PRACTITONER PROCEDURAL POLICY

Version 4.0

FINAL 02/2023

Summit Healthcare

summithealthcare.net

TABLE OF CONTENTS

ARTICLE 1 - GENERAL

1.A. DEFINITIONS

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

1.B. DELEGATION OF FUNCTIONS

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

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

1.C. SUBSTANTIAL COMPLIANCE

While every effort will be made to comply with all provisions of this Policy, technical or minor deviations from the procedures set forth within this Policy do not invalidate any review or action taken.

1.D. ADJUNCT PROFESSIONAL STAFF

Unless specified otherwise, Practitioners who seek membership to the Adjunct Professional Staff (i.e., an Allied Health Professional or Advanced Practice Provider) shall be subject to the same terms and conditions of Appointment and Reappointment as specified for Medical Staff Members. Applications for Appointment or Reappointment to the Adjunct Professional Staff shall be submitted and processed in the same manner as outlined for Medical Staff Members in this Policy.

1.E. SUMMIT HEALTHCARE EMPLOYEES

(1) Any Practitioner employed by Summit Healthcare, Summit Healthcare Medical Associates, or Northeastern Arizona Regional Care Team is bound by all of the same conditions and requirements in this Policy that apply to non-employed Practitioners.

(2) If a concern about an employed Practitioner's clinical competence or professional conduct originates with the Medical Staff, the concern may be reviewed and addressed in accordance with this or another Medical Staff policy. However, this provision does not preclude the Administrative Leadership or Human Resources from addressing an issue in accordance with Summit Healthcare's employment policies/manuals or in accordance with the terms of any applicable employment contract.

ARTICLE 2 - QUALIFICATIONS, CONDITIONS, AND RESPONSIBILITIES

2.A. QUALIFICATIONS

2.A.1. Threshold Eligibility Criteria:

(a) To be eligible for initial Appointment or Reappointment to the Medical Staff or to the Adjunct Professional Staff, individuals must:

(1) have a current, unrestricted license to practice in Arizona (or authorization to practice in Arizona via telemedicine only in compliance with A.R.S. 36-3606 A-D) that is not subject to probation and have never had a license to practice denied, limited, restricted, subject to probationary conditions, revoked, fined, subject to a letter of reprimand, or suspended, or voluntarily or involuntarily relinquished for disciplinary reasons by any state licensing agency, or such action pending;*

* Concurrent processing of an application for Appointment while the applicant is obtaining his/her Arizona license may occur with the joint approval of the CEO and the Chief of Staff, after consultation with the Department Chair, where there are no other identified issues or concerns with the application.

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

(3) have current, valid professional liability insurance coverage in a form and in amounts satisfactory to Summit Healthcare;

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

(5) have not been, and are not currently, excluded, precluded, or debarred from participation in Medicare, Medicaid, or other federal or state governmental health care program;

(6) have not had their Appointment or Clinical Privileges denied, disciplined, suspended, subject to probationary conditions, restricted, revoked, or terminated by any health care facility or health plan for reasons related to clinical

competence or professional conduct, or breach of contract or program conditions, or such action pending;

(7) consistent with their Medical Staff category and Clinical Privileges, agree to cover the Emergency Department during those times when they are on call in a prompt, efficient, and conscientious manner, in accordance with the response times set forth for their specialty, or to arrange for appropriate coverage (as determined under the Summit Healthcare On Call Policy) by another Medical Staff Member;

(8) have not resigned Appointment or relinquished Clinical Privileges during a Medical Staff Investigation or in exchange for not conducting such an Investigation;

(9) have not been convicted of, or entered a plea of guilty or no contest to, any felony; or to any misdemeanor relating to controlled substances, illegal drugs, insurance or health care fraud or abuse, child abuse, elder abuse, or violence against another;

(10) demonstrate recent clinical activity in their primary area of practice and clinical setting for requested privileges (i.e., recent practice in a hospital setting if requesting inpatient privileges) during the last two years;

(11) meet any eligibility requirements that are applicable to the Clinical Privileges being sought;

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

(13) provide documentation showing compliance with any immunizations, vaccinations, and/or screening tests (e.g., tuberculosis) required by Medical Staff or Summit Healthcare policy;

(14) have successfully completed:

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

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

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

(iv) a foreign training program that is equivalent to any of the above, as determined on a case-by-case basis pursuant to the waiver process outlined in Section 2.A.2 below;*

(15) be certified in their primary area of practice at Summit Healthcare by the appropriate specialty/subspecialty board of the American Board of Medical Specialties ("ABMS"), the AOA, the American Board of Oral and Maxillofacial Surgery, the ADA, relevant specialty/subspecialty podiatric board (as recognized by the Credentials Committee), as applicable. Those applicants who are not board certified at the time of application must (1) be board eligible at the time of Appointment, and (2) achieve board certification within the time frame of the relevant specialty; and

(16) maintain board certification and participate in maintenance of certification as required by the relevant specialty/subspecialty board of the American Board of Medical Specialties ("ABMS"), the AOA, the American Board of Oral and Maxillofacial Surgery, the ADA, relevant specialty/subspecialty podiatric board (as recognized by the Credentials Committee), as applicable, in their primary area of practice at Summit Healthcare (board certification status will be assessed at Reappointment).*

* The requirements pertaining to residency training and board certification are applicable to those individuals who apply for initial staff Appointment after January 1, 2012 and are not applicable to Medical Staff Members who were appointed prior to that date. Failure to recertify within one reappointment cycle following the Board expiration date shall result in an Automatic Relinquishment of Clinical Privileges, unless exceptional circumstances (as determined by the MEC) exist. If a waiver is requested, it will be reviewed in accordance with Section 2.A.2 of this Policy.

Those Medical Staff Members appointed prior to January 1, 2012 shall be grandfathered and shall be governed by any residency and board certification requirements that may have been in effect at the time of their initial Appointments.

(b) In addition to the applicable criteria outlined in (a) above (with the exception of those related to Emergency Department call, residency training, and board certification), individuals seeking Appointment to the Adjunct Professional Staff must:

(1) provide documentation of current Basic Life Support (BLS) for Healthcare Providers within 30 Days of initial Appointment;

(2) in the case of Allied Health Professionals, have a written Supervision agreement, as applicable, with a Supervising Physician with Clinical Privileges at Summit Healthcare (such agreement must meet all applicable requirements of state law and Summit Healthcare policy); or

(3) in the case of an Advanced Practice Provider, have a written Sponsorship agreement, as applicable, with a Sponsoring Physician with Clinical Privileges at Summit Healthcare (with such agreement meeting all applicable requirements of Summit Healthcare policy); and

(4) have completed his or her professional education and is either certified by the appropriate nationally recognized certification organization or, if he or she is not certified, must acquire the appropriate nationally recognized professional certification at the first-time certification is available (excluding Licensed Clinical Social Workers and Psychologists). All certifications must be maintained in order to remain eligible for Appointment and Reappointment, unless exceptional circumstances (as determined by the MEC) exist. If a waiver is requested, it will be reviewed in accordance with Section 2A.2 of this policy.

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

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

(b) A request for a waiver shall be submitted to the Credentials Committee for consideration. In reviewing the request for a waiver, the Credentials Committee may consider the specific qualifications of the applicant in question, input from the relevant Department Chair, and the best interests of Summit Healthcare and the communities it serves. Additionally, the Credentials Committee may, in its discretion, consider the application form and other information supplied by the applicant. The Credentials Committee's recommendation will be forwarded to the MEC. Any recommendation to grant a waiver must include the specific basis for the recommendation.

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

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

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

(f) A request for a waiver must be designated as permanent or time limited. If a waiver is granted as permanent, then the individual does not have to request a waiver at subsequent Reappointment cycles.

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

2.A.3. Factors for Evaluation:

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

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

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

(c) good reputation and character;

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

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

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

2.A.4. No Entitlement to Appointment, Reappointment, or Clinical Privileges:

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

(a) is employed by Summit Healthcare or its subsidiaries or has a contract with Summit Healthcare;

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

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

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

(e) has had in the past, or currently has, Appointment or Clinical Privileges at any hospital or health care facility;

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

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

2.A.5. Non-Discrimination:

Neither Summit Healthcare nor the Medical Staff shall discriminate in granting Appointment, Reappointment, and/or Clinical Privileges on the basis of national origin, culture, race, gender, sexual orientation, gender identity, age, ethnic/national identity, religion, disability unrelated to the provision of patient care to the extent the individual is otherwise qualified, or the patient type in which the Practitioner specializes (i.e., Medicaid patients, a high risk population, patients with costly conditions, or patients with any other characteristic protected by state, federal, or local law).

