

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

COVENANT MEDICAL CENTER

**POLICY ON
ALLIED HEALTH PROFESSIONALS**

*Adopted by the Medical Staff: April 9, 2019
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**APPENDIX A – LICENSED INDEPENDENT PRACTITIONERS
(CATEGORY I PRACTITIONERS)**

**APPENDIX B – ADVANCED PRACTICE CLINICIANS
(CATEGORY II PRACTITIONERS)**

**APPENDIX C – DEPENDENT PRACTITIONERS
(CATEGORY III PRACTITIONERS)**

ARTICLE 1

GENERAL

1.A. DEFINITIONS

The definitions that apply to terms used in all the Medical Staff documents are set forth in the Medical Staff Credentials Policy document.

1.B. DELEGATION OF FUNCTIONS

- (1) When a function 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 one or more designees.
- (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

SCOPE AND OVERVIEW OF POLICY

2.A. SCOPE OF POLICY

- (1) This Policy addresses those Allied Health Professionals who are permitted to provide patient care services in the Hospital and are listed in the Appendices to this Policy.
- (2) This Policy sets forth the credentialing process and the general practice parameters for these individuals, as well as guidelines for determining the need for additional categories of Allied Health Professionals at the Hospital.

2.B. CATEGORIES OF ALLIED HEALTH PROFESSIONALS

- (1) Only those specific categories of Allied Health Professionals that have been approved by the Board shall be permitted to practice at the Hospital. All Allied Health Professionals who are addressed in this Policy shall be classified as either Category I, Category II, or Category III practitioners.
- (2) Current listings of the specific categories of Allied Health Professionals functioning in the Hospital as Category I, Category II, and Category III practitioners are attached to this Policy as Appendices A, B, and C, respectively. The Appendices may be modified or supplemented by action of the Board, after receiving the recommendation of the MEC, without the necessity of further amendment of this Policy.

2.C. ADDITIONAL POLICIES

The Board shall adopt a separate credentialing protocol for each category of Allied Health Professional that it approves to practice in the Hospital. These separate protocols shall supplement this Policy and shall address the specific matters set forth in Section 3.B of this Policy.

ARTICLE 3

GUIDELINES FOR DETERMINING THE NEED FOR NEW CATEGORIES OF ALLIED HEALTH PROFESSIONALS

3.A. DETERMINATION OF NEED

- (1) Whenever an Allied Health Professional in a category that has not been approved by the Board requests permission to practice at the Hospital, the MEC shall appoint an ad hoc committee to evaluate the need for that particular category of Allied Health Professional and to make a recommendation to the MEC for its review and recommendation and then to the Board for final action.
- (2) As part of the process of determining need, the Allied Health Professional shall be invited to submit information about the nature of the proposed practice, why Hospital access is sought, and the potential benefits to the community by having such services available at the Hospital.
- (3) The ad hoc committee may consider the following factors when making a recommendation to the MEC and the Board as to the need for the services of this category of Allied Health Professionals:
 - (a) the nature of the services that would be offered;
 - (b) any state license or regulation which outlines the scope of practice that the Allied Health Professional is authorized by law to perform;
 - (c) any state “non-discrimination” or “any willing provider” laws that would apply to the Allied Health Professional;
 - (d) the business and patient care objectives of the Hospital, including patient convenience;
 - (e) the community’s needs and whether those needs are currently being met or could be better met if the services offered by the Allied Health Professional were provided at the Hospital;
 - (f) the type of training that is necessary to perform the services that would be offered and whether there are individuals with more training currently providing those services;
 - (g) the availability of supplies, equipment, and other necessary Hospital resources;

- (h) the need for, and availability of, trained staff to support the services that would be offered; and
- (i) the ability to appropriately supervise performance and monitor quality of care.

3.B. DEVELOPMENT OF POLICY

- (1) If the ad hoc committee determines that there is a need for the particular category of Allied Health Professional at the Hospital, the committee shall recommend to the MEC and the Board a separate policy for these practitioners that addresses:
 - (a) any specific qualifications and/or training that they must possess beyond those set forth in this Policy;
 - (b) a detailed description of their authorized scope of practice or clinical privileges;
 - (c) any specific conditions that apply to their functioning within the Hospital beyond those set forth in this Policy; and
 - (d) any supervision requirements, if applicable.
- (2) In developing such policies, the ad hoc committee shall consult the appropriate department chair(s) or section chiefs and consider relevant state law and may contact applicable professional societies or associations. The ad hoc committee may also recommend to the Board the number of Allied Health Professionals that are needed in a particular category.

ARTICLE 4

QUALIFICATIONS, CONDITIONS, AND RESPONSIBILITIES

4.A. QUALIFICATIONS

4.A.1. Eligibility Criteria:

To be eligible to apply for initial and continued permission to practice at the Hospital, Allied Health Professionals must:

- (a) have a current, unrestricted license, certification, or registration to practice in Texas (if applicable) and have never had a license, certification, or registration to practice revoked or suspended by any state licensing agency;
- (b) where applicable to their practice, have a current, unrestricted DEA registration;
- (c) be available on a continuous basis, either personally or by arranging appropriate coverage when unavailable, to respond to the needs of patients in a prompt, efficient, and conscientious manner. (“Appropriate coverage” means coverage by another individual with appropriate specialty-specific privileges as determined by the Centralized Credentials Committee.) Compliance with this eligibility requirement means that the practitioner must document and certify that he or she is willing and able to:
 - (1) respond within 30 minutes, via phone, to an initial call or page 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) Category II practitioners must have a residence in Lubbock County. This requirement does not apply to locum tenens.
- (e) have current, valid professional liability insurance coverage in such form and in amounts satisfactory to the Board;
- (f) have never been convicted of, or entered a plea of guilty or no contest to, Medicare, Medicaid, or other federal or state governmental or private third-party payer fraud or program abuse, nor have been required to pay civil monetary penalties for the same;

- (g) have never been, and are not currently, excluded, precluded, or debarred from participation in Medicare, Medicaid, or other federal or state governmental health care program;
- (h) have never had clinical privileges or scope of practice denied, revoked, or terminated by any health care facility or health plan for reasons related to clinical competence or professional conduct;
- (i) have never relinquished or resigned affiliation, clinical privileges, or a scope of practice during an investigation or in exchange for not conducting such an investigation;
- (j) have never 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;
- (k) satisfy all additional eligibility qualifications relating to their specific area of practice that may be established by the Hospital (which may include, but shall not be limited to, certification by an appropriate certifying body as defined by the Centralized Credentials Committee);
- (l) document compliance with all applicable training and educational protocols that may be adopted by the MEC or required by the Board, including, but not limited to, those involving electronic medical records, computerized physician order entry (“CPOE”), the privacy and security of protected health information, infection control, and patient safety;
- (m) 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); and
- (n) if seeking to practice as a Category II or Category III practitioner, have a supervision agreement and/or collaborative agreement with a physician who is appointed to the Medical Staff (the “Supervising Physician”).

4.A.2. Waiver of Eligibility Criteria:

- (a) Any individual who does not satisfy one or more of the criteria outlined above may request a waiver.
- (b) A request for a waiver will be submitted to the Centralized Credentials Committee for consideration. 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.

