that the hearing and appeal procedures set forth in the Medical Staff Bylaws shall be the sole and exclusive remedy with respect to any professional review action taken at this Hospital;

(25) Agrees to perform such personal, Medical Staff, committee and Hospital functions, including but not limited to: Peer review, quality or performance improvement review, utilization review, teaching, consultation assignments, emergency service and on-call functions, or exercise of staff privileges, prerogatives or other rights in the Hospital;

(26) Agrees to adhere to the institution's policies on sexual harassment, professional behavior and corporate compliance;

(27) Agrees to participate in the provision of patient care to any patient in an emergency and to serve on the emergency call roster if requested;

(28) Agrees to appropriate utilization and supervision of approved health professionals.

(29) To comply with clinical practice protocols and guidelines that are established by, and must be reported to, regulatory or accrediting agencies, or patient safety organizations, including those related to national patient safety initiatives and core measures, or clearly document the clinical reasons for variance;

(30) To comply with clinical practice protocols and guidelines pertinent to their medical specialty, as may be adopted by the Medical Staff or the Medical Staff leadership, or clearly document the clinical reasons for variance; and

(31) To maintain an e-mail address with the Medical Staff Office, which will be the official mechanism used to communicate all Medical Staff information to the member other than peer review information pertaining to the member and/or protected health information of patients (this information will not be shared outside of the Medical Staff Office).

(REV 12/13)

SECTION J: BURDEN OF PROVIDING INFORMATION

The applicant shall have the burden of producing adequate information for a proper evaluation of his competence, character, ethics and other qualifications, and of resolving any doubts about such qualifications. He shall have the burden of providing evidence that all statements made and information given on the application are factual and true. If the Department Chair, VPMA, or Credentials Committee Chair has a concern that this burden may not have been met, then the Credentials Committee, as a whole, may consider the adequacy of the information provided to resolve any doubts about the applicant's qualifications. (REV 4/09)

SECTION K: PROCEDURE FOR INITIAL APPOINTMENT

(1) **SUBMISSION OF APPLICATION**

(a) The application for Medical Staff appointment shall be submitted by the applicant to the Medical Staff Office. It must be accompanied by payment of the application fee as determined by the Medical Executive Committee. A separate record is maintained for each individual requesting Medical Staff membership or clinical privileges.

(b) After reviewing the application to determine that all questions have been answered, all references and other information or materials deemed pertinent are included, and after verifying the information provided in the application with the primary sources, the Medical Staff Office shall transmit the complete application and all supporting materials to the appropriate department chair.

(c) An application shall be deemed to be complete and ready for review by the appropriate department chair when all questions on the application form have been answered, the applicant has dated and signed in all appropriate areas, and all supporting documentation has been supplied and all information verified. Any application submitted not filled out in its entirety will be returned to the applicant. It is the responsibility of the applicant to provide a complete application, including adequate responses from references. An application shall be deemed incomplete if the need arises for new, additional or clarifying information anytime during the evaluation. It is the responsibility of the applicant to contact the Medical Staff Office to inquire about the progress of the application and provide missing documentation. Any application that is incomplete forty-five (45) days after it was forwarded to the Medical Staff Office for the standard course of information collection and verification shall be deemed to be incomplete unless this timeframe is waived by the Credentials Committee due to extenuating circumstances.

(d) In the event that an applicant is requesting membership or privileges in a department or clinical area in which the Hospital has entered into an exclusive contract for the provision of medical services in that clinical area, the applicant will be notified. If an application is provided in error, the CEO shall notify the applicant that the application will not be processed and the reasons for such action. This action shall not entitle the applicant to any procedural rights, including a hearing, as set forth in the Medical Staff Bylaws.

(2) **VERIFICATION OF INFORMATION**

(a) If all information required is not submitted by the applicant within forty-five (45) days of receipt of the application, the application will be considered incomplete and no processing will take place. One (1*)* reminder notice will be sent to the applicant after receipt of the application noting missing items or information.

(b) Upon receipt of a completed application as defined above, the applicant will be sent a letter of acknowledgment by the Medical Staff Office or its designee.

(c) Upon receipt of a completed application, the Medical Staff Office or its designee, will verify its contents from the appropriate primary source(s) and collect additional information as follows:

1. Information from all prior and current liability insurance carriers concerning claims, suits and settlements (if any) for the past ten (10) years;

2. Administrative and clinical reference questionnaires from all significant past practice settings, at the minimum for the past ten (10) years;

3. Documentation of the applicant's clinical work experiences during the past twelve (12) months;

4. Licensure status in all current or past states of licensure; (New Hampshire licensure will be verified at time of initial appointment, reappointment and expiration);

5. Academic appointments;

6. Military service;

7. When appropriate or necessary, information from the AMA or AOA Physician Masterfiles, Federation of State Medical Boards or other such databanks or approved verification sources;

8. Completion of medical/osteopathic/dental/podiatric school, residency/ fellowship programs, and if applicable, specialty board certification;

9. Documentation from three (3) peer references;

10. ECFMG certification, if applicable;

11. Information from the National Practitioner Data Bank established pursuant to the Healthcare Quality Improvement Act of 1986; including Medicare/ Medicaid sanctions;

12. Information regarding clinical ability, ethical character and ability to work with others from identified references;

13. Satisfactory explanation of any issues regarding:

    Successful or pending challenges to any state licensure(s), or Federal DEA certification(s) or voluntary or involuntary relinquishment, denial, limitation, suspension or revocation of same; voluntary or involuntary termination, suspension, diminishment, revocation, limitation or refusal of membership, employment or clinical privileges at any health care facility; involvement in any professional liability actions, settlements or final judgments and suspensions or terminations of membership from any medical society or board;

14. Any additional information as may be requested to ensure the applicant meets the criteria for Medical Staff membership;

15. Criminal background check;

16. For those applicants requesting admitting privileges, covering physicians' names and addresses.

NOTE: In the event there is undue delay in obtaining required information, the Medical Staff Office will request assistance from the applicant. Failure of an applicant to adequately respond to a request for assistance will, after forty-five (45) days, be deemed a withdrawal of the application and the applicant will be so notified by certified mail.

If any verbal exchanges take place with primary sources or references, the notes of said exchange shall be documented and placed in the applicant's confidential credentials file. If any reference refuses to respond to inquiries, the applicant shall be notified in writing.

When items noted above have been obtained, the file will then be summarized on a practitioner profile and reviewed by the Medical Staff Office in preparation for review by the appropriate Department Chair.

(3) **APPLICANT INTERVIEW POLICY**

It is St. Joseph Hospital's policy that all applicants may be required to participate in an interview as part of the application for appointment to the Medical Staff at the discretion of the Department Chair, VPMA or Credentials Committee Chair. The interview is to be conducted by the Department Chair, members of the Credentials Committee, the Credentials Committee as a whole or other designated Medical Staff member. A permanent record will be made of the interview by completion of the Credentials Interview Questionnaire, a copy of which is Exhibit E appended at the end of this document. The interview may be used to solicit information required to complete the credentials file or clarify information previously provided, e.g., malpractice history, reasons for leaving past healthcare organizations, or other matters bearing on the applicant's ability to render care at the generally recognized level for the community.

The interview may be waived in circumstances in which the applicant is well known to the Department Chair. An interview form will be completed in all cases. (REV 4/09)

SECTION L: DEPARTMENT CHAIR ACTION

All applications are presented to the Department Chair for review and report. The Department Chair reviews the application and its supporting documentation to ensure that it fulfills the established standards for membership and clinical privileges. The Department Chair must document his/her findings pertaining to adequacy of education, training and experience for all privileges requested. Reference to any criteria for clinical privileges must be documented and included in the credentials file. The Department Chair shall be available to the Credentials Committee to answer any questions that may be raised with respect to that chair's report and findings. The chairperson takes action as noted below:

(1) **DEFERRAL**

Department Chairs may not defer consideration of an application f*or any longer than thirty (30) days.* In the event a chair is unable to formulate a report for any reason, the chair must so inform the Credentials Committee and the applicant.

(2) **FAVORABLE REPORT**

When the Department Chair's report is favorable to the applicant in all respects, the application shall be promptly forwarded, together with all supporting documentation, and a signed review and action form to the Credentials Committee.

(3) **ADVERSE REPORT**

The Department Chair will document the rationale for all unfavorable findings. Reference to any criteria for clinical privileges not met will be documented and included in the credentials file. The application, along with the Department Chair's adverse report and supporting documentation, will be forwarded to the Credentials Committee.

SECTION M: EFFECT OF CREDENTIALS COMMITTEE ACTION

The Credentials Committee shall examine evidence of the applicant's character, professional competence, qualifications, prior behavior and ethical standing and shall determine, through information contained in references given by the applicant and from other sources available to the committee, including the report and findings from the chair of each clinical department in which privileges are sought, whether the applicant has established and satisfied all of the necessary qualifications for appointment and for the clinical privileges requested.

As part of the process of making its recommendation, the Credentials Committee may require the applicant to undergo a physical and/or mental examination, to assess the applicant's ability to perform the privileges requested, by a physician or physicians satisfactory to the Credentials Committee. The results of any such examination shall be made available to the committee for its consideration. Failure of an applicant to undergo such an examination within a reasonable time after being requested to do so in writing by the Credentials Committee shall constitute a voluntary withdrawal of the application for appointment and clinical privileges, and all processing of the application shall cease.

The Credentials Committee may require the applicant to meet with the committee to discuss any aspect of the applicant's application, qualifications, or clinical privileges requested. If the Credentials Committee is considering a negative recommendation, it shall offer to meet with the applicant prior to making the recommendation.

The Credentials Committee may use the expertise of the department chief or any member of the department, or an outside consultant if additional information is required regarding the applicant's qualifications.

The Credentials Committee reviews the application and votes for one of the actions noted below:

(1) **DEFERRAL**

Action by the Credentials Committee to defer the application for further consideration must be followed within thirty (30) days by subsequent recommendations as to approval or denial of, or any special limitations to, staff appointment, category of staff and prerogatives, department and/or section assignments and scope of clinical privileges. The Chair of the Credentials Committee shall promptly notify the applicant, the Medical Executive Committee, CEO and the appropriate Department by special, written notice of the action to defer.

(2) **FAVORABLE RECOMMENDATION**

When the Credentials Committee's recommendation is favorable to the applicant in all respects, the application shall be promptly forwarded, together with all supporting documentation, to the Medical Executive Committee.

(3) **ADVERSE RECOMMENDATION**

When the Credentials Committee's recommendation is adverse to the applicant, the application, with its supporting documentation, and all dissenting views, shall be forwarded to the Medical Executive Committee.

(4) **RECOMMENDATION FOR IMPOSITION OF SPECIFIC CONDITIONS**

The Credentials Committee may recommend the imposition of specific conditions. These conditions may relate to behavior (e.g., personal code of conduct) or to clinical issues (e.g., general consultation requirements, appropriate documentation requirements, proctoring,
completion of CME requirements). The Credentials Committee may also recommend that

appointment be granted for a period of less than two years in order to permit close monitoring of an individual's compliance with any conditions. Unless these matters involve the specific recommendations set forth in Section 7.1 of the Medical Staff Bylaws, such conditions do not entitle an individual to request the procedural rights set forth in Article 7 of the Bylaws.

(REV 12/13)

SECTION N: EFFECT OF MEDICAL EXECUTIVE COMMITTEE ACTION

At its next regular meeting after receipt of the application, report and recommendation of the Credentials Committee, the Medical Executive committee reviews the application and votes for one of the actions below:

(1) **DEFERRAL**

Action by the Medical Executive Committee to defer the application for further consideration must be followed within thirty (30) days by subsequent recommendations as to approval or denial of, or any special limitations to, staff appointment, category of staff and prerogatives, department or section affiliation(s), and clinical privileges. The CEO or designee shall promptly notify the applicant by special, written notice of the action to defer.

(2) **FAVORABLE RECOMMENDATION**

When the Medical Executive Committee's recommendation is favorable to the applicant in all respects, the application shall be forwarded, together with all supporting documentation, to the Board of Directors.

