

SUMMIT HEALTHCARE REGIONAL
MEDICAL CENTER
CREDENTIALING PROCEDURES MANUAL

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SECTION ONE: APPLICATION POLICY

- 1.1** Summit Healthcare Regional Medical Center (Summit Healthcare) accepts applications to the Medical Staff from licensed medical and osteopathic physicians, podiatrists and dentists. Allied Health Professionals will be permitted to apply for specific clinical privileges as approved by the Medical Staff. Only the Governing Board may make exceptions to this policy.
- 1.2** It is the policy of Summit Healthcare to process applications for appointment to the medical staff and requests for privileges only for individuals who can demonstrate that they meet the following criteria. Whenever possible, primary source verification of all requirements will be obtained:

Physicians:

- 1.2.1 Graduation from an approved school of medicine or osteopathy.
- 1.2.2 Successful completion of a formal accredited residency training program, or be currently board certified or actively participating in the examination process leading to certification (board qualified), or have four (4) years' experience in active, hospital based patient care within the preceding five (5) years.
- 1.2.3 Completion of 20 hours of category I CME as defined by the A.C.C.M.E. (Accreditation Council on Continuing Medical Education) or A.O.A. (American Osteopathic Association) in the past twelve months.

Dentists or Oral Surgeons:

- 1.2.4 Graduation from an approved school of dentistry.
- 1.2.5 Successful completion of at least one year in a postgraduate training program.

Podiatrists:

- 1.2.6 Graduation from an approved school of podiatry.
- 1.2.7 Successful completion of at least one year in a postgraduate training program or an approved preceptorship.

Allied Health Professionals

- 1.2.8 Successful completion of a formal accredited training program as required by Arizona professional licensing or certifying agency.
- 1.2.9 Documentation of current Basic Life Support (BLS) for Healthcare Providers within 30 days of initial appointment.

All:

- 1.2.10 Hold current, unrestricted professional licensure in the State of Arizona applicable to requested privileges and compliance with any continuing education obligations required under applicable law.
- 1.2.10.1 Concurrent processing of a medical staff application while an applicant is obtaining his/her professional licensure in the State of Arizona may occur with joint approval from the Chief Executive Office, or designee, and the Chief of Staff, or designee, after consultation with the Department Chair and no identified issues or concerns. (Rev. 02/17)
- 1.2.11 Hold current, unrestricted U.S. Drug Enforcement Agency certification, if applicable to the applicant's requested privileges.

- 1.2.12 Possess and maintain evidence of current malpractice insurance coverage in the amount of at least \$1 million/\$ 3 million. Information from prior and current liability insurance carriers (for the past ten years) concerning claims, suits, and settlements, must be supplied. (Rev. 6/10)
- 1.2.13 Active clinical practice (residency training acceptable) for at least the past ten (10) years. (Revised 2/04; 6/10)
- 1.2.14 Present plans for office within a reasonable distance of Summit Healthcare and plans for utilizing Summit Healthcare (excluding Telemedicine and Affiliate Medical Staff).
- 1.2.15 Evidence of skills to provide a type of service which the Governing Board has determined to be appropriate for performance within Summit Healthcare and for which a need exists.
- 1.2.16 Evidence of appropriate personal qualifications to include a record of applicant's observance of ethical standards including, without limitation:
 - 1.2.16.1 Abstinance from any participation in fee splitting or other payment, receipt or remuneration with respect to referral or patient service opportunities.
 - 1.2.16.2 A record of professionally and harmoniously working with others within an institutional setting.
 - 1.2.16.3 A record that is free of criminal history including Medicare/Medicaid/AHCCCS sanctions, felony convictions, or occurrences that would raise questions of undesirable conduct.
- 1.2.17. The background, experience and training, current competence, knowledge, judgment, ability to perform, and technique in the specialty for all privileges requested.
- 1.2.18 Upon request, provide evidence of both physical and mental health that does not impair the fulfillment of his responsibilities of the provider's membership and/or specific privileges requested by and granted to the applicant.
- 1.2.19 Evidence of freedom from infectious pulmonary tuberculosis in compliance with Summit Healthcare's policy (excluding credentialed providers rendering care via telemedicine and Affiliate Medical Staff members).

Tuberculosis screening can be done at Summit Healthcare Employee Health free of charge.

For Inpatient Privileges:

- 1.2.20 Actively practiced in a hospital setting during the past two (2) years which includes time spent in a full-time clinical fellowship/residency training. * *See Section 5.7 Minimum Clinical Activity Reappointment Guidelines for activity minimums.*

Medical Staff Board Certification Requirement

- 1.2.21 All new applicants to the Medical Staff after January 1, 2012 must be specialty board certified by a specialty board recognized or approved by the American Board of Medical Specialties (ABMS), American Osteopathic Association (AOA), American Board of Podiatric Surgery (ABPS), American Dental Association, and/or their affiliated, recognized or approved entities, or by a specialty certification board recognized and approved by Summit Healthcare Medical Staff's Credentialing Committee, in a specialty relevant to the area in which the applicant is seeking privileges, or must be in the process of receiving certification after completing requisite board education and training within a

time frame set by the applicable specialty. Providers initially credentialed after January 1, 2012 must maintain board certification in accordance with their applicable specialty board guidelines. Failure to recertify within one reappointment cycle following the Board expiration date shall result in an automatic termination of privileges, unless due to exceptional circumstances as determined by the Medical Executive Committee (MEC). If a waiver is requested, the individual requesting the waiver bears the burden of demonstrating exceptional circumstances. (Added 10/2011)

SECTION TWO: APPLICATION REQUEST PROCEDURE

- 2.1 All requests for appointment to the Medical Staff/Allied Health Professional Staff will be forwarded to Medical Staff Services. Upon receipt of a request, Medical Staff Services will provide the potential applicant with a pre-application questionnaire/minimum qualifications for membership, and initial application packet as approved by the MEC, a copy of the Medical Staff Bylaws, the Rules and Regulations, and the Credentialing Procedures Manual, which includes a description of responsibilities for Medical Staff members and all individuals granted privileges.
- 2.2 Upon receipt of a completed pre-application questionnaire/minimum qualifications for membership, Medical Staff Services will review its contents and will, if the requirements are met, authorize the release of an application to the applicant. In the event the requirements are not met, the potential applicant will be notified that s/he does not meet the minimum qualifications to apply to the Summit Healthcare medical staff. Such action and reasons for the action will be reported to the Credentials Committee by Medical Staff Services.
 - 2.2.1 If a potential applicant believes a minimum qualification is explainable, or if there are /were extenuating circumstances, s/he may provide a letter of explanation to be reviewed by the Credentials Committee at the next regularly scheduled meeting. The Credentials Committee's decision is final and does not allow for an appeal of the decision to not extend an initial application for a potential applicant. The potential applicant will be notified of the Credentials Committee's decision in writing.

SECTION THREE: INITIAL APPOINTMENT PROCEDURE

- 3.1 **APPLICATION COMPLETION.** Upon request and fulfillment of the eligibility criteria, applicants will be provided an application for appointment to the Medical Staff/Allied Health Professional Staff, privilege request form(s) and criteria for privileges, and a detailed list of requirements for completion of the application. A copy of the Medical Staff Bylaws and Rules and Regulations will be provided, or made available, to the applicant as well.
- 3.2 **APPLICATION PROCESSING.** Upon receipt of a completed application form and the non-refundable application fee, the Medical Center CEO or designee will determine if the requirements of Section 1.2 are met. If the requirements of Section 1.2 are fulfilled, the application will be processed. In the event the requirements are not met, the potential applicant will be notified that he is ineligible for Medical Staff/Allied Health Professional Staff membership. A complete application will include names and addresses of three (3) professional references who have recently worked with the applicant and directly observed his professional performance over a reasonable period of time, at least one of whom must be an individual practicing in a field similar to the applicant.
 - 3.2.1 Non-refundable application fees will be as established by vote of the Medical Executive Committee and endorsed by the Governing Board. Requests for waiver of application fees must be made in writing to the Medical Executive Committee stating the applicant's reason(s), and if appropriate, supporting documentation to support the waiver request. The Medical Executive Committee will consider each request on the merit of information

provided. The decision of the Medical Executive Committee is final.

- 3.2.2 A separate electronic credentials file for each applicant will be initiated and maintained by Medical Staff Services. The credentials file will contain information collected from the applicant and verification documentation received from primary sources, and all other relevant information to the applicant's request for membership and/or privileges and subsequent requests for reappointment.
- 3.2.3 The applications used must be on the form designated by the Medical Executive Committee and approved by the Governing Board.
- 3.2.4 In the event that an applicant chooses to withdraw their application, such request must be submitted in writing and received by the Medical Staff Services Department prior to final action by the Governing Board. (Rev 10/03)

3.3 CONDITIONS OF APPOINTMENT. The applicant must sign the application and in so doing:

- 3.3.1 Attests to the accuracy and completeness of all information on the application or accompanying documents and agrees that any inaccuracy, omission or commission will be grounds for termination of the application process.
- 3.3.2 Signifies his willingness to appear for interviews in regard to his application, peer review and Medical Center performance improvement activities.
- 3.3.3 Authorizes Medical Center and Medical Staff representatives to consult with prior and current associates and others who may have information bearing on his professional competence, character, ability to perform the privileges requested, ethical qualifications, ability to work cooperatively with others, and other qualifications for membership and the clinical privileges requested or wish to maintain.
- 3.3.4 Consents to Medical Center and Medical Staff representatives' inspection of all records and documents that may be material to an evaluation of the applicant's professional qualifications and competence to carry out the clinical privileges requested, physical and mental health status, and professional and ethical qualifications.
- 3.3.5 Releases from liability any and all Medical Center and Medical Staff representatives for their acts performed and statements made in connection with evaluation of the applicant's, credentials and qualifications to the fullest extent permitted by law.
- 3.3.6 Releases from liability all individuals and organizations who provide information to the Medical Center or the Medical Staff, including otherwise privileged or confidential information regarding the applicants background, experience, competence, professional ethics, character, physical and mental health, emotional stability, utilization practice patterns, and other qualifications for staff appointment and clinical privileges.
- 3.3.7 Authorizes and consents to Summit Healthcare representatives providing other medical centers, medical associations, licensing boards, and other organizations concerned with provider performance and the quality and efficiency of patient care, with any information relevant to such matters that Summit Healthcare may have concerning the applicant and release Summit Healthcare representatives from liability for so doing.
- 3.3.8 Signifies that the applicant acknowledges responsibility for knowing the contents of the Medical Staff Bylaws and associated manuals, rules and regulations, and agrees to abide

by their provisions.

- 3.3.9 Agrees to provide to Medical Staff Services any updated information requested on the original application and subsequent re-applications or privilege request forms. The applicant also agrees to, within ten (10) days of occurrence, to notify Medical Center representatives concerning:
- voluntary or involuntary relinquishment of medical staff membership or clinical privileges at any hospital or health care facility or licensure status;
 - voluntary or involuntary limitation, suspension, reduction, or loss of clinical privileges at any other hospital or health care facility;
 - when a patient needs to be transferred due to a complication;
 - any known major complication, even if the patient remains in the hospital;
 - involvement in any liability actions which include at a minimum, settlements made or final judgments involving the individual;
 - voluntary or involuntary cancellation of professional liability insurance;
 - previously successful or currently pending challenges to any licensure or registration or voluntary relinquishment of such license or registration;
 - DEA, or Medicare/ Medicaid/AHCCCS sanctions including both current and pending investigations and challenges;
 - conviction for fraud or any other offense; voluntary or involuntary participation in a chemical dependency rehabilitation program;
 - any current criminal charges pending of any convictions of felonies;
 - and removal from a managed care organization's panel for reasons of quality of care or unprofessional conduct.

For the purposes of this provision, the term " Summit Healthcare Regional Medical Center representatives" includes: the Governing Board, its directors and committees; the Medical Center CEO or his designee, registered nurses and other employees of the Summit Healthcare Regional Medical Center; the Medical Staff organization and all Medical Staff appointees; clinical units and committees which have responsibility for collecting and evaluating the applicant's credentials or acting upon his application; and any authorized representative of any of the foregoing.