- (c) In reviewing the request for a waiver, the Centralized Credentials Committee may consider the specific qualifications of the individual 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.
- (d) The MEC will 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) No individual is entitled to a waiver or to a hearing if the MEC recommends and/or the Board determines not to grant a waiver.
- (f) A determination that an individual is not entitled to a waiver is not a "denial" of permission to practice, clinical privileges, or scope of practice.
- (g) The granting of a waiver in a particular case does not set a precedent for any other individual or group of individuals.
- (h) An application form that does not satisfy an eligibility criterion will not be processed until the Board has determined that a waiver should be granted.

4.A.3. Factors for Evaluation:

The six ACGME general competencies (patient care, medical knowledge, professionalism, system-based practice, practice-based learning, and interpersonal communications) will be evaluated as applicable, as part of a request for permission to practice, as reflected in the following factors:

- (a) relevant training, experience, and demonstrated current competence, including medical/clinical knowledge, technical and clinical skills, clinical judgment, and an understanding of the contexts and systems within which care is provided;
- (b) adherence to the ethics of their profession, continuous professional development, an understanding of and sensitivity to diversity, and responsible attitude toward patients, families, and their profession;
- (c) ability to safely and competently perform the clinical privileges or scope of practice requested;
- (d) good reputation and character;

- (e) ability to work harmoniously with others, including, but not limited to, interpersonal and communication skills sufficient to enable them to maintain professional relationships with patients, families, and other members of health care teams; and
- (f) recognition of the importance of, and willingness to support, the Hospital's and Medical Staff's commitment to quality care and a recognition that interpersonal skills and collegiality are essential to the provision of quality patient care.

4.A.4. No Entitlement to Medical Staff Appointment:

Allied Health Professionals shall not be appointed to the Medical Staff or entitled to the rights, privileges, and/or prerogatives of Medical Staff appointment.

4.A.5. Non-Discrimination Policy:

No individual shall be denied permission to practice at the Hospital on the basis of gender, race, creed, national origin, or sexual orientation.

4.B. GENERAL CONDITIONS OF PRACTICE

4.B.1. Assumption of Duties and Responsibilities:

As a condition of permission to practice at the Hospital, all Allied Health Professionals shall specifically agree to the following:

- (a) to provide continuous and timely quality care to all patients in the Hospital for whom the individual has responsibility;
- (b) to abide by all bylaws, rules and regulations, and policies of the Medical Staff and Hospital;
- (c) to accept committee assignments and such other reasonable duties and responsibilities as may be assigned;
- (d) to maintain and monitor a current e-mail address with Medical Staff Services, which will be the primary mechanism used to communicate all routine information to the individual (peer review information or protected health information will be sent through another secure and HIPAA-compliant modality);
- (e) to provide a valid and current mobile phone number, pager number, or answering service contact information to Medical Staff Services in order to facilitate practitioner-to-practitioner communication;
- (f) to inform Medical Staff Services, in writing, of any change in the practitioner's status or any change in the information provided on the practitioner's application

form. This information will be provided with or without request, within seven business days of the occurrence of the change, and will include, but not be limited to:

- changes in licensure or certification status, DEA controlled substance authorization, or professional liability insurance coverage;
 - changes in the practitioner's primary clinical specialty area;
 - the filing of a professional liability lawsuit against the practitioner;
 - changes in the practitioner's status at any other hospital or health care entity as a result of peer review activities;
 - Changes in employment;
 - knowledge of a criminal investigation involving the practitioner, arrest, charge, indictment, conviction, or a plea of guilty or no contest in any criminal matter;
 - exclusion or preclusion from participation in Medicare/Medicaid or any sanctions imposed;
 - any changes in the practitioner's ability to safely and competently exercise clinical privileges, or scope of practice, or to perform the duties and responsibilities of permission to practice because of health status issues, including, but not limited to, impairment due to addiction, alcohol use, or other similar issue (all of which shall be referred for review under the Practitioner Health Policy); and
 - any charge of, or arrest for, driving under the influence ("DWI") (Any DWI incident will be reviewed by the Chief of Staff and the CMO so that they may understand the circumstances surrounding it. If they have any concerns after doing so, they will forward the matter for further review under the Practitioner Health Policy or this AHP Policy.);
- (g) to immediately submit to an appropriate evaluation, which may include diagnostic testing (including, but not limited to, blood and/or urine test) and/or a complete physical, mental, and/or behavioral evaluation, if at least two Medical Staff Leaders are concerned with the individual's ability to safely and competently care for patients and request such testing and/or evaluation. The health care professional(s) to perform the testing and/or evaluations must be acceptable to the Medical Staff Leaders, and the Allied Health Professional will execute all appropriate releases to permit the sharing of information with the Medical Staff Leaders;

- (h) to appear for personal or phone interviews in regard to an application for permission to practice as may be requested;
- (i) to refrain from illegal fee splitting or other illegal inducements relating to patient referral;
- (j) to refrain from assuming responsibility for diagnosis or care of hospitalized patients for which he or she is not qualified or without adequate supervision;
- (k) to refrain from deceiving patients as to the individual's status as an Allied Health Professional and to always wear proper Hospital identification of their name and status;
- (l) to seek consultation when appropriate;
- (m) to participate in the performance improvement and quality monitoring activities of the Hospital;
- (n) to complete, in a timely and legible manner, the medical and other required records, containing all information required by the Hospital, and to utilize the electronic medical record as required;
- (o) to cooperate with all utilization oversight activities;
- (p) to perform all services and conduct himself/herself at all times in a cooperative and professional manner;
- (q) to satisfy applicable continuing education requirements;
- (r) to pay any applicable application fees, assessments, and/or fines;
- (s) to strictly comply with the standards of practice applicable to the functioning of Category II practitioners in the inpatient hospital setting, as set forth in Section 6.A of this Policy;
- (t) when requested, to constructively participate in the development, review, and revision of clinical practice and evidence-based medicine protocols pertinent to his or her specialty (including those related to national patient safety initiatives and core measures), and to comply with all such protocols and pathways;
- (u) 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;

- (v) that, if there is any misstatement in, or omission from, the application, the Hospital may stop processing the application (or, if permission to practice has been granted prior to the discovery of a misstatement or omission, the permission may be deemed to be automatically relinquished). In either situation, there shall be no entitlement to the procedural rights provided in this Policy. The individual will be informed in writing of the nature of the misstatement or omission and permitted to provide a written response for the Centralized Credentials Committee's consideration. If this provision is triggered, the individual may not reapply to the Hospital for a period of at least three years.

4.B.2. Burden of Providing Information:

- (a) Allied Health Professionals seeking permission to practice or renewal of permission to practice shall have the burden of producing information deemed adequate by the Hospital for a proper evaluation of current competence, character, ethics, and other qualifications, and for resolving any doubts about such qualifications.
- (b) Allied Health Professionals seeking permission or renewal of permission to practice have the burden of providing evidence that all the statements made and information given on the application are accurate.
- (c) 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 60 days after the individual has been notified of the additional information required shall be deemed to be withdrawn.
- (d) It is the responsibility of the individual seeking permission to practice or renewal of permission to practice to provide a complete application, including adequate responses from references. An incomplete application will not be processed.

