

**MEDICAL STAFF BYLAWS, POLICIES, AND
RULES AND REGULATIONS
OF
COVENANT HEALTH**

**COVENANT MEDICAL CENTER
MEDICAL STAFF
CREDENTIALS POLICY**

*Adopted by the Medical Staff: November 28, 2017
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ARTICLE 1

GENERAL

1.A. DEFINITIONS

The following definitions shall apply to terms used in this Policy:

- (1) “ADVANCE PRACTICE PROVIDERS” (“APPs”) means individuals other than Medical Staff members who are authorized by law and by the Hospital to provide patient care services within the Hospital. All APPs are described as Category I, Category II, or Category III practitioners in the Medical Staff Bylaws documents:
 - “CATEGORY I PRACTITIONER” means a Licensed Independent Practitioner, a type of Advance Practice Provider who is permitted by law and by the Hospital to provide patient care services without direction or supervision, within the scope of his or her license and consistent with the clinical privileges granted. Category I practitioners also include those physicians not appointed to the Medical Staff who seek to exercise certain limited clinical privileges at the Hospital under the conditions set forth in the APP Policy (i.e., moonlighting residents). See Appendix A to the APP Policy.
 - “CATEGORY II PRACTITIONER” means an Advanced Practice Clinician, a type of Advance Practice Provider who provides a medical level of care or performs surgical tasks consistent with granted clinical privileges, but who is required by law and/or the Hospital to exercise some or all of those clinical privileges under the direction of, or in collaboration with, a Supervising Physician pursuant to a written supervision or collaborative agreement. See Appendix B to the APP Policy.
 - “CATEGORY III PRACTITIONER” means a Dependent Practitioner, a type of Advance Practice Provider who is permitted by law or the Hospital to function only under the direction of a Supervising Physician, pursuant to a written supervision agreement and consistent with the scope of practice granted. Except as specifically indicated in Article 6 of the APP Policy, all aspects of the clinical practice of Category III practitioners at the Hospital shall be assessed and managed by Human Resources in accordance with Human Resources policies and procedures, and the provisions of the APP Policy shall specifically **not** apply. Hereafter, as used in this Policy, the APP Policy, and the Medical Staff Bylaws, the term “Advance Practice Provider” shall mean Category I and Category II practitioners only (except for Article 6 of the APP Policy). See Appendix C to the APP Policy.

- (2) “BOARD” means the Board of Directors of each individual Hospital, which has the overall responsibility for that Hospital, or its designated committee.
- (3) “CHIEF EXECUTIVE OFFICER” (“CEO”) means the individual appointed by the Board to act on its behalf in the overall management of the Hospital.
- (4) “CHIEF MEDICAL OFFICER” (“CMO”) means the chief administrative officer of the Medical Staff appointed by the Board in consultation with the CEO, with responsibilities as set forth in the Medical Staff Bylaws and related documents.
- (5) “CLINICAL PRIVILEGES” or “PRIVILEGES” means the authorization granted by the Board to render specific patient care services, for which the Medical Staff Leaders and Board have developed eligibility and other credentialing criteria and focused and ongoing professional practice evaluation standards.
- (6) “CORE PRIVILEGES” means a defined grouping of privileges for a specialty or subspecialty that includes the fundamental patient care services that are routinely taught in residency and/or fellowship training for that specialty or subspecialty and which have been determined by the Medical Staff Leaders and Board to require closely related skills and experience.
- (7) “DAYS” means calendar days.
- (8) “DENTIST” means a doctor of dental surgery (“D.D.S.”) or doctor of dental medicine (“D.M.D.”).
- (9) “HOSPITAL” means Covenant Medical Center.
- (10) “INVESTIGATION” means a formal investigation process initiated by the Medical Executive Committee in accordance with Section 6.C.2 of this Policy. It does not include routine fact-finding that may be conducted by Medical Staff Leaders and/or Hospital staff members.
- (11) “MEDICAL EXECUTIVE COMMITTEE” (“MEC”) means the Executive Committee of the Medical Staff.
- (12) “MEDICAL STAFF” means all physicians, dentists, oral surgeons, and podiatrists who have been appointed to the Medical Staff by the Board.
- (13) “MEDICAL STAFF LEADER” means any Medical Staff Services Officer, department chair, section chief, and committee chair.
- (14) “MEMBER” means any physician, dentist, oral surgeon, and podiatrist who has been granted Medical Staff appointment by the Board.

- (15) “NOTICE” means written communication by regular U.S. mail, Hospital mail, hand delivery, e-mail, facsimile, website, or other electronic method.
- (16) “ORAL AND MAXILLOFACIAL SURGEON” means an individual with a D.D.S. or a D.M.D. degree, who has completed additional training in oral and maxillofacial surgery.
- (17) “ORGANIZED HEALTH CARE ARRANGEMENT” (“OHCA”) means the term used by the HIPAA Privacy Rule which permits the Hospital and Medical Staff to use joint notice of privacy practices information when patients are admitted to the Hospital. Practically speaking, being part of an OHCA allows the members of the Medical Staff to rely upon the Hospital notice of privacy practices and therefore relieves Medical Staff members of their responsibility to provide a separate notice when members consult or otherwise treat Hospital inpatients.
- (18) “PATIENT CONTACT” includes any admission, consultation, procedure, response to emergency call, evaluation, treatment, or service performed in the Hospital or its outpatient facilities. It shall not include referrals for diagnostic or laboratory tests.
- (19) “PERMISSION TO PRACTICE” means the authorization granted to Advance Practice Providers to exercise clinical privileges or a scope of practice.
- (20) “PHYSICIAN” includes both doctors of medicine (“M.D.s”) and doctors of osteopathy (“D.O.s”).
- (21) “SCOPE OF PRACTICE” means the authorization granted to a Category III practitioner to perform certain clinical activities and functions under the supervision of, or in collaboration with, a Supervising Physician.
- (22) “SPECIAL NOTICE” means hand delivery, certified mail (return receipt requested), or overnight delivery service providing receipt.
- (23) “SPECIAL PRIVILEGES” means privileges that fall outside of the core privileges for a given specialty, which require additional education, training, and/or experience beyond that required for core privileges in order to demonstrate competence.
- (24) “SUPERVISING PHYSICIAN” means a member of the Medical Staff with clinical privileges, who has agreed in writing to supervise or collaborate with a Category II or Category III practitioner and to accept responsibility for the actions of the Category II or Category III practitioner while he or she is practicing in the Hospital.
- (25) “SUPERVISION” means the supervision of (or collaboration with) a Category II or Category III practitioner by a Supervising Physician, that may or may not

require the actual presence of the Supervising Physician, but that does require, at a minimum, that the Supervising Physician be readily available for consultation. The requisite level of supervision (general, direct, or personal) shall be determined at the time each Category II or Category III practitioner is credentialed and shall be consistent with any applicable written supervision or collaboration agreement that may exist. (“General” supervision means that the physician is immediately available by phone, “direct” supervision means that the physician is on the Hospital’s campus, and “personal” supervision means that the physician is in the same room.)

- (26) “TELEMEDICINE” means the exchange of medical information from one site to another via electronic communications for the purpose of providing patient care, treatment, and services.
- (27) “UNASSIGNED PATIENT” means any individual who comes to the Hospital for care and treatment who does not have an attending physician, or whose attending physician or designated alternate is unavailable to attend the patient, or who does not want the prior attending physician to provide him/her care while a patient at the Hospital.

1.B. DELEGATION OF FUNCTIONS

- (1) When a function under this Policy is to be carried out by a member of Hospital management, by a Medical Staff member, or by a Medical Staff committee, the individual, or the committee through its chair, may delegate performance of the function to a qualified designee who is a practitioner or Hospital employee (or a committee of such individuals). Any such designee is bound by all the terms, conditions and requirements of this Policy. However, the delegating individual or committee is responsible for ensuring the designee performs the function as required by this Policy.
- (2) When a Medical Staff member is unavailable or unable to perform a necessary function, one or more of the Medical Staff Leaders may perform the function personally or delegate it to another appropriate individual.

ARTICLE 2

QUALIFICATIONS, CONDITIONS, AND RESPONSIBILITIES

2.A. QUALIFICATIONS

2.A.1. Threshold Eligibility Criteria:

To be eligible to apply for initial appointment or reappointment to the Medical Staff, physicians, dentists, oral surgeons, and podiatrists must:

- (a) have a current, unrestricted license to practice in Texas (or New Mexico for individuals practicing at New Mexico sites) and have never had a license to practice revoked or suspended by any state licensing agency;
- (b) where applicable to their practice, have a current, unrestricted DEA registration and state controlled substances registration;
- (c) be available on a continuous basis, either personally or by arranging appropriate coverage, to (i) respond to the needs of any of their patients who have been admitted to the Hospital; and (ii) respond to Emergency Department patients during those times when they are on call in a prompt, efficient, and conscientious manner. Compliance with this eligibility requirement means that the practitioner must document that he or she is willing and able to:
 - (1) respond within 30 minutes, via phone, to all initial phone calls or pages from the Hospital; and
 - (2) appear in person to attend to a patient within 30 minutes of being requested to do so (or more quickly as required for a particular specialty as recommended by the MEC and approved by the Board);
- (d) have current, valid professional liability insurance coverage in a form and in amounts satisfactory to the Hospital;
- (e) have not been convicted of, or entered a plea of guilty or no contest to, Medicare, Medicaid, or other federal or state governmental or private third-party payer fraud or program abuse, nor have been required to pay civil monetary penalties for the same;
- (f) have not been, and are not currently, excluded, precluded, or debarred from participation in Medicare, Medicaid, or other federal or state governmental health care program;

- (g) have not had Medical Staff appointment or clinical privileges denied, revoked, or terminated by any health care facility or health plan for reasons related to clinical competence or professional conduct;
- (h) have not resigned Medical Staff appointment or relinquished privileges during a Medical Staff investigation or in exchange for not conducting such an investigation;
- (i) have not been convicted of, or entered a plea of guilty or no contest, to any felony; or to any misdemeanor relating to controlled substances, illegal drugs, insurance or health care fraud or abuse, child abuse, elder abuse, or violence;
- (j) agree to personally fulfill all responsibilities regarding emergency service call coverage for their practice or to obtain appropriate coverage (as determined by the Centralized Credentials Committee) by another member of the Medical Staff;
- (k) have or agree to make appropriate coverage arrangements (as determined by the Centralized Credentials Committee) with other members of the Medical Staff for those times when the individual will be unavailable;
- (l) demonstrate recent clinical activity in their primary area of practice during the last two years;
- (m) meet any current or future eligibility requirements that are applicable to the clinical privileges being sought;
- (n) document compliance with all applicable training and educational protocols that may be adopted by the MEC or required by the Board, including, but not limited to, those involving electronic medical records, computerized physician order entry (“CPOE”), the privacy and security of protected health information, infection control, and patient safety;
- (o) document compliance with any health screening requirements adopted by the Medical Staff or required by the Board (i.e., TB testing, mandatory flu vaccines, and infectious agent exposures);
- (p) have successfully completed:
 - (1) a residency or fellowship training program approved by the Accreditation Council for Graduate Medical Education (“ACGME”) or the American Osteopathic Association (“AOA”) in the specialty in which the applicant seeks clinical privileges; or
 - (2) a dental or an oral and maxillofacial surgery training program accredited by the Commission on Dental Accreditation of the American Dental Association (“ADA”); or

- (3) a podiatric surgical residency program accredited by the Council on Podiatric Medical Education of the American Podiatric Medical Association; and
- (q) satisfy the following requirements pertaining to board certification:
- (1) For purposes of this provision, board certification means a recognition of competency granted after application and testing by an organization approved by the American Board of Medical Specialties (“ABMS”), the AOA, the American Board of Oral and Maxillofacial Surgery, the ADA, or the American Board of Podiatric Surgery, as applicable.
 - (2) Members of the Medical Staff on the effective date of this Credentials Policy will have no board certification requirement.
 - (3) Practitioners whose applications for privileges are being processed by Medical Staff Affairs on the effective date of this Credentials Policy will have no board certification requirement.
 - (4) Practitioners who submit applications seeking clinical privileges after the effective date of this Credentials Policy and who can demonstrate that they have obtained board certification by one of the boards designated above at some time in their careers will have no further board certification requirement. However, if an individual lost board certification involuntarily for misconduct he or she must obtain board certification in accordance with paragraph (q)(5) below.
 - (5) Physicians who apply for privileges after the effective date of this Credentials Policy and who have never obtained board certification by one of the boards designated above must become board certified within five years of initial appointment to the Medical Staff. During the time such individuals are not board certified, all CME hours required by the Texas Medical Board must be in their areas of specialization. If the applicant does not achieve board certification within five years of joining the Medical Staff, his or her Medical Staff appointment and clinical privileges will be automatically relinquished in accordance with Section 6.E.2 of this Policy. The automatic relinquishment of privileges is not an adverse action reportable to the National Practitioner Data Bank and does not entitle the applicant to a fair hearing.*

* In exceptional circumstances, the five-year time frame for initial applicants may be extended for one additional period not to exceed two years in order to permit an individual an additional opportunity to obtain certification. In order to be eligible to request an extension, an individual must, at a minimum, satisfy the following criteria:

- (1) the individual has been on the Hospital's Medical Staff for at least three consecutive years;
- (2) there have been no documented peer review concerns related to the individual's competence or behavior at the Hospital during the individual's tenure;
- (3) the individual provides a letter from the appropriate certifying board confirming that the individual remains eligible to take the certification examination within the next two years;
- (4) the appropriate department chair/section chief at the Hospital provides a favorable report concerning the individual's qualifications; and
- (5) the individual provides at least two letters of support from other members of the Medical Staff who are in good standing, who are not in the same specialty as the individual, and who have had direct experience in observing and working with the individual.

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

- (a) Any applicant who does not satisfy one or more of the threshold eligibility criteria outlined above may request that it be waived. The applicant requesting the waiver bears the burden of demonstrating exceptional circumstances, and that his or her qualifications are equivalent to, or exceed, the criterion in question.
- (b) A request for a waiver shall be submitted to the Centralized Credentials Committee for consideration. In reviewing the request for a waiver, the Centralized Credentials Committee may consider the specific qualifications of the applicant in question, input from the relevant department chair, and the best interests of the Hospital and the communities it serves. Additionally, the Centralized Credentials Committee may, in its discretion, consider the application form and other information supplied by the applicant. The Centralized Credentials Committee's recommendation will be forwarded to the MEC. Any recommendation to grant a waiver must include the specific basis for the recommendation.
- (c) The MEC shall review the recommendation of the Centralized Credentials Committee and make a recommendation to the Board regarding whether to grant or deny the request for a waiver. Any recommendation to grant a waiver must include the specific basis for the recommendation.
- (d) No applicant is entitled to a waiver or to a hearing if the Board determines not to grant a waiver. A determination that an applicant is not entitled to a waiver is not a "denial" of appointment or clinical privileges. Rather, that individual is

ineligible to request appointment or clinical privileges. A determination of ineligibility is not a matter that is reportable to either the State of Texas or the National Practitioner Data Bank.