(3) **ADVERSE RECOMMENDATION**

When the Medical Executive Committee's recommendation is adverse to the practitioner, the reasons for the adverse recommendation shall be stated and documented. The CEO or designee shall notify the practitioner by certified mail, return receipt requested. With respect to applicants seeking an initial appointment an adverse recommendation based primarily on issues of professional competence or conduct shall entitle the applicant to a review of the adverse recommendation as provided in the hearing and appeal procedures.

The Medical Executive Committee shall then hold the application until after the applicant has exercised or has been deemed to have waived his/her right to a hearing. Whenever the applicant has been deemed to have waived his/her right to a hearing, the CEO shall forward the recommendation of the Medical Executive Committee, together with all supporting documentation, to the Board.

(4) **CONTRARY RECOMMENDATION**

If the Medical Executive Committee has determined to make a recommendation contrary to the recommendation of the Credentials Committee, the Executive Committee shall either:

(a) Refer the matter back to the Credentials Committee for further investigation and preparation of responses to specific questions raised by the Medical Executive Committee prior to its final recommendation; or

(b) Set forth in its report and recommendation clear and convincing reasons, along with supporting information, for its disagreement with the Credentials Committee's recommendation. Thereafter, the Medical Executive Committee's recommendation shall be forwarded, together with the Credentials Committee's findings and recommendation, through the Chief Executive Officer to the Board.

SECTION O: BOARD OF DIRECTORS ACTION

Upon receipt of a recommendation from the Medical Executive Committee, the Board of Directors (or its designated committee) reviews the application and votes for one of the following actions:

(1) **FAVORABLE RECOMMENDATION**

The Board of Directors may:

(a) Appoint the applicant and grant clinical privileges as recommended; or

(b) Reject in whole or in part a favorable recommendation of the Medical Executive Committee; or

(c) Refer the recommendation back to the Medical Executive Committee for further consideration stating the reasons for such referral and setting a time limit within which a subsequent recommendation must be made.

If the Board determines to reject the favorable recommendation of the Medical Executive Committee, it should first discuss the matter with the Chair of the Medical Executive Committee. If the Board's determination remains unfavorable to the applicant, that determination and the reasons in support thereof shall be sent to the CEO, who shall promptly notify the applicant in writing, certified mail, return receipt requested. The applicant is entitled to request a hearing pursuant to the hearing and appeal procedures. The Board shall make no final decision until the applicant has exercised or waived the right to a hearing and appeal as outlined in the hearing and appeal procedures.

(2) **ADVERSE RECOMMENDATION**

If the Board of Trustee's action is adverse to the applicant, a special notice will be sent to him/her by the CEO and s/he shall then be entitled to the procedural rights provided in the hearing and appeal procedures.

(3) **AFTER PROCEDURAL RIGHTS**

In the case of an adverse Medical Executive Committee recommendation, the Board of Directors shall take final action in the matter as provided in the hearing and appeal procedures.

All appointments to Medical Staff membership and the granting of privileges are for up to a two-year period.

SECTION P: BASIS FOR RECOMMENDATION AND ACTION

The report of each individual or group, including the Board of Directors required to act on an application must state the reasons for each recommendation or action taken, with specific reference to the completed application and all other documentation considered. Any dissenting views at any point in the process must also be documented, supported by reasons and references, and transmitted with the majority report.

SECTION Q: CONFLICT RESOLUTION

Whenever the Board of Directors determines that it will decide a matter contrary to the Medical Executive committee's recommendations, the matter will be submitted to a committee of an equal number of Medical Staff members of the Medical Executive Committee and Board of Directors for review and recommendation before the Board of Directors makes its final decision. The committee will submit its recommendation to the Board of Directors within thirty (30) days of notification of issue.

SECTION R: NOTICE OF FINAL DECISION

(1) Notice of the Board of Directors' final decision shall be given through the Medical Staff Office. The applicant shall receive written notice of appointment and special notice of any adverse final decisions.

(2) A decision and notice of appointment includes the staff category to which the applicant is appointed, the section or department assignment and the clinical privileges s/he may exercise, and any special conditions attached to the appointment.

SECTION S: TIME PERIODS FOR PROCESSING

All individuals and groups required to act on an application for staff appointment or reappointment must do so in a timely and good faith manner and, except for good cause, each application should be processed within the following time periods:

Individual/Group	Time Period
Medical Staff Office (to collect, verify and summarize)	60 days
Department Chair	30 days
Credentials Committee (analyze and recommend)	30 days
Medical Executive committee (to reach final recommendation)	30 days
Board of Directors (render final decision)	30 days

These time periods are deemed guidelines and do not create any right to have an application processed within these precise periods. If the hearing and appellate procedures are activated, the time requirements provided therein govern the continued processing of the application.

PART THREE: PROVISIONAL PERIOD

(1) Initial appointment to the Medical Staff (for all staff categories except Emeritus) and all initial grants of clinical privileges, whether at the time of appointment, reappointment, or during the term of an appointment, shall be provisional.

(2) During the provisional period, the exercise of clinical privileges shall be evaluated by the department chair or by a physician(s) designated by the Credentials Committee through the focused professional practice evaluation process. This focused professional practice evaluation may include chart review, monitoring, proctoring, external review, and other information. The numbers and types of cases to be reviewed shall be determined by the Credentials Committee.

(3) The duration of the provisional period for initial appointment and privileges shall be from 12 to 24 months, as recommended by the Credentials Committee. The duration of the provisional period for all other initial grants of privileges shall be as recommended by the Credentials Committee.

(4) During the provisional period, a member must arrange for, or cooperate in the arrangement of, the required numbers and types of cases to be reviewed by the service chief or by other designated physicians.

(5) A newly appointed member shall automatically relinquish his or her appointment or privileges, as appropriate, at the end of the provisional period if he or she fails, during the provisional period, to:

(a) Participate in the required number of cases and cooperate with the monitoring and review conditions for privileges; or

(b) Fulfill all requirements of appointment, including but not limited to those relating to completion of medical records or emergency call responsibilities.

In the case of relinquishment of initial appointment, the individual may not reapply for appointment for two years.

(6) If a member who has been granted additional clinical privileges fails, during the provisional period, to participate in the required number of cases or cooperate with the monitoring and review conditions, the additional clinical privileges shall be automatically relinquished at the end of the provisional period.

(7) When, based on the evaluation performed during the provisional period, clinical privileges are terminated, revoked, or restricted for reasons related to clinical competence or professional conduct, the member shall be entitled to a hearing and appeal.

(REV12/13)

PART FOUR: REAPPOINTMENT PROCESS AND PROCEDURES

All reappointments and renewal of clinical privileges are for a period of up to two (2) years and will be processed according to this section. The granting of new clinical privileges to existing Medical Staff members will follow the procedures outlined in Part Six of this manual concerning the initial granting of new clinical privileges and Part Three concerning provisional status for those privileges.

Recommendations for reappointment and renewed privileges may be contingent upon an individual's compliance with certain specific conditions. These conditions may relate to concerns with behavior (e.g., code of conduct) or to concerns with clinical competence (e.g., general consultation requirements; proctoring). The imposition of such conditions does not entitle an individual to request the procedural rights set forth in Article VII of the Medical Staff Bylaws, unless the conditions fall within the scope of the recommendations set forth in Article VII.

In addition, reappointments may be recommended for periods of less than two years in order to emphasize the seriousness of the matter and to permit closer monitoring of an individual's
compliance with any conditions that may be imposed. A recommendation for reappointment for a period of less than two years does not, in and of itself, entitle an individual to the procedural rights set forth in Article VII.

SECTION A: INFORMATION COLLECTION AND VERIFICATION

(1) **FROM STAFF APPOINTEES**

On or before four (4) months prior to the date of expiration of a Medical Staff appointment, the Medical Staff Office shall notify the appointee of the date of expiration and supply him/her with a reappointment application packet. (A copy of the reappointment application is attached and is incorporated by reference as Exhibit B.) The reappointment form shall be approved by the Credentials and Medical Executive Committees and the Board of Directors.

Within 30 days of receipt of the reappointment application packet, the appointee furnishes, in writing:

(a) A completed reappointment form that includes complete information to update his/her file on items listed in his/her original application;

(b) Payment of reappointment processing fee;

(c) Information concerning continuing training and education internal and external to the hospital during the preceding period and any change in specialty board certification or re-certification;

(d) Documentation of current New Hampshire licensure;

(e) Documentation of Federal Drug Enforcement Agency registration, if applicable to the applicant's requested privileges;

(f) Documentation of completion of the current state of New Hampshire Medical Licensing Board continuing medical education relicensure requirements for the past two (2) years to include at least twenty (20) hours of Category I continuing medical education in the applicant's specialty for each two year reappointment cycle;

(g) Specific request for the clinical privileges sought on reappointment, with any basis for changes; and

(h) Requests for changes in staff category (if applicable);

(i) Every six years, a current government-issued photo ID will be required;

(j) Every 6 years, a current curriculum vitae will be required;

(k) For those applicants requesting admitting privileges, covering physicians' names and addresses;

(REV 1/08; 9/09; 10/10)

By signing the reapplication form, the appointee agrees to the same terms as identified in Part Two, Sections: H, I, J and K. Failure to file a timely reappointment application, without good cause, or failure to provide any requested information is deemed a voluntary resignation from the staff and automatically results in expiration of appointment at the end of the current appointment period. If the member fails to submit a completed application for reappointment
within twenty (20) days of the mailing, a courtesy phone call is provided as a reminder. The applicant is then instructed to provide all requested documentation within ten (10) days. If the member does not respond to this request, s/he shall be deemed to have resigned his/her membership and/or clinical privileges. In the event that such a resignation takes place, the procedures in the hearing and appeal procedures shall not apply.

The reappointment application shall be considered incomplete and shall not be processed unless the applicant is current with respect to the payment of Medical Staff dues and assessments.

The Medical Staff Office or its designee verifies the information submitted, and notifies the staff appointee of any information inadequacies or verification problems. The staff appointee then has the burden of producing adequate information and resolving any doubts about the data.

(2) **INTERNAL AND/OR EXTERNAL SOURCES**

The Medical Staff Office, in conjunction with the Performance Improvement/Quality Assessment Department personnel, collects and verifies for each staff appointee information regarding his/her professional activities to include:

(a) A summary of clinical activity at this hospital (Physician Activity Report and Performance profile) or at the primary admitting institution, during the preceding two year period;

(b) Current licensure, including any currently pending challenges to any license; (REV 10/10)

(c) Current Drug Enforcement Agency registration, if applicable to the applicant's requested privileges, including any currently pending challenges to any registration;
(REV 10/10)

(d) Maintenance of professional board certification status, if applicable;

(e) Current professional liability insurance status and any pending malpractice challenges, including claims, lawsuits, judgments or settlements since the time of the last (re)appointment;

(f) Any pending or completed disciplinary actions or sanctions;

(g) Performance and conduct in this hospital and/or other healthcare organizations, including without limitation, patterns of care, as demonstrated in findings of quality assessment or performance improvement activities, his/her clinical judgement and skills in the treatment of patients, his/her behavior and cooperation with hospital personnel, patients, and visitors;

(h) Report from National Practitioner Data Bank; including Medicare/Medicaid sanctions, and

(i) Satisfactory explanation of any issues regarding: successful or pending challenges to licensure in any state or federal DEA or voluntary or involuntary relinquishment, denial, limitation, suspension or revocation of such licensure(s) or registration(s), or voluntary or involuntary termination of membership at any health care facility;
voluntary or involuntary limitation, reduction or loss of clinical privileges at any health care facility, removal from a managed care panel for reasons of professional conduct or competence, felony convictions or charges, suspensions, sanctions or any other type of restrictions from participation in any private, federal or state health insurance program such as Medicare or Medicaid fraud and suspension or termination of membership from any medical society or specialty board; or

(j) Criminal background check;

(k) Accuracy and timeliness of medical records/hospital reports;

(l) Service on Medical Staff, department and hospital committees and other staff affairs;

(m) Compliance with all applicable bylaws, policies, rules, regulations and procedures of the Hospital and Medical Staff;

(n) Current information regarding the applicant's ability to perform the privileges requested competently and safely and to perform the duties and responsibilities of appointment; information may come from activities at this or another hospital/healthcare institution or, in the case of providers whose practice is primarily outpatient with low inpatient volumes, from three recommendations from peers (appropriate practitioners in the same or closely related professional discipline as the applicant who have personal knowledge of the applicant).