Rev. 02/2013

- 3.3.10 Agrees to provide documentation of an influenza vaccination or declination form in accordance with Hospital policy by December 31 annually.

3.4 PROCEDURE FOR PROCESSING APPLICANTS FOR INITIAL STAFF APPOINTMENT

- 3.4.1 It is the applicant's responsibility to provide a completed, signed application form and request for privileges. A completed application includes, at a minimum: a signed, dated application form and request for privileges; copies of all documents and information necessary to confirm applicant meets criteria for membership and privileges within the specified time frame requested; requested references;, and a non-refundable application fee. (Rev 12/2014)
- 3.4.2 If all information required is not submitted by the applicant within forty-five (45) days of receipt of the application, the application will be considered incomplete and no processing will take place. One reminder notice will be sent to the applicant after the receipt of the application noting missing items or information. If the requested missing items are not received within thirty (30) days, this will be interpreted as a voluntary withdrawal of the application.

- 3.4.3 Upon receipt of a completed application as defined above, the applicant will be sent notification of acknowledgment by Medical Staff Services.
- 3.4.4 The applicant's name, specialty, and board status may be posted in a designated area in order to permit current Medical Staff members to provide additional information to the Credentials Committee.
- 3.4.5 Upon receipt of a completed application, Medical Staff Services will verify its contents from the appropriate primary source(s) and collect additional information as follows:
 - 3.4.5.1 Information from all prior and current liability insurance carriers concerning claims, suits and settlements (if any) for the past ten (10) years.
 - 3.4.5.2 Administrative and clinical reference questionnaires from all significant past practice settings, at the minimum for the previous ten years.
 - 3.4.5.3 Verified documentation of the applicant's clinical work experiences as far back as possible. (Rev 10/03)
 - 3.4.5.4 Verification of licensure status in all current or past states of licensure.
 - 3.4.5.5 When appropriate or necessary, information from the AMA or AOA Physician Masterfiles, Federation of State Medical Boards or other such databanks or approved verification sources.
 - 3.4.5.6 Verification of completion of medical/osteopathic/dental/podiatric school, residency/fellowship programs, and if applicable, specialty board certification.
 - 3.4.5.7 Information from the National Practitioner Data Bank established pursuant to the Healthcare Quality Improvement Act of 1986, including Medicare/Medicaid/AHCCCS sanctions.
 - 3.4.5.8 Information regarding clinical ability, ethical character and ability to work with others from identified references.
 - 3.4.5.9 Satisfactory explanation of any issues regarding: successful or pending challenges to licensure or DEA or voluntary or involuntary relinquishment of same; voluntary or involuntary termination of membership at any health care facility; limitation or loss of clinical privileges at any health care facility, involvement in any professional liability actions, settlements or final judgments and suspensions or terminations of membership from any medical society or board.
 - 3.4.5.10 Any additional information as may be requested to ensure the applicant meets the criteria for Medical Staff membership.

NOTE: In the event there is undue delay in obtaining required information, Medical Staff Services will request assistance from the applicant. Failure of an applicant to adequately respond to a request for assistance will, after thirty (30) days, be deemed a withdrawal of the application.

- 3.4.6 **Reissuance of Application.** In the event an initial application is automatically withdrawn for failure to file a complete application (3.4.2) or for failure to adequately respond to a request for assistance and the potential applicant does not request review of extenuating circumstances by the Credentials Committee, the potential applicant must wait six (6) months before requesting a new application.

3.5 CREDENTIALS COMMITTEE POLICY AND PROCEDURE ON CLINICAL INTERVIEW

- 3.5.1 Summit Healthcare's Medical Staff may elect to conduct a personal interview of new applicants to resolve any issues or concerns identified during the credentialing process. The interview is to be conducted by members of the Credentials Committee. A permanent

record will be made of the interview by completion of the Credentials Interview Questionnaire (a copy of which is attached and incorporated by reference).

The interview may be used to solicit information required to complete the credentials file or clarify information previously provided; e.g., past malpractice history, reasons for leaving past healthcare organizations, or other matters bearing on the applicant's ability to render care at the recognized level for the community.

The interview may be waived at the discretion of the Credentials Committee Chair or designee. The Credentials Interview Questionnaire must be completed by the medical staff leader/committee who conducted the interview and placed in the applicant's credentials file.

- 3.5.2 The applicant will be notified if an interview is deemed necessary and an appointment will be scheduled by Medical Staff Services.

3.6 EFFECT OF CREDENTIALS COMMITTEE ACTION The Credentials Committee reviews the application and votes for one of the actions noted below.

3.6.1 **Deferral.** Action by the Credentials Committee to defer the application for further consideration must be followed within thirty days by subsequent recommendations as to approval or denial of, or any special limitations to, staff appointment, category of staff and prerogatives and scope of clinical privileges. The Chairman of the Credentials Committee will promptly notify the applicant by special, written notice of the action to defer.

3.6.2 **Favorable Recommendation.** When the credentials committee's recommendation is favorable to the applicant in all respects, the application will be promptly forwarded, together with all supporting documentation, to the Medical Executive Committee.

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

3.7 EFFECT OF MEDICAL EXECUTIVE COMMITTEE ACTION. The Medical Executive Committee reviews the application and votes for one of the actions noted below:

3.7.1 **Deferral.** Action by the Medical Executive Committee to defer the application for further consideration must be followed within thirty (30) days by subsequent recommendations as to approval or denial of, (or any special limitations to) staff appointment, category of staff and prerogatives, optional clinical service affiliations, and clinical privileges. The Chief of Staff will promptly notify the applicant by special, written notice of the action to defer.

3.7.2 **Favorable Recommendation.** When the Medical Executive Committee's recommendation is favorable to the applicant in all respects, the application will be forwarded, together with all supporting documentation, to the Governing Board.

3.7.3 **Adverse Recommendation.** When the Medical Executive Committee's recommendation is adverse to the applicant, a special notice will be sent to the applicant.

3.7.3.1 **Medical Staff Only.** No such adverse recommendation will be forwarded to the Governing Board until after the practitioner has exercised or has waived his right to a hearing as provided in the fair hearing section of the Medical Staff Bylaws.

3.8 GOVERNING BOARD ACTION. The Governing Board reviews the application and votes for one of the actions noted below.

3.8.1 Favorable Recommendation. The Governing Board may adopt or reject in whole or in part a favorable recommendation of the Medical Executive Committee or refer the recommendation back to the Medical Executive Committee for further consideration stating the reasons for such referral back and setting a time limit within which a subsequent recommendation must be made. Favorable action by the Governing Board is effective as its final decision.

3.8.2 Adverse Recommendation. If the Governing Board's action is adverse to the applicant, a special notice will be sent to him.

3.8.2.1 Medical Staff Only. Applicant will then be entitled to the procedural rights provided in the fair hearing section of the Medical Staff Bylaws.

3.8.3 After Procedural Rights for Medical Staff Applicants. In the case of an adverse Medical Executive Committee recommendation, the Governing Board will take final action in the matter as provided in the fair hearing section of the Medical Staff Bylaws.

3.8.4 Appointments. All appointments to Medical Staff/Allied Health Professional membership and the granting of privileges are for a two year period, except as described in Section 5 below concerning provisional status.

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

3.10 CONFLICT RESOLUTION. Whenever the Governing Board determines that it will decide a matter contrary to the Medical Executive Committee's recommendations, the matter will be submitted to the Joint Conference Committee for review and recommendation before the Governing Board makes its final decision. The committee will submit its recommendation within thirty (30) days of submission.

3.11 NOTICE OF FINAL DECISION

3.11.1 Notice of the Governing Board's final decision will be given through the Medical Center CEO to the Medical Executive Committee. The applicant will receive written notice of appointment and special notice of any adverse final decisions. Adverse final decisions will be given in writing through the Medical Center CEO to the Medical Executive Committee.

3.11.2 A decision and notice of appointment includes the staff category to which the applicant is appointed, the appropriate Medical Staff committee(s) to which he may be assigned, the clinical privileges he may exercise, and any special conditions attached to the appointment.

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

Individual/Group

Time Period

- Medical Staff Services (to collect, verify and summarize)

60 days

- Credentials Committee (analyze and recommend) 30 days
- Medical Executive Committee (to reach final recommendation) 30 days
- Governing Board (render final decision) 30 days

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

3.13 RESPONSIBILITIES OF EACH MEMBER (APPOINTEE). Each member (appointee) agrees to:

- 3.13.1 Provide appropriate and continuous care for patients at the generally recognized professional level of quality and efficiency established by Summit Healthcare's Medical Staff and to retain responsibility within his area of professional competence and expertise for the continuous care and supervision of each patient in the medical center for whom he is providing services.
- 3.13.2 Provide the name(s) of the practitioner(s) to be called in the attending physician's absence. If the staff member does not reside in the primary service area, as defined by patient demographics, he must provide the name of a covering practitioner who is a resident of the area. If no alternate practitioner is available in an emergency, then the Chief of Staff or his designee will provide for the patient's care.
- 3.13.3 Participate in continuing education related to his delineated clinical privileges and the type and nature of care offered by the Medical Center and findings from quality assessment/performance improvement activities.
- 3.13.4 Not receive from, nor pay to another physician, directly or indirectly, any portion of a fee received for professional services rendered.
- 3.13.5 Agrees to use the Medical Center and its facilities sufficiently to allow the Medical Center to evaluate his competence.
- 3.13.6 Participate in staff, committee and Medical Center functions, including but not limited to: peer review, quality or performance improvement review, utilization review, consultation assignments, emergency service and on-call functions, or exercise of staff privileges, prerogatives or other rights in the hospital.
- 3.13.7 Serve on committees of the Medical Staff, Medical Center or Governing Board when so appointed.
- 3.13.8 Provide a means of prompt communication.
- 3.13.9 Maintain in force professional liability insurance in level and amounts as may be determined by the Governing Board.
- 3.13.10 Adhere to the institution's policies on sexual harassment and unprofessional behavior.
- 3.13.11 Serve on the emergency call roster as obligated by Medical Staff Rules and Regulations.

- 3.13.12 Agrees to prepare and complete the medical and other required records in a timely fashion for all patients he admits or provides care for in the Medical Center.
- 3.13.13 Act in a respectful and courteous manner with patients, families, other Medical Staff members, Medical Center administrators, Allied Health Professionals and Medical Center employees, so as not to adversely affect patient care.
- 3.13.14 Abide by the Medical Staff Bylaws, Rules and Regulations and all other lawful standards, policies and rules of the Medical Staff and the Medical Center.
- 3.13.15 As the supervising physician or agent, provide appropriate utilization and supervision of approved Allied Health Professionals.
- 3.13.16 Agrees to provide evidence of freedom from infectious pulmonary tuberculosis in compliance with Summit Healthcare's policy (excluding credentialed providers rendering care via telemedicine and Affiliate Medical Staff members). .

Tuberculosis screening can be done at Summit Healthcare Employee Health free of charge.
- 3.13.17 Agrees to maintain life support certification(s) as required by Summit Healthcare policy, the Medical Staff Rules & Regulations, or for granted privileges/practice privileges

SECTION FOUR: PROVISIONAL STATUS

- 4.1 PROVISIONAL PERIOD.** All initial appointments and clinical privileges are provisional for a period of 12 months and all reinstatements following a Leave of Absence are for six (6) months; during which time all individuals with provisional privileges will be subject to review of their clinical performance by the Credentials Committee. The monitoring during the provisional period shall be to evaluate the member's (1) proficiency in the exercise of clinical privileges initially granted and (2) overall eligibility for continued staff membership. The initial appointment of Provisional status shall not create for the appointee any vested right to reappointment at the completion of the appointment period. (Rev 8/03) (Rev 9/06)
- 4.2 PROVISIONAL REVIEW.** All provisional members will be evaluated according to the requirements for Medical Staff membership as set forth in Section 3.13 (Responsibilities of Each Member (Appointee)). Any problems identified and reported through the Medical Center's performance improvement process will be considered during this review period. In order to qualify for advancement from Provisional status, a member must:
 - a) Successfully complete the general proctoring requirements contained in this Credentialing Procedures Manual;
 - b) Demonstrate (to the satisfaction of the MEC) his/her ability to work harmoniously with other members of the Medical Staff and with the employees of the Medical Center, and
 - c) Demonstrate (to the satisfaction of the MEC) current clinical competence for granted privileges.