- (e) The granting of a waiver in a particular case does not set a precedent for any other applicant or group of applicants.
- (f) An application for appointment that does not satisfy an eligibility criterion will not be processed until the Board has determined that a waiver should be granted.

2.A.3. Factors for Evaluation:

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

- (a) relevant training, experience, and demonstrated current competence, including medical/clinical knowledge, technical and clinical skills, and clinical judgment, and an understanding of the contexts and systems within which care is provided;
- (b) adherence to the ethics of their profession, continuous professional development, an understanding of and sensitivity to diversity, and responsible attitude toward patients and their profession;
- (c) good reputation and character;
- (d) ability to safely and competently perform the clinical privileges requested;
- (e) ability to work harmoniously with others, including, but not limited to, interpersonal and communication skills sufficient to enable them to maintain professional relationships with patients, families, and other members of health care teams; and
- (f) recognition of the importance of, and willingness to support, the Hospital's and Medical Staff's commitment to quality care and a recognition that interpersonal skills and collegiality are essential to the provision of quality patient care.

2.A.4. No Entitlement to Appointment:

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

- (a) is employed by the Hospital or its subsidiaries or has a contract with the Hospital;
- (b) is or is not a member or employee of any particular physician group;

- (c) is licensed to practice a profession in this or any other state;
- (d) is a member of any particular professional organization;
- (e) has had in the past, or currently has, Medical Staff appointment or privileges at any hospital or health care facility;
- (f) resides in the geographic service area of the Hospital; or
- (g) is affiliated with, or under contract to, any managed care plan, insurance plan, HMO, PPO, or other entity.

2.A.5. Nondiscrimination:

No individual shall be denied appointment or reappointment on the basis of gender, race, creed, age, sexual orientation, or national origin.

2.B. GENERAL CONDITIONS OF APPOINTMENT AND REAPPOINTMENT

2.B.1. Basic Responsibilities and Requirements:

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

- (a) to provide continuous and timely quality care either directly or through established coverage to all patients for whom the individual has responsibility;
- (b) to abide by all Bylaws, policies, and Rules and Regulations of the Hospital and Medical Staff in force during the time the individual is appointed;
- (c) to participate in Medical Staff affairs through committee service, participation in quality improvement and professional practice evaluation activities, and by performing such other reasonable duties and responsibilities as may be assigned;
- (d) within the scope of his or her privileges, to provide emergency service call coverage and consultations for their practices' patients;
- (e) to comply with clinical practice or evidence-based medicine protocols that are established by, and must be reported to, regulatory or accrediting agencies or patient safety organizations, including those related to national patient safety initiatives and core measures, or clearly document the clinical reasons for variance;

- (f) to comply with clinical practice or evidence-based medicine protocols pertinent to his or her medical specialty, as may be adopted by the Medical Staff or the Medical Staff leadership, or to clearly document the clinical reasons for variance;
- (g) to notify the Chief of Staff, in writing, of any change in the practitioner's status or any change in the information provided on the individual's application form. Routine administrative changes in information may be provided to the Medical Staff Services Office; however, changes involving the specific issues listed below must be provided to the Chief of Staff, with or without request, at the time of the occurrence of the change:
- any and all changes in licensure status or DEA controlled substance authorization that result from investigative or disciplinary action,
 - changes in the practitioner's Medical Staff status (appointment and/or privileges) at any other hospital or health care entity as a result of peer review activities or in order to avoid initiation of peer review activities,
 - knowledge of a criminal investigation involving the member, arrest, charge, indictment, conviction, or a plea of guilty or no contest in any criminal matter other than a misdemeanor traffic citation,
 - exclusion or preclusion from participation in Medicare/Medicaid or any sanctions imposed,
 - any changes in the practitioner's ability to safely and competently exercise clinical privileges or perform the duties and responsibilities of appointment because of health status issues, including, but not limited to, impairment due to addiction, alcohol use, or other similar issue (all of which shall be referred for review under the Practitioner Health Policy), and
 - any charge of, or arrest for, driving under the influence ("DWI") (Any DWI incident will be reviewed by the Leadership Council so that it may understand the circumstances surrounding it. If it has any concerns after doing so, it will forward the matter for further review under the Practitioner Health Policy or this Credentials Policy.);
- (h) to immediately submit to an appropriate evaluation, which may include diagnostic testing (including, but not limited to, a blood and/or urine test) and/or a complete physical, mental, and/or behavioral evaluation when there is a concern with the individual's ability to safely and competently care for patients. When time is of the essence, this decision may be made by any member of the Leadership Council; otherwise, the decision will be made by the Leadership Council as a whole. The health care professional(s) to perform the testing and/or evaluations must be acceptable to the Leadership Council and the Medical Staff member must

execute all appropriate releases to permit the sharing of information with the Leadership Council;

- (i) to appear for personal or phone interviews in regard to an application for initial appointment or reappointment, if requested;
- (j) to maintain and monitor a current Covenant Health e-mail address with the Medical Staff Services Office, which will be the primary mechanism used to communicate all Medical Staff information to the member;
- (k) to provide a valid and current mobile phone number, pager number, or answering service contact information in order to facilitate practitioner-to-practitioner communication;
- (l) to refrain from illegal fee splitting or other illegal inducements relating to patient referral;
- (m) to refrain from delegating responsibility for hospitalized patients to any individual who is not qualified or adequately supervised;
- (n) to refrain from deceiving patients as to the identity of any individual providing treatment or services;
- (o) to seek consultation whenever required or necessary;
- (p) to complete in a timely and legible manner all medical and other required records, containing all information required by the Hospital, and utilize the electronic medical record as required;
- (q) to cooperate with all utilization oversight activities;
- (r) to participate in the peer review process;
- (s) to participate in an Organized Health Care Arrangement with the Hospital and abide by the terms of the Hospital's Notice of Privacy Practices with respect to health care delivered in the Hospital;
- (t) to perform all services and conduct himself/herself at all times in a cooperative and professional manner;
- (u) to promptly pay any applicable dues, assessments, and/or fines;
- (v) to comply with all applicable training and educational protocols that may be adopted by the MEC or required by the Board, including, but not limited to, those involving electronic medical records, computerized physician order entry

(“CPOE”), the privacy and security of protected health information, infection control, and patient safety;

- (w) to satisfy continuing medical education requirements; and
- (x) that, if there is any substantive misstatement in, or omission from, the application, the Hospital may stop processing the application (or, if appointment has been granted prior to the discovery of a misstatement or omission, appointment and privileges may be deemed to be automatically relinquished). In either situation, there shall be no entitlement to a hearing or appeal. The individual will be informed in writing of the nature of the misstatement or omission and permitted to provide a written response for the Centralized Credentials Committee’s consideration. If this provision is triggered and the Centralized Credentials Committee or MEC makes the determination not to process the application further (or that clinical privileges already granted should be deemed to be automatically relinquished), the individual may not reapply to the Medical Staff for a period of at least one year.

2.B.2. Burden of Providing Information:

- (a) Individuals seeking appointment and reappointment have the burden of producing information deemed adequate by the Hospital for a proper evaluation of current competence, character, ethics, and other qualifications and for resolving any doubts about an individual’s qualifications. The information to be produced includes such quality data and other information as may be needed to assist in an appropriate assessment of overall qualifications for appointment, reappointment, and current clinical competence for any requested clinical privileges, including, but not limited to, information from other hospitals, information from the individual’s office practice, information from insurers or managed care organizations in which the individual participates, and/or receipt of confidential evaluation forms completed by referring/referred to physicians.
- (b) Individuals seeking appointment and reappointment have the burden of providing evidence that all the statements made and information given on the application are accurate and complete.
- (c) An application shall be complete when all questions on the application form have been answered, all supporting documentation has been supplied, all information has been verified from primary sources, and all application fees and applicable fines have been paid. An application shall become incomplete if the need arises for new, additional, or clarifying information at any time during the credentialing process. Any application that continues to be incomplete 30 days after the individual has been notified of the additional information required shall be deemed to be withdrawn.

- (d) The individual seeking appointment or reappointment is responsible for providing a complete application, including adequate responses from references. An incomplete application shall not be processed unless an extension is granted by the Chief of Staff in an emergent situation.

2.C. APPLICATION

2.C.1. Information:

- (a) Applications for appointment and reappointment shall contain a request for specific clinical privileges and shall require detailed information concerning the individual's professional qualifications. The applications for initial appointment and reappointment existing now and as may be revised are incorporated by reference and made a part of this Policy.
- (b) In addition to other information, the applications shall seek the following:
 - (1) information as to whether the applicant's medical staff appointment or clinical privileges have been voluntarily or involuntarily relinquished, withdrawn, denied, revoked, suspended, subjected to probationary or other conditions, reduced, limited, terminated, or not renewed at any other hospital, health care facility, or other organization, or are currently being investigated or challenged;
 - (2) information as to whether the applicant's license to practice any relevant profession in any state, DEA registration, or any state's controlled substance license has been voluntarily or involuntarily suspended, modified, terminated, restricted, or relinquished or is currently being investigated or challenged;
 - (3) information concerning the applicant's professional liability litigation experience, including past and pending claims, final judgments, or settlements; the substance of the allegations as well as the findings and the ultimate disposition; and any additional information concerning such proceedings or actions as the Centralized Credentials Committee, the MEC, or the Board may request;
 - (4) current information regarding the applicant's ability to safely and competently exercise the clinical privileges requested; and
 - (5) a copy of a government-issued photo identification.
- (c) The applicant shall sign the application and certify that he or she is able to perform the privileges requested and the responsibilities of appointment.

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

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

(a) Immunity:

To the fullest extent permitted by law, the individual releases from any and all liability, extends immunity to, and agrees not to sue the Hospital or the Board, any member of the Medical Staff or the Board, their authorized representatives, and third parties who provide information for any matter relating to appointment, reappointment, clinical privileges, or the individual's qualifications for the same. This immunity covers any actions, recommendations, reports, statements, communications, and/or disclosures involving the individual that are made, taken, or received by the Hospital, either directly or through its Medical Staff, authorized agents, or third parties in the course of credentialing and peer review activities.

(b) Authorization to Obtain Information from Third Parties:

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

(c) Authorization to Release Information to Third Parties:

The individual also authorizes Hospital and its authorized representatives to release information to other hospitals, health care facilities, managed care organizations, government regulatory and licensure boards or agencies, and their agents when information is requested in order to evaluate his or her professional qualifications for appointment, privileges, and/or participation at the requesting organization/facility, and any licensure or regulatory matter.

(d) Authorization to Share Information:

The individual specifically authorizes Covenant Health and its affiliated hospitals, either directly or through its authorized agents, to share credentialing and peer

review information pertaining to the individual's clinical competence and/or professional conduct. This information may be shared at initial appointment, reappointment, and/or any other time during the individual's appointment to the Medical Staff at a Covenant Health hospital.

(e) Hearing and Appeal Procedures:

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

(f) Legal Actions:

If, despite this Section, an individual institutes legal action challenging any credentialing, privileging, peer review, or other action affecting appointment or privileges, the individual agrees that the venue and jurisdiction for any such legal action shall be Lubbock, Texas, and that Texas law shall be the governing law. In addition, if the individual does not prevail in such legal action, he or she shall reimburse the Hospital and any member of the Medical Staff or Board involved in the action for all costs incurred in defending such legal action, including reasonable attorney's fees, expert witness fees, and lost revenues.

(g) Scope of Section:

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

- (1) whether or not appointment or clinical privileges are granted;
- (2) throughout the term of any appointment or reappointment period and thereafter;
- (3) should appointment, reappointment, or clinical privileges be revoked, reduced, restricted, suspended, and/or otherwise affected as part of the Hospital's professional review activities; and
- (4) as applicable, to any third-party inquiries received after the individual leaves the Medical Staff about his/her tenure as a member of the Medical Staff.

ARTICLE 3

PROCEDURE FOR INITIAL APPOINTMENT

3.A. PROCEDURE FOR INITIAL APPOINTMENT

3.A.1. Request for Application:

- (a) Applications for appointment shall be in a format approved by the Board, upon recommendation by the MEC and Centralized Credentials Committee.
- (b) An individual seeking initial appointment will be sent a letter that (i) outlines the threshold eligibility criteria for appointment outlined earlier in this Policy, (ii) outlines the applicable criteria for the clinical privileges being sought, and (iii) provides the application form.
- (c) Applications may be provided to residents or fellows who are in the final six months of their training. Such applications may be processed, but final action on the applications shall not become effective until all applicable threshold eligibility criteria are satisfied.

3.A.2. Initial Review of Application:

- (a) A completed application form with copies of all required documents must be returned to the Medical Staff Services Office within 30 days after receipt. The application must be accompanied by the application fee.
- (b) As a preliminary step, the application shall be reviewed by the Medical Staff Services Office to determine that all questions have been answered and that the individual satisfies all threshold eligibility criteria. Incomplete applications shall not be processed. Individuals who fail to return completed applications or fail to meet the threshold eligibility criteria shall be notified that their applications shall not be processed. A determination of ineligibility does not entitle the individual to the hearing and appeal rights outlined in this Policy.
- (c) The Medical Staff Services Office or its designee shall oversee the process of gathering and verifying relevant information, and confirming that all references and other information or materials deemed pertinent have been received.

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

- (a) Evidence of the applicant's character, professional competence, qualifications, behavior, and ethical standing shall be examined. This information may be contained in the application, and obtained from peer references (from the same discipline where practicable) and from other available sources, including the

applicant's past or current department chairs at other health care entities, residency training director, and others who may have knowledge about the applicant's education, training, experience, and ability to work with others.

- (b) An interview(s) with the applicant may be conducted. The purpose of the interview is to discuss and review any aspect of the applicant's application, qualifications, and requested clinical privileges. This interview may be conducted by a combination of any of the following: the department chair, the section chief, the Centralized Credentials Committee, a Centralized Credentials Committee representative, the MEC, the Chief of Staff, and/or the Board or its designee.