4.B.3 Attendance at Meeting:

- (a) All Physician Assistants and Certified Registered Nurse Practitioners shall attend at least two of the four quarterly meetings. This requirement does not apply to locum tenens.

4.C. APPLICATION

4.C.1. Information:

- (a) The application forms for both initial and renewed permission to practice as an Allied Health Professional shall require detailed information concerning the applicant's professional qualifications. The Allied Health Professional application forms 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 clinical privileges, scope of practice, permission to practice, and/or affiliation has ever been voluntarily or involuntarily relinquished, withdrawn, denied, revoked, suspended, reduced, subjected to probationary or other conditions, limited, terminated, or not renewed at any hospital, health care facility, or other organization, or is currently being investigated or challenged;
 - (2) information as to whether the applicant's license or certification to practice any profession in any state, DEA registration, or any state controlled substance license (if applicable) is or has ever been voluntarily or involuntarily relinquished, suspended, modified, terminated, restricted, or is currently being investigated or challenged;
 - (3) information concerning the applicant's professional liability litigation experience and/or any professional misconduct proceedings involving the applicant, in this state or any other state, whether such proceedings are closed or still pending, including the substance of the allegations of such proceedings or actions, the substance of the findings of such proceedings or actions, the ultimate disposition of any such proceedings or actions that have been closed, and any additional information concerning such proceedings or actions as the Centralized Credentials Committee, MEC or Board may deem appropriate;
 - (4) information about the applicant's current and former employment. including whether the applicant was fired or was otherwise involuntarily terminated from employment;
 - (5) current information regarding the applicant's ability to perform, safely and competently, the clinical privileges or scope of practice requested and the duties of Allied Health Professionals; and
 - (6) a copy of government-issued photo identification.
- (c) The applicant shall sign the application and certify that he or she is able to perform the clinical privileges or scope of practice requested and the responsibilities of Allied Health Professionals.

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

By requesting an application and/or applying for permission to practice, the individual expressly accepts the following conditions:

(a) Immunity:

To the fullest extent 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 for any matter relating to permission to practice, clinical privileges, scope of practice, 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, its 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 permission to practice at the Hospital, and (2) to obtain any and all communications, reports, records, statements, documents, recommendations, or disclosures of third parties that may be relevant to such questions. The individual also specifically authorizes third parties to release this information to the Hospital and its authorized representatives upon request. Further, the individual agrees to sign necessary consent forms to permit a consumer reporting agency to conduct a criminal background check on the individual and report the results to the Hospital.

(c) Authorization to Release Information to Third Parties:

The individual also authorizes Hospital representatives to release information to 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 permission to practice, clinical privileges, scope of practice, 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 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 grant of permission to practice, renewal of permission to practice, and/or any other time during the individual's affiliation with a Covenant Health hospital.

(e) Procedural Rights:

The Allied Health Professional agrees that the procedural rights set forth in this Policy are the sole and exclusive remedy with respect to any professional review action taken by the Hospital.

(f) Legal Actions:

If, despite this Section, an individual institutes legal action challenging any credentialing, privileging, peer review, or other action affecting the permission to practice, 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 are applicable in the following situations:

- (1) whether or not permission to practice, clinical privileges, or scope of practice is granted;
- (2) throughout the term of any affiliation with the Hospital and thereafter;
- (3) should permission to practice, clinical privileges, or scope of practice be denied, 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 Hospital about his or her tenure as a member of the Allied Health Professional Staff.

ARTICLE 5

CREDENTIALING PROCEDURE

5.A. PROCESSING OF INITIAL APPLICATION TO PRACTICE

5.A.1. Request for Application:

- (a) Any individual requesting an application for permission to practice at the Hospital shall be sent (i) a letter that outlines the eligibility criteria for permission to practice as outlined in this Policy, (ii) any eligibility requirements that relate to the Allied Health Professional's specific area of practice, and (iii) the application form.
- (b) An Allied Health Professional who is in a category of practitioners that has not been approved by the Board to practice at the Hospital shall be ineligible to receive an application. A determination of ineligibility does not entitle an Allied Health Professional to the procedural rights outlined in Article 8 of this Policy.

5.A.2. Initial Review of Application:

- (a) A completed application, with copies of all required documents, must be submitted to Medical Staff Services within 30 days after receipt of the application if the Allied Health Professional desires further consideration. The application must be accompanied by the application processing fee.
- (b) As a preliminary step, the application will be reviewed by Medical Staff Services to determine that all questions have been answered and that the individual satisfies all threshold criteria. Individuals who fail to return completed applications or fail to meet the eligibility criteria set forth in Section 4.A.1 of this Policy will be notified that they are not eligible for permission to practice at the Hospital and that their application will not be processed. A determination of ineligibility does not entitle an Allied Health Professional to the procedural rights outlined in Article 8 of this Policy.
- (c) Medical Staff Services shall oversee the process of gathering and verifying relevant information and confirming that all references and other information or materials deemed pertinent have been received. Once an application is complete, it shall be transmitted, along with all supporting documentation, to the applicable department chair.

5.A.3. Department Chair Procedure:

- (a) Medical Staff Services shall transmit the complete application and all supporting materials to the appropriate department chair or the individual to whom the chair has assigned this responsibility. Each chair shall prepare a written report (on a form

provided by Medical Staff Services) regarding whether the applicant has satisfied all of the qualifications for permission to practice and the clinical privileges requested.

- (b) As part of the process of making this report, the department chair has the right to meet with the applicant and the Supervising Physician (if applicable) to discuss any aspect of the application, qualifications, and requested clinical privileges. The department chair may also confer with experts within the department and outside of the department in preparing the report (e.g., other physicians, relevant Hospital department heads, nurse managers).
- (c) In the event that the department chair is unavailable or unwilling to prepare a written report, the Chair of the Centralized Credentials Committee or the Chief of Staff shall appoint an individual to prepare the report.
- (d) The department chair shall be available to answer any questions that may be raised with respect to that individual's report and findings.
- (e) In addition to review by the department chair, all individuals who are seeking permission to practice as advanced practice nurses shall also be evaluated by the Chief Nursing Officer (or designee).

5.A.4. Centralized Credentials Committee Procedure:

- (a) The Centralized Credentials Committee shall review the reports from the appropriate department chair and the Chief Nursing Officer (when applicable) and the information contained in references given by the applicant and from other available sources. The Centralized Credentials Committee shall examine evidence of the applicant's character, professional competence, qualifications, prior behavior, and ethical standing and shall determine whether the applicant has established and satisfied all of the necessary qualifications for the clinical privileges requested.
- (b) The Centralized Credentials Committee may use the expertise of any individual on the Medical Staff or in the Hospital, or an outside consultant, if additional information is required regarding the applicant's qualifications. The Centralized Credentials Committee may also meet with the applicant and, when applicable, the Supervising Physician. The appropriate department chair may participate in this interview.
- (c) After determining that an applicant is otherwise qualified for permission to practice and the clinical privileges requested, 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 permission to practice. 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 an incomplete 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 education requirements). The Centralized Credentials Committee may also recommend that permission to practice be granted for a period of less than two years in order to permit closer monitoring of an individual's compliance with any conditions.
- (e) The Centralized Credentials Committee's recommendation will be forwarded to the MEC.