(REV 10/16)

All returned documents shall be reviewed and verified as described in the initial appointment procedure in Part One of this manual.

SECTION B: PROCEDURE FOR PROCESSING APPLICATIONS

The Medical Staff Office, in conjunction with the Quality Resource/Performance Improvement Coordinator, will compile a summary of clinical activity at this hospital for each appointee due for reappointment.

(1) When the items identified in Part Four, Section A of this manual have been obtained, the file will then be summarized on a practitioner profile and forwarded to the Department Chair.

(2) Each Department Chair overseeing a Department or Service in which the practitioner requests or has exercised privileges shall review the reappointment/reappraisal application and its supporting information, the information gathered under Part Four, Section A above, and other pertinent aspects of the practitioner's activity and shall evaluate the information for continuing satisfaction of the qualifications for appointment, the department/services and staff status assignment and the privileges requested.

In the case of a Department Chair's reappointment, the review of his/her application shall be conducted by the Vice President of Medical Affairs in conjunction with an individual in the same department appointed by the Medical Staff President.

(3) If a Department Chair requires further information, the Department Chair shall notify the practitioner, in writing, through the Medical Staff Office, of the information required. If the practitioner is to provide additional information, the notice to him/her must be a special notice and must include a request for the specific information required and the deadline for response.
Failure to respond in a satisfactory manner by the date specified is deemed a resignation of staff appointment and all clinical privileges, unless the Credentials Committee determines that the failure to respond was caused by circumstances beyond the practitioner's control. The CEO shall send the practitioner special notice of any deemed resignation.

(4) Upon completion of review of the application for reappointment, each Department Chair shall document on the review form and forward to the Credentials Committee, through the Medical Staff Office, a summary report of his or her observations relative to the applicant's reappointment or non-reappointment, staff category, department or other clinical unit assignment and clinical privileges, or if no such conclusions are made, the reason therefore.

(REV 12/13)

SECTION C: CREDENTIALS COMMITTEE ACTION

The Credentials Committee reviews the appointee's file, all relevant information available to it, and forwards to the Medical Executive committee a written report with recommendations for reappointment, or non-reappointment and for staff category and clinical privileges. The decision process outlined in Part Two, Section N of this manual shall be followed.

(1) **MEETING WITH AFFECTED INDIVIDUAL**

If, during the processing of a particular individual's reappointment it becomes apparent to the Credentials Committee or its chair that the committee, in considering a recommendation that would deny reappointment, deny a requested change in staff category or clinical privileges, or reduce clinical privileges, the chair of the Credentials Committee shall notify the individual, in writing, of the general tenor of the possible
recommendation and invite the individual to meet with the committee prior to any final recommendation by the committee. At such meeting, the affected individual shall be informed of the general nature of the evidence supporting the action contemplated and shall be invited to discuss, explain or refute it.

This interview shall not constitute a hearing, and none of the procedural rules provided in these bylaws with respect to hearings shall apply, nor shall minutes of the discussion in the meeting be kept. However, the committee shall indicate as part of its report to the Board whether such a meeting occurred.

SECTION D: MEDICAL EXECUTIVE COMMITTEE ACTION

The Medical Executive committee reviews the appointee's file, the Credentials Committee report(s), and all relevant information available to it and forwards to the Board of Directors a written report with recommendations for reappointment, or non-reappointment and for staff category and clinical privileges. The decision process outlined in Part Two, Section O of this manual shall be followed.

If the Medical Executive Committee's recommendation is deemed adverse, no such adverse recommendation will be forwarded to the Board of Directors until after the practitioner has exercised or has waived his/her right to a hearing as provided in the hearing and appeal procedures.

SECTION E: FINAL PROCESSING AND BOARD OF DIRECTORS ACTION

Final processing of requests for reappointment follows the procedure set forth earlier for initial appointment, Part Two, Section P of this manual except that the effective date of the reappointment cycle shall be the last day of the month in which the Board of Directors meets.

PART FIVE: CLINICAL PRIVILEGES

SECTION A: EXERCISE OF PRIVILEGES

Medical Staff appointment or reappointment shall not confer any clinical privileges or right to practice in the hospital. Each practitioner providing clinical services at St. Joseph Hospital may exercise only those privileges granted to him by the Board of Directors, except as stated in policies adopted by the Board or emergency privileges as described herein.

SECTION B: PRIVILEGES IN GENERAL

(1) **REQUESTS**

Each application for appointment or reappointment to the Medical Staff must contain a request for specific clinical privileges, if so desired by the applicant. Specific requests must also be submitted for temporary privileges, as specified in Part Five, Section I, and for modification of privileges in the interim between reappraisals as specified in Part Five, Section H of this manual.

To be eligible for clinical privileges, an individual must have performed sufficient procedures, treatments or therapies in the previous two years to enable the department chair and the Credentials Committee to assess the applicant's current clinical competence for the privileges requested. Any individual seeking privileges who has minimal activity at this Hospital must submit a copy of his/her confidential performance improvement profile from his/her primary hospital and/or such other information as may be requested before the individual's request for specific clinical privileges shall be considered complete and processed further. (REV 1/09)

(2) **BASIS FOR PRIVILEGES DETERMINATION**

Requests for clinical privileges will be considered only when accompanied by evidence of education, training, experience, demonstrated current competence, judgment, references and other relevant information, including an appraisal by the clinical department in which such privileges are sought. The applicant shall have the burden of establishing qualifications for and competence to exercise the clinical privileges s/he requests.

Valid requests for clinical privileges will be evaluated on the basis of:

(a) Prior and continuing education, training, and experience,

(b) Utilization practice patterns,

(c) Current ability to perform the privileges requested,

(d) Demonstrated current competence,

(e) Adequate levels of malpractice insurance coverage as may be required by the Board of Directors with respect to the clinical privileges requested,

(f) Ability and judgment,

(g) Patient care needs and the hospital's capability to support the type of privileges being requested through appropriate resources and personnel,

(h) Availability of qualified coverage in the applicant's absence.

The basis for privileges determination to be made in connection with periodic reappointment or a requested change in privileges must include observed clinical performance and documented results of the staff's quality improvement program activities. Privileges determinations will also be based on pertinent information from other sources, especially other institutions and health care settings where a professional exercises clinical privileges.

The procedures by which requests for clinical privileges are processed and the specific qualifications for the exercise of privileges are as outlined in Part Two of this manual.

SECTION C: CLINICAL PRIVILEGES FOR EXPERIMENTAL PROCEDURES

Experimental drugs, procedures, or other therapies or tests may be administered or performed only after approval of the protocols involved by the Institutional Review Board and only by an approved investigator for that drug/procedure/ therapy/test. A record of the approval must be entered in the practitioner's credentials file.

SECTION D: CLINICAL PRIVILEGES FOR NEW PROCEDURES OR TREATMENTS

Whenever a Medical Staff appointee or applicant requests clinical privileges to perform a significant procedure or service not currently being performed at the Hospital (or a significant new technique to perform an existing procedure), the process outlined in this section shall be followed:

(1) A request shall be submitted to the Medical Staff Office;

(2) The Medical Staff Office shall notify the appointee/applicant that his/her request will not be processed until a determination has been made regarding whether the procedure or service will be offered by the Hospital;

(3) The matter shall then be referred to the Credentials Committee, which will meet with the requesting provider and develop a recommendation based on medical need, benefits and any other factors related to them, such as Hospital capability, resources and support services;

(4) The recommendation shall be referred to the Medical Executive Committee for recommendation or modification. The requesting provider may be present at the Medical Executive Committee to provide further input;

(5) The recommendation of the Medical Executive Committee shall be submitted to the Board of Directors for determination of whether the service or procedure will be offered by the Hospital;

(6) Should the Board of Directors or its designated committee determine to offer the procedure or service, then the Credentials Committee shall develop threshold credentialing criteria to determine the qualifications for individuals who will be eligible to request the clinical privileges at the Hospital. In developing the criteria, the Credentials Committee shall conduct research and may consult with experts via an ad hoc task force of multi-specialty physicians whose charge is to develop recommendations regarding: (1) the minimum education, training and experience necessary to perform the
procedure or service; (2) the extent of monitoring and supervision that should occur if the privileges are granted; (3) the number and types of references required; (4) the re-privileging requirements, such as continuing medical education or documented competence; and (5)a listing of any associated required resources, equipment, personnel to provide the procedure or service;

(7) The Credentials Committee shall forward its recommendations to the Medical Executive Committee and the Board of Directors for final action. The Board of Directors shall then approve the minimum threshold qualifications that an individual must demonstrate in order to be eligible to request the clinical privileges in question;

(8) Once the foregoing steps are completed, specific requests from eligible Medical Staff appointees/applicants who wish to perform the procedure or service shall be handled in accordance with the procedures for requesting an increase in clinical privileges. (REV 5/10)

SECTION E: CLINICAL PRIVILEGES THAT CROSS SPECIALTY LINES

(1) Requests for clinical privileges that traditionally have been exercised at the Hospital only by individuals from another specialty will 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.

(2) The Credentials Committee shall conduct research and consult with experts, via an ad hoc task force which may consist of Medical Staff Members, Department Chairs, individuals with special expertise or interest and those outside the Hospital.

(3) The Credentials Committee shall develop recommendations regarding:

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

(b) The extent of monitoring and supervision that should occur. These recommendations may or may not permit individuals from different specialties to request the privileges at issue. The Credentials Committee shall forward its recommendations to the Medical Executive Committee, which shall review the matter and forward its recommendation to the Board for final action.

SECTION F: SPECIAL CONDITIONS FOR DENTAL PRIVILEGES

Requests for clinical privileges for dentists are processed in the same manner as all other privilege requests. Surgical procedures performed by dentists and/or oral surgeons will be under the overall supervision of the chief of surgery. All dental patients will receive a basic medical appraisal by a physician member of the Medical Staff or a qualified oral surgeon that will be recorded in the medical record. The physician and the dentist must assess the risk and effect of any proposed procedure on the total health status of the patient.

Oral surgeons may be granted the privilege of performing a history and physical on their own patients upon submission of documentation of completion of an accredited postgraduate residency in oral/maxillofacial surgery and demonstrated current competence. A physician
appointee of the Medical Staff will also be responsible for the care of any medical problem that may be present on admission or that may arise during hospitalization. This physician will have the responsibility for the overall medical care of the patient and any surgical procedure performed must be with his/her knowledge and concurrence. "Dental" as used herein does not necessarily include oral surgeons.

SECTION G: SPECIAL CONDITIONS FOR PODIATRIC PRIVILEGES

Requests for clinical privileges for podiatrists are processed in the same manner as all other privilege requests. Surgical procedures performed by podiatrists will be under the overall supervision of the Chief of Surgery. All podiatric patients will receive a basic medical appraisal by a physician member of the Medical Staff, which will be recorded in the medical record. A designated physician shall be responsible for the medical care of the patient throughout the period of hospitalization.

SECTION H: REQUESTS FOR ADDITIONAL PRIVILEGES OR MODIFICATION TO EXISTING PRIVILEGES OR APPOINTMENT STATUS

Any Medical Staff member, either in connection with reappointment or at any other time, may request modification of staff category, department assignment, clinical privileges, or additional privileges by submitting a request form available from the Medical Staff Office. The application
must contain sufficient documentation to support any request for additional or modified privileges. If deemed appropriate, the Department Chair will determine observations or proctoring for additional or new privileges. The request for additional privileges or modification in privileges will be submitted, along with supporting documentation demonstrating additional education, training and current clinical competence and experience that justify the change in the specific privileges requested, including any observation reports, to the Department Chair. The request will be processed in the same manner as initial appointments as defined in Part Two of this manual. (REV 1/09)

(1) When approved, the applying physician will be notified and may then exercise the privilege(s) with the required observation, consultation, and/or proctoring if so designated by the Department Chair. It is the applicant's responsibility to arrange for observers, consultants or proctors and to assure that reports are submitted to the Medical Staff Office.