3.A.4. Department Chair Procedure:

- (a) The Medical Staff Services Office shall transmit the complete application and all supporting materials to the chair of the department in which the applicant seeks clinical privileges. The department chair, in consultation with the section chief and Centralized Credentials Committee Chair as may be necessary, shall prepare a written report regarding whether the applicant has satisfied all of the qualifications for appointment and the clinical privileges requested on a form provided by the Medical Staff Services Office.
- (b) The department chair shall be available to the Centralized Credentials Committee, the MEC, and the Board to answer any questions that may be raised with respect to the report and findings of that individual.

3.A.5. Centralized Credentials Committee Procedure:

- (a) The Centralized Credentials Committee shall review and consider the report prepared by the relevant department chair and shall make a recommendation.
- (b) The Centralized Credentials Committee may use the expertise of the department chair, the section chief, or any member of the department, or an outside consultant, if additional information is required regarding the applicant's qualifications.
- (c) After determining that an applicant is otherwise qualified for appointment and privileges, the Chair of the Centralized Credentials Committee shall review the applicant's Health Status Confirmation Form to determine if there is any question about the applicant's ability to perform the privileges requested and the responsibilities of appointment. If so, the Centralized Credentials Committee may require the applicant to undergo a physical, mental, and/or behavioral examination by a physician(s) satisfactory to the Centralized Credentials Committee. The results of this examination shall be made available to the Committee for its consideration. Failure of an applicant to undergo an examination within a reasonable time after being requested to do so in writing by the Centralized Credentials Committee shall be considered a voluntary withdrawal of the

application and all processing of the application shall cease. The cost of the health assessment will be borne by the applicant.

- (d) The Centralized 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 Centralized Credentials Committee may also recommend that appointment be granted for a period of less than two years in order to permit closer monitoring of an individual's compliance with any conditions. Unless these matters involve the specific recommendations set forth in Section 7.A.1(a) of this Policy, such conditions do not entitle an individual to request the procedural rights set forth in Article 7 of this Policy.

3.A.6. MEC Recommendation:

- (a) At its next regular meeting after receipt of the written findings and recommendation of the Centralized Credentials Committee, the MEC shall:
 - (1) adopt the findings and recommendation of the Centralized Credentials Committee, as its own; or
 - (2) refer the matter back to the Centralized Credentials Committee for further consideration and responses to specific questions raised by the MEC prior to its final recommendation; or
 - (3) state its reasons in its report and recommendation, along with supporting information, for its disagreement with the Centralized Credentials Committee's recommendation.
- (b) If the recommendation of the MEC is to appoint, the recommendation shall be forwarded to the Board.
- (c) If the recommendation of the MEC is unfavorable and would entitle the applicant to request a hearing in accordance with Section 7.A.1(a) of this Policy, the MEC shall forward its recommendation to the CEO, who shall promptly send Special Notice to the applicant. The CEO shall then hold the application until after the applicant has completed or waived a hearing and appeal.

3.A.7. Board Action:

- (a) The Board may delegate to a committee, consisting of at least two Board members, action on appointment, reappointment, and clinical privileges if there has been a favorable recommendation from the Centralized Credentials Committee and the MEC and there is no evidence of any of the following:

- (1) a current or previously successful challenge to any license or registration;
- (2) an involuntary termination, limitation, reduction, denial, or loss of appointment or privileges at any other hospital or other entity; or
- (3) an unusual pattern of, or an excessive number of, professional liability actions resulting in a final judgment against the applicant.

Any decision reached by the Board Committee to appoint shall be effective immediately and shall be forwarded to the Board for ratification at its next meeting.

- (b) When there has been no delegation to the Board Committee, upon receipt of a recommendation that the applicant be granted appointment and clinical privileges, the Board may:
 - (1) appoint the applicant and grant clinical privileges as recommended; or
 - (2) refer the matter back to the Centralized Credentials Committee or MEC or to another source inside or outside the Hospital for additional research or information; or
 - (3) reject or modify the recommendation.
- (c) If the Board determines to reject a favorable recommendation, it should first discuss the matter with the Chair of the Centralized Credentials Committee and the Chair of the MEC. If the Board's determination remains unfavorable to the applicant, the CEO shall promptly send Special Notice to the applicant that the applicant is entitled to request a hearing.
- (d) Any final decision by the Board to grant, deny, revise or revoke appointment and/or clinical privileges will be disseminated to appropriate individuals and, as required, reported to appropriate entities.

3.A.8. Time Periods for Processing:

Once an application is deemed complete, it is expected to be processed within 90 business days, unless it becomes incomplete. This time period is intended to be a guideline only and shall not create any right for the applicant to have the application processed within this precise time period.

3.B. FPPE TO CONFIRM COMPETENCE AND PROFESSIONALISM

All initially-granted clinical privileges, whether at the time of initial appointment, reappointment, or during the term of appointment, will be subject to focused professional practice evaluation ("FPPE") in order to confirm competence. The FPPE process for

these situations is outlined in the Policy Regarding FPPE to Confirm Practitioner Competence and Professionalism.

ARTICLE 4

CLINICAL PRIVILEGES

4.A. CLINICAL PRIVILEGES

4.A.1. General:

- (a) Appointment or reappointment shall not confer any clinical privileges or right to admit or treat patients at the Hospital. Each individual who has been appointed to the Medical Staff is entitled to exercise only those clinical privileges specifically granted by the Board.
- (b) For privilege requests to be processed, the applicant must satisfy any applicable threshold eligibility criteria.
- (c) Requests for clinical privileges that are subject to an exclusive contract will not be processed except as consistent with the contract.
- (d) Requests for clinical privileges that have been grouped into core privileges will not be processed unless the individual has applied for the full core and satisfied all threshold eligibility criteria (or has obtained a waiver in accordance with Section 4.A.2).
- (e) The clinical privileges recommended to the Board shall be based upon consideration of the following factors:
 - (1) education, relevant training, experience, and demonstrated current competence, including medical/clinical knowledge, technical and clinical skills, clinical judgment, interpersonal and communication skills, and professionalism with patients, families, and other members of the health care team and peer evaluations relating to these criteria;
 - (2) appropriateness of utilization patterns;
 - (3) ability to perform the privileges requested competently and safely;
 - (4) information resulting from ongoing and focused professional practice evaluation and other performance improvement activities, as applicable;
 - (5) availability of other qualified staff members with appropriate privileges (as determined by the Centralized Credentials Committee) to provide coverage in case of the applicant's illness or unavailability;

- (6) adequate professional liability insurance coverage for the clinical privileges requested;
 - (7) the Hospital's available resources and personnel;
 - (8) any previously successful or currently pending challenges to any licensure or registration, or the voluntary or involuntary relinquishment of such licensure or registration;
 - (9) any information concerning professional review actions or voluntary or involuntary termination, limitation, reduction, or loss of appointment or clinical privileges at another hospital;
 - (10) practitioner-specific data as compared to aggregate data, when available;
 - (11) morbidity and mortality data related to the specific individual, and when statistically and qualitatively significant and meaningful, when available; and
 - (12) professional liability actions, especially any such actions that reflect an unusual pattern or excessive number of actions.
- (f) Core privileges, special privileges, privilege delineations, and/or the criteria for the same shall be developed by the relevant section chief, department chair, and/or relevant specialty expert and shall be forwarded to the Centralized Credentials Committee for review and recommendation. The Centralized Credentials Committee will forward its recommendations to the MEC, which will review the matter and forward its recommendations to the Board for final action.
 - (g) The applicant has the burden of establishing his or her qualifications and current competence for all clinical privileges requested.
 - (h) The report of the chair of the clinical department (and/or section chief) in which privileges are sought shall be forwarded to the Chair of the Centralized Credentials Committee and processed as a part of the initial application for staff appointment.

4.A.2. Privilege Modifications and Waivers:

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

- (b) Submitting a Request. Requests for privilege modifications, waivers, and resignations must be submitted in writing or electronically to the Medical Staff Services Office.
- (c) Increased Privileges.
 - (1) Requests for increased privileges must state the specific additional clinical privileges requested and provide information sufficient to establish eligibility, as specified in applicable criteria, and current clinical competence.
 - (2) If the individual is eligible and the application is complete, it will be processed in the same manner as an application for initial clinical privileges.
- (d) Waivers.
 - (1) Any individual who does not satisfy one or more eligibility criteria for clinical privileges may request that it be waived. The individual requesting the waiver bears the burden of demonstrating **exceptional** circumstances, and that his or her qualifications are equivalent to, or exceed, the criterion in question.
 - (2) If the individual is requesting a waiver of the requirement that each member apply for the full core of privileges in his or her specialty, the process set forth in this paragraph shall apply.
 - (i) Formal Request: The individual must forward a written or electronic request to the Medical Staff Services Office, which must indicate the specific patient care services within the core that the member does not wish to provide, state a good cause basis for the request, and include evidence that the individual does not provide the patient care services at issue in any health care facility.
 - (ii) On-Call Obligations: By applying for a waiver related to limiting the scope of core privileges, the individual nevertheless agrees to participate in the on-call schedule as required by his or her practice and by his or her ER coverage contract. If, upon assessment, a patient needs a service that is no longer provided by the individual pursuant to the waiver, the individual shall work cooperatively with the other physicians in arranging for another individual with appropriate clinical privileges to care for the patient or, if such an individual is not available, in arranging for the patient's transfer.
 - (iii) Review Process: A request for a waiver shall be submitted to the Centralized Credentials Committee for consideration. In reviewing

the request for a waiver, the Centralized Credentials Committee shall specifically consider the factors outlined in Paragraph (f) below and may obtain input from the relevant department chair. The Centralized Credentials Committee's recommendation will be forwarded to the MEC, which shall review the recommendation of the Centralized Credentials Committee and make a recommendation to the Board regarding whether to grant or deny the request for a waiver. Any recommendation to grant a waiver must include the specific basis for the recommendation.

- (e) Relinquishment and Resignation of Privileges.
 - (1) Relinquishment of Individual Privileges. A request to relinquish any individual clinical privilege, whether or not part of the core, must provide a good cause basis for the modification of privileges. All such requests will be processed in the same manner as a request for waiver, as described above.
 - (2) Resignation of Appointment and Privileges. A request to resign Medical Staff appointment and relinquish all clinical privileges must specify the desired date of resignation, which must be at least 30 days from the date of the request, and be accompanied by evidence that the individual:
 - (i) has completed all medical records; and
 - (ii) will be able to appropriately discharge or transfer responsibility for the care of any hospitalized patient who is under the individual's care at the time of resignation.
- (f) Factors for Consideration. The Leadership Council and Board may consider the following factors, among others, when deciding whether to recommend or grant a modification (increases and/or relinquishments) or waiver related to privileges:
 - (1) the Hospital's mission and ability to serve the health care needs of the community by providing timely, appropriate care within its facilities;
 - (2) whether sufficient notice has been given to provide a smooth transition of patient care services;
 - (3) fairness to the individual requesting the modification or waiver, including past service and the other demands placed upon the individual; and
 - (4) how the request may affect the Hospital's ability to comply with applicable regulatory requirements, including the Emergency Medical Treatment and Active Labor Act.

- (g) Effective Date. If the Board grants a modification or waiver related to privileges, it shall specify the date that the modification or waiver will be effective. Failure of a member to request privilege modifications or waivers in accordance with this section shall, as applicable, result in the member retaining Medical Staff appointment and clinical privileges and all associated responsibilities.
- (h) Procedural Rights. No individual is entitled to a modification or waiver related to privileges. Individuals are also not entitled to a hearing or appeal or other process if a waiver or a modification related to a relinquishment of privileges is not granted.

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

- (a) Requests for clinical privileges to perform either a procedure not currently being performed at the Hospital or a new technique to perform an existing procedure (hereafter, “new procedure”) shall not be processed until (1) a determination has been made that the procedure shall be offered by the Hospital and (2) criteria to be eligible to request those clinical privileges have been established as set forth in this Section.
- (b) If the new procedure will require additional Hospital resources, as an initial step in the process, the individual seeking to perform the new procedure will prepare and submit a report to the department chair and the CMO addressing the following:
 - (1) appropriate education, training, and experience necessary to perform the new procedure safely and competently;
 - (2) clinical indications for when the new procedure is appropriate;
 - (3) whether there is empirical evidence of improved patient outcomes with the new procedure or other clinical benefits to patients;
 - (4) whether proficiency for the new procedure is volume-sensitive and if the requisite volume would be available;
 - (5) whether the new procedure is being performed at other similar hospitals and the experiences of those institutions; and
 - (6) whether the Hospital currently has the resources, including space, equipment, personnel, and other support services, to safely and effectively perform the new procedure.

Hospital administration shall review this report and consult with the Chief of Staff, the department chair, the section chief or other relevant specialty expert, and the Centralized Credentials Committee (any of which may conduct additional

research as may be necessary) and shall make a preliminary determination as to whether the new procedure should be offered to the community.

- (c) If the preliminary determination is favorable, the Centralized Credentials Committee, in consultation with the relevant department and/or clinical section leadership, will determine whether the request does constitute a “new procedure” as defined by this Section and, if it does, will then develop threshold credentialing criteria to determine those individuals who are eligible to request the clinical privileges at the Hospital. In developing the criteria, the Centralized Credentials Committee may conduct additional research and consult with the section and other experts, as necessary, and develop recommendations regarding:
 - (1) the appropriate education, training, and experience necessary to perform the procedure or service;
 - (2) the clinical indications for when the procedure or service is appropriate;
 - (3) the extent (time frame and mechanism) of focused monitoring and supervision that should occur if the privileges are granted in order to confirm competence; and
 - (4) the manner in which the procedure would be reviewed as part of the Hospital’s ongoing and focused professional practice evaluation activities.
- (d) The Centralized Credentials Committee will forward its recommendations to the MEC, which will review the matter and forward its recommendations to the Board for final action.
- (e) The Board will make a reasonable effort to render the final decision within 60 days of receipt of the MEC’s recommendation. If the Board determines to offer the procedure or service, it will then establish the minimum threshold qualifications that an individual must demonstrate in order to be eligible to request the clinical privileges in question.
- (f) Once the foregoing steps are completed, specific requests from eligible Medical Staff members who wish to perform the procedure or service may be processed.