Three months prior to the end of the provisional term, information will be solicited from the Chief of Staff, appropriate Department Chairman, Peer Review Director, and other Medical Center Departments as necessary, and in the case of an allied health professional, his/her supervising/collaborating physician. The solicited input will be regarding the provisional member's clinical competence, compliance with Medical Staff membership requirements, ability to work harmoniously with other members of the healthcare team, etc., and the reviewer's

recommendation concerning advancement to non-provisional status. Monitoring activities may include, but are not limited to, concurrent or retrospective chart review, mandatory consultation, and/or direct observation, at the discretion of the Credentialing Committee. An external, impartial peer may be utilized to review cases of a provisional Staff member at the request of the Credentials or Medical Executive Committees. The Credentials Committee will assess the provisional member's clinical competence and compliance with Medical Staff and Medical Center Rules and Regulations. A report will be provided to the Medical Executive Committee and one of the following actions will be taken: (Rev 8/03; 9/06)

4.2.1. Favorable. Recommendation of advancement from provisional status.

4.2.2. Deferral. Recommendation for extension of provisional status for one of the following reasons:

- a) Failure to complete general proctoring within the allotted timeframe or
- b) Lack of conclusive data demonstrating current clinical competence, or
- c) Lack of conclusive data demonstrating ability to comply with the responsibilities of Medical Staff Membership (CPM Section 3.13)

4.2.3. Adverse. A recommendation to terminate Medical Staff membership and/or clinical privileges.

Under special circumstances, due to the nature of a member's specialty (neonatology, pediatric cardiology, telemedicine services, and electrophysiology), data demonstrating current clinical competence may be obtained and evaluated from the member's primary admitting facility upon the recommendation of the Credentials Committee.

4.3 ACTION REQUIRED. The Credentials Committee considers the requests and information submitted to it and prepares a written report with recommendations and supporting documentation for transmittal to the Medical Executive Committee. The Credentials Committee may defer action for no more than thirty (30) days. Final processing follows the procedures set forth in the appointment process.

4.4 EXTENSION. If an initial appointee has not fulfilled the responsibilities of membership as specified in Section 3.13 or has not met the criteria for removal of the provisional status as specified in Section 4.2, then his/her provisional period may be extended for an additional period of time not to exceed twelve (12) months by approval of the Medical Executive Committee. If eligibility for advancement to non-provisional status is not met within the 24 month period, the provisional staff membership will automatically be terminated.

If an appointee does have his/her provisional period extended for an additional 12 months based upon quality of care concerns or requirements for monitoring, proctoring and/or additional education or training will be recommended by the Credentials Committee to the Medical Executive Committee.

4.5 TERMINATION BY PRACTITIONER: If the practitioner no longer wishes the privilege or privileges at issue, then his/her request for their termination will initiate the removal of these privileges without creating an adverse action triggering the fair hearing procedures.

4.6 ADVERSE CONCLUSIONS – MEDICAL STAFF PROCEDURAL RIGHTS. Whenever a provisional period (including any period of extension) expires with an adverse recommendation for the practitioner based on reasons of professional conduct or quality of care issues, or whenever extension is denied, the Medical Center CEO will provide him/her with special notice of the adverse result and of his/her entitlement to procedural rights provided in the fair hearing section of the Medical Staff Bylaws.

(Section Rev. 05/09)

SECTION FIVE: REAPPOINTMENT

All reappointments and renewal of clinical privileges are for a period of up to twenty-four (24) months and will be processed according to Sections 3 and 5 of this manual. All Staff reappointments shall be for a period to extend to the end of the month in which the next Arizona State professional license expires. Under no circumstances shall the interval between appointment and reappointment, or reappointments exceed twenty-four (24) months. The Credentials Committee may recommend to the MEC a period appointment or reappointment of less than twenty-four (24) months specifically for cause, which may or may not be reportable. Reappointment and renewal of clinical privileges shall only be extended to current members of the Medical Staff in good standing. Good standing means a current member of the Medical Staff/Allied Health Professional Staff who is currently not under suspension (excludes routine suspensions for medical records completion) and/or no actions were taken against the practitioner that resulted in a report to the National Practitioner Data Bank (NPDB). (Rev 6/04; 6/10; 12/13)

5.1 INFORMATION COLLECTION AND VERIFICATION FROM STAFF APPOINTEES. At least one hundred eighty (180) days prior to the expiration date of each Provider's appointment, Medical Staff Services shall distribute a reappointment application and new privilege request form(s) to each Staff member in good standing. An electronic reappointment packet shall be sent to the email address on file in the Medical Staff Office, and a separate notice shall be sent on how to access the electronic reappointment packet by certified mail return receipt requested. At least one hundred twenty days (120) prior to the appointment expiration date, each provider shall submit a completed reappointment application. If an application is not received by the deadline a reasonable attempt to call for follow up will be made. The application will be on a form prescribed by the Medical Executive Committee, and it shall require detailed information concerning the changes in the applicant's qualifications since his/her last review. The submitted application must contain, but not limited to, the following items: (Rev. 01/2012;12/2013)

- 5.1.1. A completed reappointment form which includes complete information to update the appointee's file on items listed in the original application or since his/her last review.
- 5.1.2. Documentation of completion of a minimum of 40 hours of CME (50 hours for Podiatry) within the past twenty-four (24) months as required by the appropriate Arizona State Licensing Boards.
- 5.1.3. Specific request for change in privileges. A request for privileges must be supported by the type and nature of evidence, which would be necessary for such privileges to be granted in an initial application.
- 5.1.4. Requests for changes in staff category.
- 5.1.5. Documentation of current Arizona State Professional License, DEA Certificate, if applicable, and malpractice insurance indicating the amount of coverage and expiration date.
- 5.1.6. Documentation of freedom from infectious pulmonary tuberculosis as outlined in Section 3.13.16.
- 5.1.7. Current copy of visa/green card for all non-US citizens.
- 5.1.8. Documentation of current PALS/ACLS/ATLS/NRP/etc. as required for requested privileges and/or departmental requirements.
- 5.1.9. Documentation, explanation of and/or current status of current/on going/pending/closed/settled malpractice suits, licensing sanctions/DEA restrictions,

voluntary or involuntary termination of membership at another facility, and/or loss or restriction of privileges at another health care facility since his/her last review.

- 5.1.10 The reappointment fee and any other applicable fee(s) as established by the Medical Executive Committee with the Governing Board's approval.

By signing the reapplication form, the appointee agrees to the same terms as identified in Section 3.13. Failure, without good cause, to file a complete application for reappointment (including all supporting documentation, as well as current address and telephone numbers) thirty (30) days prior to appointment expiration, shall result in an automatic determination by the Medical Executive Committee that the Provider's membership and privileges have been voluntarily relinquished affective the appointment period expiration.

Medical Staff Services verifies the information submitted, and notifies the Staff appointee of any information inadequacies or verification problems. The Staff appointee then has the burden of producing adequate information and/or resolving any doubts about the data. Failure of an applicant to adequately respond to a request for assistance will, after thirty (30) days, be deemed a voluntary relinquishment of Medical Staff membership and privileges. (Rev. 11/2007)

5.2 INFORMATION COLLECTION AND VERIFICATION FROM INTERNAL AND/OR EXTERNAL SOURCES. Medical Staff Services collects and verifies the following information for each staff appointee regarding his professional activities Whenever possible, primary source verification will be obtained. (Rev. 11/2007)

- 5.2.1 A summary of clinical activity at the Medical Center or at the primary admitting institution, during the preceding two year period.
- 5.2.2 Currency of licensure and registrations.
- 5.2.3 Maintenance of professional board certification status, if applicable.
- 5.2.4 Information from prior and current liability insurance carriers (for the past two years), concerning claims, suits and settlements.
- 5.2.5 Any pending or completed disciplinary actions or sanctions.
- 5.2.6 Performance and conduct in the Medical Center and/or other healthcare organizations, including without limitation, patterns of care, as demonstrated in findings of quality assessment or performance improvement activities, his clinical judgment and skills in the treatment of patients, his behavior and cooperation with Medical Center personnel, patients, and visitors.
- 5.2.7 Report from National Practitioner Data Bank; including Medicare/ Medicaid/AHCCCS sanctions.
- 5.2.8 Satisfactory explanation of any issues regarding: successful or pending challenges to licensure or DEA; or voluntary or involuntary termination of membership at any health care facility; limitation or loss of clinical privileges at any health care facility; and suspension or terminations of membership from any medical society or board.
- 5.2.9 Continuing training and education during the preceding period; as defined in Section 5.1.2.
- 5.2.10 Accuracy and timeliness of medical records/Medical Center reports.

- 5.2.11 Attendance at required Medical Staff and committee meetings.
- 5.2.12 Service on Medical Staff, and Medical Center committees.
- 5.2.13 Compliance with all applicable bylaws, policies, rules, regulations and procedures of the Medical Center and Medical Staff.

5.3 RETURNED DOCUMENTS. All returned documents will be reviewed and verified as described in the initial appointment procedure.

5.4 LATE REAPPOINTMENTS/LATE FEE PENALTY

Applications received after the submittal date as described in Section 5.1, but prior to thirty (30) days before the applicant's appointment expiration date are subject to a \$10.00 per business day late fee. Incomplete applications as described in Section 5.1 are subject to a \$10.00 per business day late fee. The reappointment application will be considered incomplete and will continue incurring a late fee penalty until all required documentation and late fee penalty are submitted to Medical Staff Services for processing. (Rev. 11/2007)

5.4.1 **Use of Late Fee Penalty:** The late fee penalty will be deposited into the Medical Staff's general fund for Medical Staff leadership education and training or other uses as approved by the Medical Executive Committee.

5.4.2 **Refund of Late Fee Penalty:** Requests for a refund of a late fee penalty must be made to the Medical Executive Committee within thirty (30) days of the Medical Executive Committee's recommendation to the Governing Board regarding a Medical Staff member's appointment and privileges. All requests must be made in writing to the Medical Executive Committee stating the applicant's reason(s), and if appropriate, supporting documentation to support the refund request. The Medical Executive Committee will consider each request on the merit of the information provided. The decision of the Medical Executive Committee is final.

5.5 REINSTATEMENT TO MEDICAL STAFF AFTER FAILURE TO FILE REAPPOINTMENT APPLICATION (Rev. 11/2007)

Practitioners who fail to file his/her reappointment application in accordance with Section 5.1 may qualify for expedited reinstatement of Medical Staff membership and privileges. Practitioners who, within the past seven (7) years, were members of the Medical Staff in good standing for at least three (3) continuous years and, whose appointment was terminated for other than disciplinary reasons may be eligible to apply for reinstatement via completion of the reappointment process. The completed reappointment application must be received by Medical Staff Services within sixty (60) days of the practitioner's appointment and privilege expiration date. Expedited reinstatement will be at the discretion of the Governing Body, based on recommendations from the Credentials Committee and the Medical Executive Committee, but must include:

- a) All portions of regular reappointment process;
- b) Verification of activities during terms of absences;
- c) Letters of recommendation;
- d) All previous due fees and fines.

A practitioner who files or requests to file a reappointment application after the sixty (60) day timeframe described above are eligible to reapply for Medical Staff membership and privileges as outlined in Section 8.1.

5.6 LOW & NO-VOLUME PROVIDERS (Rev 2/07; 05/10; 01/12)

5.6.1 Applicants for reappointment who have been determined to have LOW volume activity during their current reappointment period will be required to have the following elements:

- a) Volume of clinical activity at the provider’s primary facility that correspond to clinical privileges held at Summit Healthcare.
- b) Confirmation of medical staff status, “in good standing with no disciplinary actions, no contemplated investigations and no ongoing investigations or quality/review adverse action” at the provider’s primary facility.
- c) Confirmation that the practitioner is clinically competent for all areas covered by his or her requested privileges at the provider’s primary facility.