2.B. GENERAL CONDITIONS OF APPOINTMENT AND REAPPOINTMENT

2.B.1. Basic Responsibilities and Requirements:

As a condition of being granted Appointment or Reappointment, and as a condition of ongoing Appointment, every member of the Medical Staff and Adjunct Professional Staff specifically agrees to the following, as applicable:

(a) be available on a reasonable basis, either personally or by arranging appropriate coverage (as determined by the Credentials Committee), to provide timely quality care to all patients for whom the individual has responsibility;

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

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

(d) to comply with (or clearly document the clinical reasons for variance from) clinical practice or evidence-based medicine protocols that are established by, and must be reported to, regulatory or accrediting agencies or patient safety organizations, where adopted by the Medical Staff or the Medical Staff Leadership;

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

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

- any and all complaints regarding, or changes in, licensure status or DEA controlled substance authorization,
- adverse changes in professional liability insurance coverage,
- the filing of a professional liability lawsuit against the Practitioner,
- changes in the Practitioner's status (Appointment or Clinical Privileges) at any other hospital or health care entity as a result of disciplinary activities or in order to avoid initiation of an investigation or disciplinary activities,

- changes in the Practitioner's employment status at any medical group or hospital as a result of issues related to clinical competence or professional conduct,
- knowledge of a criminal investigation involving the individual, arrest, charge, indictment, conviction, or a plea of guilty or no contest in any criminal matter other than a misdemeanor traffic citation (traffic violations involving alleged illegal drug use or alcohol usage are not considered "minor traffic violations" for purposes of this requirement),
- exclusion, preclusion, or withdrawal from participation in Medicare/Medicaid or any sanctions imposed,
- any changes in the Practitioner's ability to safely and competently exercise Clinical Privileges or perform the duties and responsibilities of Appointment because of health status issues, including, but not limited to, a physical or mental condition that could adversely affect the Practitioner's ability to practice safely and competently, or impairment due to addiction, alcohol use, or other similar issue,
- any referral to a state board health-related program, and
- removal from a managed care organization's panel for reasons related to quality of care or unprofessional conduct;

(g) to immediately submit to an appropriate evaluation, which may include diagnostic testing (including, but not limited to, a blood and/or urine test) and/or a complete physical, mental, and/or behavioral evaluation, if at least two Medical Staff Leaders (or one Medical Staff Leader and one member of the Administrative Leadership) are concerned with the individual's ability to safely and competently care for patients. The health care professional(s) to perform the initial testing and/or evaluations (i.e., if requested to performed within 24 hours) shall be determined by the Medical Staff Leaders, and the Practitioner must execute all appropriate releases to permit the sharing of information with the Medical Staff Leaders. Any additional testing or evaluation will be carried out in accordance with Article 13 of this Policy;

(h) to meet with Medical Staff Leaders and/or members of the Administrative Leadership upon request, to provide information requested upon written request, and to participate in collegial efforts as may be requested;

(i) to appear for personal or phone interviews in regard to an application for initial Appointment or Reappointment, if requested;

(j) to maintain and monitor an e-mail address or other approved electronic communication channel (e.g., secured text, portal, etc.) with Medical Staff Services, which will be the primary mechanism used to communicate all Medical Staff and credentialing information to the Practitioner. For purposes of this responsibility, members of the Active, Active

Outpatient, and Adjunct Professional Staffs are expected to maintain and monitor a Summit Healthcare email;

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

(l) to not engage in illegal fee splitting or other illegal inducements relating to patient referral;

(m) to not delegate responsibility for hospitalized patients to any individual who is not qualified or adequately supervised;

(n) to not deceive patients as to the identity of any individual providing treatment or services (e.g., only a Physician, Podiatrist, or Dentist may be identified as "Doctor");

(o) to seek consultation whenever required or necessary;

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

(q) to cooperate with all utilization oversight and compliance activities;

(r) to abide by the terms of Summit Healthcare's Notice of Privacy Practices with respect to health care delivered at Summit Healthcare;

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

(t) to promptly pay any applicable assessments and/or fines;

(u) to use Summit Healthcare facilities sufficiently to allow the Medical Staff to evaluate his or her clinical competence;

(v) to adhere to Summit Healthcare and Medical Staff policies on sexual harassment and unprofessional conduct;

(w) to cooperate with Summit Healthcare compliance policies;

(x) to maintain life support certification(s) as required by Summit Healthcare policy, the Medical Staff Rules & Regulations, or for granted privileges/practice privileges;

(y) to satisfy continuing medical education requirements; and

(z) that, if there is any misstatement in, or omission from, the application, Summit Healthcare may stop processing the application (or, if Appointment has been granted prior to the discovery of a misstatement or omission, Appointment and Clinical Privileges may be deemed to be Automatically Relinquished). In either situation, there shall be no

entitlement to a hearing or appeal as outlined in Article 7. The individual will be informed in writing of the nature of the misstatement or omission and permitted to provide a written response for the MEC's consideration. If the determination is made to not process an application or that Appointment and Clinical Privileges should be Automatically Relinquished pursuant to this provision, the individual may not reapply for Appointment or Clinical Privileges for a period of at least one year.

2.B.2. Burden of Providing Information:

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

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

(c) Complete Application: An application shall be complete when all questions on the application form have been answered, all supporting documentation has been supplied, all information has been verified from primary sources, and any required application fees and applicable fines have been paid. An application shall become incomplete if the need arises for new, additional, or clarifying information at any time during the credentialing process. Whenever there is a need for new, additional, or clarifying information – outside of the normal, routine credentialing process – the application will not be processed until the information is provided. If the application continues to be incomplete 30 Days after the individual has been notified of the additional information required, the application shall be deemed to be withdrawn and the individual may not submit another application for Appointment or Clinical Privileges for a period of six months, unless an extension is granted by the Credentials Committee due to extenuating circumstances.

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

2.C. APPLICATION

2.C.1. Information:

(a) Applications for Appointment and Reappointment shall contain a request for specific Clinical Privileges and shall require detailed information concerning the individual's professional qualifications. The applications for initial Appointment and Reappointment existing now and as may be revised are incorporated by reference and made a part of this Policy.

(b) In addition to other information, the applications shall seek the following for a period of time covering at least the last ten years:

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

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

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

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

(5) a copy of a government-issued photo identification; and

(6) ability to work professionally and harmoniously with others within the healthcare setting.

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

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

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

(a) Immunity:

To the fullest extent of the law, the individual releases from any and all liability, extends immunity to, and agrees not to sue Summit Healthcare or the Board, any Medical Staff Member or the Board, their authorized representatives, and third parties who provide information for any matter relating to Appointment, Reappointment, Clinical Privileges, or the individual's qualifications for the same. This immunity covers any actions, recommendations, communications, and/or disclosures involving the individual that are made or taken by Summit Healthcare, its authorized agents, or third parties in the course of credentialing and Peer Review activities. This immunity also extends to any reports that are made to government regulatory and licensure boards or agencies pursuant to federal or state law.

(b) Authorization to Obtain Information from Third Parties:

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

(c) Authorization to Release Information to Third Parties:

The individual also authorizes Summit Healthcare representatives to release information to (i) other hospitals, health care facilities, managed care organizations, and their agents when information is requested in order to evaluate his or her professional qualifications for Appointment, Clinical Privileges, and/or participation at the requesting organization/facility, and (ii) government regulatory and licensure boards or agencies

pursuant to federal or state law. The disclosure of any Peer Review Information in response to such inquiries does not waive any privilege, and all such disclosures shall be made with the understanding that the receiving entity will only use such Peer Review Information for Peer Review purposes.

(d) Authorization to Share Information among Summit Healthcare Entities:

The individual specifically authorizes Summit Healthcare and its affiliates to make requests and disclosures of quality assurance information pertaining to the individual for the purpose of engaging in quality assurance activities as described in the Summit Healthcare Information Policy.

(e) Hearing and Appeal Procedures:

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

(f) Legal Actions:

If, despite this Section, an individual institutes legal action challenging any credentialing, privileging, Peer Review, or other action affecting Appointment, Reappointment, or Clinical Privileges, or any report that may be made to a regulatory board or agency, and does not prevail, consistent with the federal HCQIA of 1986, he or she shall reimburse Summit Healthcare and any Medical Staff Member or Board involved in the action for all costs incurred in defending such legal action, including reasonable attorney's fees, expert witness fees, and lost revenues.

(g) Scope of Section:

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

(1) whether or not Appointment, Reappointment, or Clinical Privileges are granted;

(2) throughout the term of any Appointment or Reappointment period and thereafter;

(3) should Appointment, Reappointment, or Clinical Privileges be revoked, reduced, restricted, suspended, and/or otherwise affected as part of Summit Healthcare's professional review activities;

(4) as applicable, to any third-party inquiries received about his or her tenure at Summit Healthcare after the individual leaves his or her practice at Summit Healthcare; and

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

ARTICLE 3 - PROCEDURE FOR INITIAL APPOINTMENT

3.A. PROCEDURE FOR INITIAL APPOINTMENT

3.A.1. Request for Application:

(a) Applications for Appointment shall be on approved forms or submitted through an approved Summit Healthcare portal/website. Applicants will pay applicable credentialing fees, as set by the MEC. (See **Appendix A**.)