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

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

- (b) As an initial step in the process, the individual seeking the privilege will prepare and submit a report to the Centralized Credentials Committee that specifies the minimum qualifications needed to perform the procedure safely and competently, whether the individual's specialty is performing the privilege at other similar hospitals, and the experiences of those other hospitals in terms of patient care outcomes and quality of care.
- (c) The Centralized Credentials Committee shall then conduct additional research and consult with experts, as necessary, including those on the Medical Staff (e.g., department chairs, section chiefs or other relevant specialty expert, individuals on the Medical Staff with special interest and/or expertise) and those outside the Hospital (e.g., other hospitals, residency training programs, specialty societies).
- (d) The Centralized Credentials Committee may or may not recommend that individuals from different specialties be permitted to request the privileges at issue. If it does, the Committee may develop recommendations regarding:
 - (1) the appropriate education, training, and experience necessary to perform the clinical privileges in question;
 - (2) the clinical indications for when the procedure is appropriate;
 - (3) the manner of addressing the most common complications that arise which may be outside of the scope of the clinical privileges that have been granted to the requesting individual;
 - (4) the extent (time frame and mechanism) of focused monitoring and supervision that should occur if the privileges are granted in order to confirm competence;
 - (5) the manner in which the procedure would be reviewed as part of the Hospital's ongoing and focused professional practice evaluation activities (which may include assessment of both long-term and short-term outcomes for all relevant specialties); and
 - (6) the impact, if any, on emergency call responsibilities.
- (e) The Centralized Credentials Committee shall forward its recommendations to the MEC, which shall review the matter and forward its recommendations to the Board for final action. The Board shall make a reasonable effort to render the final decision within 60 days of receipt of the MEC's recommendation.
- (f) Once the foregoing steps are completed, specific requests from eligible Medical Staff members who wish to exercise the privileges in question may be processed.

4.A.5. Clinical Privileges for Dentists and Oral and Maxillofacial Surgeons:

- (a) The scope and extent of surgical procedures that a dentist or an oral and maxillofacial surgeon may perform in the Hospital shall be delineated and recommended in the same manner as other clinical privileges.
- (b) Surgical procedures performed by dentists or oral and maxillofacial surgeons shall be under the overall supervision of the relevant department chair. A medical history and physical examination of the patient shall be made and recorded by a qualified practitioner who has been granted clinical privileges to complete medical histories and physical examinations before dental surgery shall be performed (with the exception of (c) below), and a designated physician shall be responsible for the medical care of the patient throughout the period of hospitalization.
- (c) Oral and maxillofacial surgeons who admit patients without underlying health problems may perform a complete admission history and physical examination and assess the medical risks of the procedure on the patient if they are deemed qualified to do so by the Centralized Credentials Committee and MEC.
- (d) The dentist or oral and maxillofacial surgeon shall be responsible for the dental care of the patient, including the dental history and dental physical examination, as well as all appropriate elements of the patient's record. Dentists and oral and maxillofacial surgeons may write orders within the scope of their license and consistent with the Medical Staff Rules and Regulations and in compliance with the Hospital and Medical Staff Bylaws and this Policy.

4.A.6. Clinical Privileges for Podiatrists:

- (a) The scope and extent of surgical procedures that a podiatrist may perform in the Hospital shall be delineated and recommended in the same manner as other clinical privileges.
- (b) Surgical procedures performed by podiatrists shall be under the overall supervision of the relevant department chair. A medical history and physical examination of each patient shall be made and recorded by a qualified practitioner who has been granted clinical privileges to complete medical histories and physical examinations before podiatric surgery shall be performed, and a designated physician shall be responsible for the medical care of the patient throughout the period of hospitalization.
- (c) The podiatrist shall be responsible for the podiatric care of the patient, including the podiatric history and the podiatric physical examination, as well as all appropriate elements of the patient's record. Podiatrists may write orders which are within the scope of their license and consistent with the Medical Staff Rules

and Regulations and in compliance with the Hospital and Medical Staff Bylaws and this Policy.

4.A.7. Physicians in Training:

- (a) Physicians in residency training shall not hold appointments to the Medical Staff and shall not be granted specific privileges. The program director, clinical faculty, and/or attending staff member shall be responsible for the direction and supervision of the on-site and/or day-to-day patient care activities of each trainee, who shall be permitted to perform only those clinical functions set out in curriculum requirements, affiliation agreements, and/or training protocols approved by the Hospital and the MEC or their designee(s). The applicable program director shall be responsible for verifying and evaluating the qualifications of each physician in training.
- (b) A physician in training at the fellowship level may also request clinical privileges in an area for which he or she has already completed residency training if he or she can demonstrate that all necessary eligibility criteria as set forth in this Policy have been met. Requests for privileges shall be reviewed in accordance with the initial credentialing process outlined in this Policy and, if granted, shall be subject to all relevant oversight provisions, including ongoing and focused professional practice evaluation. Physicians in training at the fellowship level may not be granted clinical privileges in the specialty area in which they are currently in training as part of their training program.

4.A.8. Telemedicine Privileges:

- (a) To provide telemedicine services, a qualified individual must be a member of the Medical Staff and must be granted telemedicine privileges.
- (b) Requests for initial or renewed telemedicine privileges shall be processed through the Centralized Credentials Committee. A request for telemedicine privileges will be processed through the same process for Medical Staff applications as set forth in this Policy. The individual must satisfy all qualifications and requirements set forth in this Policy, except those relating to geographic location, coverage arrangements, and emergency call responsibilities.
- (c) Telemedicine privileges, if granted, shall be for a period of not more than two years.
- (d) Individuals granted telemedicine privileges shall be subject to the Hospital's peer review activities. The results of the peer review activities, including any adverse events and complaints filed about the practitioner providing telemedicine services from patients, other practitioners or staff, will be shared with the entity providing telemedicine services.

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

4.B. TEMPORARY CLINICAL PRIVILEGES

4.B.1. Eligibility to Request Temporary Clinical Privileges:

- (a) Applicants. To receive temporary privileges, an applicant must be reviewed and approved by the Chief of Staff. After approval, the CEO, acting as the representative of the Board, may grant temporary privileges effective immediately. The granting of temporary privileges must be reviewed and approved by the Board at its next regularly scheduled meeting. Temporary privileges may be granted only for urgent patient care needs and only under the following conditions:
 - (1) the applicant has submitted a complete application, along with any application fee;
 - (2) the verification process is complete, including verification of current licensure, relevant training or experience, current competence, ability to exercise the privileges requested, and current professional liability coverage; compliance with privileges criteria; and consideration of information from the National Practitioner Data Bank, from a criminal background check, and from OIG queries;
 - (3) the applicant demonstrates that (i) there are no current or previously successful challenges to his or her licensure or registration, and (ii) he or she has not been subject to involuntary termination of Medical Staff membership or involuntary limitation, reduction, denial, or loss of clinical privileges, at another health care facility;
 - (4) the application is pending review by the MEC and the Board, following a favorable recommendation by the Centralized Credentials Committee, after considering the evaluation of the department chair; and
 - (5) temporary privileges for a Medical Staff applicant will be granted for a maximum period of 120 consecutive days.
- (b) Locum Tenens. To receive locum tenens temporary privileges, an applicant must be reviewed and approved by the Chief of Staff. After approval, the CEO, acting as the representative of the Board, may grant locum tenens temporary privileges effective immediately. The granting of locum tenens temporary privileges must be reviewed and approved by the Board at its next regularly scheduled meeting. Locum tenens temporary privileges (both admitting and treatment) may be granted only to an individual serving as a locum tenens for a member of the Medical Staff who is on vacation, attending an educational seminar, or ill, and/or

otherwise needs coverage assistance for a period of time, and only under the following conditions:

- (1) the applicant has submitted an appropriate application, along with any application fee;
 - (2) the verification process is complete, including verification of current licensure, relevant training or experience, current competence (verification of good standing in at least the five most recent hospitals in which the individual practiced), ability to exercise the privileges requested, and current professional liability coverage; compliance with privileges criteria; and consideration of information from the National Practitioner Data Bank, from a criminal background check, and from OIG queries;
 - (3) the applicant demonstrates that (i) there are no current or previously successful challenges to his or her licensure or registration, and (ii) he or she has not been subject to involuntary termination of Medical Staff membership or involuntary limitation, reduction, denial, or loss of clinical privileges, at another health care facility;
 - (4) the applicant has received a favorable recommendation from the Centralized Credentials Committee Chair, after considering the evaluation of the department chair;
 - (5) the applicant will be subject to any focused professional practice requirements established by the Hospital; and
 - (6) the individual may exercise locum tenens privileges for a maximum of 180 days, consecutive or not, anytime during the 24-month period following the date they are granted, subject to the following conditions:
 - (i) the individual must notify the Medical Staff Services Office at least 15 days prior to each time that s/he will be exercising these privileges (exceptions for shorter notice periods may be considered in situations involving health issues); and
 - (ii) along with this notification, the individual must inform the Medical Staff Services Office of any change that has occurred to any of the information provided on the initial application for locum tenens privileges.
 - (7) Individuals serving as locum tenens are non-staff practitioners and are not eligible for Medical Staff membership.
- (c) Visiting. Temporary privileges may also be granted in other limited situations by the CEO, upon recommendation of the Chief of Staff and the applicable

department chair, when there is an important patient care, treatment, or service need. Specifically, temporary privileges may be granted for situations such as the following:

- (1) the care of a specific patient;
- (2) when a proctoring or consulting physician is needed, but is otherwise unavailable; or
- (3) when necessary to prevent a lack or lapse of services in a needed specialty area.

The following factors will be considered and verified prior to the granting of temporary privileges in these situations: current licensure, relevant training or experience, current competence (verification of good standing in all hospitals where the individual practiced for at least the previous two years), current professional liability coverage acceptable to the Hospital, and results of a query to the National Practitioner Data Bank, from a criminal background check, and from OIG queries. The grant of clinical privileges in these situations will not exceed 60 days. In exceptional situations, this period of time may be extended in the discretion of the CEO and the Chief of Staff.

- (d) Automatic Expiration. All grants of temporary privileges shall automatically expire upon the date specified at the time of initial granting unless further affirmative action is taken by the relevant department chair, the Chair of the Centralized Credentials Committee, the Chief of Staff, and the CEO with approval of the Board to renew such temporary privileges.
- (e) Compliance with Bylaws and Policies. Prior to any temporary privileges being granted, the individual must agree in writing to be bound by the bylaws, rules and regulations, policies, procedures, and protocols of the Medical Staff and the Hospital.
- (f) FPPE. Individuals who are granted temporary privileges will be subject to the Hospital policy regarding focused professional practice evaluation.

4.B.2. Supervision Requirements:

Special requirements of supervision and reporting may be imposed on any individual granted temporary clinical privileges.

4.B.3. Withdrawal of Temporary Clinical Privileges:

- (a) The CEO may withdraw temporary admitting privileges at any time, after consulting with the Chief of Staff, the Chair of the Centralized Credentials Committee, the department chair, the section chief, or the CMO. Clinical

privileges shall then expire as soon as patients have been discharged or alternate care has been arranged.

- (b) If the care or safety of patients might be endangered by continued treatment by the individual granted temporary privileges, the CEO, the department chair, the Chief of Staff, or the CMO may immediately withdraw all temporary privileges. The department chair or the Chief of Staff shall assign to another member of the Medical Staff responsibility for the care of such individual's patients until they are discharged or an appropriate transfer arranged. Whenever possible, consideration shall be given to the wishes of the patient in the selection of a substitute physician.

4.C. EMERGENCY SITUATIONS

- (1) For the purpose of this section, an "emergency" is defined as a condition which could result in serious or permanent harm to a patient(s) and in which any delay in administering treatment would add to that harm.
- (2) In an emergency situation, a member of the Medical Staff may administer treatment to the extent permitted by his or her license, regardless of department status or specific grant of clinical privileges.
- (3) When the emergency situation no longer exists, the patient shall be assigned by the department chair or the Chief of Staff to a member with appropriate clinical privileges, considering the wishes of the patient.

4.D. DISASTER PRIVILEGES

- (1) When the disaster plan has been implemented and the immediate needs of patients in the facility cannot be met, the CEO, the CMO, or the Chief of Staff may use a modified credentialing process to grant disaster privileges to eligible volunteer licensed independent practitioners ("volunteers"). Safeguards must be in place to verify that volunteers are competent to provide safe and adequate care.
- (2) Disaster privileges are granted on a case-by-case basis after verification of identity and licensure.
 - (a) A volunteer's identity may be verified through a valid government-issued photo identification (i.e., driver's license or passport).
 - (b) A volunteer's license may be verified in any of the following ways:
 - (i) current Hospital picture ID card that clearly identifies the individual's professional designation;
 - (ii) current license to practice;
 - (iii) primary source verification of the license;
 - (iv) identification indicating that the individual has been granted authority to render patient care in disaster circumstances or is a member of a Disaster Medical Assistance Team, the

Medical Resource Corps, the Emergency System for Advance Registration of Volunteer Health Professionals, or other recognized state or federal organizations or groups; or (v) identification by a current Hospital employee or Medical Staff member who possesses personal knowledge regarding the individual's ability to act as a volunteer during a disaster.

- (3) Primary source verification of a volunteer's license will begin as soon as the immediate situation is under control and must be completed within 72 hours from the time the volunteer begins to provide service at the Hospital.
- (4) In extraordinary circumstances when primary source verification cannot be completed within 72 hours, it should be completed as soon as possible. In these situations, there must be documentation of the following: (a) the reason primary source verification could not be performed in the required time frame; (b) evidence of the volunteer's demonstrated ability to continue to provide adequate care; and (c) an attempt to obtain primary source verification as soon as possible. If a volunteer has not provided care, then primary source verification is not required.
- (5) The Medical Staff will oversee the care provided by volunteer licensed independent practitioners. This oversight shall be conducted through direct observation, mentoring, clinical record review, or other appropriate mechanism developed by the Medical Staff and Hospital.

4.E. CONTRACTS FOR SERVICES

From time to time, the Hospital may enter into contracts with practitioners and/or groups of practitioners for the performance of clinical and administrative services at the Hospital. All individuals providing clinical services pursuant to such contracts will obtain and maintain clinical privileges at the Hospital, in accordance with the terms of this Policy.

ARTICLE 5

PROCEDURE FOR REAPPOINTMENT

5.A. PROCEDURE FOR REAPPOINTMENT

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

5.A.1. Eligibility for Reappointment:

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

- (a) completed all medical records and be current at time of reappointment;
- (b) completed all continuing medical education requirements;
- (c) satisfied all Medical Staff responsibilities, including payment of dues, fines, and assessments;
- (d) continued to meet all qualifications and criteria for appointment and the clinical privileges requested, including those set forth in Section 2.A.1 of this Policy;
- (e) if applying for clinical privileges, had sufficient patient contacts to enable the assessment of current clinical judgment and competence for the privileges requested. Any individual seeking reappointment who has minimal activity at the Hospital must submit such information as may be requested (such as a copy of his/her confidential quality profile from his/her primary hospital, clinical information from the individual's private office practice, and/or a quality profile from a managed care organization or insurer), before the application shall be considered complete and processed further; and
- (f) paid any reappointment processing fee.