5.6.2 Applicants for reappointment who have been determined to have had less than five (5) documented patient encounters at Summit Healthcare during their current reappointment period, with the exception of telemedicine services, will be automatically moved to the Affiliate Medical Staff category. The following elements, in addition to those listed above, are required to have the following elements for reappointment:

- a) Confirmation of medical staff status, “in good standing with no disciplinary actions, no contemplated investigations and no ongoing investigations or quality/review adverse action” from the provider’s primary facility.
- b) Provide the name and contact information of at least two (2) peers to evaluate character and judgment.

5.6.3 The Credentialing Committee, Medical Executive Committee, or Governing Board may request further information if deemed necessary.

5.6.4 Failure of the applicant to provide all required information will be deemed a voluntary resignation for the medical staff.

5.7 MINIMUM CLINICAL ACTIVITY REAPPOINTMENT GUIDELINES

The following minimum clinical activity reappointment guidelines will be used to help determine current competency for the provider’s current reappointment period. All applicants for reappointment must have a minimum of five (5) documented patient encounters within the provider’s current reappointment period at Summit Healthcare, with the exception of telemedicine services. Activity from the provider’s primary facility may be used to meet the following activity guidelines, provided the activity is the same for current privileges at Summit Healthcare.

Specialty	Proposed Minimum Reappointment Clinical Activity
<u>Anesthesiology/CRNA</u>	Management and participation in 100 general/regional anesthesiology patients within the past 24 months with acceptable outcomes.
<u>Emergency Medicine</u>	Documentation/attestation of management of at least 200 emergency patients during the past 24 months with acceptable outcomes. Documentation of a case log from other facilities is acceptable for part-time providers.

<u>Family Medicine Specialties (FM, GYN, Pediatrics, etc.)</u>	For inpatient privileges: Documentation/attestation of management of at least 20 inpatients during the past 24 months with acceptable outcomes.
<u>Medicine Specialties</u>	For inpatient privileges: Documentation/attestation of management of at least 20 inpatients during the past 24 months with acceptable outcomes.
<u>General Surgery</u>	Document successfully performed/managed at least 200 inpatients or outpatient surgical procedures during the past 24 months with acceptable outcomes.
<u>Obstetrics</u>	Documentation/attestation of management of at least 30 obstetric procedures/cases during the past 24 months with acceptable outcomes.
<u>Ophthalmology</u>	Management and participation in 50 inpatient or outpatient ophthalmology patients within the past 24 months with acceptable outcomes.
<u>Orthopedic Surgery</u>	Management and participation in 100 orthopedic surgery patients within the past 24 months with acceptable outcomes.
<u>Otolaryngology (ENT)</u>	Documentation/attestation of the performance of at least 100 otolaryngology (ENT) surgical procedures during the past 24 months with acceptable outcomes.
<u>Pain Management</u>	Documentation/attestation of the performance of pain management procedures for at least 50 inpatients or outpatients as the attending physician (or senior resident), at an accredited facility, during the past 24 months.
<u>Pathology</u>	Management and participation in 100 clinical pathology cases within the past 24 months with acceptable outcomes.
<u>Plastic Surgery</u>	Management and participation in 100 plastic surgery patients within the past 24 months with acceptable outcomes.
<u>Podiatry</u>	Documentation/attestation of the management of podiatric problems and/or the performance of podiatric surgical procedures for at least 50 inpatients or outpatients during the past 24 months with acceptable outcomes.
<u>Radiology</u>	Documentation/attestation of management of at least 20 invasive/interventional radiologic procedures during the past 24 months with acceptable outcomes.
<u>Radiation Oncology</u>	Documentation/attestation of radiation oncological inpatient/outpatient or consultative services for at least 50 patients during the past 24 months with acceptable outcomes.
<u>Urology</u>	Documentation/attestation of urological inpatient/outpatient or consultative services for at least 100 patients during the past 24 months with acceptable outcomes.
<u>Vascular Surgery</u>	Documentation/attestation of the management of vascular surgical problems for at least 100 inpatients or outpatients during the past 24 months with acceptable outcomes.

For providers who do not meet the minimum clinical competency requirements (listed above) at the time of reappointment, any of the following, or combination of, may occur at the discretion of the MEC.

- a. Shortened reappointment with [n] cases proctored to determine clinical competence during the shortened reappointment term.
- b. Completion of [n] additional Category 1 CME specific to the provider's specialty/procedure(s).
- c. Requirement of additional training for specific procedures to be completed prior to the end of the reappointment term.
- d. Automatic change of staff membership to the Affiliate Staff Category.
(Added 04/2009; Rev 05/2010; 12/2016)

SECTION SIX: PROCEDURE FOR PROCESSING APPLICATIONS FOR STAFF REAPPOINTMENT

6.1 PROCEDURE FOR PROCESSING APPLICATIONS FOR STAFF REAPPOINTMENT. Medical Staff Services, in conjunction with Quality/Performance Improvement, will compile a summary of clinical activity the Medical Center for each appointee due for reappointment.

The completed file, including all documentation mentioned above, will be sent to the credentials committee for review. All physicians will be notified by the Medical Staff Services Department of each committee meeting at which their reapplication will be reviewed.

6.1.1 Credentials Committee Action. The Credentials Committee reviews the appointee's file, all relevant information available to it, and forwards to the Medical Executive Committee a written report with recommendations for reappointment, or non reappointment and for staff category and clinical privileges. The decision process outlined in Section 3.6 of this manual will be followed.

6.1.2 Medical Executive Committee Action. The Medical Executive Committee reviews the appointee's file, the Credentials Committee report(s), and all relevant information available to it and forwards to the Governing Board a written report with recommendations for reappointment, or non reappointment and for staff category and clinical privileges. The decision process outlined in Section 3.7 of this manual will be followed.

If the Medical Executive Committee's recommendation is deemed adverse, no such adverse recommendation will be forwarded to the Governing Board until after the practitioner has exercised or has waived his right to a hearing as provided in the fair hearing section of the Medical Staff Bylaws.

6.1.3 Final processing and governing board Action. Final processing of requests for reappointment follows the procedure set forth in Section 3.8 for initial appointment. For the purpose of reappointment an "adverse recommendation" by the Governing Board as used in these provisions means a recommendation or action to deny reappointment, to deny a requested change in, or to change without the Staff appointee's consent, his Staff category; or to deny or restrict requested clinical privileges. The terms "applicant" and "appointment" as used in these sections will be read respectively, as "Staff appointee" and "reappointment".

SECTION SEVEN: CLINICAL PRIVILEGES

7.1 EXERCISE OF PRIVILEGES. A practitioner providing clinical services at Summit Healthcare may exercise only those privileges granted to him by the Governing Board or emergency privileges as described herein.

7.2 PRIVILEGES IN GENERAL

7.2.1 Requests. Each application for appointment or reappointment to the Medical Staff/Allied Health Professional Staff must contain a request for specific clinical privileges if so desired by the applicant. Specific requests must also be submitted for temporary privileges, as specified in Section 7.7, and for modification of privileges in the interim between reappraisals as specified in Section 7.6 of this manual.

7.2.2 Basis For Privileges Determination. Requests for clinical privileges will be considered only when accompanied by evidence of education, training, experience, and demonstrated current competence as specified by the Medical Center. In the event a request for privileges

is submitted for a procedure for which no criteria have been created, the request will be tabled for a reasonable period of time during which the Governing Board will, after receiving recommendations from the Credentials and Medical Executive Committees, approve the necessary criteria. Once objective criteria have been established, the original request will be processed as described herein.

Valid requests for clinical privileges will be evaluated on the basis of prior and continuing education, training, experience, utilization practice patterns, appropriate level of malpractice insurance, current ability to perform the privileges requested, and demonstrated current competence, ability and judgment. Additional factors that may be used in determining privileges include: patient care needs for, and the Medical Center's capability to support, the type of privileges being requested, and the availability of qualified coverage in the applicant's absence. The basis for privileges determination to be made in connection with periodic reappointment, or a requested change in privileges, must include observed clinical performance and documented results of the Medical Staff's quality improvement program activities. Privileges determinations will also be based on pertinent information from other sources, especially other institutions and health care settings where the professional exercises clinical privileges.

7.2.3 **Observation Policies.** New and additional clinical privileges will be subject to current approved Observation Policies outlined in Section 7 of this manual.

7.2.4 **Procedure for Processing Requests.** The procedure by which requests for clinical privileges are processed and the specific qualifications for the exercise of privileges are as outlined in Section 3 of this manual.

7.3 **SPECIAL CONDITIONS FOR DENTAL AND PODIATRIC PRIVILEGES.** Requests for clinical privileges for dentists and podiatrists are processed in the same manner as all other privilege requests. .

7.4 **TELEMEDICINE AND TELERADIOLOGY PRIVILEGES**

7.4.1 **Definitions:** Telemedicine: the provision of clinical services to patients by physicians and practitioners from a distance via electronic communication. The distant-site telemedicine physician or practitioner provides clinical services to the hospital either simultaneously or non-simultaneously. Source: Centers for Medicare & Medicaid Services (CMS). Distant Site: site where the practitioner providing the telemedicine services is located.

7.4.2 The Medical Executive Committee shall determine which patient care, treatment, and services may be provided by practitioners through a telemedicine link. The clinical services offered must be consistent with commonly accepted quality standards. Telemedicine and Teleradiology services may be used in the event of a disaster when the emergency preparedness plan has been activated, and the organization is unable to meet immediate patient needs with resources on hand. Under such circumstances, the requirements in the Hospital's Emergency Preparedness (Disaster Plan) shall apply.

7.4.3 Practitioners providing care, treatment, and services of a patient via telemedicine link are subject to the credentialing and privileging process of Summit Healthcare. The practitioner may be privileged at Summit Healthcare using credentialing information from the distant site if the distant site is a Medicare-accredited organization. Under this option, the applicant would complete the Summit Healthcare application, and Summit Healthcare would obtain and utilize the distant site's primary source verified information including, but not limited to, licensure, education, training, the ability to perform privileges requested, and health status (that was obtained within 180 days from the receipt of the application with the exception of education and training verifications). At a minimum, Summit

Healthcare will re-verify Arizona medical licensure, perform a query of the National Practitioner Data Bank (NPDB), perform an Office of the Inspector General (OIG) (LEIE) Exclusions query, an Excluded Parties List System (EPLS) query, perform an AOA-/AMA-Profile query, and a Criminal Background Screening (a statement from a telehealth/telemedicine group indicating the date of the last Criminal Background Screening within the past 12 months and any identified issues/concerns may be utilized by Summit Healthcare as primary source). The information will be used for decision making in regard to granting of telemedicine privileges and membership. The application approval process outlined in the Credentialing Procedures Manual will be utilized.

7.4.4 The Medical Executive Committee shall continually evaluate the hospital's ability to provide these services safely, and must evaluate the performance of the services by practitioners at reappointment, renewal, or revision of clinical privileges.

7.5 SPECIAL CONDITIONS FOR ALLIED HEALTH PROFESSIONALS:

Requests to perform specified patient care services from authorized Allied Health Professionals are processed in the same manner as all other privilege requests

7.6 REQUESTS FOR ADDITIONAL PRIVILEGES OR MODIFICATION TO EXISTING PRIVILEGES. Any Provider requesting additional privileges or a modification to existing privileges must submit a "Request for Additional Privileges" form available from Medical Staff Services. Certain privileges will require observation as defined in current approved Observation Policies. (See Section 7) If deemed appropriate, observations for other privileges will be determined by the Credentials Committee. The request for additional privileges or modification in privileges will be submitted, along with supporting documentation, including the observation reports, to the Credentials Committee. The request will be processed in the same manner as initial appointments as defined in Sections 3.6 through 3.8 of this manual.

When approved, the applying practitioner will be notified and may then exercise the privilege(s) with the required observation, consultation, and/or proctoring. It is the applicant's responsibility to arrange for observers, consultants or proctors and to assure that reports are submitted to Medical Staff Services.