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

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

3.A.2. Initial Review of Application:

(a) All submitted applications will be reviewed by Medical Staff Services to determine that all questions have been answered and that the individual satisfies all threshold eligibility criteria. Incomplete applications shall not be processed. Individuals who fail to submit a complete application or who fail to meet the threshold eligibility criteria will be notified that their application will not be processed. A determination of ineligibility or that an application is incomplete does not entitle the individual to the hearing and appeal rights outlined in this Policy and is not reportable to any state agency or to the National Practitioner Data Bank.

(b) Medical Staff Services shall oversee the process of gathering and verifying relevant information and confirming that all references and other information or materials deemed pertinent have been received.

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

(a) Evidence of the applicant's character, professional competence, qualifications, behavior, and ethical standing shall be examined. This information may be contained in the application and obtained from peer references (from the same discipline where practicable) and from other available sources, including the applicant's past or current department chair at other health care entities, residency training director, and others

who may have knowledge about the applicant's education, training, experience, and ability to work with others. The National Practitioner Data Bank will be queried as required.

(b) Evaluations provided by references that are based on records or proceedings of Peer Review conducted in another hospital, including portions of National Practitioner Data Bank reports, are considered to be privileged Peer Review Information and maintained as such.

(c) An interview(s) with the applicant may be conducted. The purpose of the interview is to discuss and review any aspect of the applicant's application, qualifications, and requested Clinical Privileges. This interview may be conducted by a combination of any of the following: the relevant Department Chair, the Credentials Committee, a Credentials Committee representative, the MEC, the Chief of Staff, and/or the CMO. Applicants do not have the right to be accompanied by counsel to interviews being requested by any of the individuals or committees referenced above.

3.A.4. Credentials Committee Procedure:

(a) Medical Staff Services shall transmit the complete application and all supporting materials to the Credentials Committee. A member of the Credentials Committee shall prepare a report regarding whether the applicant has satisfied all of the qualifications for Appointment and the Clinical Privileges requested. These reports are considered to be Peer Review Information.

(b) The full Credentials Committee shall review and consider the report prepared by the Credentials Committee member and shall make a recommendation. In making this recommendation, the Credentials Committee may use the expertise of a Department Chair, Division Chief, another Medical Staff Member, Adjunct Professional Staff members, or an outside consultant, if additional information is required regarding the applicant's qualifications.

(c) After determining that an applicant is otherwise qualified for Appointment and Clinical Privileges, the Credentials Committee shall review the applicant's Health Assessment Questionnaire Form to determine if there is any question about the applicant's ability to perform the Clinical Privileges requested and the responsibilities of Appointment. If so, the Credentials Committee may require the applicant to undergo a health assessment by a Physician or entity who is acceptable to the Credentials Committee in order to obtain a second opinion on the Practitioner's ability to practice safely and competently, as approved by the MEC and the Practitioner.

(1) Failure of an applicant to undergo an examination 30 Days after being requested to do so in writing by the Credentials Committee shall be considered a voluntary withdrawal of the application unless an exception is granted. All processing of the application shall cease and the individual may not submit another application for Appointment or Clinical Privileges for a period of one year.

(2) The cost of the health assessment may be borne by the applicant.

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

3.A.5. MEC Recommendation:

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

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

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

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

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

(c) If the recommendation of the MEC is unfavorable and would entitle the applicant to request a hearing in accordance with Section 7.A.1(a) of this Policy, the MEC shall forward its recommendation to the CEO, who shall promptly send Special Notice to the applicant. The CEO shall then hold the application until after the applicant has completed or waived a hearing and appeal.

3.A.6. Board Action:

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

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

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

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

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

(b) Full Board Review: When there has been no delegation to the Board Committee, upon receipt of a recommendation that the applicant be granted Appointment and Clinical Privileges, the Board may:

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

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

(3) reject or modify the recommendation.

(c) If the Board determines to reject a favorable recommendation, the Joint Conference Committee shall be convened to discuss the matter. If the Board's determination remains unfavorable to the applicant after the Joint Conference Committee is convened, the CEO shall promptly send Special Notice to the applicant that the applicant is entitled to request a hearing.

3.A.7. Time Periods for Processing:

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

ARTICLE 4 - CLINICAL PRIVILEGES

4.A. CLINICAL PRIVILEGES

4.A.1. General:

(a) Appointment or Reappointment shall not confer any Clinical Privileges or right to admit or treat patients at Summit Healthcare. Practitioners are entitled to exercise only those Clinical Privileges specifically granted by the Board.

(b) Requests for Clinical Privileges will be processed in the same manner as Appointment. In order for the request to be processed, the applicant must satisfy any applicable threshold eligibility criteria for the Clinical Privileges requested.

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

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

4.A.2. Privilege Modifications and Waivers:

(a) Scope. This Section applies to all requests for modification of Clinical Privileges during the term of Appointment (increases and resignations) and waivers related to eligibility criteria for Clinical Privileges or the scope of those Clinical Privileges.

(b) Increased Privileges.

(1) Requests for increased Clinical Privileges must be submitted in writing or electronically to Medical Staff Services. The request must state the specific additional Clinical Privileges requested and provide information sufficient to establish eligibility, as specified in applicable criteria, and current clinical competence.

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

(c) Waivers of Eligibility Criteria. Any individual who does not satisfy one or more eligibility criteria for Clinical Privileges may request that it be waived. The individual requesting the waiver bears the burden of demonstrating exceptional circumstances and that his or her qualifications are equivalent to, or exceed, the criterion in question.

(d) Opting Out of the Core at the Time of Appointment or Reappointment. Any individual who wishes to opt out of the full core in his or her specialty may indicate his or her wishes by striking those privileges on the privilege delineation form at the time of Appointment or Reappointment. The MEC will consider the following factors before making a recommendation to the Board on whether to grant the request to opt out of the core:

(1) the scope of the individual's practice at Summit Healthcare and within the community (e.g., does the individual provide the patient care services at issue in any health care facility);

(2) fairness to the individual making the request, including the scope of the individual's current clinical practice and other demands placed on him/her;

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

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

(5) how the request may affect Summit Healthcare's ability to comply with applicable regulatory requirements, including the Emergency Medical Treatment and Active Labor Act, and otherwise serve the community's needs.

(e) Relinquishment of Individual Privileges During the Term of Appointment. A request to relinquish any individual Clinical Privilege, whether or not part of the core, during an individual's term of Appointment must be made via a written or electronic request to Medical Staff Services. The request must indicate the specific patient care services that the individual does not wish to provide and state a good cause basis for the request. The request will then be reviewed by the MEC, which will make a recommendation to the Board for final action.

(f) Resignation of Appointment and All Clinical Privileges. Any individual who wishes to resign his or her Appointment and Clinical Privileges shall provide notification of such decision to Medical Staff Services. This notification should indicate the individual's specific resignation date. On the effective date of the individual's resignation, completion of the following Medical Staff obligations will be confirmed, recorded in the individual's Confidential File, and may be divulged in response to any future credentialing inquiries concerning the individual:

(1) completion of all medical records;

(2) appropriate management of any hospitalized patients who were under the individual's care at the time of resignation (i.e., patients were discharged or transferred to another Practitioner with appropriate Clinical Privileges); and

(3) completion of any scheduled Emergency Department call (or arrangement for appropriate coverage prior to resigning).

(g) Procedural Rights. No individual is entitled to a modification or waiver related to Clinical Privileges. Individuals are also not entitled to a hearing or appeal or other process if a waiver or a modification related to a relinquishment of Clinical Privileges is not granted.

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

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

(b) As an initial step in the process, the individual seeking to perform the new procedure will prepare and submit a report to the CMO identifying the new procedure the individual is seeking to bring to Summit Healthcare.

(c) The Administrative Leadership will review the request in light of the following factors and any other deemed relevant:

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

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

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

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

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

(6) whether the new procedure is financially viable or provides a needed service to the community that cannot otherwise be met; and

(7) whether Summit Healthcare currently has the resources, including space, equipment, personnel (including nursing), staff training, and other support services, to safely and effectively perform the new procedure.

The Administrative Leadership shall also consult with the Chief of Staff, the relevant Department Chair and/or Division Chief, and the Credentials Committee (any of which may conduct additional research as may be necessary) before making a preliminary determination as to whether the new procedure should be offered to the community.