SECTION I: TEMPORARY PRIVILEGES

(1) **CONDITIONS**

Temporary privileges may be granted only in the circumstances described below, only to an appropriately licensed practitioner, only upon written request and when verified information supports a favorable determination regarding the requesting practitioner's qualifications, ability and judgment to exercise the privileges requested. The request for temporary privileges must also include a description of the important patient care need that justifies the granting of temporary privileges.

All requests for temporary privileges must include a completed application for temporary privileges, verification of current licensure, relevant training or experience, current competence, ability to perform the privileges requested, results of a National Practitioner Data Bank query and a statement from the applicant that there is no current or previously successful challenge to licensure or registration, applicant has not been subject to voluntary or involuntary termination of Medical Staff membership at another organization or has not been subject to voluntary or involuntary limitation, reduction, denial or loss of clinical privileges at another organization; all positive professional references, positive attestation of ability to perform the privileges requested and criminal background check.

(2) **CIRCUMSTANCES**

Upon written concurrence of the Department Chair, Credentials Committee Chair, and the Medical Staff President, the Chief Executive Officer or designee(s) may grant temporary privileges in unusual circumstances where it is necessary to avoid undue hardship to the hospital and to fulfill an important patient need:

(a) **PENDENCY OF A COMPLETE, CLEAN APPLICATION**

After receipt of a completed application for staff appointment, including a request for specific temporary privileges, for a period of not more than thirty (30) days and may be renewed for up to a total of ninety (90) days.

Such requests will not be processed until the application has been reviewed and recommended by the Department Chair and Credentials Committee and is awaiting review and approval by the Medical Executive Committee and the Board of Directors. If such temporary privileges are granted, the applicant shall act under the supervision of the chair or designee of the department in which the applicant has requested primary privileges

(b) **CARE OF SPECIFIC PATIENT(S) OR PERFORMANCE OF SPECIFIC PROCEDURE(S)**

Upon receipt of a written request for specific temporary privileges for the care of one or more specific patients or the performance of one or more specific procedures from a practitioner who is not an applicant for staff appointment, but who is a member in good standing of another Joint Commission accredited or Center for Medicare and Medicaid Services (CMS) or state-certified facility with approved privileges and documentation and verification of all information noted above; and demonstrated competence in the service(s) or procedure(s) to be provided or performed and a recommendation from the appropriate department chair.

Such privileges shall be restricted to the care of the specific patient(s) or performance of the specific procedure(s) for which they are granted and shall terminate upon the discharge of the patient. Such privileges shall be granted no more than four times in any twelve-month period. If additional requests are submitted, the practitioner must make full application to the Medical Staff.

(c) **LOCUM TENENS**

Upon receipt of a written request for specific temporary privileges, an appropriately licensed practitioner who has submitted all the required information as noted above, with documented

competence in the privileges requested, who is serving as a locum tenens, (providing temporary services due to a hospital need, such as an increase in volume or activity or taking the place of a Medical Staff appointee for a temporary period of time) without applying for appointment to the staff, may be granted temporary privileges for a period of one hundred (100) days per year. If an individual wishes to provide locum tenens coverage on a more regular basis, staff appointment shall be required. The locum tenens applicant, who is taking the place of a Medical Staff appointee, is limited to treatment of the patients of the staff appointee for whom this
practitioner is serving as a locum tenens and does not entitle him to admit
his/her own patients to the hospital. Service on the emergency room specialty coverage program may be required.

The locum tenens applicant who is providing temporary services due to an identified hospital need, such as an increase in volume or activity, may be granted admitting privileges.

(3) **EMERGENCY CREDENTIALING**

For situations where the hospital cannot wait for locums credentialing due to an unexpected disaster (not meeting Part 17 Emergency Credentialing at the time of Disaster Policy) an intermediate emergency credentialing process may be used. Examples of such situations would include pandemics, natural disasters, unexpected severe provider shortages. This situation would need to be documented and declared by the Hospital President and/or President of the Medical Staff.

In this situation the minimum requirements for a provider to be granted privileges would be reduced to the DNV/NIAHO requirements, to include:

- Complete medical staff application and privilege forms;
- Primary source verification of licensure, education, specific training, experience, (AMA Master Profile or Osteopathic Physician Profile Report from American Osteopathic Information Association is acceptable) and current competence;
- Verification of ECFMG (as applicable);
- Current Federal Narcotics Registration (DEA) number (if required);
- Two Peer Recommendations;
- Review of involvement in any professional liability action; and
- Receipt of database profiles from/through professional sources (e.g., AMA, AOA, NPDB, OIG, Medicare/Medicaid exclusions

Once these minimum requirements are met, the Provider may be granted locum privileges as indicated above. The Medical Staff Office will continue to process the application, obtaining all information required under Part 4 section A of these bylaws. If adverse information is found during this time, the Termination of Temporary Privileges section will apply.

(4) **TERMINATION OF TEMPORARY PRIVILEGES**

Upon the discovery of any information relative to the endangerment of a patient's life or well-being or the occurrence of any event of a nature which raises questions about a practitioner's professional qualifications or ability to exercise any or all of the temporary privileges granted, the Chief Executive Officer or his/her designee, upon consultation with the Department Chair or the Medical Staff President, may terminate any or all of a
practitioner's temporary privileges. In the event of any such termination, the practitioner's patients then in St. Joseph Hospital will be assigned to another practitioner by the Department Chair for supervision. The wishes of the patient shall be considered, when feasible, in choosing a substitute practitioner.

(4) **RIGHTS OF THE PRACTITIONER WITH TEMPORARY PRIVILEGES**

A practitioner is not entitled to the procedural rights afforded by the hearing and appeal procedures because his/her request for temporary privileges is refused or because all or any part of his/her temporary privileges are terminated or suspended.

(5) **EMERGENCY PRIVILEGES**

In case of an emergency, any Medical Staff appointee is authorized to the degree authorized by his/her license to do everything possible to save the patient's life or to save
the patient from serious harm, to the degree permitted by the appointee's license, but regardless of staff category, or level of privileges. A practitioner exercising emergency privileges is obligated to summon all consultative assistance deemed necessary and to arrange appropriate follow-up. When an emergency situation no longer exists, the practitioner must request the privileges necessary if s/he wishes to continue to treat the patient. In the event such temporary privileges are denied or such privileges are not requested, the patient shall be assigned to an appropriate person currently appointed to the Medical Staff.

For the purpose of this section, an “emergency” is defined as a condition which could result in serious or permanent harm to a patient or in which the life of a patient is in immediate danger and any delay in administering treatment would add to that harm or danger.

SECTION J: TELEMEDICINE PRIVILEGES

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

(2) After considering the recommendation of the MEC, the Board shall determine the clinical services to be provided through telemedicine.

(3) A qualified individual may be granted telemedicine privileges regardless of whether the individual is appointed to a category of the Medical Staff.

(5) Requests for initial or renewed telemedicine privileges shall be processed through one of the following options:

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

(b) If the individual requesting telemedicine privileges is practicing at a Medicare-participating hospital or telemedicine entity, a request for telemedicine privileges may be processed using an abbreviated process that relies on the credentialing and privileging decisions made by the distant-site hospital or entity. In such cases, the Hospital must ensure, through a written agreement, that the distant hospital or entity will comply with all applicable Medicare regulations. In addition, the distant hospital or entity must provide: (1) a current list of privileges granted to the practitioner; (2) information indicating that the applicant has actively exercised the relevant privileges during the previous 12 months and has done so in a competent manner; (3) a signed attestation that the applicant satisfies all of the distant hospital or entity's qualifications for the clinical privileges granted; (4) a signed attestation that the information is complete, accurate, and up-to-date; and (5) 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 regarding the granting of telemedicine privileges and to the Board for final action.

(6) The Hospital may apply the qualifications set forth in this Manual to any applicant for telemedicine privileges, regardless of which option is followed.

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

(8) Individuals granted telemedicine privileges shall be subject to the Hospital's performance improvement and ongoing and focused professional practice evaluation activities. The results of the professional practice evaluation activities, including any adverse events and complaints filed about the practitioner providing telemedicine services, will be shared with the hospital or entity providing telemedicine services.

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

(REV 12/13)

SECTION K: AMBULATORY PRIVILEGES

(1) **DEFINITION**

Members of the Active or Courtesy Medical Staff of St. Joseph Hospital who desire to be associated with the Hospital but wish to exercise limited clinical privileges on an inpatient basis, including members who provide services at hospital-affiliated outpatient facilities and clinics, may apply for Ambulatory Privileges. The primary purpose of Ambulatory Privileges is to permit these members access to Hospital services for their patients by referral to members of the Active or Courtesy Staff with Inpatient Privileges while, at the same time, providing follow-up care on an outpatient basis for unassigned patients presenting to the Emergency Department and providing additional physician alternatives for patients with outpatient needs.

(2) **EDUCATION, TRAINING AND EXPERIENCE**

Meets the minimum requirements for Active or Courtesy Staff membership.

(3) **ADDITIONAL MINIMUM REQUIREMENTS**

(a) Actively participate in the peer review and performance improvement process when requested.

(b) Attend required Medical Staff meetings when so notified and serve on Medical Staff committees when appointed.

(c) Establish and provide the Hospital with evidence of a formal arrangement with a Medical Staff member with inpatient privileges to provide inpatient care for their patients.

(d) When on call, provide telephone on-call coverage for the Emergency Department for the purpose of accepting follow-up care for patients requiring admission or to assist in arranging for follow-up care for patients to be discharged from the Emergency Department.

(e) When on call, accept and provide follow-up care for unassigned patients who present to the Hospital's Emergency Department.

(4) **PRIVILEGES**

(a) May visit their hospitalized patients and review such patient's medical records and may enter progress notes in the patient's record.

(b) May provide consultation within an area of special clinical expertise when requested by their Department Chair or a member of the Medical Staff regarding a patient who is attended by such member of the Medical Staff, and shall enter their consultative opinion in the inpatient medical record, according to the Rules and Regulations of the Medical Staff.

(c) May use the Hospital's outpatient diagnostic and therapeutic facilities.

(d) May provide required medical record documentation for outpatient treatment or pre-procedure clearance for elective outpatient or inpatient procedures according to the Rules and Regulations of the Medical Staff.

(e) May apply for and be granted appropriate special clinical privileges for ambulatory care as per the CPM.

(f) May not enter orders in the inpatient medical record except as allowed above.

(g) May not admit or attend to inpatients, exercise any inpatient clinical privileges or actively participate in the provision or management of care to inpatients at the Hospital except as allowed above. (REV 5/10, 8/11, 9/11)

(5) **DETERMINATION OF CURRENT COMPETENCE**

A recommendation by the Department Chair at the end of the Provisional Period and at Reappointment will be made to the Credentials Committee based on a review of recommendations from three peers who are directly familiar with the applicant's outpatient practice through referral, consultation or shared care, and additional data such as:

(a) Quality and resource management data regarding outpatient and consultative activity;

(b) Peer review data;

(c) Review of quality data from other Medicare participating organizations where the applicant has clinical privileges. This review may be based on the recommendation of the Department Chair from that organization and may be used in lieu of the peer recommendations above. (REV 11/08, REV 6/09, REV 10/16)

SECTION L: CONSULTING PRIVILEGES

(1) **DEFINITION**

Members of either the Active or Courtesy Staff with special expertise in a specific area of clinical practice, including current specialty or subspecialty board certification, who respond to a request for consultation on a particular patient from that patient's attending physician or Department Chair.

(2) **PRIVILEGES**

(a) May enter their consultative opinion and may enter orders only as appropriate for their consultation into the medical record.

(b) May not admit or attend to inpatients.

(c) No minimum required number of consultations as the availability of consultation represents a critical patient care activity even in specialties with minimal inpatient volume.

(d) Core privileges for consultants include history & physical exam, review of laboratory, imaging and other studies, and ordering of further testing or treatment for the condition for which they were consulted.

(e) May exercise such other privileges as may be requested in writing and granted to them pursuant to the CPM. (REV 11/11)

SECTION M: MILFORD MEDICAL CENTER/ ST. JOSEPH HOSPITAL SETTING SPECIFIC PRIVILEGES

Certain privileges cannot be exercised in Milford Medical Center (MMC) due to lack of support and/or equipment such as surgical operations and procedures that require anesthesia backup. All evaluation and management privileges can be exercised safely at the MMC. In addition, minor diagnostic and therapeutic procedures with or without local anesthesia and moderate sedation may be performed.