5.A.5. MEC Procedure:

- (a) At its next meeting, after receipt of the written findings and recommendation of the Centralized Credentials Committee, the MEC shall:
 - (1) adopt the findings and recommendations 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; or
 - (3) set forth in its report and recommendation clear and convincing reasons, along with supporting information, for its disagreement with the Centralized Credentials Committee's recommendation.
- (b) If the MEC's recommendation is favorable to the applicant, the Committee shall forward its recommendation to the Board, through the CEO, including the findings and recommendation of the department chair and the Centralized Credentials Committee. The MEC's recommendation must specifically address the clinical privileges requested by the applicant, which may be qualified by any probationary or other conditions or restrictions relating to such clinical privileges.
- (c) If the MEC's recommendation is unfavorable and would entitle the applicant to the procedural rights set forth in this Policy, the MEC shall forward its recommendation to the CEO, who shall notify the applicant of the recommendation and his or her procedural rights. The CEO shall then hold the MEC's recommendation until after the individual has completed or waived the procedural rights outlined in this Policy.

5.A.6. Board Action:

- (a) The Board may delegate to a committee, consisting of at least two Board members (at least one of which will be a physician), to take action on applications if there has been a favorable recommendation from the Centralized Credentials Committee and the MEC (or their designees) and there is no evidence of any of the following:
 - (1) a current or previously successful challenge to any license, certification, or registration;
 - (2) an involuntary termination, limitation, reduction, denial, or loss of permission to practice, clinical privileges, or scope of practice 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 and grant the clinical privileges requested 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 a Board committee, upon receipt of a recommendation that the applicant be granted permission to practice and clinical privileges requested, the Board may:
 - (1) grant the applicant permission to practice and clinical privileges as recommended; or
 - (2) refer the matter back to the 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) Before 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 the procedural rights as outlined in this Policy.
- (d) Any final decision by the Board to grant, deny, revise, or revoke permission to practice and/or clinical privileges will be disseminated to appropriate individuals and, as required, reported to appropriate entities.

5.B. CLINICAL PRIVILEGES

5.B.1. General:

The clinical privileges recommended to the Board for Category I and Category II practitioners will be based upon consideration of the following factors:

- (a) education, relevant training, experience, and demonstrated current competence, including medical/clinical knowledge, technical and clinical skills, clinical judgment, interpersonal and communication skills, and professionalism with patients, families and other members of the health care team and peer evaluations relating to the same;
- (b) ability to perform the privileges requested competently and safely;
- (c) information resulting from ongoing and focused professional practice evaluation and performance improvement activities, as applicable;
- (d) adequate professional liability insurance coverage for the clinical privileges requested;
- (e) the Hospital's available resources and personnel;
- (f) any previously successful or currently pending challenges to any licensure or registration, or the voluntary or involuntary relinquishment of such licensure or registration;
- (g) any information concerning professional review actions or voluntary or involuntary termination, limitation, reduction, or loss of appointment or clinical privileges at another hospital;
- (h) practitioner-specific data as compared to aggregate data, when available;
- (i) morbidity and mortality data, when available; and
- (j) professional liability actions, especially any such actions that reflect an unusual pattern or excessive number of actions; and
- (k) any applicable medical staff policies, rules and regulations.

5.B.2. FPPE to Confirm Competence and Professionalism:

All new clinical privileges for Category I and Category II practitioners, regardless of when they are granted (initial permission to practice, renewal of permission to practice, or at any time in between), will be subject to focused professional practice evaluation ("FPPE") in

order to confirm competence. The FPPE process for these situations is outlined in the Policy on FPPE to Confirm Practitioner Competence and Professionalism.

5.C. TEMPORARY CLINICAL PRIVILEGES

5.C.1. Request for Temporary Clinical Privileges:

- (a) Applicants: Temporary privileges for an applicant for initial permission to practice may be granted by the CEO, acting as the Board's representative, upon recommendation of the Chief of Staff and the department chair, when a Category I or Category II practitioner has submitted a completed application and the application is pending review by the MEC and the Board. Prior to temporary privileges being granted in this situation, the credentialing process must be complete, including, where applicable, verification of current licensure, relevant training or experience, current competence, ability to exercise the privileges requested, and compliance with criteria, and consideration of information from the National Practitioner Data Bank and from a criminal background check. In order to be eligible for temporary privileges, an individual must demonstrate that there are no current or previously successful challenges to his or her licensure or registration and that he or she has not been subject to involuntary termination of membership, or involuntary limitation, reduction, denial, or loss of clinical privileges at another health care facility.
- (b) Locum Tenens: The CEO, acting as the Board's representative, upon recommendation of the Chief of Staff and the applicable department chair, may grant temporary privileges to a Category I or Category II practitioner serving as a locum tenens for an individual who is on vacation, attending an educational seminar, or ill, and/or otherwise needs coverage assistance for a period of time. Prior to temporary privileges being granted in this situation, the verification process must be complete, including, where applicable, verification of current licensure, relevant training or experience, current competence, ability to exercise the privileges requested, and compliance with criteria, and consideration of information from the National Practitioner Data Bank and from a criminal background check. In order to be eligible for temporary privileges, an individual must demonstrate that there are no current or previously successful challenges to his or her licensure or registration and that he or she has not been subject to involuntary termination of membership, or involuntary limitation, reduction, denial, or loss of clinical privileges at another health care facility.
- (c) Compliance with Bylaws and Policies: Prior to temporary privileges being granted, the individual must agree in writing to be bound by all applicable bylaws, rules and regulations, and policies, procedures, and protocols.
- (d) Time Frames and Automatic Expiration: Temporary privileges will be granted for a specific period of time, not to exceed 180 days, and will expire at the end of the time period for which they are granted.

5.C.2. Withdrawal of Temporary Clinical Privileges:

The CEO may withdraw temporary privileges for any reason, at any time, after consulting with the Chief of Staff, the Chair of the Centralized Credentials Committee or the department chair.

5.D. PROCESSING APPLICATIONS FOR RENEWAL TO PRACTICE

5.D.1. Submission of Application:

- (a) The grant of permission to practice will be for a period not to exceed two years. A request to renew clinical privileges will be considered only upon submission of a completed renewal application.
- (b) At least six months prior to the date of expiration of an Allied Health Professional's clinical privileges, Medical Staff Services will notify the individual of the date of expiration and provide the individual with a renewal application. A completed renewal application must be returned to Medical Staff Services within 30 days.
- (c) Failure to return a completed application within 30 days shall 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 two months prior to the expiration of the individual's current term will result in automatic expiration of clinical privileges at the end of the then current term, unless the application can still be processed in the normal course, without extraordinary effort on the part of Medical Staff Services and the Medical Staff Leaders.
- (d) Once an application for renewal of clinical privileges has been completed and submitted, it will be evaluated following the same procedures outlined in this Policy regarding initial applications.