7.8 TEMPORARY PRIVILEGES

7.8.1 **Conditions.** Temporary privileges may be granted only in the circumstances described below, only to an appropriately licensed practitioner, only upon written request and when verified information reasonably supports a favorable determination regarding the requesting practitioner's qualifications, ability and judgment to exercise the privileges requested. Information which must be obtained and verified prior to the granting of temporary privileges includes: current Arizona State professional licensure, current DEA registration (if applicable), current and appropriate level of professional liability insurance, malpractice history, three positive references specific to the applicant's competence, training and ability to perform the privileges requested from relevant medical peers, and results from a query to the National Practitioner Data Bank, pursuant to the Health Care Quality Improvement Act of 1986. Special requirements of consultation and reporting may be imposed by the Chief of Staff. Except in unusual circumstances, temporary privileges will not be granted unless the practitioner has agreed in writing to abide by the bylaws, rules and regulations and policies of the Medical Staff and Summit Healthcare in all matters relating to his temporary privileges. Whether or not such written agreement is obtained, these bylaws, rules, regulations and policies control all matters relating to the exercise of clinical privileges. (Rev 6/10)

7.8.2 **Circumstances:** Temporary privileges may only be granted at the recommendation of the

Chief of Staff or designee and the Chairman of the Credentials Committee or designee and the Chief Executive Officer or designee. The Chief of Staff or Chair of the Credentials Committee may also request assistance in the review and assessment of such a request by an appropriate subject matter expert prior to making a recommendation to the Medical Center CEO. (Rev 8/03)

7.8.2.1 **Pendency of Application.** After receipt of a completed application for staff appointment, including a request for specific temporary privileges, for an initial period of not more than thirty (30) days. Additional extensions may be considered by the Credentials Committee.

7.8.2.2 **Care of Specific Patient(s) or Performance of Specific Procedure(s).** Upon receipt of a written request for specific temporary privileges for the care of one or more specific patients or the performance of one or more specific procedures from a practitioner who is not an applicant for staff appointment or a current Affiliate Medical Staff member, but who is a member in good standing of a comparable facility with appropriate accreditation with approved privileges and demonstrated competence in the service(s) or procedure(s) to be provided or performed. Such privileges will be granted no more than four times in any twelve-month period. Applications will be processed in the same manner as for all other applicants. (Rev 4/03; 6/10)

7.8.2.3. **Locum Tenens.** Locum Tenens applications will be processed in the same manner as for all other applicants. After receipt of a completed application for Locum Tenens appointment and a written request for specific temporary privileges, an appropriately licensed practitioner with documented competence who is serving as a Locum Tenens (providing temporary services or taking the place of a Medical Staff appointee for a temporary period of time), may be granted temporary privileges for a period of one hundred eighty (180) days in one year. If Locum Tenens services exceeds more than one hundred eighty (180) days in one year the physician must apply for Active or Consulting medical staff membership.

The Locum Tenens physician who has been granted temporary privileges will be subject to compliance with the provisional status review and observation requirements for new medical staff appointees and will have full procedural rights of membership. Service on the emergency room specialty coverage program may be required.

If a physician returns to serve subsequent Locum Tenens assignments, a Request for Locum Tenens Appointment form (See Exhibit F), along with an addendum questionnaire (See Exhibit G) must be completed by the physician for each Locum Tenens assignment. A temporary privileges form signed by the physician and the Medical Center's CEO will be kept on file and updated every six months. Any expired credentials must also be resubmitted. The credentials files of Locum Tenens physicians will be kept open for two (2) years from the last granting of privileges.

7.8.3 **Termination Of Temporary Privileges.** Upon the discovery of any information or the occurrence of any event of a nature which raises question about a practitioner's professional qualifications or ability to exercise any or all of the temporary clinical privileges granted, such privileges of that practitioner may be terminated. Any two of the following persons, acting in concurrence, will have the power to terminate temporary privileges. The Chief of Staff or his designee, the Chief Executive Officer or his designee, the Medical Executive Committee as a whole, or the Governing Board as a whole. Such

termination will become effective immediately upon notice to the practitioner, however prompt notice will also be given to the Chief of Staff, the Chief Executive Officer, the Medical Executive Committee and the Governing Board. In the event of any such termination, the practitioner's patients then in Summit Healthcare, whose treatment is no longer appropriately provided by such practitioner, will be assigned to another practitioner by the Chief of Staff, with notification of the CEO. The wishes of the patient will be considered where feasible in choosing a substitute practitioner.

7.8.4 Rights Of The Practitioner With Temporary Privileges. With the exception of Locum Tenens appointees, a practitioner is not entitled to the procedural rights afforded by the fair hearing procedures because his request for temporary privileges is refused or because all or any part of his temporary privileges are terminated or suspended.

7.8.5 Emergency Privileges: In case of an emergency, any Medical Staff appointee is authorized to the degree authorized, by his/her license, to do everything possible to save the patient's life or to save the patient from serious harm, to the degree permitted by the appointee's license, but regardless of staff category, or level of privileges. A practitioner exercising emergency privileges is obligated to summon all consultative assistance deemed necessary and to arrange appropriate follow-up.

7.9 DISASTER/EMERGENCY PRIVILEGES

When the Emergency Management Plan for Summit Healthcare has been activated, the hospital may be unable to handle the immediate and emergent patient needs. During a disaster it may be necessary to grant temporary privileges to volunteer physicians, podiatrists, physician assistants or nurse practitioners who are eligible as Licensed Practitioners (LP). A medical disaster occurs when the destructive effects of natural or man-made forces overwhelm the ability of a given area or community to meet the demands for health care (Source: American College of Emergency Physicians policy statement, Disaster Medical Services).

7.9.1 Practitioners who do not possess clinical privileges at Summit Healthcare may be granted temporary disaster privileges by the Chief Executive Officer (CEO) (or designee) or the Chief of Staff (COS) (or designee) when the Hospital Incident Command Center has been activated, for the duration of the disaster situation. Granting of these privileges will be determined on a case-by-case basis and are not a "right" of the requesting provider.

7.9.2 Emergency privileges may be granted upon review and evaluation of any of the following:

7.9.2.1 Practitioner with a valid government-issued identification issued by a state, federal, or regulatory agency (i.e. a driver's license or a passport), and at least one of the following:

7.9.2.1.1 Current hospital photo ID card that clearly identifies professional designation; or

7.9.2.1.2 A current license to practice and a valid picture ID issued by a state, federal, or regulatory agency; or

7.9.2.1.3 Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT); the Medical Reserve Corps (MRC) or the Emergency System for Advanced Registration of Volunteer Health Professionals (ESAR-VHP); or other recognized state or federal organization or group; or

- 7.9.2.1.4 Identification indicating that the individual has been granted authority to render patient care, treatment, and services in disaster circumstances (such authority having been granted by a federal, state, or municipal entity).
- 7.9.3 Providers granted disaster privileges shall be assigned to a Medical Staff member, in the same specialty if possible, with whom to collaborate in the care of disaster victims.
- 7.9.4 The Medical Staff oversees the performance and professional practice, care, treatment and services provided by the volunteer practitioner through direct observation, mentoring, and clinical record review.
- 7.9.5 If resources are available, the volunteer provider will be issued a photo ID Badge which must be worn at all times during the disaster.
- 7.9.6 Providers who receive disaster privileges pursuant to this policy will be covered for professional and general liability for acts undertaken in this capacity on behalf of Summit Healthcare.
- 7.9.7 **Primary source verification.** As soon as power is available, internet is reconnected or telephone communication is returned primary source verification will occur. The Medical Staff Office will address the verification process as a high priority, and will begin the verification process of the credentials and privileges of individuals who receive disaster privileges as soon as the immediate situation is under control. The verification process will be identical to the process described under 7.8 - Temporary Privileges.
 - 7.9.7.1 Photocopies of the above listed documents should be made and retained in the Medical Staff Office.
 - 7.9.7.2 Primary source verification begins as soon as the immediate situation is under control and is completed within 72 hours from the time the volunteer provider presented to the hospital.

If primary source verification cannot be completed within 72 hours of the provider's arrival due to extraordinary circumstances, the Medical Staff Office will document all of the following:

 - 7.9.7.2.1 The reason verification could not be performed within 72 hours of the provider's arrival;
 - 7.9.7.2.2 Evidence of the provider's demonstrated ability to continue to provide adequate care, treatment, and services; and
 - 7.9.7.2.3 Evidence of an attempt to perform primary source verification as soon as possible.
 - 7.9.7.3 If the volunteer provider has not provided any care, treatment or services under the disaster privileges process, primary source verification would not be required.
- 7.9.8 **Continuation of disaster privileges.** Based on the oversight of each volunteer provider, the CEO or the COS (or their designee(s)) will determine within 72 hours of the provider's arrival if granted disaster privileges should continue.

7.9.10 **Termination of disaster privileges.** Termination of temporary disaster privileges shall occur:

7.9.10.1 When the emergency situation no longer exists, or when Medical Staff members can adequately provide care; or

7.9.10.2 In the event that verification of information results in negative or adverse information about the qualifications of the provider;

7.9.10.3 When temporary disaster privileges are otherwise removed by the individual(s) authorized to grant temporary disaster privileges.

7.10 **PROCTORING/FOCUSED PROFESSIONAL PRACTICE EVALUATION (FPPE)/PERFORMANCE MONITORING**

Proctoring applies to all new staff members and existing members requesting additional privileges regardless of specialty or category of membership when direct patient care is involved. Proctoring is an objective evaluation of a physician's clinical competence by a proctor who represents, and is responsible to, the medical staff. Initial applicants seeking privileges or existing medical staff members requesting new or expanded privileges are proctored while providing the services for which privileges are requested. In addition, existing members may be required to be proctored as a condition of renewal of privileges (i.e., when a practitioner requests renewal of a privilege that has been performed so infrequently that it is difficult to assess the practitioner's current competence in that area). Proctoring is not imposed as a form of discipline but rather to assess competency, and is not considered an investigation as defined in the Medical Staff Bylaws, thereby not subject to regulations afforded in the investigation process. Proctoring should be imposed only for such period (or number of cases) as is reasonably necessary to enable such assessment. Medical Staff members shall be entitled to the procedural rights described in the Fair Hearing Plan only when and if proctoring is imposed as a form of discipline for a medical disciplinary cause or reason. The decision and process to perform FPPE for current medical staff members with existing privileges based on trends or patterns of performance identified by Ongoing Professional Practice Evaluation (OPPE)/Peer Review are outside the scope of this Section.

7.10.1 **Definition of Proctoring**

For purposes of this section, proctoring is a focused professional practice evaluation (FPPE) or "focused evaluation", which is a time-limited period to evaluate and determine a practitioner's current competence for newly requested privileges, or when there are concerns regarding the provision of safe, high quality care by a current medical staff member as recognized through the peer review process. In addition to specialty-specific issues, proctoring also will address the six (6) general competencies of physician performance as identified below.

1. *Patient care:* Practitioners are expected to provide patient care that is appropriate, and effective for the promotion of health, prevention of illness, treatment of disease, and at the end of life.
2. *Medical and clinical knowledge:* Practitioners are expected to demonstrate knowledge of established and evolving biomedical, clinical, and social sciences, and the application of their knowledge to patient care and the education of others.
3. *Practice-based learning and improvement:* Practitioners are expected to be able to use scientific evidence and methods to investigate, evaluate, and improve patient care.

4. *Interpersonal and communication skills:* Practitioners are expected to demonstrate interpersonal and communication skills that enable them to establish and maintain professional relationships with patients, families, and other members of healthcare teams.
5. *Professionalism:* Practitioners are expected to demonstrate behaviors that reflect a commitment to continuous professional development, ethical practice, an understanding and sensitivity to diversity, and a responsible attitude toward their patients, their profession, and society.
6. *Systems-based practice:* Practitioners are expected to demonstrate both an understanding of the contexts and systems in which healthcare is provided, and the ability to apply this knowledge to improve and optimize healthcare.

7.10.2 Medical Staff Ethical Position on Proctoring

The proctor's role is typically that of a monitor to evaluate technical and cognitive skills of another practitioner, not a consultant or mentor. A practitioner serving as a proctor for the purpose of assessing and reporting on the competence of another practitioner is an agent of the hospital. The proctor shall receive no compensation directly or indirectly from any patient for this service, and shall have no duty to the patient to intervene if the care provided by the proctored practitioner appears to be deficient. However, the proctor is expected to report immediately to the appropriate department chair, or hospital authority any concerns regarding the care being rendered by the proctored practitioner that has the potential for imminent patient harm. The proctor or any other practitioner, may render emergency medical care to the patient for medical complications arising from the care provided by the proctored practitioner. The hospital will defend and indemnify any practitioner who is subjected to a claim or suit arising out of his or her acts or omissions in the role of proctor.