(d) If the preliminary determination of Summit Healthcare is favorable, the Credentials Committee will determine whether the request constitutes a "new procedure" as defined by this Section or if it is an extension of an existing Clinical Privilege. If it is determined that it does constitute a "new procedure," the Credentials Committee will then determine whether the Clinical Privilege belongs in the relevant core and/or develop threshold credentialing criteria to determine those individuals who are eligible to request the Clinical Privileges at Summit Healthcare. In developing the criteria, the Credentials Committee may conduct additional research and consult with experts, as necessary, and develop recommendations regarding:

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

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

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

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

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

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

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

(a) Requests for Clinical Privileges that previously at Summit Healthcare have been exercised only by individuals from another specialty shall not be processed until the steps outlined

in this Section have been completed and a determination has been made regarding the individual's eligibility to request the Clinical Privileges in question.

(b) As an initial step in the process, the individual seeking the Clinical Privilege will prepare and submit a report to the Credentials Committee that specifies the minimum qualifications needed to perform the procedure safely and competently, whether the individual's specialty is performing the Clinical Privilege at other similar hospitals, and the experiences of those other hospitals in terms of patient care outcomes and quality of care.

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

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

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

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

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

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

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

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

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

4.A.5. Practitioners in Training:

(a) Practitioners in training shall not hold Appointments to the Medical Staff or Adjunct Professional Staff and shall not be granted Clinical Privileges. The program director, clinical faculty, and/or attending staff member shall be responsible for the direction and supervision of the on-site and/or day-to-day patient care activities of each trainee, who shall be permitted to perform only those clinical functions set out in curriculum requirements, affiliation agreements, and/or training protocols approved by Summit Healthcare and the MEC or their designee(s). The applicable program director shall be responsible for verifying and evaluating the qualifications of each Physician in training.

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

4.A.6. Telemedicine Privileges for Distant-Site Practitioners:

(a) A qualified individual providing services at a distant-site location may be granted Telemedicine Privileges regardless of whether the individual is appointed to the Medical Staff or the Adjunct Professional Staff.

(b) Requests for initial or renewed Telemedicine Privileges by distant-site Practitioners shall be processed using credentialing information from the distant site hospital that participates in Medicare or a Telemedicine entity (as that term is defined by Medicare), as follows:

(1) The individual seeking Telemedicine Privileges must complete a Summit Healthcare application, and Summit Healthcare will obtain and utilize the distant site's primary source verified information including, but not limited to, licensure, education, training, the ability to perform the Telemedicine 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).

(2) 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 (Note: 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 Appointment to the Telemedicine Staff. The application approval process outlined in Article 3 of this Policy will be utilized.

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

(d) The MEC shall continually evaluate Summit Healthcare's ability to provide these services safely, and must evaluate the performance of the services provided by Distant-site Practitioners at Reappointment, renewal, or revision of Clinical Privileges.

(e) Distant-site Practitioners who are granted Telemedicine Privileges shall be subject to Summit Healthcare's Peer Review activities. The results of the Peer Review activities, including any adverse events and complaints filed about the distant-site Practitioner providing Telemedicine services from patients, other Practitioners or staff, will be shared with the distant-site Practitioner's hospital or Telemedicine entity.

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

4.B. TEMPORARY CLINICAL PRIVILEGES

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

(a) Applicants. Temporary Privileges for an applicant for initial Appointment may be granted by the CEO, the Chief of Staff, and the Credentials Committee Chair, or their designee(s), under the following conditions:

(1) the applicant has submitted a complete application, along with any application fee;

(2) the verification process is complete, including verification of current licensure, relevant training or experience, current competence, ability to exercise the Clinical Privileges requested, and current professional liability coverage; compliance with Clinical Privileges criteria; and consideration of information from the National Practitioner Data Bank, from a criminal background check, and from OIG queries;

(3) the applicant demonstrates that (i) there are no current or previously successful challenges to his or her licensure or registration, and (ii) he or she has not been subject to involuntary termination of Appointment or involuntary limitation, reduction, denial, or loss of Clinical Privileges, at another health care facility;

(4) the application is pending review by the MEC and the Board; and

(5) Temporary Privileges for an applicant for initial Appointment will be granted for a maximum period of 60 consecutive Days.

(b) Locum Tenens. The CEO, the Chief of Staff, and the Credentials Committee Chair may grant Temporary Privileges to an individual serving as a locum tenens for a Practitioner who is on vacation, attending an educational seminar, or ill, and/or otherwise needs coverage assistance for a period of time, under the following conditions:

(1) the applicant has submitted an appropriate application, along with any application fee;

(2) the verification process is complete, including verification of current licensure, current competence (verification of good standing in hospitals where the individual practiced for at least the previous 10 years), ability to exercise the Clinical Privileges requested, and current professional liability coverage; compliance with Clinical Privileges criteria; and consideration of information from the National Practitioner Data Bank and from OIG queries;

(3) the applicant demonstrates that (i) there are no current or previously successful challenges to his or her licensure or registration, and (ii) he or she has not been subject to involuntary termination of Appointment or involuntary limitation, reduction, denial, or loss of Clinical Privileges, at another health care facility; and

(4) the individual may exercise Locum Tenens Privileges for a maximum of 180 Days, consecutive or not, anytime during the 24-month period following the date they are granted, subject to the following conditions:

(i) the individual must notify Medical Staff Services at least 10 Days prior to each time that he or she will be exercising these Clinical Privileges (exceptions for shorter Notice periods may be considered in situations involving health issues); and

(ii) along with this notification, the individual must inform Medical Staff Services of any change that has occurred to any of the information provided on the initial application for Locum Tenens Privileges.

(c) Visiting. Temporary Privileges may also be granted in other limited situations by the CEO, the Chief of Staff, and the Credentials Committee Chair when there is an important patient care, treatment, or service need. Specifically, Temporary Privileges may be granted for situations such as the following:

(1) the care of a specific patient;

(2) the performance of specific procedure(s);

(3) when a proctoring or consulting Physician is needed, but is otherwise unavailable; or

(4) when necessary to prevent a lack or lapse of services in a needed specialty area.

The following factors will be considered and/or verified prior to the granting of Temporary Privileges in these situations: current licensure, relevant training or experience, current competence (verification of good standing in the individual's most recent hospital affiliation), current professional liability coverage acceptable to Summit Healthcare, and results of a query to the National Practitioner Data Bank, and from OIG queries. The grant of Clinical Privileges in these situations will not exceed 60 Days. The verifications for such grants of Clinical Privileges shall generally be accomplished in advance; however, in an emergency situation, where life-threatening circumstances exist, the verifications listed above may be completed immediately after the grant of Clinical Privileges. In exceptional situations, this period of time may be extended in the discretion of the CEO, the Chief of Staff, and the Credentials Committee Chair.

(d) Automatic Expiration. All grants of Temporary Privileges shall automatically expire upon the date specified at the time of initial granting unless further affirmative action is taken by the CEO, the Chief of Staff, and the Credentials Committee Chair with approval of the Board to renew such Temporary Privileges.

(e) Compliance with Bylaws and Policies. Prior to any Temporary Privileges being granted, the individual must agree in writing to be bound by the Bylaws, Rules and Regulations, policies, procedures, and protocols of the Medical Staff and Summit Healthcare.

4.B.2. Supervision Requirements:

Special requirements of supervision and reporting may be imposed on any individual granted Temporary Privileges.

4.B.3. Withdrawal of Temporary Privileges:

(a) The CEO may withdraw Temporary Privileges at any time, after consulting with the Chief of Staff, the Credentials Committee Chair, or the relevant Department Chair. Clinical Privileges shall then expire as soon as patients have been discharged or alternate care has been arranged.

(b) If the care or safety of patients might be endangered by continued treatment by the individual granted Temporary Privileges, the CEO or the CMO and the relevant Department Chair or the Chief of Staff may immediately withdraw all Temporary Privileges. The Department Chair or the Chief of Staff shall assign to another Practitioner responsibility for the care of such individual's patients until they are discharged or an appropriate transfer arranged. Whenever possible, consideration shall be given to the wishes of the patient in the selection of a substitute Physician.

4.C. EMERGENCY SITUATIONS

(1) For the purpose of this section, an "emergency" is defined as a condition which could result in serious or permanent harm to a patient(s) and in which any delay in administering treatment would add to that harm.

(2) In an emergency situation, a Practitioner may administer treatment to the extent permitted by his or her license, regardless of department status or specific grant of Clinical Privileges.

(3) When the emergency situation no longer exists, the patient shall be assigned by the relevant Department Chair or the Chief of Staff to a Medical Staff Member with appropriate Clinical Privileges, considering the wishes of the patient.

4.D. DISASTER PRIVILEGES

(1) When the Emergency Management Plan for Summit Healthcare has been implemented and the immediate needs of patients in the facility cannot be met, the CEO or the Chief of Staff may use a modified credentialing process to grant Disaster Privileges to eligible volunteer licensed independent practitioners ("volunteers"). Safeguards must be in place to verify that volunteers are competent to provide safe and adequate care.

(2) Disaster Privileges are granted on a case-by-case basis after verification of identity and licensure.