PART SIX: QUESTIONS INVOLVING MEDICAL STAFF MEMBERS

SECTION A: COLLEGIAL INTERVENTION

(1) This manual encourages collegial and educational efforts by Medical Staff leaders and Hospital administration, to address questions relating to an individual's clinical practice and/or professional conduct. The goal of these efforts is to arrive at voluntary, responsive actions by the individual to resolve questions that have been raised.

(2) Collegial efforts may include, but are not limited to, counseling, sharing of comparative data, monitoring and additional training or education.

(3) All collegial intervention efforts by Medical Staff leaders and Hospital administration are part of the Hospital's performance improvement and professional peer review activities;

(4) The relevant Medical Staff leader shall determine whether it is appropriate to include documentation of collegial intervention efforts in an individual's confidential file. If documentation is included in an individual's file, the individual will have an opportunity to review it and respond in writing. The response shall be maintained in that individual's file along with the original documentation.

(5) Collegial intervention efforts are encouraged, but are not mandatory, and shall be within the discretion of the appropriate Medical Staff leaders.

(6) Medical Staff leaders may also handle these matters using other applicable policies.

SECTION B: INVESTIGATION – INITIAL REVIEW

Whenever a concern or question has been raised or where collegial efforts have not resolved an issue, regarding:

(1) The clinical competence or clinical practice of any members of the Medical Staff, including the care, treatment or management of a patient or patients;

(2) The known or suspected violation by any Medical Staff appointee of applicable ethical standards or the bylaws, policies, rules or regulations of the hospital or the Medical Staff, including but not limited to the hospital's quality assessment, risk management, and utilization review programs; and/or

(3) Behavior or conduct on the part of any Medical Staff appointee 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 appointee to work harmoniously with others.

The matter may be referred to the President of the Medical Staff, any Department Chair, Chairperson of the Credentials Committee, Chair of a standing committee, Chief Executive Officer or the Chair of the Board.

The person to whom the matter is referred shall make sufficient inquiry to satisfy him/herself that the concern or question raised is credible, and if so, shall forward it in writing to the Executive Committee.

No action taken pursuant to this section shall constitute an investigation.

SECTION C: INITIATION OF INVESTIGATION

(1) When a concern or question involving clinical competence or behavior/conduct is referred to or raised by, the Medical Executive Committee, that committee shall determine either to discuss the matter with the physician concerned, or to begin an investigation. An investigation shall begin only after a formal resolution of the Medical Executive Committee to that effect. The Medical Executive Committee may also, by formal resolution, initiate an investigation on its own motion.

(2) The Executive Committee shall promptly inform the individual that an investigation has begun, unless, in the Committee's judgment, informing the individual would compromise the investigation or disrupt the operation of the Hospital or Medical Staff.

(3) The Board may also determine to commence an investigation and may delegate the investigation to the Executive Committee, a subcommittee of the Board, or an Ad Hoc Committee.

(4) The President of the Medical Staff shall keep the Chief Executive Officer fully informed of all action taken in connection with an investigation.

SECTION D: INVESTIGATIVE PROCEDURE

(1) Once a determination has been made to begin an investigation, the Executive Committee shall either investigate the matter itself, request that the Credentials Committee conduct the investigation, or appoint an individual or ad hoc committee ("investigating committee") to conduct the investigation. The investigation committee shall not include partners, associates or relatives of the individual being investigated. The investigating committee may include individuals not on the Medical Staff. Whenever the questions raised concern the clinical competence of the individual under review, the investigating committee shall include a peer of the individual (e.g. physician, dentist, and podiatrist).

(2) The investigating committee shall have the authority to review relevant documents and interview individuals. It shall also have available to it the full resources of the Medical Staff and the Hospital, as well as the authority to use outside consultants, if needed. An outside consultant or agency may be used whenever a determination is made by the Hospital and investigating committee that:

(a) The clinical expertise needed to conduct the review is not available on the Medical Staff; or

(b) The individual under review is likely to raise, or has raised, questions about the objectivity of other practitioners on the Medical Staff; or

(c) The individuals with the necessary clinical expertise on the Medical Staff would not be able to conduct a review without risk of allegations of bias, even if such allegations are unfounded.

(3) The investigating committee may require a physical and mental examination of the individual by health care professional(s) acceptable to it. The investigating committee shall make the results of such examination available for consideration.

(4) The individual shall have an opportunity to meet with the investigating committee before it makes its report. Prior to this meeting, the individual shall be informed of the general questions being investigated. At the meeting, the individual shall be invited to discuss, explain or refute the questions that gave rise to the investigation. A summary of the interview shall be made by the investigating committee and included with its report to the Executive Committee. This meeting is not a hearing, and one of the procedural rules for hearings shall apply. The individual being investigated shall not have the right to be represented by legal counsel at this meeting.

(5) The investigating committee shall make a reasonable effort to complete the investigation and issue its report within thirty (30) days of being requested to perform the investigation by the Executive Committee, provided that an outside review is not necessary. When an outside review is necessary, the investigating committee shall make a reasonable effort to complete the investigation and issue its report within sixty to ninety (60-90) days of receiving the results of the outside review. These time frames are intended to serve as guidelines and, as such, shall not be deemed to create any right for an individual to have an investigation completed within such time periods. In the event the investigating committee is unable to complete the investigation and issue its report within these time frames, it shall inform the individual of the reasons for the delay and the approximate date on which it expects to complete the investigation.

(6) At the conclusion of the investigation, the investigating committee shall prepare a report with its findings, conclusions and recommendations. The report shall be presented to the Executive Committee for further review.

(7) In making their recommendations, the investigating committee and the Executive Committee shall strive to achieve a consensus as to what is in the best interests of patient care and the smoother 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:

(a) Relevant literature and clinical practice guidelines, as appropriate;

(b) All of the opinions and views that were expressed throughout the review, including report(s) from any outside review(s);

(c) Any information or explanations provided by the individual under review.

SECTION E: RECOMMENDATION

(1) The Medical Executive Committee may accept, modify, or reject any recommendation it receives from the investigating committee. Specifically the Medical Executive Committee may:

(a) Determine that no action is justified,

(b) Issue a letter of guidance or counsel,

(c) Issue a letter of warning or reprimand,

(d) Impose conditions for continued appointment,

(e) Impose a requirement for monitoring or consultation,

(f) Recommend additional training or education,

(g) Recommend reduction of clinical privileges,

(h) Recommend suspension of clinical privileges for a term,

(i) Recommend revocation of staff appointment and/or clinical privileges, or

(j) Make any other recommendation that it deems necessary or appropriate.

(2) A recommendation by the Medical Staff Executive Committee that entitles the affected 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
the individual has exercised or has been deemed to have waived the right to a hearing and appeal. At the time the individual has been deemed to have waived the right to a hearing, the CEO shall forward the recommendation of the Medical Staff Executive Committee, together with all supporting documentation, to the Board. The chair of the Medical Staff Executive Committee or his designee shall be available to the Board or its appropriate Committee to answer any questions that may be raised with respect to the recommendation.

(3) If the recommendation of the Medical Staff Executive Committee does not entitle the individual to a hearing, it shall take effect immediately and shall remain in effect unless modified by the Board.

(4) In the event that the Board considers a modification to the recommendation of the Executive Committee that would entitle the individual to request a hearing, the Chief
Executive Officer shall inform the individual by special notice. No final action shall occur until the individual has completed or waived a hearing and appeal.

(5) When applicable, any recommendation 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.

SECTION F: PRECAUTIONARY SUSPENSION OF CLINICAL PRIVILEGES

(1) GROUNDS FOR PRECAUTIONARY SUSPENSION

(a) Whenever failure to take action may result in imminent danger to the health and/or safety of any individual, the MEC, the President of the Medical Staff, the department chair, the CEO, or the Board Chair is authorized to: (1) afford the individual an opportunity to voluntarily refrain from exercising privileges pending an investigation; or (2) suspend of restrict all or any portion of an individual's clinical privileges pending an investigation.

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

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

(d) A precautionary suspension is effective immediately and shall be promptly reported to the CEO and the President of the Medical Staff. A precautionary suspension shall remain in effect unless it is modified by the CEO or MEC.

(e) Within three days of the imposition of a suspension, a brief written description of the reason(s) for the action, including the names and medical record numbers of the patient(s) involved (if any), shall be provided to the individual. (REV 12/13)

(2) **MEDICAL STAFF EXECUTIVE COMMITTEE PROCEDURE**

(a) Within a reasonable time, not to exceed 14 days of the imposition of the suspension, the MEC shall review the reasons for the suspension.

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

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

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

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

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

(g) Upon the imposition of a precautionary suspension, the President of the Medical Staff shall assign responsibility for the care of any hospitalized patients to another individual with appropriate clinical privileges. Whenever possible, consideration shall be given to the wishes of the patient in the selection of a covering physician. (REV12/13)

PART SEVEN: OTHER ACTIONS CONCERNING PERSONS HOLDING CURRENT APPOINTMENTS TO THE MEDICAL STAFF

SECTION A: FAILURE TO COMPLETE MEDICAL RECORDS

The admitting and clinical privileges (elective and emergency) of any individual shall be deemed to be automatically relinquished for failure to complete medical records in accordance with applicable regulations governing the same, after notification by the Medical Records Department of such delinquency. Such relinquishment shall continue until all records of the individual's patients are no longer delinquent. Failure to complete the medical records that caused relinquishment of clinical privileges within sixty (60) days from the relinquishment of such privileges shall constitute an automatic relinquishment of all clinical privileges and resignation from the Medical Staff. Medical record completion requirements and enforcement policies are further defined in the Medical Staff Rules and Regulations.

SECTION B: ACTION BY FEDERAL OR STATE LICENSING AGENCY

(1) Action by the appropriate federal and/or state licensing board or agency revoking or suspending an individual's professional license, or loss or lapse of state license to practice for any reason, shall result in automatic relinquishment of Medical Staff appointment and clinical privileges.

(2) Whenever an individual's federal or state controlled substance certificate is revoked, limited or suspended, the individual shall automatically and correspondingly be divested of the right to prescribe medications covered by the certificate as of the time such action becomes effective and through its term. Whenever an individual's state or federal controlled substance certificate is subject to probation, the individual's right to prescribe such medications shall automatically become subject to the same terms of the probation as of the date such action becomes effective throughout its term.

SECTION C: FAILURE TO BE ADEQUATELY INSURED

If at any time an appointee's professional liability insurance coverage lapses, falls below the required minimum, is terminated or otherwise ceases to be in effect (in whole or in part), the appointee's clinical privileges that would be affected shall be automatically relinquished or restricted as applicable, as of that date, until the matter is resolved, adequate professional liability insurance coverage is restored, and an application for reinstatement of privileges has been approved by the Medical Executive Committee and the Board.

SECTION D: CRIMINAL ACTIVITY

Any medical staff appointee who has been convicted of any felony or of any misdemeanor involving violations of laws pertaining to controlled substances, illegal drugs, or Medicare, Medicaid or insurance fraud or abuse, or any appointee who pleads guilty or nolo contendere to charges pertaining to the same shall automatically relinquish his or her Medical Staff appointment and all clinical privileges. The Medical Executive Committee may consider a waiver of this provision except for the exclusions as defined in Section E below.

SECTION E: EXCLUSION FROM ANY FEDERALLY FUNDED PAYOR PROGRAM

Any medical staff appointee whose participation in the Medicare, Medicaid or any other federally funded program is terminated by either or both of those programs, or who is otherwise excluded or precluded from participation in any such program, shall automatically relinquish his or her Medical Staff appointment and all clinical privileges as of the effective date of the termination, exclusion or preclusion. If the appointee's participation in those programs is not fully reinstated by the expiration of the appointee's then current reappointment term, the appointee will be deemed to have voluntarily resigned from the Medical Staff at that time. It shall be the duty of all appointees to promptly inform the Hospital of any action taken by either such program in this regard.