5.A.2. Factors for Evaluation:

In considering an individual's application for reappointment, the factors listed in Section 2.A.3 of this Policy will be considered. Additionally, the following factors will be evaluated as part of the reappointment process:

- (a) compliance with the Bylaws, rules and regulations, and policies of the Medical Staff and the Hospital;

- (b) participation in Medical Staff duties, including committee assignments, emergency call as may be required by contract, consultation requests, quality of medical record documentation, cooperation with case management, participation in quality improvement, utilization activities, and professional practice evaluation activities, and such other reasonable duties and responsibilities as assigned;
- (c) the results of the Hospital's performance improvement and professional practice evaluation activities, taking into consideration practitioner-specific information compared to aggregate information concerning other individuals in the same or similar specialty (provided that, other practitioners will not be identified);
- (d) any focused professional practice evaluations;
- (e) verified complaints received from patients, families, and/or staff; and
- (f) other reasonable indicators of continuing qualifications.

5.A.3. Reappointment Application:

- (a) An application for reappointment shall be furnished to members at least six months prior to the expiration of their current appointment term. A completed reappointment application must be returned to the Medical Staff Services Office within 30 days.
- (b) Failure to return a completed application within 30 days may result in the assessment of a reappointment late fee, which must be paid prior to the application being processed. In addition, failure to submit a complete application at least one month prior to the expiration of the member's current term shall result in the automatic expiration of appointment and clinical privileges at the end of the then current term of appointment unless the application can still be processed in the normal course, without extraordinary effort on the part of the Medical Staff Services Office and the Medical Staff Leaders. If an individual's privileges lapse due to a processing delay, subsequent Board action may be to grant reappointment and renewal of clinical privileges using the filed application, in accordance with the expedited process set forth in Section 3.A.7(a).
- (c) Reappointment shall be for a period of not more than two years.
- (d) The application shall be reviewed by the Medical Staff Services Office to determine that all questions have been answered and that the individual satisfies all threshold eligibility criteria for reappointment and for the clinical privileges requested.
- (e) The Medical Staff Services Office shall oversee the process of gathering and verifying relevant information and shall also be responsible for confirming that all relevant information has been received.

5.A.4. Processing Applications for Reappointment:

- (a) The Medical Staff Services Office shall forward the application to the relevant department chair and the Centralized Credentials Committee Chair and the application for reappointment shall be processed in a manner consistent with applications for initial appointment.
- (b) Additional information may be requested from the applicant if any questions or concerns are raised with the application or if new privileges are requested.

5.A.5. Conditional Reappointments:

- (a) Recommendations for reappointment and renewed privileges may be contingent upon an individual's compliance with certain specific conditions. 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). Unless the conditions involve the matters set forth in Section 7.A.1(a) of this Policy, the imposition of such conditions does not entitle an individual to request the procedural rights set forth in Article 7 of this Policy.
- (b) Reappointments may be recommended for periods of less than two years in order to permit closer monitoring of an individual's compliance with any conditions that 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 7.
- (c) In addition, in the event the applicant for reappointment is the subject of an unresolved professional practice evaluation concern, a formal investigation, or a hearing at the time reappointment is being considered, a conditional reappointment for a period of less than two years may be granted pending the completion of that process.

5.A.6. Potential Adverse Recommendation:

- (a) If the Centralized Credentials Committee or the MEC is considering a recommendation to deny reappointment or to reduce clinical privileges, the committee chair will notify the member of the possible recommendation and invite the member to meet prior to any final recommendation being made.
- (b) Prior to this meeting, the member will be notified of the general nature of the information supporting the recommendation contemplated.

- (c) At the meeting, the member will be invited to discuss, explain, or refute this information. A summary of the interview will be made and included with the committee's recommendation.
- (d) This meeting is not a hearing, and none of the procedural rules for hearings will apply. The member will not have the right to be accompanied by legal counsel at this meeting and no recording (audio or video) of the meeting shall be permitted or made.

5.A.7. Time Periods for Processing:

Once an application is deemed complete and verified, it is expected to be processed within 90 days, unless it becomes incomplete. This time period is intended to be a guideline only and shall not create any right for the applicant to have the application processed within this precise time period.

ARTICLE 6

QUESTIONS INVOLVING MEDICAL STAFF MEMBERS

6.A. COLLEGIAL INTERVENTION AND PROGRESSIVE STEPS

- (1) This Policy encourages the use of progressive steps by Medical Staff Leaders and Hospital management, beginning with collegial and educational efforts, 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) All of these efforts are fundamental components of the Hospital's professional practice evaluation activities, and are confidential and protected in accordance with Texas law.
- (3) "Collegial Intervention" means a face-to-face discussion between a Medical Staff member and one or more Medical Staff Leaders, including the CMO. The CMO may participate at the Leadership Council's request. There will be a follow-up letter that summarizes the discussion and, when applicable, the expectations regarding the practitioner's future practice and/or conduct in the Hospital. The follow-up letter may include a Performance Improvement Plan.
- (4) Collegial intervention efforts involve reviewing and following up on questions raised about the clinical practice and/or conduct of Medical Staff members and conducting counseling, education, and related steps, such as the following:
 - (a) advising colleagues of all applicable policies, such as policies regarding appropriate behavior, communication issues, emergency call obligations, and the timely and adequate completion of medical records; and
 - (b) sharing comparative quality, utilization, and other relevant information, including any variations from clinical practice or evidence-based protocols or guidelines, in order to assist individuals to conform their practices to appropriate norms.
- (5) The relevant Medical Staff Leader(s) shall document collegial intervention efforts in an individual's confidential file. The individual shall have an opportunity to review any formal documentation prepared by the Medical Staff Leader(s) and respond in writing. The response shall be maintained in that individual's file along with the original documentation.
- (6) Collegial intervention efforts are encouraged, but are not mandatory, and shall be within the discretion of the appropriate Medical Staff Leaders, including the CMO.

- (7) Should a recommendation be made or an action taken that entitles a Medical Staff member to a hearing in accordance with this Policy, the member is entitled to be accompanied by legal counsel at that hearing. However, Medical Staff members do not have the right to be accompanied by counsel when the Medical Staff leadership is engaged in collegial intervention efforts or other progressive steps. These efforts are intended to resolve issues in a constructive manner and do not involve the formal hearing process. In addition, there shall be no recording (audio or video) or transcript made of any meetings that involve collegial intervention or progressive steps activities.
- (8) When a question arises, the Medical Staff and/or Hospital Leaders may address it pursuant to the collegial intervention provisions of this Section, refer the matter for review in accordance with the Professional Practice Evaluation Policy, Professionalism Policy, Practitioner Health Policy, or other relevant policy, or refer it to the MEC for its review and consideration.

6.B. PROFESSIONAL PRACTICE EVALUATION ACTIVITIES

Professional practice evaluation activities shall be conducted in accordance with the Professional Practice Evaluation Policy, the Professionalism Policy, and/or the Practitioner Health Policy. Matters that are not satisfactorily resolved through collegial intervention efforts or through one of these policies shall be referred to the MEC for its review in accordance with Section 6.C below. Such interventions and evaluations, however, are not mandatory prerequisites to MEC review.

6.C. INVESTIGATIONS

6.C.1. Initial Review:

- (a) Whenever a serious question has been raised, where collegial efforts or actions under the Professional Practice Evaluation Policy have not resolved an issue, and/or when there is a single instance of such severity that in the discretion of Medical Staff Leaders it requires further review, regarding:
 - (1) the clinical competence or clinical practice of any member of the Medical Staff, including the care, treatment or management of a patient or patients;
 - (2) the safety of or proper care being provided to patients;
 - (3) the known or suspected violation by any member of the Medical Staff of applicable ethical standards or the Bylaws, rules and regulations, and policies of the Hospital or the Medical Staff; and/or
 - (4) conduct by any member of the Medical Staff 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 member to work harmoniously with others,

the matter will be referred to the Leadership Council.

- (b) In addition, if the Board becomes aware of information that raises concerns about any Medical Staff member, the matter shall be referred to the Chief of Staff, the department chair, the section chief, the chair of a standing committee, the CMO, or the CEO for review and appropriate action in accordance with this Policy.
- (c) The person to whom the matter is referred shall conduct or arrange for an inquiry to determine whether the question raised has sufficient credibility to warrant further review and, if so, shall forward it in writing to the MEC.
- (d) No action taken pursuant to this Section shall constitute an investigation.

6.C.2. Initiation of Investigation:

- (a) When a question involving clinical competence or professional conduct is referred to, or raised by, the MEC, the MEC shall review the matter and determine whether to conduct an investigation, to direct the matter to be handled pursuant to another policy (e.g., Professionalism Policy; Practitioner Health Policy; Professional Practice Evaluation Policy), or to proceed in another manner. The MEC may determine to refer matters involving disruptive behavior or sexual harassment to the Board for further action. Prior to making its determination, the MEC may discuss the matter with the individual. An investigation shall begin only after a formal determination by the MEC to do so.
- (b) The MEC shall inform the individual that an investigation has begun. Notification may be delayed if, in the MEC's judgment, informing the individual immediately would compromise the investigation or disrupt the operation of the Hospital or Medical Staff.

6.C.3. Investigative Procedure:

- (a) Once a determination has been made to begin an investigation, the MEC shall either investigate the matter itself, request that the Centralized Credentials Committee conduct the investigation, or appoint an ad hoc committee to conduct the investigation, keeping in mind the conflict of interest guidelines outlined in Article 8. Any ad hoc committee may include individuals not on the Medical Staff. Whenever the questions raised concern the clinical competence of the individual under review, the ad hoc committee shall include a peer of the individual (e.g., physician, dentist, oral surgeon, or podiatrist).
- (b) The committee conducting the investigation ("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:

- (1) the clinical expertise needed to conduct the review is not available on the Medical Staff;
 - (2) the individual under review is likely to raise, or has raised, questions about the objectivity of other practitioners on the Medical Staff;
 - (3) 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; or
 - (4) the thoroughness and objectivity of the investigation would be aided by such an external review.
- (c) The investigating committee may require a physical, mental, and/or behavioral examination of the individual by health care professional(s) acceptable to it. The individual being investigated shall execute a release (in a form approved or provided by the investigating committee) allowing (i) the investigating committee (or its representative) to discuss with the health care professional(s) conducting the examination the reasons for the examination; and (ii) the health care professional(s) conducting the examination to discuss and provide documentation of the results of such examination directly to the investigating committee. The cost of such health examination shall be borne by the individual.
- (d) The individual shall have an opportunity to meet with the investigating committee in person 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. No recording (audio or video) or transcript of the meeting shall be permitted or made. A summary of the interview shall be prepared by the investigating committee and included with its report. This meeting is not a hearing, and none of the procedural rules for hearings shall apply. The individual being investigated shall not have the right to be accompanied by legal counsel at this meeting.
- (e) The investigating committee shall make a reasonable effort to complete the investigation and issue its report within 30 days of the commencement of the investigation, provided that an 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 30 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.

- (f) At the conclusion of the investigation, the investigating committee shall prepare a report with its findings, conclusions, and recommendations.
- (g) In making its recommendations, the investigating committee shall strive to achieve a consensus as to what is in the best interests of patient care and the smooth operation of the Hospital, while balancing fairness to the individual, recognizing that fairness does not require that the individual agree with the recommendation. Specifically, the committee may consider:
 - (1) relevant literature and clinical practice guidelines, as appropriate;
 - (2) all of the opinions and views that were expressed throughout the review, including report(s) from any outside review(s);
 - (3) any information or explanations provided by the individual under review; and
 - (4) other information as deemed relevant, reasonable, and necessary by the investigating committee.
- (h) If a committee other than the MEC functioned as the investigating committee, the investigating committee report shall be forwarded to the MEC for its review and recommendation.

6.C.4. Recommendation:

- (a) The MEC may accept, modify, or reject any recommendation it receives from an investigating committee. Specifically, the MEC may:
 - (1) determine that no action is justified;
 - (2) issue a letter of guidance, counsel, warning, or reprimand;
 - (3) impose conditions for continued appointment;
 - (4) impose a requirement for monitoring, proctoring, or consultation;
 - (5) impose a requirement for additional training or education;
 - (6) recommend reduction of clinical privileges;
 - (7) recommend suspension of clinical privileges for a term;

- (8) recommend revocation of appointment and/or clinical privileges; or
 - (9) make any other recommendation that it deems necessary or appropriate.
- (b) A recommendation by the MEC that would entitle the individual to request a hearing shall be forwarded to the CEO, who shall promptly inform the individual by Special Notice. The CEO shall hold the recommendation until after the individual has completed or waived a hearing and appeal.
 - (c) If the determination of the MEC does not entitle the individual to request a hearing, it shall take effect immediately and shall remain in effect unless modified by the Board.
 - (d) In the event the Board considers a modification to the recommendation of the MEC that would entitle the individual to request a hearing, the CEO shall inform the individual by Special Notice. No final action shall occur until the individual has completed or waived a hearing and appeal.
 - (e) When applicable, any recommendations or actions that are the result of an investigation or hearing and appeal shall be monitored by the Leadership Council on an ongoing basis through the Hospital's performance improvement activities or pursuant to the applicable policies regarding conduct, as appropriate.

6.D. PRECAUTIONARY SUSPENSION OR RESTRICTION OF CLINICAL PRIVILEGES

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

- (a) Whenever, in their sole discretion, failure to take such action may result in imminent danger to the health and/or safety of any individual, the MEC or one of the Chief of Staff, the Vice Chief of Staff, or the chair of a clinical department, acting in conjunction with either the CMO or the CEO, shall have the authority to (1) afford an individual an opportunity to voluntarily refrain from exercising privileges pending an investigation; or (2) suspend or restrict all or any portion of an individual's clinical privileges as a precaution.
- (b) A precautionary suspension or restriction can be imposed at any time, including, but not limited to, immediately after the occurrence of an event that causes concern, following a pattern of occurrences that raises concern, or following a recommendation of the MEC that would entitle the individual to request a hearing.
- (c) Precautionary suspension or restriction is an interim step in the professional review activity, but it is not a complete professional review action in and of itself. It shall not imply any final finding of responsibility for the situation that caused the suspension or restriction.

- (d) A precautionary suspension or restriction shall become effective immediately upon imposition, shall immediately be reported in writing to the CEO and the Chief of Staff, and shall remain in effect unless the MEC recommends a modification or termination and such recommendation is approved by the CEO, acting as the representative of the Board. The Board will consider the recommendation at its next regularly scheduled meeting.
- (e) The individual in question shall be provided a brief written description of the reason(s) for the precautionary suspension, including the names and medical record numbers of the patient(s) involved (if any), within three days of the imposition of the suspension.