(a) A volunteer's identity may be verified through a valid government-issued photo identification (i.e., driver's license or passport) and at least one of the following:

(i) current hospital picture ID card that clearly identifies the individual's professional designation;

(ii) current license to practice;

(iii) identification indicating that the individual has been granted authority to render patient care in disaster circumstances or is a member of a Disaster Medical Assistance Team ("DMAT"), the Medical Resource Corps ("MRC"), the Emergency System for Advance Registration of Volunteer Health Professionals ("ESAR-VHP"), or other recognized state or federal organizations or groups;

(iv) identification by a current Summit Healthcare employee or Medical Staff Member who possesses personal knowledge regarding the individual's ability to act as a volunteer during a disaster; or

(v) 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).

(3) Primary source verification will occur as soon as power is available, internet is reconnected or telephone communication is returned. Medical Staff Services 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 and must be completed within 72 hours from the time the volunteer begins to provide service at Summit Healthcare. The verification process will be identical to the process described under Section 4.B Temporary Privileges.

(4) When primary source verification cannot be completed within 72 hours, it should be completed as soon as possible. In these situations, there must be documentation of the following:

(a) the reason primary source verification could not be performed within 72 hours;

(b) evidence of the volunteer's demonstrated ability to continue to provide adequate care; and

(c) an attempt to obtain primary source verification as soon as possible.

If a volunteer has not provided care, then primary source verification is not required.

(5) Volunteers shall be assigned to a Medical Staff Member, in the same specialty if possible, with whom to collaborate in the care of disaster victims.

(6) The Medical Staff will oversee the care provided by volunteers. This oversight shall be conducted through direct observation, mentoring, clinical record review, or other appropriate mechanism developed by the Medical Staff.

(7) If resources are available, the volunteer will be issued a photo ID Badge which must be worn at all times during the disaster.

(8) To the extent applicable, volunteers 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 by the federal Volunteer Protection Act, applicable state immunity statutes (including Arizona Revised Statute 32-1471 addressing Good Samaritan liability protection), and/or by Summit Healthcare directly.

(9) Based on the oversight of each volunteer, the CEO or the Chief of Staff will determine within 72 hours of the arrival if granted Disaster Privileges should continue.

(10) Termination of Disaster Privileges shall occur (i) when the emergency situation no longer exists; (ii) when Medical Staff Members can adequately provide care; (iii) in the event that verification of information results in negative or adverse information about the qualifications of the provider; or (iv) when Disaster Privileges are otherwise removed by the individuals(s) authorized to grant Disaster Privileges.

(11) When the Emergency Management Plan has been implemented, it may also be necessary to maximize Summit Healthcare's clinical resources by allowing Practitioners who are already privileged at Summit Healthcare to provide basic clinical and patient care services that are outside of their specialties or beyond the scope of their current Clinical Privilege delineations. These expanded patient care services may only be provided upon the direction of the MEC or the Board.

4.E. PROCEDURES FOR INITIAL FPPE TO CONFIRM COMPETENCE

Initial FPPE will be carried out in accordance with Article 15 of this Policy.

4.F. CONTRACTS FOR SERVICES

(1) From time to time, Summit Healthcare may enter into contracts with Practitioners and/or groups of Practitioners for the performance of clinical and/or administrative services at Summit Healthcare. All individuals functioning pursuant to such contracts shall obtain

and maintain Appointment and/or Clinical Privileges at Summit Healthcare, in accordance with the terms of this Policy.

(2) To the extent that any such contract confers the exclusive right to perform specified services at Summit Healthcare, no other person may exercise Clinical Privileges to perform the specified services while the contract is in effect.

(3) If entering into such an exclusive contract would have the effect of preventing an existing Practitioner from exercising Clinical Privileges that had previously been granted, the Board will request the MEC's review of the matter. The MEC (or a subcommittee of its members appointed by the MEC) will review the quality of care and service implications of the proposed exclusive contract and provide a report of its findings and recommendations to the Board within 30 Days.

(4) After receiving the MEC's report, the Board shall determine whether or not to proceed with the exclusive contract. If the Board determines to do so, and if that determination would have the effect of preventing an existing Practitioner from exercising Clinical Privileges that had previously been granted, the affected Practitioner shall be given notice of the exclusive contract and have the right to meet with the Board or a committee designated by the Board to discuss the matter prior to the effective date of the contract in question. At the meeting, the affected Practitioner shall be entitled to present any information relevant to the decision to enter into the exclusive contract. That individual shall not be entitled to any other procedural rights with respect to the decision or the effect of the contract on his/her Clinical Privileges, notwithstanding any other provision of this Policy. The inability of a Practitioner to exercise Clinical Privileges because of such an exclusive contract is not a matter that requires a report to the state licensure board or to the National Practitioner Data Bank.

(5) In the event of any conflict between this Policy or the Medical Staff Bylaws and the terms of any contract, the terms of the contract shall control.

ARTICLE 5 - PROCEDURE FOR REAPPOINTMENT

5.A. GENERAL

All terms, conditions, requirements, and procedures relating to initial Appointment shall apply to continued Appointment, Reappointment, and Clinical Privileges.

5.B. Eligibility for Reappointment

(1) To be eligible to apply for Reappointment and renewal of Clinical Privileges, an individual must have, during the previous Appointment term:

(a) satisfied all Medical Staff responsibilities, including payment of any fines and assessments;

(b) continued to meet all qualifications and criteria for Appointment and the Clinical Privileges requested, including those set forth in Section 2.A.1 of this Policy;

(c) paid the Reappointment processing fee, if any; and

(d) if applying for Clinical Privileges, had sufficient patient contacts to enable the assessment of current clinical judgment and competence for the Clinical Privileges requested. Any individual seeking Reappointment who has minimal activity at Summit Healthcare must submit such information as may be requested and as described in Section 5.G of this Policy.

(2) In addition, a Practitioner history report showing any clinical cases or conduct issues that have been reviewed during the current term of Appointment and their dispositions will be generated for consideration by the Credentials Committee. The Leadership Council will also provide the Credentials Committee a confidential summary regarding any Practitioner health issues it is actively monitoring.

5.C. FACTORS FOR EVALUATION

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

(1) the results of Summit Healthcare's Peer Review activities and other applicable performance improvement activities;

(2) assessments regarding an individual's compliance with the Bylaws, Rules and Regulations, and policies of the Medical Staff and Summit Healthcare;

(3) participation in Medical Staff duties, including committee assignments, emergency call, consultation requests, cooperation with case management, participation in quality improvement, utilization activities, and Peer Review activities, and such other reasonable duties and responsibilities as assigned;

(4) verified complaints and/or positive feedback received from patients, families, and/or staff; and

(5) other reasonable indicators of continuing qualifications.

5.D. REAPPOINTMENT APPLICATION

(1) An application for Reappointment shall be made available to Practitioners at least 180 Days prior to the expiration of their current Appointment term. A completed Reappointment application must be returned to Medical Staff Services within 30 Days of receipt.

(2) Failure to submit a complete application by the indicated submittal date but prior to 30 Days before the current Appointment term expiration date are subject to a $10 per business day late fee, which must be paid prior to the application being processed. In addition, failure to submit a complete application at least 30 Days prior to the expiration of the Practitioner's current term shall result in the automatic expiration of Appointment and Clinical Privileges at the end of the then current term of Appointment unless the application can still be processed in the normal course, without extraordinary effort on the part of Medical Staff Services and the Medical Staff Leaders.

(3) If an individual's Appointment and Clinical Privileges lapse due to a processing delay, subsequent Board action may be to grant Reappointment and renewal of Clinical Privileges using the filed application, in accordance with the expedited process set forth in Section 3.A.6(a).

(4) A Medical Staff member whose Appointment and Clinical Privileges lapse due to his/her own delay may qualify for expedited reinstatement of Appointment and Clinical Privileges. Practitioners who, within the past seven years, were in good standing for at least three continuous years, and whose Appointment lapsed 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 60 Days of the Practitioner's Appointment and Clinical Privilege expiration

date. Expedited reinstatement will be at the discretion of the Board, based on recommendations from the Credentials Committee and the MEC, but must include:

(a) all portions of regular Reappointment process;

(b) verification of activities during terms of absence;

(c) letters of recommendation; and

(d) payment of all previous dues, fees, and fines.

A Practitioner who files or requests to file a Reappointment application after the 60 Day time frame described above are eligible to reapply for Appointment and Clinical Privileges as outlined in Article 3.

(5) Reappointment shall be for a period of not more than two years.

(6) The application shall be reviewed by Medical Staff Services to determine that all questions have been answered and that the individual satisfies all threshold eligibility criteria for Reappointment and for the Clinical Privileges requested.

(7) Medical Staff Services shall oversee the process of gathering and verifying relevant information and shall also be responsible for confirming that all relevant information has been received.

5.E. PROCESSING APPLICATIONS FOR REAPPOINTMENT

(1) Medical Staff Services shall forward the evaluation form to the relevant Department Chair and the application for Reappointment shall be processed in a manner consistent with applications for initial Appointment.