5.D.2. Renewal Process:

- (a) The procedures pertaining to an initial request for clinical privileges, including eligibility criteria and factors for evaluation, will be applicable in processing requests for renewal for these practitioners.
- (b) As part of the process for renewal of clinical privileges, the following factors will be considered:
 - (1) an assessment prepared by the applicable department chair;
 - (2) an assessment prepared by a peer, if possible;

- (3) results of the Hospital's performance improvement and ongoing and focused professional practice evaluation activities, taking into consideration, when applicable, practitioner-specific information compared to aggregate information concerning other individuals in the same or similar specialty (provided that, other practitioners will not be identified);
 - (4) resolution of any verified complaints received from patients or staff; and
 - (5) any focused professional practice evaluations.
- (c) For Category II practitioners, the following information will also be considered:
- (1) an assessment prepared by the Supervising Physician(s); and
 - (2) any applicable medical staff policies, rules and regulations.

ARTICLE 6

CONDITIONS OF PRACTICE APPLICABLE TO CATEGORY II AND CATEGORY III PRACTITIONERS

6.A. STANDARDS OF PRACTICE FOR THE UTILIZATION OF CATEGORY II AND CATEGORY III PRACTITIONERS IN THE HOSPITAL SETTING

- (1) Category II and Category III practitioners are not permitted to function independently in the Hospital setting. As a condition of being granted permission to practice at the Hospital, all Category II and Category III practitioners specifically agree to abide by the standards of practice set forth in this Section. In addition, as a condition of being permitted to utilize the services of Category II practitioners in the Hospital, all Medical Staff members who serve as Supervising Physicians to such individuals also specifically agree to abide by the standards set forth in this Section. All admitting orders must identify the supervising physician.
- (2) The following standards of practice apply to the functioning of Category II and Category III practitioners in the Hospital setting:
 - (a) Admitting Privileges. Category II and Category III practitioners are not granted admitting privileges and therefore may not admit patients independent of the Supervising Physician. However, a Category II practitioner is permitted to write admission orders on behalf of a Supervising Physician who has inpatient admitting privileges.
 - (b) Consultations. Category II and Category III practitioners may not independently provide patient consultations in lieu of the practitioners' Supervising Physicians. A Category II or Category III practitioner may gather data, order tests, and generate documentation; however, the Supervising Physician must personally perform the requested consultation in accordance with the time frames set forth in any applicable policies, rules, and regulations.
 - (c) Emergency On-Call Coverage. Category II practitioners may not independently participate in the emergency on-call roster (formally, or informally by agreement with their Supervising Physicians), in lieu of the Supervising Physician who is on-call pursuant to the applicable policies, rules, and regulations. It shall be within the discretion of the Emergency Department physician requesting assistance whether it is appropriate to contact a Category II practitioner prior to the Supervising Physician. However, when contacted by the Emergency Department physician, the Supervising Physicians (or their covering physician) must personally respond to all calls in a timely manner, in accordance with requirements set forth in the Medical Staff Credentials Policy. Following discussion with

the Emergency Department, the Supervising Physician may direct a Category II practitioner to see the patient, gather data, order tests, and generate documentation for further review by the Supervising Physician. However, the Supervising Physician must still personally see the patient when requested by the Emergency Department physician.

- (d) Calls Regarding Supervising Physician's Hospitalized Inpatients. It shall be within the discretion of the Hospital personnel requesting assistance whether it is appropriate to contact a Category II practitioner prior to the Supervising Physician. Category II practitioners may not independently respond to calls from the floor or special care units regarding hospitalized inpatients if such calls were specifically directed to the Supervising Physician. The Supervising Physician must personally respond to all calls directed to him or her in a timely manner consistent with the requirements set forth in all applicable policies, rules, and regulations.
- (e) Daily Inpatient Rounds for Attending Physicians. Category II or Category III practitioners may not independently perform daily inpatient rounds in lieu of their Supervising Physicians. A Category II or Category III practitioner is permitted to perform daily inpatient rounds; however, all inpatients must also be visited daily by the Supervising Physician (or a designated physician). The Supervising Physician (or a designated physician) will review, revise and cosign the practitioner's notes and orders pursuant to all applicable policies, rules, and regulations.

6.B. CHANGES IN SUPERVISING PHYSICIAN

Category II and Category III practitioners must notify Medical Staff Services of changes in Supervising Physicians, at least 30 days in advance of any such change. The notification to Medical Staff Services shall include the name and clinical practice area of the new Supervising Physician. Changes in Supervising Physician must be approved by the Medical Staff leadership before such changes may become effective, in one of the following ways:

- (1) No change in clinical specialty area. If a requested change in Supervising Physician does not involve a change in a Category II or Category III practitioner's clinical specialty area, the requested change shall be reviewed by the Chief of Staff and the Leadership Council. If no concerns are identified, the change in Supervising Physician shall take effect immediately upon review. All such changes shall then be sent to the Centralized Credentials Committee and the MEC for information purposes.
- (2) Change in clinical specialty area. If a requested change in Supervising Physician involves a change in a Category II or Category III practitioner's primary clinical specialty area, the requested change must be reviewed by the Centralized Credentials Committee and the MEC before such change may become effective. If

either Committee identifies concerns regarding whether the Category II or Category III practitioner meets the threshold eligibility criteria in the relevant specialty area or whether the individual has sufficient current clinical competence in the new clinical specialty area, such concerns must be resolved before the requested change in Supervising Physician may take effect. A determination by the Centralized Credentials Committee and/or the MEC that a Category II or Category III practitioner is not eligible to practice in a particular specialty area is not a denial of clinical privileges or a scope of practice and does not entitle the individual to the due process rights set forth in this Policy.

6.C. OVERSIGHT BY SUPERVISING PHYSICIAN

- (1) Any activities permitted to be performed at the Hospital by a Category II practitioner shall be performed only under the supervision or direction of a Supervising Physician. Any activity permitted to be performed at the hospital by a Category III practitioner shall be performed pursuant to the order of a supervising physician.
- (2) Category II practitioners may function in the Hospital only so long as (i) they are supervised by a Supervising Physician who is currently appointed to the Medical Staff, and (ii) they have a current, written supervision agreement with the Supervising Physician. In addition, should the Medical Staff appointment or clinical privileges of the Supervising Physician be revoked or terminated, the Category II practitioner's permission to practice at the Hospital and clinical privileges or scope of practice shall be automatically relinquished (unless the individual will be supervised by another approved physician on the Medical Staff).
- (3) As a condition of clinical privileges or a scope of practice, a Category II practitioner and their Supervising Physician must provide the Hospital with a copy of any written supervision or collaboration agreement that may be required by the state as well as notice of any revisions or modifications that are made to any such agreements between them. This notice must be provided to Medical Staff Services within three days of any such change.

6.D. QUESTIONS REGARDING AUTHORITY OF A CATEGORY II PRACTITIONER

- (1) Should any Medical Staff member or Hospital employee who is licensed or certified by the state have any question regarding the clinical competence or authority of a Category II practitioner, either to act or to issue instructions outside the physical presence of the Supervising Physician in a particular instance, the Medical Staff member or Hospital employee shall have the right to require that the Category II practitioner's Supervising Physician validate, either at the time or later, the instructions of the Category II practitioner. Any act or instruction of the Category II practitioner shall be delayed until such time as the staff member or Hospital

employee can be certain that the act is clearly within the scope of the Category II practitioner's activities as permitted by the Board.