SECTION F: FAILURE TO PROVIDE REQUESTED INFORMATION

If at any time an appointee fails to provide required information pursuant to a formal request by either the Credentials or Medical Executive Committee or the Chief Executive Officer, the appointee's clinical privileges shall be deemed to be automatically relinquished until the required information is provided to the satisfaction of the requesting party. For purposes of this section "required information" shall include, but not be limited to (1) physical or mental examinations as specified elsewhere in this policy or (2) information necessary to explain an investigation, professional review action, or resignation at another facility or agency; or (3) information pertaining to professional liability actions involving the appointee.

SECTION G: FAILURE TO ATTEND SPECIAL CONFERENCE

Whenever there is an apparent or suspected deviation from standard clinical practice involving any appointee, the appropriate department chair or the Medical Staff President may notify the individual that s/he is required to attend a special conference to consider the matter. The conference shall be held with certain individual Medical Staff leaders and/or with a committee of the Medical Staff. The notice to the appointee regarding this conference shall be given by certified mail, return receipt requested, at least seven (7) days prior to the conference and shall inform the appointee that attendance at the conference is mandatory. Failure of the appointee to attend the conference shall be reported to the Credentials Committee. Unless excused by the Credentials Committee upon showing of good cause, such failure shall constitute automatic relinquishment of all or such portion of the appointee's clinical privileges as the Credentials Committee may direct. Such relinquishment shall remain in effect until the matter is resolved.

SECTION H: CONFIDENTIALITY AND REPORTING

(1) **REPORTS REGARDING PRIVILEGES**

Actions taken and recommendations made pursuant to this policy shall be treated as confidential in accordance with applicable legal requirements and such policies regarding confidentiality as are stated in the Medical Staff Bylaws or as may be adopted by the Medical Staff and the Board. In addition, the CEO, or his/her designee shall make reports of actions taken pursuant to this policy to such governmental agencies as may be required by law.

(2) **CONFIDENTIALITY**

All records and other information generated in connection with and/or as a result of professional review activities shall be confidential and each individual or committee member participating in such review activities shall agree to make no disclosures of any such information, except as authorized, in writing by the CEO or by legal counsel to the Hospital. Any breach of confidentiality by an individual or committee member may result in a professional review action, and/or may result in appropriate legal action to ensure that confidentiality is preserved, including application to a court of law for injunctive or other relief.

SECTION I: PEER REVIEW PROTECTION

All minutes, reports, recommendations, communications, and actions made or taken pursuant to this policy are deemed to be covered by the provisions of NH RSV 151:13-a, NH RSA 329:29 and the provisions of any federal or state statutes and regulations relating to providing protection to peer review or related activities. Furthermore, the committees and/or panels charged with making reports, findings, recommendations or investigations pursuant to this policy shall be considered to be acting on behalf of the Hospital and its Board when engaged in such professional review activities and thus shall be deemed to be "professional review bodies" as that term is defined in the Health Care Quality Improvement Act of 1986.

PART EIGHT: REAPPLICATION AFTER ADMINISTRATIVE REVOCATION

A practitioner who has had his/her appointment and/or clinical privileges administratively revoked for:

(1) Failure to maintain current professional liability insurance in the specified amount;

(2) Failure to maintain current New Hampshire Medical License;

(3) Failure to pay Medical Staff dues or assessments;

(4) Failure to comply with Hospital's Immunization and TB Policy;

(5) Failure to obtain board certification within five (5) years of completion of training;

May request reinstatement of appointment and/or appropriate privileges by submitting the requested documentation i.e., proof of current professional liability insurance, current New Hampshire Medical License, payment of dues, proof of board certification, compliance with Hospital's Immunization and TB Policy. The practitioner must also submit a written summary of relevant activities during the period of revocation if applicable.

If the documentation is received within 90 days of administrative revocation of privileges, the practitioner will be reinstated. Requests received after this time interval will be processed as a new application in accordance with Part Two of this manual. (REV 7/08, 808)

PART NINE: MODIFICATION OF STAFF STATUS

SECTION A: LEAVE OF ABSENCE

(1) An individual appointed to the Medical Staff may request a leave of absence by submitting a written request to the CEO through the Medical Staff Office. The request must state the beginning and ending dates of the leave, which will not exceed one year, and the reasons for the leave.

(2) Members of the Medical Staff must report to the CEO or designee 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. Under such circumstances, the CEO, in consultation with the President of the Medical Staff, may trigger an automatic leave of absence.

(3) The CEO or President of the Medical Staff will determine whether a request for a leave of absence will be granted. In determining whether to grant a request, the CEO will consult with the President of the Medical Staff and the relevant department chief. The granting of a leave of absence, or reinstatement, as appropriate, may be conditioned upon the individual's completion of all medical records.

(4) During the leave of absence, the individual will not exercise any clinical privileges at St. Joseph Hospital. In addition, the individual will be excused from all Medical Staff responsibilities (e.g., meeting attendance, committee service, emergency service call obligations) during this period.

(5) Individuals requesting reinstatement will submit a written summary of their professional activities during the leave, and any other information that may be requested by the Hospital. Requests for reinstatement will then be reviewed by the relevant department chief, the chair of the Credentials Committee, the President of the Medical Staff, and the CEO. If all these individuals make a favorable recommendation on reinstatement, the Medical Staff member 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, any of the individuals reviewing the request have any questions or concerns, those questions will be noted and the reinstatement request will be forwarded to the full Credentials Committee, MEC, and Board for review and recommendation. However, if a request for reinstatement is not granted, for reasons related to clinical competence or professional conduct, the individual will be entitled to request a hearing and appeal.

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

(7) Absence for longer than one year will result in automatic relinquishment of Medical Staff appointment and clinical privileges unless an extension is granted by the CEO. Extensions will be considered only in extraordinary cases where the extension of a leave is in the best interest of the Hospital.

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

(9) Leaves of absence are matters of courtesy, not of right. In the event that it is determined that an individual has not demonstrated good cause for a leave, or where a request for extension is not granted, the determination will be final, with no recourse to a hearing and appeal. (REV 8/11)

SECTION B: MODIFICATION OF STAFF OR DEPARTMENT STATUS

Any Medical Staff Member, either in connection with reappointment or at any other time, may request modification of staff category or department assignment by submitting a written request to the Medical Staff Office. The request must contain sufficient supporting documentation to support the modification in status.

SECTION C: RESIGNATION

A practitioner may resign his/her staff appointment and/or clinical privileges by providing written notice, through the Medical Staff Office, to the Department Chair. The resignation shall specify the reason for the resignation and the effective date. A practitioner who resigns his/her staff appointment and/or clinical privileges is obligated to fully and accurately complete all portions of all medical records for which s/he is responsible prior to the effective date of resignation. Failure to do so shall result in an entry in the practitioner's credentials file acknowledging the resignation and indicating that it became effective under unfavorable circumstances and may be considered a matter of professional conduct that could adversely affect the health or welfare of a patient and so is reportable to the National Practitioner Data Bank pursuant to Health Care Quality Improvement Act of 1986.

SECTION D: REAPPLICATION AFTER RESIGNATION

A staff member that resigns under favorable circumstances may reapply for membership. Any such application is processed in accordance with the procedures set forth in section two of this manual as an initial application. If the resignation is due to an adverse recommendation that may have resulted in a report the National Practitioner Databank or during an investigation then the individual may not apply within five (5) years for Medical Staff Appointment per section 7.27 of the Medical Staff Bylaws. If the applicant in question chooses to reapply after five (5) years, he/she must submit such additional information as the Medical Staff and/or Board of Directors requires demonstrating that the basis of the earlier adverse action no longer exists. If such information is not provided the application will be considered incomplete and voluntarily withdrawn and will not be processed.

PART TEN: PHYSICIAN HEALTH

SECTION A: PHYSICIAN HEALTH FUNCTION

The Medical Executive Committee shall establish a designated subcommittee which will establish or select an established, monitoring and counseling program in which a practitioner who is determined to be impaired by drugs, alcohol or other substance or chemical abuse or who is known to have a physical, mental or emotional impairment or illness which affects his/her ability to perform the privileges requested, shall be required to participate. A description of the roles and responsibilities of this committee as well as the procedures to be followed is found in the Medical Staff Rules and Regulations and Policy Manual. As appropriate to the particular conditions and circumstances involved and as necessary to protect the health and safety of the Hospital's patients, this program shall address the following components:

(1) Education of the Medical Staff and other Hospital personnel about illness and impairment recognition issues specific to physicians;

(2) An identified process for self-referral by a physician and referral by other hospital personnel;

(3) Referral of the affected physician to the appropriate professional internal or external resources for the diagnosis and treatment of the condition or concerns;

(4) Maintenance of the confidentiality of the physician seeking referral or referred for assistance, except as limited by law, ethical obligation or when the safety of a patient is threatened;

(5) Evaluation of the credibility of a complaint, allegation or concern;

(6) Monitoring of the affected physician and the safety of patients until the rehabilitation, treatment or any disciplinary process is complete;

(7) Status of the impaired practitioner's (IP) staff appointment and clinical privileges during the term of the program;

(8) In the case of alcohol or drug impairment, the frequency and procedural requirements for urine/blood screens, counseling by an approved therapist, attendance at meetings for recovering substance abusers conducted by an approved organization, and any other tests/examinations;

(9) Identification of any physician, psychotherapist or other individual who will be actively involved in treating the IP during the term of the program or treatment, the condition for which the physician/psychotherapist/other individual is providing treatment, any drugs that are being prescribed in the course of said treatment, and the physician's/ psychotherapist's/ other individual's signed agreement to provide his/her opinion on treatment progress and the degree to which the practitioner's judgment and/or clinical skills are impaired;

(10) Medical Staff authority to whom, the frequency with which, and the required content of reports on compliance with and results from the monitoring and counseling or treatment program are to be made;

(11) Sanctions for failure of the IP to comply with the terms of the monitoring, counseling or treatment program;

(13) Reporting to the Medical Staff leadership instances in which a physician is providing unsafe treatment.

SECTION B: KNOWN OR SUSPECTED PHYSICAL/MENTAL HEALTH IMPAIRMENTS OR SUSPECTED SUBSTANCE ABUSE

A practitioner who is known to have or who is suspected of having a physical/mental health impairment or who is suspected of having a drug, alcohol or other chemical or substance abuse problem shall be required to provide such information, to obtain such examinations, or to submit to such tests, including random on-the-spot tests, as may reasonably be requested by any two of: The Medical Staff President, a Department Chair, or the CEO or from such practitioner as designated by said two authorities.

PART ELEVEN: PRACTITIONER PROVIDING CONTRACTUAL SERVICES

SECTION A: EXCLUSIVITY POLICY

The Hospital may enter into contracts with physicians, groups of physicians or other health care providers for the performance of clinical services at the Hospital. To the extent that any such contract confers the exclusive right to perform specified services at the Hospital on any individual or group of individuals, no other individual may exercise clinical privileges to perform the specified services while the contract is in effect. Individuals performing specified professional services pursuant to contracts with the Hospital must meet the same qualifications, must be processed in the same manner, and must fulfill all the obligations of appointment as any other applicant or staff appointee.

Application for initial appointment or for clinical privileges related to St. Joseph Hospital facilities or services covered by exclusive agreements will not be accepted or processed unless submitted in accordance with the existing contract or agreement with the hospital.

PART TWELVE: MEDICO-ADMINISTRATIVE OFFICERS

SECTION A: DEFINITION OF MEDICO-ADMINISTRATIVE OFFICERS

A medico-administrative officer is a practitioner engaged by the hospital either full or part time in an administratively responsible capacity, whose activities may also include clinical responsibilities such as direct patient care, teaching, or supervision of the patient care activities of other practitioners under the officer's direction.

A medico-administrative officer must achieve and maintain Medical Staff appointment and clinical privileges appropriate to his/her clinical responsibilities, and discharge staff obligations appropriate to his/her staff category, in the same manner applicable to all other staff members.

SECTION B: EFFECT OF REMOVAL FROM OFFICE OR ADVERSE CHANGE IN APPOINTMENT STATUS OR CLINICAL PRIVILEGES

(1) Where a contract exists between the officer and the hospital, its terms govern any of the following matters that are addressed in it:

   (a) The effect of removal from the medico-administrative office on the officer's staff appointment and clinical privileges; and

   (b) The effect of an adverse change in the officer's staff appointment or clinical privileges on his/her remaining in office.