6.D.2. MEC Procedure:

- (a) The MEC shall review the matter resulting in a precautionary suspension or restriction (or the individual's agreement to voluntarily refrain from exercising clinical privileges) within a reasonable time under the circumstances, not to exceed 14 days. Prior to, or as part of, this review, the individual shall be given an opportunity to meet with the MEC. The individual may propose ways other than precautionary suspension or restriction to protect patients and/or employees, depending on the circumstances. Neither the MEC nor the individual shall be accompanied by legal counsel at this meeting, and no recording (audio or video) or transcript of the meeting shall be permitted or made.
- (b) After considering the matters resulting in the suspension or restriction and the individual's response, if any, the MEC shall determine the appropriate next steps, which may include, but not be limited to, commencing a focused review or a formal investigation, or recommending some other action that is deemed appropriate under the circumstances. The MEC shall also determine whether the precautionary suspension or restriction should be continued, modified, or terminated pending the completion of the focused review or investigation (and hearing and appeal, if applicable).
- (c) There is no right to a hearing based on the imposition or continuation of a precautionary suspension or restriction.

6.D.3. Care of Patients:

- (a) Immediately upon the imposition of a precautionary suspension or restriction, the relevant section chief, acting with the assistance of the CMO, will be in charge of or oversee the care of the suspended individual's hospitalized patients, or otherwise aid in implementing the precautionary restriction, as appropriate. The assignment shall be effective until the patients are discharged. The wishes of the patient shall be considered in the selection of a covering physician.

- (b) All members of the Medical Staff have a duty to cooperate with the Chief of Staff, the department chair, the MEC, the CMO, and the CEO in enforcing precautionary suspensions or restrictions.

6.E. AUTOMATIC RELINQUISHMENT/ACTIONS

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

Failure to complete medical records, after notification by the medical records department of delinquency, shall result in automatic relinquishment of all clinical privileges (except that the individual must complete all scheduled emergency service obligations or arrange appropriate coverage). Relinquishment shall continue until all delinquent records are completed and reinstatement accomplished in accordance with applicable policies and rules and regulations. Failure to complete the medical records that caused relinquishment within the time required by applicable policies and rules and regulations shall result in automatic resignation from the Medical Staff.

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

- (a) Any action taken by any licensing board, professional liability insurance company, court or government agency regarding any of the matters set forth below, or any failure to satisfy any of the threshold eligibility criteria set forth in this Policy, must be promptly reported by the Medical Staff member to the CMO or the Chief of Staff.
- (b) An individual's appointment and clinical privileges shall be automatically relinquished, without the right to the procedural rights outlined in this Policy, if an individual fails to satisfy any of the threshold eligibility criteria set forth in Section 2.A.1 of this Policy on a continuous basis (except for board certification requirements, which shall be assessed at time of reappointment). This includes, but is not limited to, the following occurrences:
 - (1) Licensure: Revocation, expiration, suspension, or the placement of restrictions on an individual's license.
 - (2) Controlled Substance Authorization: Revocation, expiration, suspension or the placement of restrictions on an individual's DEA or state controlled substance authorization.
 - (3) Insurance Coverage: Termination or lapse of an individual's professional liability insurance coverage, or other action causing the coverage to fall below the minimum required by the Hospital or cease to be in effect, in whole or in part.

- (4) Medicare and Medicaid Participation: Debarment, proposed debarment, termination, exclusion, or preclusion by government action from participation in the Medicare/Medicaid or other federal or state health care programs.
 - (5) Criminal Activity: Arrest, charge, indictment, conviction, or a plea of guilty or no contest pertaining to any felony; or to any misdemeanor involving (i) controlled substances; (ii) illegal drugs; (iii) Medicare, Medicaid, or insurance or health care fraud or abuse; (iv) child abuse; (v) elder abuse; or (vi) violence against another. (DWIs will be addressed in the manner outlined in Section 2.B.1(g).)
- (c) Automatic relinquishment shall take effect immediately upon notice to the Hospital and continue until the matter is resolved and the individual is reinstated, if applicable.
 - (d) If the underlying matter leading to automatic relinquishment is resolved within 60 days, the individual may request reinstatement. Failure to resolve the matter within 60 days of the date of relinquishment shall result in an automatic resignation from the Medical Staff.
 - (e) Request for Reinstatement.
 - (1) Requests for reinstatement following the expiration or lapse of a license, controlled substance authorization, and/or insurance coverage will be processed by the Medical Staff Services Office. If any questions or concerns are noted, the Medical Staff Services Office will refer the matter for further review in accordance with (e)(2) below.
 - (2) All other requests for reinstatement shall be reviewed by the Chief of Staff (requests for reinstatement from automatic relinquishments that were triggered by the occurrence of criminal or regulatory activity shall also be reviewed by the CMO). If the Chief of Staff (and CMO, when applicable) approves the reinstatement, then the CEO, acting as the Board's representative, may approve the reinstatement effective immediately. The reinstatement must be reviewed and approved by the Board at its next regularly scheduled meeting. If the Chief of Staff does not approve the reinstatement, the questions or concerns will be noted and the request for reinstatement shall be forwarded to the full Centralized Credentials Committee, the MEC, and the Board for review, recommendation and approval

6.E.3. Failure to Complete or Comply with Training or Educational Requirements:

Failure to complete or comply with training or educational requirements that are adopted by the MEC or required by the Board, including, but not limited to, those pertinent to

electronic medical records, computerized physician order entry (“CPOE”), the privacy and security of protected health information, infection control, or patient safety shall result in the automatic relinquishment of all clinical privileges. Any relinquishment will continue in effect until documentation of compliance is provided to the satisfaction of the requesting party. If the requested information is not provided within 30 days of the date of relinquishment, it shall result in automatic resignation from the Medical Staff.

6.E.4. Failure to Provide Requested Information:

Failure to provide information pertaining to an individual’s qualifications for appointment, reappointment, or clinical privileges, in response to a written request from the Centralized Credentials Committee, the MEC, the Leadership Council, the Committee on Professional Enhancement, the CMO, the CEO, or any other committee authorized to request such information, shall result in the automatic relinquishment of all clinical privileges. The information must be provided within the time frame established by the requesting party. Any relinquishment will continue in effect until the information is provided to the satisfaction of the requesting party. If the requested information is not provided within 30 days of the date of relinquishment, it shall result in automatic resignation from the Medical Staff.

6.E.5. Failure to Attend Special Meeting:

- (a) Whenever there is a concern regarding the clinical practice or professional conduct involving any individual, a Medical Staff Leader may require the individual to attend a special meeting with one or more of the Medical Staff Leaders and/or with a standing or ad hoc committee of the Medical Staff.
- (b) No legal counsel shall be present at this meeting, and no recording (audio or video) or transcript shall be permitted or made.
- (c) The notice to the individual regarding this meeting shall be given by Special Notice at least three days prior to the meeting and shall inform the individual that attendance at the meeting is mandatory.
- (d) Failure of the individual to attend the meeting shall result in the automatic relinquishment of all clinical privileges until such time as the individual does attend the special meeting. If the individual does not attend the special meeting within 30 days of the date of relinquishment, it shall result in automatic resignation from the Medical Staff.

6.F. LEAVES OF ABSENCE

6.F.1. Initiation:

- (a) Individuals appointed to the Medical Staff must request a leave of absence if they are going to be away from patient care activities for more than 30 days. Requests

for a leave of absence shall be submitted in writing to the Chief of Staff. Except in extraordinary circumstances, this request must be submitted at least 30 days prior to the anticipated start of the leave in order to permit adjustment of the call roster and assure adequate coverage of clinical and/or administrative activities. The request must state the beginning and ending dates of the leave, which shall not exceed one year, and the reasons for the leave.

- (b) The MEC shall determine whether to recommend to the Board that a request for a leave of absence be granted. The Board will then consider the request at its next regularly scheduled meeting. If the requested leave of absence is to begin before the Board's next regularly scheduled meeting, then after the MEC's affirmative recommendation, the CEO, acting as the representative of the Board, may grant the leave of absence effective immediately. Once again, the Board will then consider the request at its next regularly scheduled meeting. The granting of a leave of absence or reinstatement, as appropriate, may be conditioned upon the individual's completion of all medical records.
- (c) If a member of the Medical Staff is away from patient care responsibilities for longer than 30 days and the reason for such absence is related to his or her physical or mental health or otherwise to his or her ability to care for patients safely and competently, and the individual has not requested a leave of absence, the CMO, in consultation with the Chief of Staff, may trigger an automatic medical leave of absence.

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

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

6.F.3. Reinstatement:

- (a) Individuals requesting reinstatement shall submit a written summary of their professional activities during the leave, and any other information that may be requested by the Hospital. Requests for reinstatement shall then be reviewed by the Leadership Council. If the Leadership Council makes a favorable recommendation on reinstatement, the Medical Staff member may immediately resume clinical practice at the Hospital. This determination shall then be forwarded to the Centralized 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 shall be noted and the reinstatement request shall be forwarded to the full Centralized Credentials Committee, MEC, and Board for review and recommendation. If a request for reinstatement is not granted, for reasons related to clinical competence or professional conduct, the individual shall be entitled to request a hearing and appeal.

- (b) If the leave of absence was for health reasons (except for maternity leave), the request for reinstatement must be accompanied by a report from the individual's physician indicating that the individual is physically and/or mentally capable of resuming a hospital practice and safely exercising the clinical privileges requested.
- (c) Absence for longer than one year shall result in automatic relinquishment of Medical Staff appointment and clinical privileges unless an extension is granted by the MEC. Extensions shall be considered only in extraordinary cases where the extension of a leave is in the best interest of the Hospital.
- (d) If an individual's current appointment is due to expire during the leave, the individual must apply for reappointment, or appointment and clinical privileges shall lapse at the end of the appointment period.
- (e) Failure to request reinstatement from a leave of absence in a timely manner shall be deemed a voluntary resignation of Medical Staff appointment and clinical privileges.
- (f) Leaves of absence are matters of courtesy, not of right. In the event that it is determined that an individual has not demonstrated good cause for a leave, or where a request for extension is not granted, the determination shall be final, with no recourse to a hearing and appeal.

6.G. ACTION AT COVENANT MEDICAL CENTER OR
COVENANT CHILDREN'S HOSPITAL

- (1) Covenant Medical Center and Covenant Children's Hospital will share information regarding the implementation or occurrence of any of the following actions with each other with regard to individuals who have been granted Medical Staff appointment, clinical privileges, or any other permission to care for patients at both Hospitals:
 - (a) automatic relinquishment of appointment or clinical privileges;
 - (b) a voluntary agreement to refrain from exercising some or all clinical privileges for a period of time;
 - (c) any involuntary modification of appointment or clinical privileges;
 - (d) a Performance Improvement Plan; and/or
 - (e) a conditional appointment, a conditional continued appointment, or a conditional reappointment.

- (2) Upon receipt of notice that any of the actions set forth in Paragraph (1) have occurred at either Covenant Medical Center or Covenant Children's Hospital, that action will automatically and immediately take effect at the corresponding Hospital receiving such notice.
- (3) The Board may waive the automatic effectiveness of such an action at the receiving Hospital, after its receipt of a recommendation to do so from the MEC at that Hospital. However, the automatic effectiveness of the action, as set forth in Paragraph (2), will continue until such time as a waiver has been granted and the practitioner has been notified in writing of such. Waivers are within the discretion of the Board and are final. They will be granted only as follows:
 - (a) in exceptional circumstances;
 - (b) based on a finding that the granting of a waiver will not affect patient safety, quality of care, or Hospital operations; and
 - (c) after a full review of the specific circumstances and any relevant documents (including peer review documents) from the Hospital where the action first occurred. The burden is on the affected practitioner to provide evidence showing that a waiver is appropriate.
- (4) Neither the automatic effectiveness of any action set forth in Paragraph (1) at either Covenant Medical Center or Covenant Children's Hospital, nor the denial of a waiver pursuant to this Section, will entitle any individual to any additional procedural rights (including advance notice or additional peer review), formal investigation, hearing, or appeal.

ARTICLE 7

HEARING AND APPEAL PROCEDURES

7.A. INITIATION OF HEARING

7.A.1. Grounds for Hearing:

- (a) An individual is entitled to request a hearing whenever the MEC makes one of the following recommendations:
 - (1) denial of initial appointment to the Medical Staff;
 - (2) denial of reappointment to the Medical Staff;
 - (3) revocation of appointment to the Medical Staff;
 - (4) denial of requested clinical privileges;
 - (5) revocation of clinical privileges;
 - (6) suspension of clinical privileges for more than 30 days (other than precautionary suspension);
 - (7) mandatory concurring consultation requirement (i.e., the consultant must approve the course of treatment in advance); or
 - (8) denial of reinstatement from a leave of absence if the reasons relate to clinical competence or professional conduct.
- (b) No other recommendations shall entitle the individual to a hearing.
- (c) If the Board makes any of these determinations without an adverse recommendation by the MEC, an individual would also be entitled to request a hearing. For ease of use, this Article refers to adverse recommendations of the MEC. When a hearing is triggered by an adverse recommendation of the Board, any reference in this Article to the “MEC” shall be interpreted as a reference to the “Board.”

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

None of the following actions shall constitute grounds for a hearing, and they shall take effect without hearing or appeal, provided that the individual shall be entitled to submit a written explanation to be placed into his or her file:

- (a) determination that an applicant for membership fails to meet the threshold eligibility qualifications or criteria for membership;
- (b) ineligibility to request membership or privileges, or to continue privileges, because a relevant specialty is closed under a Medical Staff development plan or is covered under an exclusive provider agreement;
- (c) failure to process a request for a privilege when the individual does not meet the eligibility criteria to hold the privilege;
- (d) determination that an application is incomplete or untimely;
- (e) determination that an application shall not be processed due to a misstatement or omission;
- (f) change in assigned staff category or a determination that an individual is not eligible for a specific staff category;
- (g) expiration of membership and privileges as a result of failure to submit an application for reappointment within the allowable time period;
- (h) issuance of a letter of guidance, counsel, warning, or reprimand;
- (i) determination that conditions, monitoring, supervision, proctoring, or a general consultation requirement (i.e., the individual must obtain a consult but need not get prior approval for the treatment) is appropriate for an individual;
- (j) determination that a requirement for additional training or continuing education is appropriate for an individual;
- (k) the voluntary acceptance of a Performance Improvement Plan;
- (l) any requirement to complete a health assessment, diagnostic testing, a complete physical, mental or behavioral evaluation, or a clinical competency evaluation pursuant to any Bylaws-related document;
- (m) conducting an investigation into any matter or the appointment of an ad hoc investigating committee;
- (n) grant of conditional appointment or reappointment or of an appointment or reappointment period that is less than two years;
- (o) refusal of the Hospital to consider a request for appointment, reappointment, or privileges within five years of a final adverse decision regarding such request;
- (p) precautionary suspension;

- (q) automatic relinquishment of appointment or privileges or automatic resignation;
- (r) denial of a request for leave of absence, for an extension of a leave or for reinstatement from a leave if the reasons do not relate to clinical competence or professional conduct;
- (s) removal from the on-call roster or any other reading panel;
- (t) withdrawal of temporary privileges;
- (u) requirement to appear for a special meeting; and
- (v) termination of any contract with or employment by the Hospital.