- (2) Any question regarding the clinical practice or professional conduct of a Category II practitioner shall be immediately reported to the Chief of Staff, the Chair of the Centralized Credentials Committee, the relevant department chair, the CMO, or the CEO, who shall undertake such action as may be appropriate under the circumstances. The individual to whom the concern has been reported will also discuss the matter with the Supervising Physician.

6.E. RESPONSIBILITIES OF SUPERVISING PHYSICIAN

- (1) Physicians who wish to utilize the services of a Category II practitioner in their clinical practice at the Hospital must notify Medical Staff Services of this fact in advance and must ensure that the individual has been appropriately credentialed in accordance with this Policy or with Human Resources policies and procedures before the Category II or Category III practitioner participates in any clinical or direct patient care of any kind in the Hospital.
- (2) In order to request the prerogative to supervise Category II practitioners in the Hospital setting, members of the Medical Staff who wish to function as Supervising Physicians must provide documentation showing completion of all required continuing medical education that describes the legal relationship and obligations regarding such supervisory relationships and must provide documentation certifying the competence of the Category II practitioner in relation to the clinical privileges or scope of practice that the individual is seeking to exercise.
- (3) The Supervising Physician will remain responsible for all care provided by the Category II practitioner in the Hospital.
- (4) Supervising Physicians who wish to utilize the services of a Category II practitioner in the inpatient setting specifically agree to abide by the standards of practice set forth in Section 6.A above.
- (5) The number of Category II practitioners acting under the supervision of one Supervising Physician, as well as the care they may provide, will be consistent with applicable state statutes and regulations and any other policies adopted by the Hospital. The Supervising Physician will make all appropriate filings with the State Board of Medicine regarding the supervision and responsibilities of the Category II practitioner, to the extent that such filings are required and shall provide a copy of the same to Medical Staff Services.
- (6) It will be the responsibility of the Supervising Physician to ensure that the Category II practitioner maintains professional liability insurance in amounts required by the Board. The insurance must cover any and all activities of the Category II practitioner in the Hospital. The Supervising Physician will furnish evidence of

such coverage to the Hospital. The Category II practitioner will act in the Hospital only while such coverage is in effect.

ARTICLE 7

QUESTIONS INVOLVING ALLIED HEALTH PROFESSIONALS

7.A. COLLEGIAL INTERVENTION AND PROGRESSIVE STEPS

- (1) As part of the Hospital's performance improvement and professional practice evaluation activities, this Policy encourages the use of collegial efforts and progressive steps with Allied Health Professionals (and their Supervising Physicians, as applicable) by Medical Staff Leaders and Hospital management in order to arrive at voluntary, responsive actions by individuals to resolve questions that have been raised. Collegial intervention efforts are not mandatory and shall be within the discretion of the appropriate Medical Staff Leaders.
- (2) Collegial intervention efforts may include, but are not limited to, counseling, sharing of comparative data, monitoring, and additional training or education. All such efforts shall be documented in an individual's confidential file.
- (3) 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.
- (4) Allied Health Professionals 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. Should a recommendation be made or an action taken that entitles a Category I or Category II practitioner to a hearing in accordance with this Policy, the individual is entitled to be accompanied by legal counsel at that hearing.
- (5) 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.

7.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 7.C below. Such interventions and evaluations, however, are not mandatory prerequisites to MEC review.

7.C. INVESTIGATIONS

7.C.1. Initiation of Investigation:

When a question involving clinical competence or professional conduct of an Allied Health Professional is referred to, or raised by, the MEC, the MEC will review the matter and determine whether to conduct an investigation, to direct the matter to be handled pursuant to another policy, or to proceed in another manner.

7.C.2. Investigative Procedure:

- (a) The MEC will either investigate the matter itself, request that the Centralized Credentials Committee conduct the investigation, or appoint an ad hoc committee to conduct the investigation (“investigating committee”). The investigating committee will not include relatives or financial partners of the Allied Health Professional or, where applicable, the Allied Health Professional’s Supervising Physician. Whenever the questions raised concern the clinical competence of the individual under review, the ad hoc committee shall include a peer of the individual (e.g., an Allied Health Professional in a similar discipline).
- (b) The investigating committee will have the authority to review relevant documents and interview individuals. It will also have available to it the full resources of the Medical Staff and the Hospital.
- (c) The investigating committee will also have the authority to use outside consultants, if needed.
- (d) The investigating committee may require a physical, mental, and/or behavioral examination of the individual by a health care professional(s) acceptable to the committee. The individual being investigated shall execute a release (in a form approved or provided by the investigating committee) allowing (i) the investigating committee (or its representative) to discuss with the health care professional(s) conducting the examination the reasons for the examination; and (ii) the health care professional(s) conducting the examination to discuss and provide documentation of the results of such examination directly to the investigating committee. The cost of such health examination shall be borne by the individual.
- (e) The individual will have an opportunity to meet with the investigating committee before it makes its report. Prior to this meeting, the individual will be informed of the general questions being investigated. At the meeting, the individual will be invited to discuss, explain, or refute the questions that gave rise to the investigation. No recording (audio or video) or transcript of the meeting shall be permitted or made. A summary of the interview will be prepared. This meeting is not a hearing,

and none of the procedural rules for hearings will apply. The individual being investigated will not have the right to be accompanied by legal counsel at this meeting.

- (f) The investigating committee will make a reasonable effort to complete the investigation and issue its report within 30 days of the commencement of the investigation, provided that an outside review is not necessary. When an outside review is necessary, the investigating committee will make a reasonable effort to complete the investigation and issue its report within 30 days of receiving the results of the outside review. These time frames are intended to serve only as guidelines.
- (g) At the conclusion of the investigation, the investigating committee will prepare a report with its findings, conclusions, and recommendations.

7.C.3. 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 permission to practice;
 - (4) impose a requirement for monitoring, proctoring, or consultation;
 - (5) impose a requirement for additional training or education;
 - (6) recommend reduction of clinical privileges or scope of practice;
 - (7) recommend suspension of clinical privileges or scope of practice for a term;
 - (8) recommend revocation of clinical privileges or scope of practice; or
 - (9) make any other recommendation that it deems necessary or appropriate.
- (b) A recommendation by the MEC that would entitle the individual to request a hearing will be forwarded to the CEO, who will promptly inform the individual by Special Notice. The CEO will hold the recommendation until after the individual has completed or waived a hearing and appeal.
- (c) If the MEC makes a recommendation that does not entitle the individual to request a hearing, it will take effect immediately and will remain in effect unless modified by the Board.

7.D. ADMINISTRATIVE SUSPENSION

- (1) The Chief of Staff, the Vice Chief of Staff, the CMO, and the MEC will each have the authority to impose an administrative suspension of all or any portion of the clinical privileges of any Allied Health Professional whenever a question has been raised about such individual's clinical care or professional conduct.
- (2) An administrative suspension will become effective immediately upon imposition, will immediately be reported in writing to the CEO and the Chief of Staff, and will remain in effect unless or until modified by the CEO or the MEC. The imposition of an administrative suspension does not entitle an Allied Health Professional to the procedural rights set forth in Article 8 of this Policy.
- (3) Upon receipt of notice of the imposition of an administrative suspension, the CEO and Chief of Staff will forward the matter to the MEC, which will review and consider the question(s) raised and thereafter make a recommendation to the Board.