(2) In the absence of a contract or where the contract is silent on the matter, upon termination of the contractual arrangement, the Medical Staff membership or privileges of the Medico-Administrative Official may be terminated without hearing and appellate review.

PART THIRTEEN: PERIOD REVIEW, ADOPTION AND AMENDMENT

SECTION A: REVIEW PERIOD

The Credentials and Medical Executive Committees will review this Credentials Procedure Manual every two years.

SECTION B: AMENDMENT

This Credentials Procedure Manual will be initially adopted by resolution of the Credentials Committee, Medical Executive Committee, the Active Medical Staff and the Board of Directors. Thereafter, it may be amended or repealed, in whole or in part, by a resolution of the Credentials and Medical Executive Committees recommended to and adopted by the Board of Directors.

SECTION C: CORRECTIONS

The Credentials Committee may correct typographical, spellings or other obvious errors in this manual. The Medical Executive Committee may also make any changes specifically required by law, state regulation or The Joint Commission standards.

SECTION D: RESPONSIBILITIES AND AUTHORITY

The procedures outlined in the Medical Staff and St. Joseph Hospital's Corporate Bylaws regarding Medical Staff responsibility and authority to formulate, adopt and recommend Medical Staff Bylaws and amendments thereto apply as well to the formulation, and adoption of this Credentials Procedure Manual.

PART FOURTEEN: ALLIED HEALTH PROFESSIONALS POLICY

(1) The Board of Directors will determine which categories of Allied Health Professionals (AHP) will be permitted to practice at St. Joseph Hospital (Hospital) consistent with community need and the mission of the Hospital. Such practitioners must be qualified by academic and clinical or other training to practice in a clinical or supportive role in providing services. All individuals shall provide services only as permitted by the Hospital and as stipulated by the individual practitioner's license, if any, and the laws of the State of New Hampshire.

(2) Allied Health Professionals are not Medical Staff appointees and accordingly have no staff member duties or rights.

(3) Allied Health Professionals are classified as either Licensed Independent Practitioners (LIP), Advanced Dependent Practitioners (ADP), or Dependent Practitioners (DP).

(a) LIPs include Psychologists, Dentists, Certified Nurse Midwives, Advanced Practice Registered Nurses, Certified Registered Nurse Anesthetists, and others as determined by the Board, regardless of employment.

(b) ADPs include Physician Assistants and others as determined by the Board, regardless of employment.

(c) DPs include Surgical Assistants, Private and Specialty Scrub Assistants, Medical Assistants, Registered Nurse First Assistants, and others as determined by the Board, who are employed by members of the Medical Staff.

(4) All AHPs shall continuously meet the following minimum qualifications:

(a) Professional liability insurance which covers the scope of practice requested in an amount of at least $1,000,000/$3,000,000.00 or as determined by the Board;

(b) Current unrestricted license, if applicable, in the State of New Hampshire;

(c) A record free of previous imposition of terms of probation or limitation of practice by any State or limitation of scope of practice at any Hospital or other healthcare institution;

(d) Current unrestricted DEA registration, if applicable to the applicant's requested privileges;

(e) The names of three peers, as appropriate, at least two of whom are not associated or about to be associated with the applicant in professional practice or related to the applicant by blood or marriage, and who have had extensive experience in observing and working with the applicant, and who can provide adequate references pertaining to the applicant's professional competence and character; at least two such references shall be in the same specialty as the applicant;

(f) Abstinence from any participation in fee splitting or other payment, receipt or remuneration with respect to referral or patient service opportunities;

(g) Ability to work professionally and harmoniously with others in an institutional setting including compliance with the Hospital's policy regarding sexual or other harassment and with the corporate integrity program;

(h) Appropriate written and verbal communication skills;

(i) A record that is free of current Medicare/Medicaid/CHAMPUS sanctions, insurance fraud or abuse or payment of civil money penalties for same or exclusion from such programs for the past 3 years;

(j) Demonstrate his/her background, experience and training, current clinical competence, knowledge, judgment, and ability to perform the requested clinical privileges, including a positive reference from the director of the applicants training program and/or immediate past supervisor as appropriate;

(k) Maintain, and provide evidence upon request of, both physical and mental health that does not impair the fulfillment of his/her clinical privileges.

(l) Satisfactory completion of the Hospital orientation program outlining safety and fire codes, emergency/disaster plans, infection control/performance improvement/risk management activities;

(m) Submit to criminal background check at time of initial application and at time of biannual review.

(5) LIPs may provide patient care services within the limits of their license, professional skills and abilities. They shall be credentialed and granted delineated privileges in accordance with the procedure for Medical Staff appointment to the extent appropriate. They shall be assigned to a Medical Staff department based on their privileges. They shall:

(a) Exercise independent judgment in their areas of competence and participate directly in patient management as permitted by their privileges;

(b) Record reports and progress notes on patient records and write orders to the extent established in the Medical Staff Bylaws, CPM, Rules and Regulations and associated Medical Staff documents consistent with their clinical privileges, license, certificate or other legal credentials.

(6) ADPs shall be credentialed and privileged in accordance with the procedure for Medical Staff appointment to the extent appropriate. The Board shall approve core privileges, after input by the Medical Executive Committee, for each category of ADPs permitted to practice at the hospital. DPs shall practice pursuant to a scope of practice developed in a similar fashion. All ADPs and DP's shall practice under the supervision of a physician with appropriate clinical privileges at the Hospital, within the clinical privileges/scope of practice for their category of AHP, and according to the description of clinical duties and responsibilities supplied by their employer. ADPs and DPs shall be assigned to the department of their Supervising Physician.

(7) The level(s) of supervision for LIPs, based on their privileges, and other AHPs may include any of the following:

(a) Direct: Physician must be physically present to observe the AHP and may not supervise more than 2 AHPs at a time. Examples include critical procedures or unstable patients, in such settings as the OR, ICU or ED.

(b) Indirect: Physician must be physically present in hospital and immediately available to the AHP. Examples include acutely ill but stable patients, in such settings as the medical/surgical units, ICU, OR or ED.

(c) Available: Physician is not required to be physically present as long as the Supervising Physician and the AHP can easily be in contact with each other by an electronic communication device. Examples include stable patients with chronic or sub acute illness on medical/surgical units, or acute inpatient rehabilitation units. AHPs experienced in critical care and meeting criteria set out in separate privilege form, may be granted permission from their supervising physician to perform critical procedures or attend unstable patient in the ICU. This must be specified on their supervising physician statement.

(d) Protocol Supervision: AHP carries out tasks that are defined by protocol or procedure. Examples include patients seen in the anti-coagulation clinic, wound clinic, or nursery.

(e) No Supervision Required: LIPs practicing their core privileges. An example would include ambulatory care in the office setting.

(8) AHPs who meet the minimum qualifications may request an application for permission to practice as an Allied Health Professional from the Medical Staff Office. Each ADP and DP must provide:

(a) A description of clinical duties and responsibilities from their employer that is consistent with the privileges/scope of practice appropriate for their category;

(b) A letter of supervision (if required for delineated privileges or scope of practice) from their supervising physician assuming full responsibility for the conduct of said individual within the Hospital as well as assuming responsibility to acquaint the AHP with the applicable Medical Staff and Hospital documents, Medical Staff members and Hospital personnel.

(9) ADP's and DP's clinical duties and responsibilities within the hospital shall terminate if his or her supervising physician's Medical Staff appointment is terminated or if the supervising physician's

clinical privileges are curtailed to the extent that the AHP's services are no longer necessary or permissible.

(10) ADP's and DP's clinical duties and responsibilities within the hospital shall terminate if their employment is terminated.

(11) The Department Chair of the department to which an AHP is assigned will review the application and supporting documentation when it is complete and has been verified by the Medical Staff Office for appropriateness of education, training, experience, evidence of current clinical competence and core privileges. The Chair shall indicate review by writing comments on and signing the appropriate form.

(12) The Credentials Committee acting on behalf of the Medical Executive Committee shall review the qualifications of all Allied Health Professionals who apply for permission to practice in the hospital, interview such applicants as may be necessary, and seek additional information from other AHPs, hospital department head(s), nurse manager(s) and medical director(s) as may be necessary. The Committee shall make a written report of its findings and recommendations to the MEC for LIP or ADP, but to the CEO for DP.

(13) All Allied Health Professionals shall be subject to continual review of their performance and periodic reappraisals of their clinical activities by their Department Chair.

(a) LIPs and ADPs shall undergo biannual reappraisals following generally the same procedures as members of the Medical Staff including the Medical Staff Professional Development Policy to the extent possible.

(b) DP's shall have a written annual evaluation by their supervising physician that will be forwarded to the Department Chair. This evaluation shall be considered along with any other information available through the Hospital's Quality and Resource Management activities or other sources within the Hospital to confirm competency consistent with those similar practitioners who are employed by the Hospital. The Department Chair's evaluation shall be reviewed by the Credentials Committee and a written report forwarded to the CEO.

(14) The Hospital retains the right, through the CEO, effective immediately, to suspend or terminate any or all of an Allied Health Professional's privileges or functions without recommendation from the MEC. The Allied Health Professional is not eligible for the interview, hearing or appeal procedures of the Medical Staff.

(a) An LIP or ADP suspended or terminated shall be told the reasons for such action and, if he or she requests in writing to the CEO within 30 days, shall be entitled to have such action reviewed by the Credentials Committee in no less than 10 days or longer than 60 days from the receipt of the request unless extended by the CEO for good cause. At any review meeting, the individual shall be present and be allowed to fully participate. The MEC and Board of Directors shall review any action recommended after such review. If the final recommendation is adverse, the LIP or ADP may request in writing to the CEO within 10 days an appellate review. The grounds for appeal shall be limited to the following: substantial failure to comply with the AHP Policy so as to deny a fair review; the recommendation of the Credentials Committee was made arbitrarily, capriciously, with prejudice; or the recommendation of the Credentials Committee was not supported by substantial evidence based on the record of the review. The time, place, notice, nature of appellate review, and final decision of the Board shall follow the Medical Staff process to the extent possible. In the event the affected individual does not request a review or appeal within

the time and in the manner required by this policy, the individual shall be deemed to have waived the right of such review or appeal and to have accepted the suspension or termination.

(b) When a DP is suspended or terminated, his or her employer shall be notified as to the reasons for such action. The employer shall be afforded an opportunity for Credentials Committee review if requested in writing to the CEO within 30 days. At any review meeting the employer may be present and be allowed to fully participate. The MEC and Board of Directors shall review any action recommended by the Credentials Committee. No further review or appeal process is available for suspension or termination of DP.

(REV 2/07; 9/29/09; 9/29/15, 11/23/2015,12/18/2018)

PART FIFTEEN: ANCILLARY SERVICES POLICY

PURPOSE

Privileging of Physicians (MD/DO), Chiropractors (DC), Advanced Practice Registered Nurses (APRN), Physician Assistants (PA), Naturopathic Doctors (ND), Doctors of Optometry (OD), Oral and Maxillofacial Surgeons (DMD/DDS), Dentists (DMD/DDS), Podiatrists (DPM), and Certified Professional Midwives (CPM) who may or may not be members of the Medical Staff for use of ancillary services.

POLICY

St. Joseph Hospital will accept orders for ancillary services only from Physicians, Chiropractors, APRNs, PAs, NDs, ODs, DMDs, DDSs, DPMs, and CPMs, independent of Medical Staff status, under the following circumstances:

1. The Physician is currently licensed in:
   a) The State of New Hampshire; or
   b) The State of Massachusetts, the State of Maine, or the State of Vermont, provided they do not maintain an office in New Hampshire; or
   c) Any other state if the patient is visiting from that state.
2. The Chiropractor is currently licensed in the State of New Hampshire.
3. The Advanced Practice Registered Nurse is currently licensed in the State of New Hampshire or the State of Massachusetts.
4. The Physician Assistant must have a supervising physician who has privileges to order ancillary services.
5. The Naturopathic Doctor is currently licensed in the State of New Hampshire.
6. The Doctor of Optometry is currently licensed in the State of New Hampshire.
7. The Oral and Maxillofacial Surgeon is currently licensed in the State of New Hampshire.
8. The Dentist is currently licensed in the State of New Hampshire.
9. The Podiatrist is currently licensed in the State of New Hampshire.
10. The Certified Professional Midwife is certified by the New Hampshire Midwifery Council.