7.B. THE HEARING

7.B.1. Notice of Recommendation:

The CEO shall promptly give Special Notice of a recommendation which entitles an individual to request a hearing. This notice shall contain:

- (a) a statement of the recommendation and the general reasons for it;
- (b) a statement that the individual has the right to request a hearing on the recommendation within 30 days of receipt of this notice; and
- (c) a copy of this Article.

7.B.2. Request for Hearing:

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

7.B.3. Notice of Hearing and Statement of Reasons:

- (a) The CEO shall schedule the hearing and provide, by Special Notice to the individual requesting the hearing, the following:
 - (1) the time, place, and date of the hearing;
 - (2) a proposed list of witnesses who shall give testimony at the hearing and a brief summary of the anticipated testimony;

- (3) the names of the Hearing Panel members (or Hearing Officer) and Presiding Officer, if known; and
 - (4) a statement of the specific reasons for the recommendation, including a list of patient records (if applicable), and a general description of the information supporting the recommendation. This statement does not bar presentation of additional evidence or information at the hearing, so long as the additional material is relevant to the recommendation or the individual's qualifications and the individual has a sufficient opportunity to review and rebut the additional information.
- (b) The hearing shall begin no sooner than 30 days after the notice of the hearing, unless an earlier hearing date has been specifically agreed to in writing by the parties.

7.B.4. Hearing Panel, Presiding Officer, and Hearing Officer:

(a) Hearing Panel:

The CEO, after consulting with the Chief of Staff, shall appoint a Hearing Panel in accordance with the following guidelines:

- (1) The Hearing Panel shall consist of at least three members, at least one of which must be a physician, and may include any combination of:
 - (i) any member of the Medical Staff, provided the member has not actively participated in the matter at any previous level; and/or
 - (ii) physicians or laypersons not connected with the Hospital (i.e., physicians not on the Medical Staff or laypersons not affiliated with the Hospital).
- (2) Knowledge of the underlying peer review matter, in and of itself, shall not preclude the individual from serving on the Panel.
- (3) Employment by, or other contractual arrangement with, the Hospital or an affiliate shall not preclude an individual from serving on the Panel.
- (4) The Panel shall not include any individual who is in direct economic competition with the individual requesting the hearing.
- (5) The Panel shall not include any individual who is professionally associated with, related to, or involved in a referral relationship with, the individual requesting the hearing.

- (6) The Panel shall not include any individual who is demonstrated to have an actual bias, prejudice, or conflict of interest that would prevent the individual from fairly and impartially considering the matter.
 - (7) In addition, the appointment of the Hearing Panel shall comply with the guidelines set forth in the conflict of interest provisions found in Article 8 of this Policy.
- (b) Presiding Officer:
- (1) The CEO, after consulting with the Chief of Staff, shall appoint a Presiding Officer who shall be an attorney. The Presiding Officer may not be, or represent clients who are, in direct competition with the individual who requested the hearing and may not currently represent the Hospital in any legal matters. The Presiding Officer shall not act as an advocate for either side at the hearing.
 - (2) The Presiding Officer shall:
 - (i) allow the participants in the hearing to have a reasonable opportunity to be heard and to present evidence, subject to reasonable limits on the number of witnesses and duration of direct and cross-examination;
 - (ii) prohibit conduct or presentation of evidence that is cumulative, excessive, irrelevant or abusive or that causes undue delay;
 - (iii) maintain decorum throughout the hearing;
 - (iv) determine the order of procedure;
 - (v) rule on all matters of procedure and the admissibility of evidence; and
 - (vi) conduct argument by counsel on procedural points within or outside the presence of the Hearing Panel at the Presiding Officer's discretion.
 - (3) The Presiding Officer may be advised by legal counsel to the Hospital with regard to the hearing procedure.
 - (4) The Presiding Officer may participate in the private deliberations of the Hearing Panel and be a legal advisor to it, but shall not be entitled to vote on its recommendations.

(c) Hearing Officer:

- (1) As an alternative to a Hearing Panel, for matters limited to issues involving professional conduct, the CEO, after consulting with the Chief of Staff, may appoint a Hearing Officer, preferably an attorney, to perform the functions of a Hearing Panel. The Hearing Officer may not be, or represent clients who are, in direct economic competition with the individual requesting the hearing.
- (2) If a Hearing Officer is appointed instead of a Hearing Panel, all references in this Article to the “Hearing Panel” or “Presiding Officer” shall be deemed to refer to the Hearing Officer.

(d) Objections:

Any objection to any member of the Hearing Panel, to the Presiding Officer, or to the Hearing Officer, shall be made in writing, within 10 days of receipt of notice, to the CEO. A copy of such written objection must be provided to the Chief of Staff and must include the basis for the objection. The Chief of Staff shall be given a reasonable opportunity to comment. The CEO shall rule on the objection and give notice to the parties. The CEO may request that the Presiding Officer make a recommendation as to the validity of the objection.

(e) Compensation:

The Hearing Panel, Presiding Officer, and/or Hearing Officer may be compensated by the Hospital, but the individual requesting the hearing may participate in any such compensation should the individual wish to do so.

7.B.5. Counsel:

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

7.C. PRE-HEARING PROCEDURES

7.C.1. General Procedures:

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

7.C.2. Time Frames:

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

- (a) the pre-hearing conference shall be scheduled at least 14 days prior to the hearing;
- (b) the parties shall exchange witness lists and proposed documentary exhibits at least 10 days prior to the pre-hearing conference; and
- (c) any objections to witnesses and/or proposed documentary exhibits must be provided at least five days prior to the pre-hearing conference.

7.C.3. Witness List:

- (a) At least 10 days before the pre-hearing conference, the individual requesting the hearing shall provide a written list of the names of witnesses expected to offer testimony on his or her behalf.
- (b) The witness list shall include a brief summary of the anticipated testimony.
- (c) The witness list of either party may, in the discretion of the Presiding Officer, be amended at any time during the course of the hearing, provided that notice of the change is given to the other party.

7.C.4. Provision of Relevant Information:

- (a) Prior to receiving any confidential documents, the individual requesting the hearing must agree that all documents and information shall be maintained as confidential and shall not be disclosed or used for any purpose outside of the hearing. The individual must also provide a written representation that his/her counsel and any expert(s) have executed Business Associate agreements in connection with any patient Protected Health Information contained in any documents provided.
- (b) Upon receipt of the above agreement and representation, the individual requesting the hearing shall be provided with a copy of the following:
 - (1) copies of, or reasonable access to, all patient medical records referred to in the statement of reasons, at the individual's expense;
 - (2) reports of experts relied upon by the MEC;
 - (3) copies of relevant minutes (with portions regarding other physicians and unrelated matters deleted); and

- (4) copies of any other documents relied upon by the MEC.

The provision of this information is not intended to waive any privilege under the Texas peer review protection statutes.

- (c) The individual shall have no right to discovery beyond the above information. No information shall be provided regarding other practitioners on the Medical Staff. In addition, there is no right to depose, interrogate, or interview witnesses or other individuals prior to the hearing.
- (d) At least 10 days prior to the pre-hearing conference (or as otherwise agreed upon by both sides), each party shall provide the other party with its proposed exhibits. All objections to documents or witnesses shall be submitted in writing at least five days in advance of the pre-hearing conference. The Presiding Officer shall not entertain subsequent objections unless the party offering the objection demonstrates good cause.
- (e) Evidence unrelated to the reasons for the recommendation or to the individual's qualifications for appointment or the relevant clinical privileges shall be excluded.
- (f) Neither the individual, nor any other person acting on behalf of the individual, may contact Hospital employees or Medical Staff members whose names appear on the MEC's witness list or in documents provided pursuant to this section concerning the subject matter of the hearing, until the Hospital has been notified and has contacted the individuals about their willingness to be interviewed. The Hospital will advise the individual who has requested the hearing once it has contacted such employees or Medical Staff members and confirmed their willingness to meet. Any employee or Medical Staff member may agree or decline to be interviewed by or on behalf of the individual who requested a hearing.

7.C.5. Pre-Hearing Conference:

The Presiding Officer shall require the individual and the MEC or their representatives (who may be counsel) to participate in a pre-hearing conference, which shall be held no later than 14 days prior to the hearing. At the pre-hearing conference, the Presiding Officer shall resolve all procedural questions, including any objections to exhibits or witnesses. The Presiding Officer shall establish the time to be allotted to each witness's testimony and cross-examination. It is expected that the hearing shall last no more than 12 hours, with each side being afforded approximately six hours to present its case, in terms of both direct and cross-examination of witnesses. Both parties are required to prepare their case so that a hearing shall be concluded after a maximum of 12 hours. The Presiding Officer may, after considering any objections, grant limited extensions upon a demonstration of good cause and to the extent compelled by fundamental fairness.

7.C.6. Stipulations:

The parties and their counsel, if applicable, shall use their best efforts to develop and agree upon stipulations, so as to provide for a more orderly and efficient hearing by narrowing the issues on which live testimony is reasonably required.

7.C.7. Provision of Information to the Hearing Panel:

The following documents shall be provided to the Hearing Panel in advance of the hearing: (a) a pre-hearing statement that either party may choose to submit; (b) exhibits offered by the parties following the pre-hearing conference, (without the need for authentication); and (c) any stipulations agreed to by the parties.

7.D. HEARING PROCEDURES

7.D.1. Rights of Both Sides and the Hearing Panel at the Hearing:

- (a) At a hearing, both sides shall have the following rights, subject to reasonable limits determined by the Presiding Officer:
 - (1) to call and examine witnesses, to the extent they are available and willing to testify;
 - (2) to introduce exhibits;
 - (3) to cross-examine any witness on any matter relevant to the issues;
 - (4) to have representation by counsel who may call, examine, and cross-examine witnesses and present the case; and
 - (5) to submit proposed findings, conclusions, and recommendations to the Hearing Panel after the conclusion of the hearing session(s).
- (b) If the individual who requested the hearing does not testify, he or she may be called and questioned.
- (c) The Hearing Panel may question witnesses, request the presence of additional witnesses, and/or request documentary evidence.

7.D.2. Record of Hearing:

A stenographic reporter shall be present to make a record of the hearing. The cost of the reporter shall be borne by the Hospital. Copies of the transcript shall be available at the individual's expense. Oral evidence shall be taken only on oath or affirmation administered by any person entitled to notarize documents in this state.

7.D.3. Failure to Appear:

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

7.D.4. Presence of Hearing Panel Members:

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

7.D.5. Persons to be Present:

The hearing shall be restricted to those individuals involved in the proceeding and the Chief of Staff. The CEO and CMO may also attend. In addition, administrative personnel may be present as requested by the Chief of Staff, the CEO, or the CMO.

7.D.6. Order of Presentation:

The MEC shall first present evidence in support of its recommendation. Thereafter, the burden shall shift to the individual who requested the hearing to present evidence.

7.D.7. Admissibility of Evidence:

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

7.D.8. Post-Hearing Statement:

Each party shall have the right to submit a written statement, and the Hearing Panel may request that statements be filed, following the close of the hearing.

7.D.9. Postponements and Extensions:

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

7.E. HEARING CONCLUSION, DELIBERATIONS, AND RECOMMENDATIONS

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

Consistent with the burden on the individual to demonstrate that he or she satisfies, on a continuing basis, all criteria for initial appointment, reappointment and clinical privileges, the Hearing Panel shall recommend in favor of the MEC unless it finds that the individual who requested the hearing has proved, by clear and convincing evidence, that the recommendation that prompted the hearing was arbitrary, capricious, or not supported by credible evidence.

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

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

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

The Hearing Panel shall deliver its report to the CEO. The CEO shall send by Special Notice a copy of the report to the individual who requested the hearing. The CEO shall also provide a copy of the report to the MEC.

7.F. APPEAL PROCEDURE

7.F.1. Time for Appeal:

- (a) Within 14 days after notice of the Hearing Panel's recommendation, either party may request an appeal. The request shall be in writing, delivered to the CEO either in person or by certified mail, return receipt requested, and shall include a statement of the reasons for appeal and the specific facts or circumstances which justify further review.
- (b) If an appeal is not requested within 14 days, an appeal is deemed to be waived and the Hearing Panel's report and recommendation shall be forwarded to the Board for final action.

7.F.2. Grounds for Appeal:

The grounds for appeal shall be limited to the following:

- (a) there was substantial failure by the Hearing Panel to comply with this Policy and/or the Medical Staff Bylaws during the hearing, so as to deny a fair hearing; and/or
- (b) the recommendations of the Hearing Panel were made arbitrarily or capriciously and/or were not supported by credible evidence.

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

Whenever an appeal is requested as set forth in the preceding Sections, the Chair of the Board (or the CEO on behalf of the Chair) shall schedule and arrange for an appeal. The individual shall be given Special Notice of the time, place, and date of the appeal. The appeal shall be held as soon as arrangements can reasonably be made, taking into account the schedules of all the individuals involved.

7.F.4. Nature of Appellate Review:

- (a) The Board may serve as the Review Panel or the Chair of the Board may appoint a Review Panel composed of not less than three persons, either members of the Board or others, including but not limited to reputable persons outside the Hospital, to consider the record upon which the recommendation before it was made and recommend final action to the Board.
- (b) Each party shall have the right to present a written statement in support of its position on appeal. The party requesting the appeal shall submit a statement first and the other party shall then have ten days to respond. In its sole discretion, the Review Panel may allow each party or its representative to appear personally and make oral argument not to exceed 30 minutes.
- (c) When requested by either party, the Review Panel may, in its discretion, accept additional oral or written evidence subject to the same rights of cross-examination provided at the Hearing Panel proceedings. Such additional evidence shall be accepted only if the Review Panel determines that the party seeking to admit it has demonstrated that it is relevant, new evidence that could not have been presented at the hearing, or that any opportunity to admit it at the hearing was improperly denied.