7.E. AUTOMATIC RELINQUISHMENT/ACTIONS

- (1) An Allied Health Professional's clinical privileges or scope of practice shall be automatically relinquished, without entitlement to the procedural rights outlined in this Policy, in the following circumstances:
 - (a) the Allied Health Professional no longer satisfies any of the threshold eligibility criteria set forth in Section 4.A.1 or any additional threshold credentialing qualifications set forth in the specific Hospital policy relating to his or her discipline;
 - (b) the Allied Health Professional is arrested, charged, indicted, convicted, or enters a plea of guilty or no contest to any felony; or to any misdemeanor involving (i) controlled substances; (ii) illegal drugs; (iii) Medicare, Medicaid, or insurance or health care fraud or abuse; (iv) child abuse; (v) elder abuse; or (vi) violence against another (DWIs will be addressed in the manner outlined in Section 4.B.1(e) of this Policy);
 - (c) the Allied Health Professional fails to provide information pertaining to his or her qualifications for clinical privileges in response to a written request from the Centralized Credentials Committee, the Leadership Council, the CoPE, the MEC, the CMO, the CEO, or any other committee authorized to request such information;
 - (d) the Allied Health Professional fails to complete or comply with training or educational requirements that are adopted by the MEC or required by the Board, including, but not limited to, those pertinent to electronic medical

records, computerized physician order entry (“CPOE”), the privacy and security of protected health information, infection control, or patient safety;

- (e) the Allied Health Professional fails to attend a special meeting at the request of a Medical Staff Leader to discuss a concern with clinical practice or professional conduct;
- (f) a determination is made that there is no longer a need for the services of a particular discipline or category of Allied Health Professional;
- (g) a Category II practitioner fails, for any reason, to maintain an appropriate relationship with a Supervising Physician as defined in this Policy; or
- (h) a certified registered Nurse Practitioner or a Physician Assistant fails to attend at least two of their four quarterly meetings. This requirement does not apply to locum tenens.

(2) Requests for reinstatement.

- (a) Requests for reinstatement following the expiration of a license/certification/registration, controlled substance authorization, and/or insurance coverage will be processed by Medical Staff Services. If any questions or concerns are noted, Medical Staff Services will refer the matter for further review in accordance with (b) below.
- (b) All other requests for reinstatement will be reviewed by the Leadership Council. If the Leadership Council makes a favorable recommendation on reinstatement, the Allied Health Professional may immediately resume clinical practice at the Hospital. This determination will then be forwarded to the Centralized Credentials Committee, the MEC, and the Board for ratification. If, however, any of these individuals reviewing the request has any questions or concerns, those questions will be noted and the reinstatement request will be forwarded to the full Centralized Credentials Committee, MEC, and Board for review and recommendation.

7.F. LEAVE OF ABSENCE

- (1) An Allied Health Professional may request a leave of absence, for a period not to exceed a year, by submitting a written request to the CEO, acting as the representative of the board. The CEO will determine whether a request for a leave of absence shall be granted. Requests for reinstatement must be made at least 30 days prior to the conclusion of the leave of absence.
- (2) Allied Health Professionals must request a leave of absence if they will be away from patient care responsibilities for more than 30 days. If an Allied Health Professional is away from patient care responsibilities for longer than 30 days and

the reason for such absence is related to their physical or mental health or otherwise to their ability to care for patients safely and competently, and the individual has not requested a leave of absence, the CEO, in consultation with the Chief of Staff and the CMO, may trigger an automatic medical leave of absence.

- (3) Individuals requesting reinstatement will submit a written summary of their professional activities during the leave, and any other information that may be requested by the Hospital. Requests for reinstatement will then be reviewed by the Leadership Council. If the Leadership Council makes a favorable recommendation on reinstatement, the Allied Health Professional may immediately resume practice. This determination will then be forwarded to the Centralized Credentials Committee, the MEC, and the Board for ratification. If, however, any of the individuals reviewing the request has any questions or concerns, those questions will be noted and the reinstatement request will be forwarded to the full Centralized Credentials Committee, MEC, and Board for review and recommendation. In the event the MEC determines to take action that would entitle the individual to the procedural rights set forth in Article 8, the individual will be given Special Notice.
- (4) If the leave of absence was for health reasons (except for maternity leaves), the request for reinstatement must be accompanied by a report from the individual's physician indicating that the individual is physically and/or mentally capable of resuming a hospital practice and safely exercising the clinical privileges requested.

7.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 Allied Health Professionals who maintain permission to practice and clinical privileges or scope of practice at both Hospitals:
 - (a) automatic relinquishment of clinical privileges or scope of practice;
 - (b) a voluntary agreement to refrain from exercising some or all clinical privileges or scope of practice for a period of time;
 - (c) any involuntary modification of clinical privilege or scope of practice;
 - (d) a Performance Improvement Plan; and/or
 - (e) a conditional grant of initial, continued, or renewed clinical privileges or scope of practice.
- (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 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 8

PROCEDURAL RIGHTS FOR ALLIED HEALTH PROFESSIONALS

Allied Health Professionals shall not be entitled to the hearing and appeals procedures set forth in the Medical Staff Credentials Policy. Any and all procedural rights to which these individuals are entitled are set forth in this Article.

8.A. NOTICE OF RECOMMENDATION AND HEARING RIGHTS

- (1) In the event a recommendation is made by the MEC that a Category I or Category II practitioner not be granted clinical privileges or that the privileges previously granted be restricted for a period of more than 30 days, terminated, or not renewed, the individual will receive Special Notice of the recommendation. The Special Notice will include a general statement of the reasons for the recommendation and will advise the individual that he or she may request a hearing.
- (2) The rights and procedures in this Section will also apply if the Board, without a prior adverse recommendation from the MEC, makes a recommendation not to grant clinical privileges or that the privileges previously granted be restricted, terminated, or not renewed. In this instance, all references in this Article to the MEC will be interpreted as a reference to the Board.
- (3) If the Category I or Category II practitioner wants to request a hearing, the request must be in writing, directed to the CEO, within 30 days after receipt of written notice of the adverse recommendation.
- (4) The hearing will be convened as soon as is practical, but no sooner than 30 days after the notice of the hearing, unless an earlier hearing date has been specifically agreed to by the parties.

8.B. HEARING COMMITTEE

- (1) If a request for a hearing is made in a timely manner, the CEO, in conjunction with the Chief of Staff, shall appoint a Hearing Committee composed of up to three individuals (including, but not limited to, individuals appointed to the Medical Staff, Allied Health Professionals, Hospital management, individuals not connected to the Hospital, or any combination of these individuals) and a Presiding Officer, who may be legal counsel to the Hospital. The Hearing Committee shall not include anyone who previously participated in the recommendation, any relatives or practice partners of the Category I or Category II practitioner, or any competitors of the affected individual.
- (2) As an alternative to the Hearing Committee described in paragraph (a) of this Section, the CEO, in conjunction with the Chief of Staff, may instead appoint a

Hearing Officer to perform the functions that would otherwise be carried out by the Hearing Committee. The Hearing Officer shall preferably be an attorney at law. The Hearing Officer may not be in direct economic competition with the individual requesting the hearing and shall not act as a prosecuting officer or as an advocate to either side at the hearing. If the Hearing Officer is an attorney, he or she shall not represent clients who are in direct economic competition with the affected individual. In the event a Hearing Officer is appointed instead of a Hearing Committee, all references in this Article to the Hearing Committee shall be deemed to refer instead to the Hearing Officer, unless the context would clearly otherwise require.