PROCEDURE

1. The Hospital will verify licensure and ensure that the practitioner is eligible to participate in federal and state health programs using on-line resources. Additional information, such as NPI number, DEA

number, office address, phone number, fax number, e-mail address and proof of malpractice coverage may be requested by the Hospital. Ancillary privileges will automatically expire every two years. Practitioners will be re-privileged at the time of subsequent activity.

2. The practitioner shall be limited to ordering only those tests or services that are within the scope of his/her license to order and consistent with CMS regulatory guidelines for beneficiaries of federally funded health care programs. The order shall be confined to outpatient laboratory, rehabilitation services, radiology, neurology, and cardiopulmonary testing. Orders from a Certified Professional Midwife will be confined to OB ultrasounds, mammograms, and prenatal labs.

3. The practitioner's ordering practice shall be reviewed for medical appropriateness and necessity. Orders that lack evidence of medical appropriateness or necessity shall not be performed and the practitioner shall be so notified.

4. All diagnostic tests that are routinely accompanied by a physician interpretation shall be subject to interpretation by a member of the Medical Staff with such privileges and the interpretation shall be provided to the ordering practitioner.

5. Practitioners ordering ancillary services who do not qualify for ancillary privileges under the circumstances above, will be so notified (if possible) and will be placed on a "do not accept" list distributed to Hospital departments. (REV 4/07, 12/10, 6/11, 12/12, 1/13, 1/14, 3/14, 8/14)

PART SIXTEEN: EMAIL CREDENTIALING AND PEER REVIEW MATTERS POLICY

PURPOSE

To allow confidential use of electronic information transfer via email with attachments by members of the Medical Staff in the course of conducting credentialing, privileging and peer review activities.

POLICY

Members of the Medical or Hospital Staff who use electronic information transfer for credentialing, privileging, peer review activities or any other Medical Staff business shall sign a consent agreeing that:

1. Subject lines shall contain: "Privileged and Confidential Medical Staff Transmittal" or similar indication of the nature of the transmission;

2. The following confidentiality statement shall be added to each email text: "The information contained in this email and any attachments is confidential and intended only for disclosure to and use by the person named. **This information is not encrypted and may be read if electronically intercepted**. Distribution, publication, reproduction or use of this email or attachments, in whole or in part, by any person other than the intended recipient is strictly prohibited. If you have received this transmission erroneously, please notify us immediately by return email and destroy the transmission, its contents and any copies thereof;"

3. Receipt of the email by the intended party shall be documented by electronic return receipt requested;

4. Unauthorized individuals shall be prevented from having access to the email/information whether at the office or home;

5. Email information shall be deleted from the recipient's computer immediately after transacting the business at hand;

6. No patient or practitioner specific identifying information will be included in documents that contain confidential information;

7. Medical Staff Office shall be informed if there is any fear the information was sent to unauthorized individuals;

8. Medical Staff Office shall be informed immediately of any change in email address.

PART SEVENTEEN: EMERGENCY CREDENTIALING AT TIME OF DISASTER POLICY

POLICY

In the event of a mass disaster, Medical Staff members and employees may not be able to provide all the care required by individuals seeking treatment at our facilities. Under such circumstances, the CEO or his designee is authorized to grant temporary emergency privileges or authorization to physicians, nurses, and other professionals to treat patients upon receipt of satisfactory evidence that such individuals are licensed or otherwise capable of providing services to patients. Government-issued photo identification shall be required. Furthermore, notwithstanding any existing delineation of privileges or scope of authority, Medical Staff members, employees and volunteers are authorized to take whatever steps they reasonably believe are necessary to save or preserve the life or health of patients or the public health during a mass disaster. The Disaster will be considered terminated when the CEO or Incident Commander (IC) has deactivated the response phase of the incident.

PROCEDURE

1. After activation of the emergency credentialing policy by the CEO or IC, physicians, oral surgeons, physician assistants, nurse practitioners, and psychologists wishing to provide volunteer services to patients during a mass disaster will be directed to the Medical Staff Office. Volunteer registered nurses will be directed to Patient Care Services. Therapists and technologists will be directed to Human Resources. All Medical Staff Services Professionals and the VPMA will be notified by the Hospital Communication Specialist of the emergency condition so as to be available for emergency credentialing.

2. The Medical Staff Office will require the following:

   a) Current New Hampshire state licensure OR licensure in another state with current identification indicating that the practitioner is a member of a federal Disaster Medical Assistance Team (DMAT), Emergency System for Advanced Registration of Volunteer Health Professionals (ESAR-VHP), Medical Reserve Corp (MRC), or other federal emergency medical service;

   b) Current malpractice coverage;

   c) Current healthcare facility affiliations;

   d) Type of specialty and privileges currently held elsewhere;

   e) Government issued photo identification.

3. The Medical Staff Office shall establish a file for each practitioner, collect copies of documents and record information provided by the practitioner. Attempts should be made to verify membership and privileges in good standing at the main healthcare facility affiliation and medical malpractice coverage. Current state licensure will be verified with a primary source. Depending on the severity of the disaster and the need for patient services, this verification may take place retrospectively.

4. Verification or confirmation of information can be made via e-mail, fax, Internet or telephone, with written documentation of information received to be maintained in the credentials file.

5. Once the information has been collected and verified as above, the Medical Staff Office shall present the information to the appropriate department chair or designee OR the Medical Staff President or designee for review. Their signature on the designated form shall indicate a favorable recommendation. The information will then be forwarded to the Hospital CEO or IC, who may grant temporary emergency privileges for up to 72 hours in those cases pending complete verification or until the end of the disaster situation for completely verified credentials files.

6. The Medical Staff Office shall query OIG and, when appropriate, the National Practitioner Data Bank and the AMA master file as soon as possible. Responses to these queries will be maintained in the practitioner's file and any irregularities or inconsistent information noted will be brought to the attention of the CEO or designee immediately. Verification of information and privileging shall be completed as soon as the situation allows following the process for granting temporary privileges to fulfill an important patient care need.

7. All temporary emergency privileges shall expire immediately when the CEO or IC deactivates the response phase of the incident.

8. The Medical Staff Office shall create a written confirmation of the granting of emergency privileges and provide such documentation to the practitioner who shall work under the direction of a Medical Staff Member as assigned by the appropriate Department Chair or designee.

9. A photographic identification card indicating emergency staff status shall be issued by Security for the duration of the medical emergency as soon as possible. (REV 8/15/10)

PART EIGHTEEN: HOSPITAL-AFFILIATED PHYSICIAN EMPLOYEES

A. Except as provided below, a physician who is employed by the Hospital, or by an affiliate of the Hospital, will be governed by the Employer's employment policies and manuals and the terms of the physician's employment relationship or written contract. To the extent that the Employer'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 or written contract will apply.

B. A request for appointment, reappointment or clinical privileges, submitted by an applicant or member who is employed by the Hospital, or by an affiliate of the Hospital, will be processed in accordance with the terms for this Policy. A report regarding each such employed physician's qualifications will be made to the Employer in order to assist the Employer in making employment decisions.

C. If a concern about the clinical competence, conduct or behavior of a physician who is employed by the Hospital or by an affiliate of the Hospital arises, then the concern may be reviewed and addressed in accordance with this Policy, in which event a report will be provided to the Employer. However, nothing herein shall require the Employer to follow this Policy. (New 12/13)

PART NINETEEN: USE OF TERMS

(1) When used herein the terms "Relevant peer review committee," "credentials committee," "President," "Department Chair," "Medical Staff Coordinator" and "Board of Directors" are construed to include

"designee."

(2) "All supporting documentation," means the application form and its accompanying information, the reports and recommendations of the Department Chair, Credentials Committee, Medical Executive Committee and all dissenting views, if any.

(3) "Adverse recommendation" from the Medical Executive Committee or an "adverse action" by the Board of Directors as referred to in the appointment process means a recommendation or action to change, without the staff appointee's consent, his/her clinical assignment; to reduce staff category without his/her consent; or to deny or restrict requested clinical privileges. *The term "applicant" and "appointments" as used in these Sections shall be read, respectively, as "staff appointee" and "conclusion of the provisional status."

(4) "Adverse action" by the Board of Directors means action to deny appointment, reappointment or to deny or restrict requested clinical privileges, or any change in staff category without the staff appointee's consent.

(5) "Special notice" correspondence sent by certified mail, return receipt requested.

ADOPTION AND APPROVAL

ADOPTED BY THE MEDICAL STAFF:

Robert Quirbach, MD 1/08/2002
Medical Staff President Date:

Peter Davis, FACHE/CEO 1/29/2002
President, St. Joseph Hospital Date:

REVISIONS:

CC: 12/06/04	MEC: 12/14/04	BOD: 12/21/04
CC: 7/11/05	MEC: 7/12/05	BOD: 7/18/05
CC: 9/12/05	MEC: 9/13/05	BOD: 9/27/05
CC: 10/3/05	MEC: 10/11/05	BOD: 10/25/05
CC: 12/5/05	MEC: 12/13/05	BOD: 12/20/05
CC: 1/9/06	MEC: 1/10/06	BOD: 1/31/06
CC: 4/3/06	MEC: 4/11/06	BOD: 4/25/06
CC: 6/5/06	MEC: 6/13/06	BOD: 6/27/06
CC: 1/8/07	MEC: 2/13/07	BOD: 2/27/07
CC: 4/2/07	MEC: 4/10/07	BOD: 4/30/07
CC: 7/09/07	MEC: 7/10/07	BOD: 7/19/07
CC: 8/06/07	MEC: 8/14/07	BOD: 8/27/07
CC: 9/08/07	MEC: 9/09/07	BOD: 9/25/07
CC: 1/07/08	MEC: 1/08/08	BOD: 1/29/08
CC: 7/07/08	MEC: 7/08/08	BOD: 7/24/08
CC: 8/04/08	MEC: 8/12/08	BOD: 8/14/08
CC: 11/03/08	MEC: 11/11/08	BOD: 11/25/08
CC: 1/05/09	MEC: 1/13/09	BOD: 1/27/09
CC: 2/02/09	MEC: 2/10/09	BOD: 2/24/09
CC: 4/06/09	MEC: 4/14/09	BOD: 4/28/09
CC: 5/04/09	MEC: 5/12/09	BOD: 5/26/09
CC: 6/01/09	MEC: 6/09/09	BOD: 6/30/09
CC: 8/31/09	MEC: 9/08/09	BOD: 9/29/09
CC: 7/12/10	MEC: 7/13/10	BOD: 8/25/10
CC: 10/04/10	MEC: 10/12/0	BOD: 10/26/10
CC: 12/13/10	MEC: 12/14/10	BOD: 12/21/10
CC: 3/1/11	MEC: 3/8/11	BOD: 3/29/11
CC: 9/06/11	MEC: 9/13/11	BOD: 9/27/11
CC: 11/1/11	MEC: 11/08/11	BOD: 11/29/11
CC: 12/4/12	MEC: 12/11/12	BOD: 12/18/12
CC: 1/7/13	MEC: 1/8/13	BOD: 1/29/13
CC: 6/13, 12/13	MEC: 6/13, 12/13	BOD: 12/17/13
CC: 1/7/14	MEC: 1/14/14	BOD: 1/26/14
CC: 2/14/14	MEC: 2/11/14; 3/11/14	BOD: 3/24/14
CC: 4/1/14	MEC: 4/8/14	BOD: 4/22/14
CC: 7/01/14	MEC: 8/12/14	BOD: 8/26/14
CC: 12/02/14	MEC: 12/09/14	BOD: 12/16/14
CC; 4/7/15	MEC: 4/14/15	BOD: 4/21/15
CC: 9/1/15	MEC: 9/8/15	BOD: 9/29/15
CC: 10/6/15	MEC: 11/10/15	BOD 11/23/15
CC: 12/04/2018	MEC: 12/11/2018	BOD: 12/18/2018
CC: 03/12/2020	MEC: 03/12/2020	BOD: 03/17/2020

The Medical Staff Office retains all revised copies on file.