7.10.3 Medical Staff Oversight

The Credentials Committee is charged with the responsibility of monitoring compliance with proctoring/FPPE. It accomplishes this oversight through receiving regular status reports related to the progress of all practitioners required to be proctored under this section as well as any issues or problems involved in implementation of this section. The Department Chair shall be responsible for overseeing the proctoring process for all applicants assigned to their Department.

The medical staff committees involved with Ongoing Professional Practice Evaluation (OPPE) will provide the Credentials Committee with data systematically collected for OPPE that is appropriate to confirm current competence for these practitioners during the FPPE period.

7.10.4 Proctoring Methods

Proctoring may utilize a combination of the following methods to obtain the best understanding of the care provided by the practitioner:

- **Prospective Proctoring:** Presentation of cases with planned treatment outlined for treatment concurrence, review of case documentation for treatment concurrence or completion of a written or oral examination or case simulation.
- **Concurrent Proctoring:** Direct observation of the procedure being performed or medical management either through observation of practitioner interactions with patients and staff or review of clinical history and physical and review of treatment orders during the patients hospital stay.

- **Retrospective Evaluation:** Review of case record after care has been completed. May also involve interviews of personnel directly involved in the care of the patient.

Specialists who most often provide cognitive care, as opposed to procedural care, are usually evaluated prospectively or retrospectively. Prospective proctoring and concurrent proctoring are the preferred methods of evaluating practitioners who request privileges to perform various procedures. Each specialty will recommend to the Credentials Committee the appropriate methods that will include the types of proctoring to be used, the data sources and collection methods and the method for evaluating the data. The appropriate proctoring methods for an individual practitioner will be determined by the Credentials Committee based on recommendation from the specialties and approved by the MEC. Each specialty specific proctoring methods will be reviewed, updated, and approved no less than bi-annually.

Should there be insufficient patient activity at Summit Healthcare Regional Medical Center to make an assessment of competency, an individual practitioner could remain on Focused Professional Practice Evaluation indefinitely.

7.10.4.1 In the case of a consultant, this could be accomplished by the active attending physician's assessment of the consultation services.

7.10.4.2 In the case of an admitting physician, the department chair and/or designee could review cases concurrent to care.

7.10.4.3 Additional review parameters to be assigned based on any concerns for past practice patterns.

7.10.5 Sources of Data

Proctoring data can be obtained for all dimensions of practitioner competence from multiple data sources. Data may be individual case specific or rate data from multiple cases. Data may be derived from information specifically obtained for FPPE or for OPPE.

FPPE data may include:

- Personal interaction with the practitioner by the proctor
- Detailed medical record review by the proctor
- Interviews of hospital staff interacting with the practitioner
- Surveys of hospital staff interacting with the practitioner
- Chart audits by non-medical staff personnel based on medical staff defined criteria for initial appointees

The data obtained by the proctor will be recorded in the proctoring form approved by each specialty to structure the proctoring data for consistency and inter-rater reliability.

OPPE data may include:

- Routine chart audits by non-medical staff personnel for important clinical functions
- Data abstracted for external comparative databases used to evaluate current medical staff members
- Occurrence reports
- Findings of cases identified for review by medical staff peer review committees
- Electronic claims data used to evaluate current medical staff members
- Patient satisfaction surveys

7.10.6 Duration of Proctoring Period (Rev. 2/2013)

Each practitioner granted clinical privileges must be proctored for at least six (6) months (not to be confused with provisional advancement) or the minimum number of cases as determined by the Department Committee(s). Proctoring shall begin when the practitioner is informed of appointment to the medical staff or granting of additional privilege(s). Based on the class of the applicant, newly granted privileges shall be considered under FPPE either for a specific period of time or for a specific number of patients/procedures based on the specialty recommendation to the Credentials Committee, and the Credentials Committee determination for non-specialty specific general competency issues. The Credentials Committee may alter this as needed. Providers who do not complete their observations at the end of three (3) months may be asked to attend a special conference with the Credentials Committee for explanation of why observations have not been completed. The proctoring period may be extended for a period not to exceed one (1) additional year if either initial concerns are raised that require further evaluation or if there is insufficient activity during the initial period. Failure to complete proctoring/FPPE shall result in an automatic determination by the Medical Executive Committee that the Medical Staff membership and privileges have been voluntarily relinquished.

The medical staff may take into account the practitioners previous experience in determining the approach and extent of proctoring needed to confirm current competency. The practitioner experience may fall into one of the following categories:

- 7.10.6.1 Recent training program graduate from another facility
- 7.10.6.2 Practitioner with experience at another medical staff of at least two (2) years.

Department	Minimum Requirement
All Departments	Telemedicine Staff – No observation requirements.
Emergency Medicine Department	<p><u>Emergency Medicine Specialty</u> Ten (10) cases reviewed by Active Staff member of the Service to determine the applicant’s ability to provide the evaluation and management services for their patients. Initial scheduling will allow for another member of the Emergency Medicine Service to provide direct observations.</p> <p><u>Radiology Specialty:</u></p> <ul style="list-style-type: none"> • Five (5) direct observations and five (5) chart reviews
Family Medicine	<p>Family Medicine Specialty:</p> <ul style="list-style-type: none"> • FPs and Pediatrics – 5 case reviews for all ages. • OB/GYN: 3 observed cases with 3 additional case reviews. • Level II Nursery – 2 cases concurrently reviewed and 5 cases retrospectively reviewed. <p><u>OB/GYN Specialty:</u></p> <ul style="list-style-type: none"> • 3 Cesarean Sections with physician assists, • 2 Cesarean Sections chart reviews • 3 major gynecological procedures • 2 open abdominal cases within the first year • 3 vaginal deliveries for new residents; no requirement for Board certified physicians.
Medicine Department	All Specialties (except Pathology):

	<ul style="list-style-type: none"> • Three (3) cases observed. For medical management – retrospective review; for procedures – concurrent observations
Surgery Department	<p>All Surgical Specialties:</p> <ul style="list-style-type: none"> • New Physicians <ul style="list-style-type: none"> Board Certified*: 3 observations & 3 chart reviews NOT Board Certified: 6 observations (3 from previous facility if meet our criteria) and 3 chart reviews • New Procedure <ul style="list-style-type: none"> Board Certified*: 2 observations and 2 chart reviews NOT Board Certified: 4 observations and 2 chart reviews <p>All observations are to be done, when possible, by a colleague of similar surgical specialty. Observations to be arranged by the surgeon. Chart reviews to be carried out by the appointed person. Observed and reviewed cases are first cases done at Summit Healthcare and must be major cases.</p> <p>*Board Certified: Must be a recognized board by either the ABMS, AOA, ADA or American Board of Podiatry.</p> <p><u>Pathology:</u></p> <ul style="list-style-type: none"> • Frozen sections – 5 • Cytology preliminary evaluations – 10 • Peripheral smear review – 10 • Surgical pathology sign-out – 20 • Cytology case sign out – 5 • Transfusion reaction work up - 1

7.10.7 Circumstances Which May Require External Professional Practice Evaluation (PPE)

External professional practice evaluation will take place under the following circumstances if deemed appropriate by the Chief of Staff and/or the Risk Manager.

7.10.7.1 Cases involving litigation, or the potential for a lawsuit as determined by Risk Management.

7.10.7.2 Ambiguity – when dealing with vague or conflicting recommendations from internal reviewers or medical staff committees and conclusions from this review will directly affect a practitioner’s membership or privileges.

7.10.7.3 Lack of internal expertise – when no one on the medical staff has adequate expertise in the specialty under review or when the only practitioners on the medical staff with that expertise are determined to have a conflict of interest regarding the practitioner under review as described above.

- 7.10.7.4 New technology – when a medical staff member requests permission to use new technology or perform a procedure new to the hospital and the medical staff does not have the necessary subject matter expertise to adequately evaluate the quality of care involved.
- 7.10.7.5 Miscellaneous issues – for evaluation of a credential file, or for assistance in developing a benchmark for quality monitoring. In addition, the MEC or the Governing Board may require external professional practice evaluation in any circumstances deemed appropriate by either of these bodies.

7.10.8 Responsibilities

7.10.8.1 Responsibilities of the Proctor:

Proctor(s) must be members in good standing of the Active Medical Staff of Summit Healthcare Regional Medical Center and must have privileges in that specialty area relative to the privilege(s) to be evaluated. Exceptions may be made with prior approval by the Chief of Staff, or his or her designee, and the Risk Manager. The proctor shall accomplish this evaluation by:

1. Use appropriate methods and tools approved by the MEC for that specialty.
2. Ensure the confidentiality of the proctoring results and forms and deliver the completed proctoring forms to the Medical Staff Services Office.
3. Submit a summary proctor report at the conclusion of the FPPE period.
4. If the practitioner being proctored is not sufficiently available or lacks sufficient cases to complete the proctoring process in the prescribed timeframe, the proctor shall request the Credentials Committee for an extension of the proctoring period to complete the report.
5. If at any time during the proctoring period, the proctor has concerns about the practitioner's competency to perform specific clinical privileges or care related to a specific patient(s), the proctor shall promptly notify the department chair.
6. Evaluate the proctored practitioner's performance from the time of admission until discharge and should evaluate the indications for admission, discharge, diagnostic workup and therapy management.

a. Surgery/Invasive Procedures: If surgery or invasive procedure is performed, the proctor should evaluate the indication for the procedure, the technique for the procedure, how it is performed, and the preoperative, operative and postoperative care of the patient. They may utilize the patient's chart, discussion with the practitioner, and actual observation as the basis for the review. Invasive medical procedures will be proctored by observation unless the case is an emergency or as otherwise specified in the Section's policies.

b. Medical Care: If medical care is provided, the proctor should review the care of the patient, utilizing the patient's chart, discussions with the practitioner, and actual observation, as necessary, as the basis for the review.

7.10.8.2 Responsibility of the Practitioner Being Proctored

The practitioner being proctored shall:

1. For concurrent proctoring, make every reasonable effort to be available to the proctor including notifying the proctor of each patient where care is to be evaluated in sufficient time to allow the proctor to concurrently observe or review the care provided. For elective surgical or invasive procedures where direct observation is required, and the specialty required proctoring be completed before the practitioner can perform the procedure without a proctor present, the practitioner must secure agreement from the proctor to attend the

- procedure. In an emergency, the practitioner may admit and treat the patient and must notify the proctor as soon as reasonably possible.
2. Provide the proctor with information about the patient's clinical history, pertinent physical findings, pertinent lab and x-ray results, the planned course of treatment or management and direct delivery of a copy of histories and physicals, operative reports, consultations and discharge summaries documented by the proctored physician to the proctor.
 3. Shall have the prerogative of requesting from the department chair a change of proctor if disagreements with the current proctor may adversely affect his or her ability to satisfactorily complete the proctorship. The department chair will make recommendation on this matter to the Medical Executive Committee for final action.
 4. Inform the proctor of any unusual incident(s) associated with his/her patients.

7.10.8.3 Responsibilities of the Department Chair

Each medical staff department chair shall be responsible for:

1. Assignment of proctors as noted above.
2. Assist in establishing a minimum number of cases/procedures to be proctored and determining when the proctor must be present. When there are interdepartmental privileges, the Credentials Committee and Medical Executive Committee shall determine the minimum number of cases/procedures to review.
3. Identifying the names of medical staff members eligible to serve as proctors as noted above.
4. If at any time during the proctoring period, the proctor notifies the department chair that s/he has concerns about the practitioner's competency to perform specific clinical privileges or care related to a specific patient(s), based on the recommendations of the proctor, the department chair shall then review the medical records of the patient(s) treated by the practitioner being proctored and shall:
 - a. Intervene and adjudicate the conflict if the proctor and the practitioner disagree as to what constitutes appropriate care for a patient; or
 - b. Review the case for possible referral to the peer review committee;
 - c. Recommend to the Medical Executive Committee that:
 1. Additional or revised proctoring requirements be imposed upon the practitioner;
 2. Practitioner Improvement Plan be undertaken pursuant to the Peer Review Policy.