- (3) The hearing shall be convened as soon as is practical, but no sooner than 30 days after the notice of the hearing, unless an earlier hearing date has been specifically agreed to by the parties.

8.C. HEARING PROCESS

- (1) A record of the hearing will be maintained by a stenographic reporter or by a recording of the proceedings. Copies of the transcript will be available at the individual's expense.
- (2) The hearing will last no more than six hours, with each side being afforded approximately three hours to present its case, in terms of both direct and cross-examination of witnesses.
- (3) At the hearing, a representative of the MEC will first present the reasons for the recommendation. The Category I or Category II practitioner will be invited to present information to refute the reasons for the recommendation.
- (4) Both parties will have the right to present witnesses. The Presiding Officer will permit reasonable questioning of such witnesses.
- (5) The Category I or Category II practitioner and the MEC may be accompanied at the hearing by legal counsel. However, while counsel may be present at the hearing, counsel will not call, examine, or cross-examine witnesses or present the case.
- (6) The Category I or Category II practitioner will have the burden of demonstrating, by clear and convincing evidence, that the recommendation of the MEC was arbitrary, capricious, or not supported by substantial evidence. The quality of care provided to patients and the smooth operation of the Hospital will be the paramount considerations.
- (7) The Category I or Category II practitioner and the MEC will have the right to prepare a post-hearing memorandum for consideration by the Hearing Committee.

The Presiding Officer will establish a reasonable schedule for the submission of such memoranda.

8.D. HEARING COMMITTEE REPORT

- (1) Within 20 days after the conclusion of the proceeding or submission of the post-hearing memoranda, whichever date is later, the Hearing Committee will prepare a written report and recommendation. The Hearing Committee will forward the report and recommendation, along with all supporting information, to the CEO. The CEO will send a copy of the written report and recommendation by Special Notice to the Category I or Category II practitioner and to the MEC.
- (2) Within ten days after notice of such recommendation, the Category I or Category II practitioner and/or the MEC may make a written request for an appeal. The request must include a statement of the reasons, including specific facts, which justify an appeal.
- (3) The grounds for appeal will be limited to an assertion that there was substantial failure to comply with this Policy during the hearing, so as to deny a fair hearing, and/or that the recommendation of the Hearing Committee was arbitrary, capricious, or not supported by substantial evidence.
- (4) The request for an appeal will be delivered to the CEO by Special Notice.
- (5) If a written request for appeal is not submitted timely, the appeal is deemed to be waived and the recommendation and supporting information will be forwarded to the Board for final action. If a timely request for appeal is submitted, the CEO will forward the report and recommendation, the supporting information and the request for appeal to the Board. The Chair of the Board will arrange for an appeal.

8.E. APPELLATE REVIEW

- (1) An Appellate Review Committee appointed by the Chair of the Board will consider the record upon which the adverse recommendation was made. New or additional written information that is relevant and could not have been made available to the Hearing Committee may be considered at the discretion of the Appellate Review Committee. This review will be conducted within 30 days after receiving the request for appeal.
- (2) The Category I or Category II practitioner and the MEC will each have the right to present a written statement on appeal.
- (3) At the sole discretion of the Appellate Review Committee, the Category I or Category II practitioner and a representative of the MEC may also appear personally to discuss their position.

- (4) Upon completion of the review, the Appellate Review Committee will provide a report and recommendation to the full Board for action. The Board will then make its final decision based upon the Board's ultimate legal responsibility to grant privileges and to authorize the performance of clinical activities at the Hospital.
- (5) The Category I or Category II practitioner will receive Special Notice of the Board's action. A copy of the Board's final action will also be sent to the MEC for information.

ARTICLE 9

HOSPITAL EMPLOYEES

- (A) Except as provided below, the employment of an Allied Health Professional by the Hospital shall be governed by the Hospital's employment policies and manuals and the terms of the individual's employment relationship and/or written contract. To the extent that the Hospital's employment policies or manuals, or the terms of any applicable employment contract, conflict with this Policy, the employment policies, manuals and descriptions and terms of the individual's employment relationship and/or written contract shall apply.
- (B) Except as noted in (A), Hospital-employed Allied Health Professionals are bound by all of the same conditions and requirements in this Policy that apply to non-Hospital employed Allied Health Professionals.
- (C) A request for clinical privileges, on an initial basis or for renewal, submitted by a Category I or Category II practitioner who is seeking employment or who is employed by the Hospital shall be processed in accordance with the terms of this Policy, and the Medical Staff Leadership shall determine whether the individual is qualified for the privileges requested. A report regarding each practitioner's qualifications shall then be made to Hospital management or Human Resources (as appropriate) to assist the Hospital in making employment decisions.
- (D) If a concern about an employed Allied Health Professional's clinical competence or professional conduct originates with the Medical Staff, the concern may be reviewed and addressed in accordance with Articles 7 and 8 of this Policy, after which a report will be provided to Hospital management or Human Resources (as appropriate). This provision does not preclude Hospital management or Human Resources from addressing an issue in accordance with the Hospital's employment policies/manuals or in accordance with the terms of any applicable employment contract.

ARTICLE 10

AMENDMENTS

- (A) Proposed amendments to this Policy shall be presented to the MEC
- (B) This Policy may then be amended by a majority vote of the members of the MEC present and voting at any meeting of that Committee where a quorum exists. Notice of all proposed amendments shall be provided to each voting 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.
- (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 Medical Staff bylaws or rules and regulations or Hospital policies pertaining to the subject matter thereof.

Covenant Medical Center

Adopted by the Medical Staff: April 9, 2019

Approved by the Board: April 25, 2019

APPENDIX A

Those individuals currently practicing as Category I practitioners at the Hospital are as follows:

Covenant Medical Center

Audiologists

Clinical Psychologists

Licensed Professional Counselors

Marriage and Family Counselors

Covenant Children's Hospital

Audiologists

Clinical Psychologists

Licensed Professional Counselors

Marriage and Family Counselors

APPENDIX B

Those individuals currently practicing as Category II practitioners at the Hospital are as follows:

Covenant Medical Center

Cardiovascular Pump Perfusionists

Certified Registered Nurse Practitioners

Physician Assistants

Certified Surgical Technologist/Certified First Assistant (CST/CFA) or Certified Surgical Assistant (CSA)

Covenant Children's Hospital

Cardiovascular Pump Perfusionists

Certified Registered Nurse Practitioners

Physician Assistants

APPENDIX C

Those individuals currently practicing as Category III practitioners at the Hospital are as follows:

Covenant Medical Center

Orthotists

Prosthetists

Covenant Children's Hospital

Orthotists

Prosthetists