(2) Additional information may be requested from the applicant if any questions or concerns are raised with the application or if new Clinical Privileges are requested.

5.F. CONDITIONAL REAPPOINTMENTS

(1) Recommendations for Reappointment and renewed Clinical Privileges may be contingent upon an individual's compliance with certain specific conditions that have been recommended. These conditions may relate to behavior (e.g., personal code of conduct) or to clinical issues (e.g., general consultation requirements, appropriate documentation requirements, including timely completion of medical records, proctoring, completion of CME requirements). Unless the conditions involve the matters set forth in Section 7.A.1(a) of this Policy, such conditions do not entitle an individual to request the procedural rights set forth in Article 7 of this Policy.

(2) Reappointments may be recommended for periods of less than two years in order to permit closer monitoring of an individual's compliance with any conditions that have been recommended. A recommendation for Reappointment for a period of less than two years does not, in and of itself, entitle an individual to the procedural rights set forth in Article 7.

(3) In addition, in the event the applicant for Reappointment is the subject of an unresolved Peer Review concern, an Investigation, or a hearing at the time Reappointment is being considered, a conditional Reappointment for a period of less than two years may be granted pending the completion of that process.

5.G. LOW AND NO VOLUME PRACTITIONERS

(1) Applicants for Reappointment who have been determined to have low volume activity during their current term of Appointment will be required to provide the following elements:

(a) volume of clinical activity at the Practitioner's primary facility that correspond to Clinical Privileges held at Summit Healthcare (See **Appendix B** for Proposed Minimum Reappointment Clinical Activity);

(b) confirmation of Medical Staff status, "in good standing with no reviews, no contemplated investigations and no ongoing investigations or quality/review adverse action" at the Practitioner's primary facility;

(c) confirmation that the Practitioner is clinically competent for all areas covered by his or her requested Clinical Privileges at the Practitioner's primary facility; and

(d) confirmation from at least two peers to evaluate character and judgment.

(2) With the exception of telemedicine services, applicants for Reappointment who have been determined to have had fewer than five documented patient encounters at Summit Healthcare during their current Reappointment period may be moved to another Medical Staff category that more accurately reflects their practice patterns.

5.H. POTENTIAL ADVERSE RECOMMENDATION

(1) If the Credentials Committee or MEC is considering a recommendation to deny Reappointment or to reduce Clinical Privileges, the Chair will notify the individual of the possible recommendation and invite him or her to meet prior to any final recommendation being made.

(2) Prior to this meeting, the individual will be notified of the general nature of the information supporting the recommendation contemplated.

(3) At the meeting, the individual will be invited to discuss, explain, or refute this information. A summary of the interview will be made and included with the Credentials Committee's and/or MEC's recommendation.

(4) This meeting is not a hearing, and none of the procedural rules for hearings will apply. The individual will not have the right to be accompanied by legal counsel at this meeting and no recording (audio or video) of the meeting shall be permitted or made.

5.I. TIME PERIODS FOR PROCESSING

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

ARTICLE 6 - QUESTIONS INVOLVING PRACTITIONERS WITH CLINICAL PRIVILEGES

6.A. GENERAL

(1) The primary objective of this Article is to establish a positive, educational approach to addressing performance, conduct, and health issues involving Practitioners who practice at Summit Healthcare in order to arrive at voluntary, responsive actions by the Practitioner to resolve any concern that has been raised and promote a culture of continuous improvement.

(2) When a performance, conduct, or health issue involving a Practitioner is referred to the Leadership Council or the Peer Review Committee, it will follow the steps of review described in the Medical Staff's Peer Review Policy and other policies.

(3) In addition, the Medical Staff Leaders have been authorized by the Medical Staff and the Board to utilize/invoke the tools outlined in this Article to address concerns about a Practitioner. These tools include, but are not limited to, the following:

(i) Collaborative Leadership Efforts as described in Section 6.C of this Policy;

(ii) Progressive Steps as described in Section 6.C of this Policy;

(iii) requesting a Practitioner voluntarily refrain from clinical practice as described in Section 6.D of this Policy;

(iv) issuing a precautionary suspension as described in Section 6.D of this Policy;

(v) determining an Automatic Relinquishment of Appointment and Clinical Privileges has occurred, as described in Section 6.F of this Policy; and

(vi) approving a leave of absence as described in Section 6.G of this Policy.

Where these efforts fail to resolve an issue and/or when there is an issue of such severity that it requires, in the discretion of the Medical Staff Leaders and/or the Administrative Leadership, a more formal review, Section 6.E of this Article outlines the steps for conducting an Investigation.

6.B. PEER REVIEW ACTIVITIES

Peer Review activities shall be conducted in accordance with the relevant Medical Staff policies. Matters that are not satisfactorily resolved through Collaborative Leadership Efforts, Progressive Steps, or through one of these policies shall be referred to the MEC for its review in accordance with Section 6.E below. Such interventions and evaluations, however, are not mandatory prerequisites to MEC review.

6.C. COLLABORATIVE LEADERSHIP EFFORTS AND PROGRESSIVE STEPS

(1) This Policy encourages the use of Collaborative Leadership Efforts and Progressive Steps by Medical Staff Leaders and the Administrative Leadership to address questions relating to an individual's clinical practice, professional conduct, and/or health. The goal of these efforts is to arrive at voluntary, responsive actions by the individual to resolve questions that have been raised. Medical Staff Leaders and the Administrative Leadership have been authorized by the MEC, Leadership Council, and the PRC to engage in Collaborative Leadership Efforts and Progressive Steps and all of these activities are undertaken on behalf of these committees as part of their Peer Review functions.

(2) Collaborative Leadership Efforts include activities such as:

(a) informal mentoring, coaching, or counseling by a Medical Staff Leader (e.g., advising an individual of policies regarding appropriate behavior, communication issues, emergency call obligations, or the timely and adequate completion of medical records); and

(b) sharing comparative data, including any variations from clinical practice or evidence-based protocols or guidelines, in order to assist the individual with conforming his or her practice to appropriate norms.

There is no expectation that these efforts will be documented in the individual's Confidential File, though documentation may be created in the discretion of the Medical Staff Leaders.

(3) Progressive steps are defined as follows:

(a) addressing minor performance issues through an Informational Letter;

(b) sending an Educational Letter that describes opportunities for improvement and provides guidance and suggestions;

(c) facilitating a formal Collegial Intervention (i.e., a planned, face-to-face meeting between an individual and one or more Medical Staff Leaders) in order to directly discuss a matter and the steps needed to be taken to resolve it;

(d) developing a voluntary enhancement plan (which will not be disclosed on any affiliation verifications); and

(e) recommending a Performance Improvement Plan to the MEC, which may include a wide variety of tools and techniques that can result in a constructive and successful resolution of the concern (and which will be disclosed on affiliation verifications for ten years following the Performance Improvement Plan).

All Progressive Steps shall be documented in the individual's Confidential File in a constructive manner and maintained in a confidential manner consistent with its documentation's privileged status. Any written responses to any of these Progressive Steps that may be received from the individual shall also be included in the individual's Confidential File.

(4) All Collaborative Leadership Efforts and Progressive Steps are fundamental and integral components of Summit Healthcare's Peer Review activities and are confidential and privileged in accordance with Arizona law. Copies of any formal documentation that is prepared by a Medical Staff Leader regarding such efforts and Progressive Steps, including follow-up letters, are confidential and constitute Peer Review Information under Arizona law.

(5) Unless otherwise stated in another policy, Collaborative Leadership Efforts and Progressive Steps are encouraged, but are not mandatory, and shall be within the discretion of the appropriate Medical Staff Leaders and the Administrative Leadership, acting on behalf of Peer Review Committees. When a question arises, the Medical Staff Leaders and/or Administrative Leadership may:

(a) address it pursuant to the Collaborative Leadership Efforts and Progressive Steps provisions of this Section;

(b) refer the matter for review in accordance with another relevant Medical Staff policy (e.g., Peer Review Policy); or

(c) refer it to the MEC for its review and consideration in accordance with Section 6.E of this Article.

(6) Should any recommendation be made or an action taken that entitles an individual to a hearing in accordance with this Policy, the individual is entitled to be accompanied by legal counsel at that hearing. However, Practitioners do not have the right to be accompanied by counsel when the Medical Staff Leaders and Administrative Leadership

are engaged in Collaborative Leadership Efforts or other Progressive Steps. These efforts are intended to resolve issues in a constructive manner and do not involve the formal hearing process. In addition, there shall be no recording (audio or video) or transcript made of any meetings that involve Collaborative Leadership Efforts or Progressive Steps activities.