7.10.8.4 Responsibilities of the Medical Staff Services Office

The Medical Staff Services Office shall:

1. Send a letter to the practitioner being proctored and to the assigned proctor containing the following information:
 - a. A copy of the privilege form(s) of the practitioner being proctored
 - b. The name, address and telephone numbers of the practitioner being proctored and the proctor
 - c. A copy of this Proctoring Policy and Procedure
 - d. Proctoring forms to be completed by the Proctor
2. Develop a mechanism (in coordination with Information Services Department) for tracking all admissions or procedures performed by the practitioner being proctored.

3. Provide information to appropriate hospital departments about practitioners being proctored including the name of the proctor and a supply of proctoring forms as needed.
4. Contact both the proctor and the practitioner being proctored on a monthly basis to ensure that proctoring and chart reviews are being conducted as required.
5. Periodically submit a report to Credentials Committee and MEC of proctorship activity for all practitioners being proctored.
6. At the conclusion of the proctoring period, submit a summary proctor report to the Credentials Committee and MEC.

7.10.8.5 Responsibilities of the Credentials Committee

The Credentials Committee shall:

1. Have the responsibility of monitoring compliance with this policy and procedure.
2. Receive regular status reports related to the progress of all practitioners required to be proctored as well as any issues or problems involved in implementation of this policy and procedure.
3. Make recommendations to the MEC regarding clinical privileges based on information obtained from the proctoring process.

7.11 **Notification of Privileges**

Medical Staff Services will inform the practitioner and appropriate hospital patient care areas/departments of privileges granted, as well as any revisions or revocations of the practitioner's privileges. Furthermore, whenever a practitioner's privileges are limited, revoked, or in any way constrained, the hospital must, in accordance with State and/or Federal laws or regulations, report those constraints to the appropriate State and Federal authorities, registries, and/or data bases such as the National Practitioner Data Bank.

7.12 **Physician Proctoring by External Providers**

Physician proctors (who may also be referred to as preceptors) who do not hold privileges as Summit Healthcare may be invited to observe a Medical Staff member carry out a defined number of procedures and provide a subsequent evaluation. Prior to doing so, the proctor/preceptor must complete and return the following documentation:

1. Proctoring Agreement Form
2. Non-privileged Physician Proctor/Preceptor Information Form
3. Copy of government ID (i.e. driver's license, passport, etc.) to verify identify
4. Current malpractice insurance certificate
5. TB clearance within the past 12 months (refer to Section 1.2.17)
6. Proctor/Preceptor Information Form, including signed authorization to release information

7.12.1 The proctor/preceptor must be approved by the Chief of Staff or his/her designee after Medical Staff Services personnel have performed the following required verifications:

1. National Practitioner Data Bank (NPDB)
2. Medical License(s) in state(s) where currently practicing
3. Letter of good standing from current institution
4. OIG and Sanctions screenings
5. AMA/AOIA Profile to illustrate education/training

No external proctor/preceptor may function and no cases may be scheduled by the Medical

Staff member without signed authorization.

- 7.12.2 The proctor/preceptor is responsible to the Hospital, not to the medical staff member, to make written recommendations regarding the knowledge and skill of the medical staff member to carry out the proposed procedure(s). The proctor/preceptor shall submit a written report using the appropriate form as provided by Medical Staff Services.

As an observer, the proctor/preceptor may scrub in, and assist as necessary. As may any physician, the proctor/preceptor may intervene in cases of emergency, to save the patient from harm.

7.12.3 Procedure

7.12.3.1 At minimum, 30 days prior to the planned procedure(s), the Medical Staff member requesting proctoring and/or direct preceptorship must notify Medical Staff Services and complete the Request for Additional Privileges form (including the name and contact information of the proctor/preceptor). Processing may take up to 60 days, and is subject to final approval by the Hospital Governing Board.

7.12.3.2 For new procedures (where new equipment and/or techniques will be utilized), specific credentialing criteria for the procedure must be submitted and go through the Hospital's current approval process. The Credentials Committee will determine the need for and circumstances of the proctoring and/or preceptorship process, including number of cases to be observed, qualifications of the proctor(s)/preceptor(s), and all other pertinent matters.

7.12.3.3 Prior to providing proctoring/direct preceptorship, the external proctor/preceptor must provide a notarized copy of his/her government ID, proof of Arizona medical licensure, and current malpractice insurance coverage. The proctor/preceptor must also provide verification of TB clearance within the past 12 months.

7.12.3.4 Medical Staff Services personnel will verify licensure and training (via AMA, AOI, or other appropriate primary source verification), query the National Practitioner Data Bank (NPDB) and appropriate sanction monitoring sites to include the Office of the Inspector General (OIG). Medical Staff Services personnel will request a letter from the proctor/preceptor's primary practice location showing that he/she is on staff, in good standing, and hold appropriate privilege(s) for which s/he is proctoring/preceptoring.

7.12.3.5 The Chief of Staff or his/her designee shall review and approve the proctor verification form and attached documentation prior to the proctor/preceptor's attending the case. The Chief of Staff may make inquiry from other sources in a similar manner as for applications to the Medical Staff. Where the Chief of Staff is the applicant, the Vice-Chief of Staff or Treasurer of the Medical Staff may serve in his/her stead.

7.12.3.6 Prior to the initiation of the proctoring/direct preceptorship process, the applicant for new privileges must agree in writing to

hold harmless the Hospital, its medical staff and other staff members, and the proctor(s)/preceptor(s), when acting in good faith, from any legal proceedings arising from any recommendation(s) that may result from the proctoring process.

- 7.12.3.7 The Chief of Staff or his/her designee shall notify the proctor/preceptor, the medical staff member and the appropriate Hospital staff, such as the Surgical Services Director, etc., upon the proctor/preceptor's approval, after reviewing the supporting documentation and appropriate credentialing criteria documentation, where applicable.
- 7.12.3.8 Any emergency interventions by the proctor/preceptor shall be documented and form part of the proctor/preceptor's report, and shall be documented by the attending procedural physician in the medical record.
- 7.12.3.9 The proctor/preceptor's report shall include the factual observations obtained, with a recommendation regarding the ability of the Medical Staff member to perform the training or experience and repeat mentoring, or any other appropriate recommendations. The report, along with the Chief of Staff's recommendation, shall be forwarded to the Credentials Committee for consideration.

SECTION EIGHT: REAPPLICATION AND MODIFICATIONS OF MEMBERSHIP STATUS OR PRIVILEGES AND EXHAUSTION OF REMEDIES

8.1 REAPPLICATION AFTER ADVERSE CREDENTIALS DECISION. Except as otherwise determined by the Medical Executive Committee or Governing Board in light of exceptional circumstances, a practitioner who has received a final adverse decision or who has resigned or withdrawn an application for appointment or reappointment or clinical privileges is not eligible to reapply to the Medical Staff for a period of at least one (1) year from the date of the notice of the final adverse decision or the effective date of the resignation or application withdrawal, unless special consideration has been provided by the MEC. Any such application is processed in accordance with the procedures set forth in Section 3 of this manual. As part of the reapplication, the practitioner must submit such additional information as the Medical Staff and/or Governing Board requires demonstrating that the basis of the earlier adverse action no longer exists. If such information is not provided, the reapplication will be considered incomplete and voluntarily withdrawn and will not be processed any further.

No practitioner may submit or have more than one application for initial appointment or reappointment at any given time.

8.2 REAPPLICATION AFTER ADMINISTRATIVE REVOCATION. A practitioner who has had his appointment or clinical privileges administratively revoked for any of the following reasons may request reinstatement:

- 8.2.1 Failure to maintain current professional liability insurance in the specified amount.
- 8.2.2 Failure to pay assessments by the specified date.
- 8.2.3 Failure to comply with CME requirements of appointment/reappointment.
- 8.2.4 Failure to attend the specified number of Medical Staff meetings per the Medical Staff Bylaws.

The practitioner may request reinstatement of appointment and/or appropriate privileges by submitting a written request for reinstatement along with documentation that he has resolved the reason for the revocation, i.e., proof of current professional liability insurance, payment of dues, completion of appropriate number and type of continuing medical education credits, completion of meeting attendance requirements. The practitioner must also submit a written summary of relevant activities during the period of revocation.

The request will be processed in the same manner as defined in Section 3 of this manual.

8.3 REQUEST FOR MODIFICATION OF APPOINTMENT STATUS OR PRIVILEGES. A staff appointee, either in connection with reappointment or at any other time, may request modification of staff category or clinical privileges by submitting a written request to Medical Staff Services. A modification request must be on the prescribed form and must contain all pertinent information supportive of the request. All requests for additional clinical privileges must be accompanied by information demonstrating additional education, training and current clinical competence in the specific privileges requested. A modified application is processed in the same manner as a reappointment, which is outlined in Section 5 of this manual.

A practitioner who determines that he no longer exercises or wishes to restrict or limit the exercise of particular privileges that he has been granted will send written notice, through Medical Staff Services, to the Medical Executive Committee. A copy of this notice will be included in the practitioner's credentials file.

- 8.4 RESIGNATION OF STAFF APPOINTMENT.** A practitioner may resign his Staff appointment and/or clinical privileges by providing written notice to the Chief of Staff. The resignation will specify the reason for the resignation and the effective date. A practitioner who resigns his Staff appointment and/or clinical privileges is obligated to fully and accurately complete all portions of all medical records for which he is responsible within 60 days of the effective date of resignation. Failure to do so will result in an entry in the practitioner's credentials file acknowledging the resignation and indicating that it became effective under unfavorable circumstances and will be considered a matter of professional conduct that could adversely affect the health or welfare of a patient and as such, be reportable to the National Practitioner Data Bank pursuant to the Health Care Quality Improvement Act of 1986.
- 8.5 EXHAUSTION OF ADMINISTRATIVE REMEDIES.** Every practitioner agrees that when corrective action is initiated or taken, or when an adverse action or recommended action as defined in the fair hearing procedures of the Medical Staff Bylaws is proposed or made, he will exhaust all of the administrative remedies afforded in the various sections of the Medical Staff Bylaws.
- 8.6 REPORTING REQUIREMENTS.** The Medical Center CEO or his designee will be responsible for assuring that the Medical Center satisfies its obligations under the Health Care Quality Improvement Act of 1986 and its successor statutes.

SECTION NINE: LEAVE OF ABSENCE

- 9.1 LEAVE STATUS.** A staff appointee who is in good standing in the medical staff category to which they are assigned, may obtain a voluntary leave of absence by providing written notice to the Chief of Staff for transmittal to the Medical Center CEO. The notice must state the reasons for the leave and approximate period of time of the leave, which may not exceed two (2) years, except for military service. (Rev 9/06)

If a prior leave of absence has been taken, a staff appointee is not eligible for a subsequent leave of absence until they have been reinstated for at least the same amount of time as the length of the most recent leave of absence. (Rev 9/06)

During the period of time of the leave, the staff appointee's clinical privileges, prerogatives and responsibilities are suspended.

- 9.2 TERMINATION OF LEAVE:** At least thirty days prior to the termination of the leave, or at any earlier time, the staff appointee may request reinstatement by sending a written notice to the Chief of Staff. For a leave of absence of six months or greater, the staff appointee must submit a written summary of clinical activities during their leave of absence. If the leave of absence occurred during the reappointment term expiration, the staff appointee must complete the reappointment process before the termination of leave is granted. (Rev 9/06)

If an individual takes a leave of absence for the purpose of treatment, that individual shall not be considered for reinstatement until it has been established, to the Medical Executive Committee's satisfaction, that the individual is safe to return to practice.

Individuals on leave of absence due to illness must present a letter from their treating physician attesting to the practitioner's ability to perform privileges requested before reinstatement will be considered.

The Medical Executive Committee makes a recommendation to the Governing Board concerning reinstatement to a six month provisional status, and the applicable procedures are followed. (Rev 8/03)

Failure without good cause to request reinstatement and to provide a summary of activities during the LOA as required, shall be deemed a voluntary resignation from the Medical Staff and shall result in automatic termination of Medical Staff membership and clinical privileges. A request for membership subsequently received from a member so terminated shall be submitted and processed in the manner specified for applications for initial appointment.