7.G. BOARD ACTION

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

- (a) Within 30 days after the Board (i) considers the appeal as a Review Panel, (ii) receives a recommendation from a separate Review Panel, or (iii) receives the Hearing Panel's report and recommendation when no appeal has been requested, the Board shall consider the matter and take final action.
- (b) The Board may review any information that it deems relevant, including, but not limited to, the findings and recommendations of the MEC, Hearing Panel, and Review Panel (if applicable). The Board may adopt, modify, or reverse any recommendation that it receives or, in its discretion, refer the matter to any individual or committee for further review and recommendation, or make its own decision based upon the Board's ultimate legal authority for the operation of the Hospital and the quality of care provided.
- (c) The Board shall render its final decision in writing, including specific reasons, and shall send Special Notice to the individual. A copy shall also be provided to the MEC for its information.

7.G.2. Further Review:

Except where the matter is referred by the Board for further action and recommendation by any individual or committee, the final decision of the Board shall be effective immediately and shall not be subject to further review. If the matter is referred for further action and recommendation, such recommendation shall be promptly made to the Board in accordance with the instructions given by the Board.

7.G.3. Right to One Hearing and One Appeal Only:

No member of the Medical Staff shall be entitled to more than one hearing and one appellate review on any matter. If the Board denies initial appointment to the Medical Staff or reappointment or revokes the appointment and/or clinical privileges of a current member of the Medical Staff, that individual may not apply for staff appointment or for those clinical privileges for a period of five years unless the Board provides otherwise.

7.H. MEDIATION

- (1) With respect to matters involving an individual's request for initial appointment, reappointment, initial clinical privileges, and/or renewed clinical privileges at the Hospital, either party may request mediation prior to final action being taken by the Board.

- (2) Any request for mediation shall be made in writing and shall be delivered to the CEO either in person or by certified mail, return receipt requested, within the following time frames:
- (a) within ten days after receipt of a Review Panel's recommendation; or
 - (b) in the case of an appeal that is held before the full Board, within ten days after the adjournment of the appeal.

If mediation is not requested within these time frames, the mediation shall be deemed to be waived and the Review Panel's recommendation shall be forwarded to the Board for final action, or, in the case of an appeal held before the full Board, the Board shall take final action.

- (3) If mediation is requested, it shall be conducted within a reasonable period of time. The Board shall then take final action on the matter within 30 days after conclusion of the mediation process.

ARTICLE 8

CONFLICT OF INTEREST GUIDELINES

(**Appendix A** to this Policy is a chart that summarizes these conflict of interest guidelines.)

8.A.1. General Principles:

- (a) All those involved in credentialing and professional practice evaluation activities must be sensitive to potential conflicts of interest in order to be fair to the individual whose qualifications are under review, to protect the individual with the potential conflict, and to protect the integrity of the review process.
- (b) It is also essential that peers participate in credentialing and professional practice evaluation review activities in order for these activities to be meaningful and effective. Therefore, whether and how an individual can participate must be evaluated reasonably, taking into consideration common sense and objective principles of fairness.

8.A.2. Self or Immediate Family Members:

No immediate family member (spouse, parent, child, sibling, or in-law) of a practitioner whose application or care is being reviewed shall participate in any aspect of the review process, except to provide information, nor may an applicant or individual under review participate in any aspect of the review process involving that individual.

8.A.3. Treatment Relationship:

An individual who has provided professional health services to a practitioner whose application or care is under review shall not participate in the review process regarding the practitioner except as follows:

- (a) if the patient-physician relationship has terminated and the review process does not involve the health condition for which the practitioner sought professional health services;
- (b) to provide information that was not obtained through the treatment relationship;
or
- (c) to provide information that was obtained through the treatment relationship, as authorized by the practitioner.

8.A.4. Employment or Contractual Relationship with the Hospital:

Employment by, or other contractual arrangement with, the Hospital or an affiliate shall not, in and of itself, preclude an individual from participating in credentialing and

professional practice evaluation activities. Rather, participation by such individuals shall be evaluated as outlined in the paragraphs below.

8.A.5. Actual or Potential Conflict Situations:

With respect to a practitioner whose application or care is under review, actual or potential conflict situations involving other members of the Medical Staff include, but are not limited to, the following:

- (a) significant financial relationship exists (e.g., members of small, single specialty group; significant referral relationship; partners in business venture);
- (b) being a direct competitor;
- (c) close friendship;
- (d) a history of personal conflict;
- (e) personal involvement in the care of a patient which is subject to review;
- (f) raising the concern that triggered the review; or
- (g) prior participation in review of the matter at a previous level.

Any such individual shall be referred to as an “Interested Member” in the remainder of this Article for ease of reference.

8.A.6. Guidelines for Participation in Credentialing and Professional Practice Evaluation Activities:

An Interested Member shall have the obligation to disclose any actual or potential conflict of interest. When an actual or potential conflict situation exists as outlined in the paragraph above, the following guidelines shall be used.

- (a) Initial Reviewers. An Interested Member may participate as an initial reviewer as long as there is a check and balance provided by subsequent review by a Medical Staff committee. This applies, but is not limited to, the following situations:
 - (1) participation in the review of applications for appointment, reappointment, and clinical privileges because of the Centralized Credentials Committee’s and MEC’s subsequent review of credentialing matters; and
 - (2) participation as case reviewers in professional practice evaluation activities because of a Professional Practice Evaluation Committee’s (Peer Review Committee’s) subsequent review of peer review matters.

- (b) Centralized Credentials Committee, Committee for Professional Enhancement, or Leadership Council Member. An Interested Member may fully participate as a member of these committees because these committees do not make any final recommendation that could adversely affect the clinical privileges of a practitioner, which is only within the authority of the MEC. However, the chairs of these committees always have the discretion to recuse an Interested Member if they determine that the Interested Member's presence would inhibit full and fair discussion of the issue or would skew the recommendation or determination of the committee.
- (c) Ad Hoc Investigating Committee. Once a formal investigation has been initiated, additional precautions are required. Therefore, an Interested Member may not be appointed as a member of an ad hoc investigating committee, but may be interviewed and provide information to the ad hoc investigating committee if necessary for the committee to conduct a full and thorough investigation.
- (d) MEC. An Interested Member will be recused and may not participate as a member of the MEC when the MEC is considering a recommendation that could adversely affect the clinical privileges of a practitioner, subject to the rules for recusal outlined below.
- (e) Board. An Interested Member will be recused and may not participate as a member of the Board when the Board is considering a recommendation that could adversely affect the clinical privileges of a practitioner, subject to the rules for recusal outlined below.

8.A.7. Guidelines for Participation in Development of Privileging Criteria:

Recognizing that the development of privileging criteria can have a direct or indirect financial impact on particular physicians, the following guidelines apply. Any individual who has a personal interest in privileging criteria, including criteria for privileges that cross specialty lines or criteria for new procedures, may:

- (a) provide information and input to the Centralized Credentials Committee or an ad hoc committee charged with development of such criteria;
- (b) participate in the discussions or actions of the Centralized Credentials Committee or an ad hoc committee charged with development of such criteria because these committees do not make the final recommendation regarding the criteria (however, the Chair of the Centralized Credentials Committee or ad hoc committee always has the discretion to recuse an Interested Member in a particular situation, in accordance with the rules for recusal outlined below); but
- (c) not participate in the discussions or actions of the MEC when it is considering its final recommendation to the Board regarding the criteria or participate in the final discussions or action of the Board related to the criteria.

8.A.8. Rules for Recusal:

- (a) When determining whether recusal in a particular situation is required, the Chief of Staff or committee chair shall consider whether the Interested Member's presence would inhibit full and fair discussion of the issue before the committee, skew the recommendation or determination of the committee, or otherwise be unfair to the practitioner under review.
- (b) Any Interested Member who is recused from participating in a committee or Board meeting must leave the meeting room prior to the committee's or Board's final deliberation and determination, but may answer questions and provide input before leaving.
- (c) Any recusal will be documented in the committee's or Board's minutes.
- (d) Whenever possible, an actual or potential conflict should be brought to the attention of the Chief of Staff or committee/Board chair, a recusal determination made, and the Interested Member informed of the recusal determination prior to the meeting.

8.A.9. Other Considerations:

- (a) Any member of the Medical Staff who is concerned about a potential conflict of interest on the part of any other member, including but not limited to the situations noted in the paragraphs above, must call the conflict of interest to the attention of the Chief of Staff (or to the Vice Chief of Staff if the Chief of Staff is the person with the potential conflict), or the applicable committee/Board chair. The member's failure to notify will constitute a waiver of the claimed conflict. The Chief of Staff or the applicable committee/Board chair has the authority to make a final determination as to how best to manage the situation, guided by this Article, including recusal of the Interested Member, if necessary.
- (b) No staff member has a right to compel the disqualification of another staff member based on an allegation of conflict of interest. Rather, that determination is within the discretion of the Medical Staff Leaders or Board chair, guided by this Article.
- (c) The fact that an individual chooses to refrain from participation or is excused from participation in any credentialing or peer review activity, shall not be interpreted as a finding of actual conflict that inappropriately influenced the review process.

ARTICLE 9

CONFIDENTIALITY AND PEER REVIEW PROTECTION

9.A. CONFIDENTIALITY

Actions taken and recommendations made pursuant to this Policy shall be strictly confidential. Individuals participating in, or subject to, credentialing and professional practice evaluation activities shall make no disclosures of any such information (discussions or documentation) outside of committee meetings, except:

- (1) when the disclosures are to another authorized member of the Medical Staff or authorized Hospital employee and are for the purpose of researching, investigating, or otherwise conducting legitimate credentialing and professional practice evaluation activities;
- (2) when the disclosures are authorized by a Medical Staff or Hospital policy; or
- (3) when the disclosures are authorized, in writing, by the CEO or by legal counsel to the Hospital.

Any breach of confidentiality may result in a professional review action and/or appropriate legal action. Such breaches are unauthorized and do not waive the peer review privilege. Any member of the Medical Staff who becomes aware of a breach of confidentiality must immediately inform the CEO or the Chief of Staff (or the Vice Chief of Staff if the Chief of Staff is the person committing the claimed breach).

9.B. PEER REVIEW PROTECTION

- (1) All credentialing and professional practice evaluation activities pursuant to this Policy and related Medical Staff documents shall be performed by “peer review committees” in accordance with Texas law. These committees include, but are not limited to:
 - (a) all standing and ad hoc Medical Staff and Hospital committees;
 - (b) all departments and sections;
 - (c) hearing panels;
 - (d) the Board and its committees; and
 - (e) any individual acting for or on behalf of any such entity, including but not limited to department chairs, section chiefs, committee chairs and

members, officers of the Medical Staff, the CMO, all Hospital personnel, and experts or consultants retained to assist in peer review activities.

All oral or written communications, reports, recommendations, actions, and minutes made or taken by peer review committees are confidential and covered by the applicable provisions of Texas law.

- (2) All peer review committees shall also be deemed to be “professional review bodies” as that term is defined in the Health Care Quality Improvement Act of 1986, 42 U.S.C. §11101 *et seq.*

ARTICLE 10

AMENDMENTS

- (A) Proposed amendments to this Policy shall be presented to the MECs of both Covenant Medical Center and Covenant Children's Hospital.
- (B) This Policy may then be amended by a majority vote of the members of each MEC present and voting at any meeting of that Committee where a quorum exists. Notice of all proposed amendments shall be provided to each voting staff member of the Medical Staff at least 14 days prior to the MEC meeting, and any voting staff member may submit written comments to the MEC.
- (C) If there is any disagreement between the MECs for the two Hospitals with respect to an amendment(s), a joint meeting shall be scheduled to discuss and resolve the disagreement. If the differences cannot be resolved at the joint meeting, a subcommittee consisting of two members of each MEC shall be appointed to resolve the issue and the determination of that subcommittee shall be considered final, subject to the approval of the Board.
- (D) No amendment shall be effective unless and until it has been approved by the Board.

ARTICLE 11

ADOPTION

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

Adopted by the Medical Staff: November 28, 2017

Approved by the Board: December 5, 2017

APPENDIX A

CONFLICT OF INTEREST GUIDELINES

Potential Conflicts	Levels of Participation								
	Provide Information	Individual Reviewer Application/ Case	Committee Member					Hearing Panel	Board
			Credentials	Leadership Council	CPE	MEC	Ad Hoc Investigating		
Self or family member	Y	N	R	R	R	R	N	N	R
Treatment relationship*	Y**	N	R	R	R	R	N	N	R
Employment relationship with hospital	Y	Y	Y	Y	Y	Y	Y	Y	Y
Significant financial relationship	Y	Y	Y	Y	Y	R	N	N	R
Direct competitor	Y	Y	Y	Y	Y	R	N	N	R
Close friends	Y	Y	Y	Y	Y	R	N	N	R
History of conflict	Y	Y	Y	Y	Y	R	N	N	R
Provided care in case under review (but not subject of review)	Y	Y	Y	Y	Y	R	N	N	R
Reviewed at prior level	Y	Y	Y	Y	Y	R	N	N	R
Raised the concern	Y	Y	Y	Y	Y	R	N	N	R

* A “relevant treatment relationship” exists (1) if the individual and the practitioner are in a current patient-physician relationship or (2) if the patient-physician relationship has terminated but the review process involves the health condition for which the practitioner sought professional health services.

** An individual may provide information that was not obtained through a treatment relationship. However, an individual may provide information that was obtained through a treatment relationship only after obtaining the practitioner’s HIPAA-compliant authorization for the disclosure.

Y – (green “Y”) means the Interested Member may serve in the indicated role; no extra precautions are necessary.

Y – (yellow “Y”) means the Interested Member may generally serve in the indicated role. It is legally permissible for Interested Members to serve in these roles because of the check and balance provided by the multiple levels of review and the fact that the Credentials Committee, Leadership Council, and Committee for Professional Enhancement have no disciplinary authority. In addition, the Chair of the Credentials Committee, Leadership Council, or CPE always has the authority and discretion to recuse a member in a particular situation if the Chair determines that the Interested Member’s presence would inhibit the full and fair discussion of the issue before the committee, skew the recommendation or determination of the committee, or otherwise be unfair to the practitioner under review.

N – (red “N”) means the individual may not serve in the indicated role.

R – (red “R”) means the individual must be recused in accordance with the rules for recusal.

Rules for Recusal

- Interested Members must leave the meeting room prior to the committee’s or Board’s final deliberation and determination, but may answer questions and provide input before leaving.
- If an Interested Member is recused on a particular issue, the recusal shall be specifically documented in the minutes.
- Whenever possible, an actual or potential conflict should be raised and resolved prior to the meeting by the committee or Board chair, and the Interested Member informed of the recusal determination in advance.
- No Medical Staff member has the RIGHT to demand the recusal of another member – that determination is within the discretion of the Medical Staff Leaders in accordance with these guidelines.
- Voluntarily choosing to refrain from participating in a particular situation is not a finding or an admission of an actual conflict or any improper influence on the process.