6.D. PRECAUTIONARY SUSPENSION OR RESTRICTION OF CLINICAL PRIVILEGES

6.D.1. Grounds for Precautionary Suspension or Restriction/Requests to Voluntarily Refrain:

(a) Whenever, in their sole discretion, failure to take such action may result in imminent danger to the health and/or safety of any individual, the MEC, any Medical Staff Officer or Department Chair, acting in conjunction with the CEO or the CMO, shall have the authority to proceed as follows:

(1) request that the individual agree to voluntarily refrain from exercising Clinical Privileges pending further review of the circumstances by the Leadership Council in accordance with Section 6.D.2 of this Policy; or

(2) if the individual is unwilling to voluntarily refrain from practicing pending further review, to suspend or restrict all or any portion of the individual's Clinical Privileges as a precaution, which actions shall be reviewed by the MEC in accordance with Section 6.D.3 of this Policy.

(b) The above actions can be taken at any time, including, but not limited to, immediately after the occurrence of an event that causes concern, following a pattern of occurrences that raises concern, or following a recommendation of the MEC that would entitle the individual to request a hearing.

(c) Precautionary suspension or Restriction, or an agreement to refrain, is an interim step in the professional review activity, but it is not a complete professional review action in and of itself. It shall not imply any final finding of responsibility for the situation that caused the suspension, Restriction, or agreement.

(d) These actions shall become effective immediately, shall promptly be reported in writing to the CEO, the CMO, and the Chief of Staff, and shall remain in effect unless the action is modified by the CEO or MEC.

(e) The individual in question shall be provided a letter via Special Notice that memorializes the individual's agreement to voluntarily refrain from practicing or the imposition of a precautionary suspension and terms related to the same. The correspondence shall also contain a brief written description of the reason(s) for the action, including the names and medical record numbers of the patient(s) involved (if any), within three Days of the action.

6.D.2. Leadership Council Review Process for an Agreement to Voluntarily Refrain from Practicing:

(a) The Leadership Council shall review the matter resulting in an individual's agreement to voluntarily refrain from exercising Clinical Privileges within a reasonable time under the circumstances, not to exceed 14 Days. As part of this review, the individual shall be given an opportunity to meet with the Leadership Council. Neither the Leadership Council nor the individual shall be accompanied by legal counsel at this meeting, and no recording (audio or video) or transcript of the meeting shall be permitted or made; however, minutes of the meeting shall be prepared.

(b) After considering the matter resulting in an individual's agreement to voluntarily refrain and the individual's response, if any, the Leadership Council shall determine the appropriate next steps, which may include, but not be limited to, commencing a focused review, referring the matter for review pursuant to another policy, referring the matter to the MEC with a recommendation to initiate an Investigation, or taking some other action that is deemed appropriate under the circumstances. The Leadership Council shall also determine whether the agreement to voluntarily refrain from practicing should be continued throughout any further review process.

(c) There is no right to a hearing based on an individual's agreement to voluntarily refrain from exercising his or her Clinical Privileges in accordance with this Section.

6.D.3. MEC Review Process for Precautionary Suspensions or Restrictions:

(a) The MEC shall review the matter resulting in a precautionary suspension or Restriction within a reasonable time under the circumstances, not to exceed 14 Days. As part of this review, the individual shall be given an opportunity to meet with the MEC. The individual may propose ways other than precautionary suspension or Restriction to protect patients and/or employees, depending on the circumstances. Neither the MEC nor the individual shall be accompanied by legal counsel at this meeting, and no recording (audio or video) or transcript of the meeting shall be permitted or made; however, minutes of the meeting shall be prepared.

(b) After considering the matters resulting in the suspension or Restriction and the individual's response, if any, the MEC shall determine the appropriate next steps, which may include, but not be limited to, commencing a focused review or an Investigation, or recommending some other action that is deemed appropriate under the circumstances. The MEC shall also determine whether the precautionary suspension or Restriction should be continued, modified, or terminated pending the completion of the focused review or Investigation (and hearing and appeal, if applicable).

(c) There is no right to a hearing based on the imposition or continuation of a precautionary suspension or Restriction.

6.D.4. Care of Patients:

(a) Immediately upon an individual's agreement to voluntarily refrain from practicing or the imposition of a precautionary suspension or Restriction, the Department Chair or the Chief of Staff shall assign to another individual with appropriate Clinical Privileges responsibility for care of the individual's hospitalized patients, or to otherwise aid in implementing the precautionary suspension, Restriction, or agreement to refrain from practicing, as appropriate. The assignment shall be effective until the patients are discharged. The wishes of the patient shall be considered in the selection of a covering Physician but may not always be accommodated.

(b) All Practitioners have a duty to cooperate with the Chief of Staff, the Department Chair, the MEC, the CMO, and the CEO in enforcing precautionary suspensions or Restrictions, or agreements to voluntarily refrain from practicing.

6.E. INVESTIGATIONS

6.E.1. Initial Review:

(a) Where Collaborative Leadership Efforts, Progressive Steps, and/or other efforts under the policies of the Medical Staff have not resolved an issue and/or when there is an issue of such severity that in the discretion of Medical Staff Leaders it requires further review, regarding:

(1) the clinical competence or clinical practice of any Practitioner, including the care, treatment or management of a patient or patients;

(2) the safety or proper care being provided to patients;

(3) the known or suspected violation by any Practitioner of applicable ethical standards or the Bylaws, Rules and Regulations, and policies of Summit Healthcare or the Medical Staff; and/or

(4) conduct by any Practitioner that is considered lower than the standards of Summit Healthcare or disruptive to the orderly operation of Summit Healthcare or its Medical Staff, including the inability of an individual to work harmoniously with others,

the matter may be referred to the Leadership Council, the Chief of Staff, the Department Chair, the chair of a standing committee, the CMO, or the CEO.

(b) In addition, if the Board becomes aware of information that raises concerns about any Practitioner, the matter may be referred to the Leadership Council, the Chief of Staff, the applicable Department Chair, the chair of a standing committee, the CMO, or the CEO for review and appropriate action in accordance with this Policy.

(c) The person to whom the matter is referred shall conduct or arrange for an inquiry to determine whether the question raised has sufficient credibility to warrant further review and, if so, shall forward it in writing to the MEC.

(d) No action taken pursuant to this Section shall constitute an Investigation.

6.E.2. Initiation of Investigation:

(a) When a question involving clinical competence or professional conduct is referred to, or raised by, the MEC, the MEC shall review the matter and determine whether to conduct an Investigation, to direct the matter to be handled pursuant to another policy (e.g., peer review policy), or to proceed in another manner that the MEC believes is appropriate. Prior to making its determination, the MEC may discuss the matter with the individual involved. An Investigation shall begin only after a formal determination by the MEC to do so. The MEC's determination shall be recorded in the minutes of the meeting where the determination is made.

(b) The MEC shall inform the individual that an Investigation has begun. The notification shall include:

(1) the date on which the Investigation was commenced;

(2) the committee that will be conducting the Investigation, if already identified;

(3) a statement that the individual will be given the opportunity to meet with the committee conducting the Investigation before the Investigation concludes; and

(4) a copy of Section 6.E.3 of this Policy, which outlines the process for Investigations.

This notification may be delayed if, in the MEC's judgment, informing the individual immediately would compromise the Investigation or disrupt the operation of Summit Healthcare or Medical Staff.

6.E.3. Investigative Procedure:

(a) Selection of Investigating Committee.

Once a determination has been made to begin an Investigation, the MEC shall either investigate the matter itself or appoint an ad hoc committee to conduct the Investigation, keeping in mind the conflict of interest guidelines outlined in Article 9. Any ad hoc committee may include individuals not on the Medical Staff and is a Peer Review Committee as defined in the Medical Staff Glossary. Whenever the questions raised concern the clinical competence of the individual under review, the ad hoc committee shall include a peer of the individual (e.g., Physician, Dentist, Podiatrist, Advanced Practice Provider, or Allied Health Professional).

(b) Investigating Committee's Review Process.

(1) The committee conducting the Investigation ("investigating committee") shall have the authority to review relevant documents and interview individuals. A summary of each interview will be prepared and the interviewee will be asked to review, revise, and sign his or her summary, which will then be included as an attachment to the investigating committee's report.

(2) The investigating committee shall also have available to it the full resources of the Medical Staff and Summit Healthcare, including the authority to arrange for an external review, if needed. An external review may be used whenever Summit Healthcare and investigating committee determine that:

(i) there are ambiguous or conflicting findings by internal reviewers;

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

(iii) an external review is advisable to prevent allegations of bias, even if unfounded; or

(iv) the thoroughness and objectivity of the Investigation would be aided by such an external review.

If a decision is made to obtain an external review, the individual under Investigation shall be notified of that decision and the nature of the external

review. Upon completion of the external review, the individual shall be provided a copy of the reviewer's report.