SECTION TEN: MEDICAL & PROFESSIONAL STUDENT AND RESIDENTS

10.1 MEDICAL & PROFESSIONAL STUDENTS. Medical students who are currently enrolled and are in good standing in an accredited school of medicine or osteopathy, or students of other professional practices enrolled and in good standing in an appropriate, accredited school of that profession (i.e. nurse practitioner, physician assistant, psychologists) may observe and participate in the care of patients in the Medical Center under the supervision of their preceptoring physician. The preceptor must be a member of the Active or Consulting Medical Staff who has received authorization from the student's school to act as a preceptor.

The scope of duties and responsibilities will be defined and communicated to the student. Direct supervision by the preceptor is required. The preceptor will assume full responsibility for any and all of the student's actions.

A contract or letter of agreement between the school and Summit Healthcare must include evidence of liability insurance coverage for the student.

All entries in the medical record by the student must be countersigned by the preceptor.

Prior to approval to participate in patient care, the student must submit the following documents/information to Medical Staff Services which, will maintain all records relevant to the student: letter of introduction from the school specifying arrangements for the student's elective preceptorship and stating that the student is in good standing with verification of malpractice insurance coverage for the student; a letter to Summit Healthcare from the physician preceptor stating dates the student will be in attendance at Summit Healthcare and the current work assignment and responsibilities; and proof of current immunization status.

The student will be subject to all applicable bylaws, rules and policies of the Summit Healthcare Medical Staff and Medical Center.

10.2 MEDICAL RESIDENTS. Physicians who are in their second year or more of residency training may be permitted to participate in the care of patients at Summit Healthcare, as defined in the training protocol applicable to his particular year of training, as developed by the applicable training program director and the physician preceptor.

Approved residents may practice at the Medical Center under the supervision of a physician preceptor who is a member of the Active or Consulting Medical Staff at Summit Healthcare and who is responsible for the resident's activities.

All entries in the medical record and treatment orders by the resident must be countersigned by the resident's preceptor prior to the record being permanently filed.

Prior to approval to practice, the resident must submit the following documents or information to Medical Staff Services which will maintain all records relevant to the resident: copy of active or supervised state license (if applicable) –out of state residents must obtain a temporary Professional State License registration; copy of federal DEA certificate (if applicable); proof of current immunization status, letter of introduction and plan for the resident's rotation at Summit Healthcare from the residency program director stating that the resident is in good standing within the program; proof of professional liability insurance coverage; a letter to the hospital from the physician preceptor stating dates the resident will be attendance at Summit Healthcare and the current work assignment and responsibilities.

The resident will be subject to all applicable bylaws, rules and policies of the Summit Healthcare Medical Staff and Medical Center.

SECTION ELEVEN: PRACTITIONER PROVIDING CONTRACTUAL SERVICES

- 11.1 EXCLUSIVITY POLICY.** Whenever Medical Center policy specifies that certain Medical Center facilities or services may be used on an exclusive basis in accordance with contracts or letters of agreement between Summit Healthcare and qualified practitioners, then other staff appointees must, except in an emergency or life threatening situation, adhere to this exclusivity policy in arranging care for their patients who are being treated or who have been admitted to the Medical Center. Application for initial appointment or for clinical privileges related to Summit Healthcare facilities or services covered by exclusive agreements will not be accepted or processed unless submitted in accordance with the existing contract or agreement with the Medical Center.
- 11.2 QUALIFICATIONS:** A practitioner who is or will be providing specified professional services pursuant to a contract or a letter of agreement with the Medical Center must meet the same qualifications, must be processed in the same manner, and must fulfill all the obligations of his appointment category as any other applicant or staff appointee.
- 11.3 EFFECT OF STAFF APPOINTMENT TERMINATION.** Because practice at the Medical Center is always contingent upon continued Staff appointment and also constrained by the extent of clinical privileges enjoyed, a practitioner's right to use Medical Center facilities is automatically terminated when the staff appointment expires or is terminated. The extent of his clinical privileges is automatically limited to the extent that the pertinent clinical privileges are diminished, restricted or revoked. The effect of an adverse change in clinical privileges on continuation of a (re)contract/employment is governed solely by the terms of the contract/employment arrangement. If the contract/employment arrangement is silent on the matter, the Governing Board will determine it after soliciting and considering the recommendations of relevant components and officials of the staff.
- A Medical Staff member providing professional services under a contract will not have his clinical privileges terminated for reasons pertaining to quality of care or professional conduct issues without the same rights to the hearing and appeal procedures identified in the fair hearing section of the Medical Staff Bylaws, as available to all members of the Medical Staff.
- 11.4 EFFECT OF CONTRACT/EMPLOYMENT EXPIRATION OR TERMINATION.** The effect of expiration or other termination of a contract upon a practitioner's staff appointment and clinical privileges will be governed solely by the terms of the practitioner's contract with Summit Healthcare. If the contract is silent on the matter, then contract expiration or other termination alone will not affect the practitioner's staff appointment status or clinical privileges.

SECTION TWELVE: MEDICAL ADMINISTRATIVE OFFICERS

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

12.1 EFFECT OF REMOVAL FROM OFFICE OR ADVERSE CHANGE IN APPOINTMENT STATUS OR CLINICAL PRIVILEGES

- 12.1.1. Where a contract exists between the Medical/Administrative Officer and the Medical Center, its terms govern any of the following matters that are addressed in it:
 - 12.1.1.1 The effect of removal from the Medical/Administrative Office on the officer's staff appointment and clinical privileges.
 - 12.1.1.2 The effect of an adverse change in the officer's staff appointment or clinical privileges on his remaining in office.
- 12.1.2 In the absence of a contract or where the contract is silent on the matter:
 - 12.1.2.1 Removal from office has no effect on appointment status or clinical privileges.
 - 12.1.2.2 The effect of an adverse change in appointment status or clinical privileges on continuance in office will be as determined by the Governing Board after requesting and considering the recommendations of relevant components and officials of the staff.
 - 12.1.2.3 A physician Medical/Administrative Officer has the same procedural rights as all other medical staff members in the event of an adverse change in appointment status or clinical privileges unless the change is, by contract, a consequence of removal from office.

SECTION THIRTEEN: REVIEW PERIOD, ADOPTION AND AMENDMENT

- 13.1 REVIEW PERIOD.** This Manual will be reviewed every two years by the Credentials and Medical Executive Committees.
- 13.2 AMENDMENT.** The Credentialing Procedure Manual will be initially adopted by resolution of the Medical Executive Committee, voted upon by the whole Medical Staff and the Governing Board. Thereafter, it may be amended or repealed, in whole or in part, by a resolution of the Medical Executive Committee, recommended to and adopted by, the Governing Board.
- 13.3 CORRECTIONS.** The Credentials Committee may correct typographical, spellings or other obvious errors in this manual. The Medical Executive Committee may also make any changes specifically required by law, state regulation. (Rev 4/03)
- 13.4 RESPONSIBILITIES AND AUTHORITY.** The procedures outlined in the Medical Staff and Summit Healthcare’s Corporate Bylaws regarding Medical Staff responsibility and authority to formulate, adopt and recommend Medical Staff Bylaws and amendments thereto, apply as well to the formulation, and adoption of this Credentialing Procedure Manual.

SECTION FOURTEEN: CREDENTIALING FEES

Medical Staff initial application and reappointment fees as established by the Medical Executive Committee and approved by the Governing Board (see CPM Section 3.2 and 5.1.10) are as follows:

14.1 Initial Application fees:

a.	Active Medical Staff	\$125.00
b.	Affiliate Medical Staff	\$200.00
c.	Associate Medical Staff	\$200.00
d.	Consulting Medical Staff	\$200.00
e.	Telemedicine Medical Staff	\$200.00
f.	Allied Health Professional	\$125.00
	<i>(Exception: RNFA, CST and Surgical Technician)</i>	\$62.50
g.	Podiatry	\$125.00

14.2 Reappointment fees: (Rev. 02/10)

a.	Active Medical Staff	
	Attendance at Medical Staff meetings (i.e. General Medical Staff, Department/Division Meetings, as listed in the Bylaws, Quality Improvement, etc.):	
	6 or more per year	No reappointment fee
	5 or less per year	\$100.00
b.	Affiliate/Associate (if previously on staff)	\$50.00
c.	Associate Medical Staff	\$100.00
d.	Consulting Medical Staff	\$100.00
e.	Telemedicine Medical Staff	\$100.00
f.	Affiliate Medical Staff	\$100.00
g.	Allied Health and Podiatry Only	
	Less than 10 cases in the hospital per year	\$100.00
	More than 10 cases in the hospital per year	No reappointment fee

Fees are non-refundable and may not be waived for recruited physicians. Fees are to be deposited in the Medical Staff General Fund to be used at the discretion of the MEC.

SECTION FIFTEEN: DISCLOSURE OF AFFILIATION INFORMATION

Summit Healthcare’s policy is to provide sufficient information to other healthcare facilities or organizations to allow for complete and responsible assessments of practitioners seeking to gain privileges. Information that will be shared with other facilities upon receipt of request from other healthcare facilities or organizations and release of information signed by the healthcare provider shall include:

- 15.1 Dates of affiliation with Summit Healthcare
- 15.2 Medical Staff status
- 15.3 Practicing specialty
- 15.4 If the applying practitioner was subject to any of the following focused or formal peer review that resulted in an adverse action by the MEC:
 - 15.4.1 the imposition of condition or limitation to clinical privileges;
 - 15.4.2 probation;
 - 15.4.3 additional training requirements;
 - 15.4.4 reprimand or the imposition of any observation/supervision requirement not related to the customary, initial appointment requirements; or
 - 15.4.5 the termination/revocation of privileges
- 15.5 Resignation of staff membership and/or privileges to avoid discipline, revocation, or termination
- 15.6 Final disciplinary actions taken by the Medical Executive Committee and/or the Governing Board of Directors
- 15.7 Clinical data from the most relevant reappointment/assessment, if available, to include number of admissions, consultations, and/or procedures
- 15.8 Leadership roles, recognitions, awards and services within the organization

The response does not include administrative suspensions related to medical records, liability insurance coverage and other such matters. Questions regarding performance, judgment, technical skills and competence require subjective analysis and opinion are outside the scope of affiliation/hospital appointment verification provided by Summit Healthcare.

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SECTION SIXTEEN: USE OF TERMS

- 16.1** When used herein the terms "Relevant peer review committee," Credentials Committee, "President," "Chief of Staff," " Director of Medical Staff Services" and "Governing Board" are construed to include "designee."
- 16.2** "All supporting documentation," means the application form and its accompanying information, the reports and recommendations of the Credentials Committee, Medical Executive committee and all dissenting views, if any.
- 16.3** "Adverse recommendation" from the Medical Executive Committee or an "adverse action" by the Governing Board as referred to in the appointment process means a recommendation or action to change, without the staff appointee's consent, his clinical assignment; to reduce staff category without his consent; to deny or restrict requested clinical privileges. *The term "applicant" and "appointments" as used in these sections will be read, respectively, as "staff appointee" and "conclusion of the provisional status".
- 16.4** "Adverse action" by the Governing Board means action to deny appointment or to deny or restrict requested clinical privileges.
- 16.5** "Special notice" correspondence sent by certified mail, return receipt requested.
- 16.6** "Medical Staff" means the formal organization of all licensed physicians, podiatrists, and oral surgeons who are credentialed and privileged to attend patients at Summit Healthcare.
- 16.7** "Allied Health Professional" or "AHP" means an individual, other than a licensed physician, dentist, or podiatrist who are credentialed and privileged to attend patients at Summit Healthcare. The term "Allied Health Professional" or "AHP" includes both "Allied Health Professionals" and "Allied Health Professionals – Advance Practice Professionals" or "AHP-APP" as defined in the Medical Staff Bylaws.
- 16.8** "Practitioner" means either Medical Staff or AHP member.

ADOPTION

This Credentialing Procedures Manual is adopted and made effective upon approval of the Governing Board, superseding and replacing any and all other Credentialing Procedures Manuals, rules, regulations, policies, manuals or Medical Center policies pertaining the subject matter thereof.

Adopted by the Medical Staff on: May 19, 2020
Dated

Approved by the Governing Board on: May 28, 2020
Dated