(3) The investigating committee may require a physical, mental, and/or behavioral examination of the individual by a health care professional(s) acceptable to it. The individual being investigated shall execute a release (in a form approved or provided by the investigating committee) allowing (i) the investigating committee (or its representative) to discuss with the health care professional(s) conducting the examination the reasons for the examination; and (ii) the health care professional(s) conducting the examination to discuss and provide documentation of the results of such examination directly to the investigating committee. The cost of such health examination may be borne by the individual.

(c) Meeting with the Investigating Committee.

(1) The individual under Investigation shall have an opportunity to meet with the investigating committee before it makes its report. Prior to this meeting, the individual shall be informed of the general questions being investigated. The investigating committee may also ask the individual to provide written responses to specific questions related to the Investigation and/or a written explanation of his or her perspective on the events that led to the Investigation for review by the investigating committee prior to the meeting.

(2) This meeting is not a hearing, and none of the procedural rules for hearings shall apply. No recording (audio or video) or transcript of the meeting shall be permitted or made. Neither the individual being investigated, nor the investigating committee will be accompanied by legal counsel at this meeting.

(3) At the meeting, the individual shall be invited to discuss, explain, or refute the questions that gave rise to the Investigation or that have been identified by the investigating committee during its review. A summary of the interview shall be prepared by the investigating committee and included with its report. The interview summary will be shared with the individual prior to the investigating committee finalizing its report, so that he or she may review it and recommend suggested changes. Suggested changes should only be accepted if the investigating committee believes it more accurately reflects what occurred at the meeting.

(d) Time Frames for Investigation.

The investigating committee shall make a reasonable effort to complete the Investigation and issue its report within 30 Days of the commencement of the Investigation, provided that an external review is not necessary. When an external review

is necessary, the investigating committee shall make a reasonable effort to complete the Investigation and issue its report within 30 Days of receiving the results of the external review. These time frames are intended to serve as guidelines and, as such, shall not be deemed to create any right for an individual to have an Investigation completed within such time periods.

(e) Investigating Committee's Report.

(1) At the conclusion of the Investigation, the investigating committee shall prepare a report of the Investigation. The report should include a summary of the review process (e.g., a list of documents that were reviewed, any individuals who were interviewed, etc.), specific findings and conclusions regarding each concern that was under review, and the investigating committee's recommendations.

(2) In making its recommendations, the investigating committee shall strive to achieve a consensus as to what is in the best interests of patient care and the smooth operation of Summit Healthcare, while balancing fairness to the individual, recognizing that fairness does not require that the individual agree with the recommendation. Specifically, the committee may consider:

(i) relevant literature and clinical practice guidelines, as appropriate;

(ii) all of the opinions and views that were expressed throughout the review, including report(s) from any external review(s);

(iii) any information or explanations provided by the individual under review; and

(iv) other information as deemed relevant, reasonable, and necessary by the investigating committee.

6.E.4. Recommendation:

(a) The MEC may accept, modify, or reject any recommendation it receives from an ad hoc investigating committee if one was appointed by the MEC. In either case, at the conclusion of the Investigation, the MEC may:

(1) determine that no action is justified;

(2) issue a letter of guidance, counsel, warning, or reprimand;

(3) impose conditions for continued Appointment;

(4) impose a requirement for monitoring, proctoring, or consultation;

(5) impose a requirement for additional training or education;

(6) develop a Performance Improvement Plan;

(7) recommend reduction of Clinical Privileges;

(8) recommend suspension of Clinical Privileges for a term;

(9) recommend revocation of Appointment and/or Clinical Privileges; or

(10) make any other recommendation that it deems necessary or appropriate.

Consistent with the burden to provide information outlined in Section 2.B.2 of this Policy, any expenses associated with any of the recommendations outlined above (e.g., the cost of obtaining additional training or education) will be borne by the individual unless waived by the MEC.

(b) A recommendation by the MEC that would entitle the individual to request a hearing shall be forwarded to the CEO, who shall promptly inform the individual by Special Notice. The CEO shall hold the recommendation until after the individual has completed or waived a hearing and appeal.

(c) If the determination of the MEC does not entitle the individual to request a hearing, it shall take effect immediately and shall remain in effect unless modified by the Board.

(d) In the event the Board considers a modification to the recommendation of the MEC that would entitle the individual to request a hearing, the CEO shall inform the individual by Special Notice. No final action shall occur until the individual has completed or waived a hearing and appeal.

(e) When applicable, any recommendations or actions that are the result of an Investigation or hearing and appeal shall be monitored by Medical Staff Leaders on an ongoing basis through Summit Healthcare's performance improvement activities or pursuant to the applicable policies regarding conduct, as appropriate.

6.F. AUTOMATIC RELINQUISHMENT/ACTIONS

(1) An Automatic Relinquishment is considered an administrative action that occurs by operation of this Policy. As such, it does not trigger an obligation on the part of Summit Healthcare to file a report with the National Practitioner Data Bank or any state licensing agency and will take effect without hearing or appeal.

(2) Except as otherwise provided below, an Automatic Relinquishment of Appointment and Clinical Privileges will be effective immediately upon actual or Special Notice to the individual. Such Notice will be provided after confirmation of the event(s) that led to the Automatic Relinquishment by the Chief of Staff, the CMO, and/or CEO.

6.F.1. Action by Government Agency or Insurer and Failure to Satisfy Threshold Eligibility Criteria:

(a) Any action taken by any licensing board, professional liability insurance company, court or government agency regarding any of the matters set forth below, or any failure to satisfy any of the threshold eligibility criteria set forth in this Policy, must be promptly reported by the affected individual to Medical Staff Services.

(b) An individual's Appointment and Clinical Privileges shall be Automatically Relinquished, without the right to the procedural rights outlined in this Policy, if an individual fails to satisfy any of the threshold eligibility criteria set forth in Section 2.A.1 of this Policy on a continuous basis (except for board/national certification requirements, excluding Adjunct Professional Staff members licensed by the Arizona State Board of Nursing, which shall be assessed at time of Reappointment). This includes, but is not limited to, the following occurrences:

(1) Licensure: Revocation, expiration, suspension, the placement of Restrictions on an individual's license/authorization, or an individual's license/authorization being placed on probationary status.

(2) Controlled Substance Authorization: Revocation, expiration, suspension or the placement of Restrictions on an individual's DEA controlled substance authorization.

(3) Insurance Coverage: Termination or lapse of an individual's professional liability insurance coverage, or other action causing the coverage to fall below the minimum required by Summit Healthcare or cease to be in effect, in whole or in part.

(4) Medicare and Medicaid Participation: Withdrawal or debarment, proposed debarment, termination, exclusion, or preclusion by government action or from

participation in the Medicare/Medicaid or other federal or state health care programs.

(5) Criminal Activity: Arrest, charge, indictment, conviction, or a plea of guilty or no contest pertaining to any felony; or to any misdemeanor involving (i) controlled substances; (ii) illegal drugs; (iii) Medicare, Medicaid, or insurance or health care fraud or abuse; (iv) child abuse; (v) elder abuse; or (vi) violence against another.

(c) Automatic relinquishment shall take effect immediately upon Special Notice and shall continue until the matter is resolved and the individual is reinstated, if applicable.

(d) If the underlying matter leading to Automatic Relinquishment is resolved within 30 Days, the individual may request reinstatement. In addition, if an arrest, charge or indictment as defined in (5) above has not been fully resolved within the 30-Day time period, an individual may request reinstatement but bears the burden of demonstrating, in the full discretion of the Leadership Council, that the underlying matter does not raise concerns about the individual's professional qualifications and/or ability to completely and safely exercise Clinical Privileges. Failure to resolve the matter within 30 Days of the date of relinquishment shall result in an automatic resignation of the individual's Appointment and Clinical Privileges.

6.F.2. Failure to Complete Medical Records:

Failure to complete medical records, after notification by the medical records department of delinquency, may result in Automatic Relinquishment of all Clinical Privileges in accordance with the time frames as set forth in the Medical Staff Rules and Regulations (except that the individual must complete all scheduled emergency service obligations or arrange appropriate coverage). Relinquishment shall continue until all delinquent records are completed and reinstatement accomplished in accordance with applicable policies and rules and regulations. Failure to complete the medical records that caused relinquishment within the time required by applicable policies and rules and regulations shall result in automatic resignation of the individual's Appointment and Clinical Privileges.

6.F.3. Failure to Provide Requested Information:

(a) Failure of a Practitioner to inform Medical Staff Services, in writing or via e-mail, as soon as possible, but in all cases within 10 Days, of any change in the Practitioner's status or any change in the information provided on the individual's application form as described in Section 2.B.1(f) of this Policy will result in the Automatic Relinquishment of Appointment and Clinical Privileges.

(b) Failure to provide information pertaining to an individual's qualifications for continued Appointment or Clinical Privileges, in response to a written request from the CEO, the CMO, the Credentials Committee, the MEC, the Leadership Council, the PRC, or any other committee authorized to request such information, shall result in the Automatic Relinquishment of the individual's Appointment and Clinical Privileges until the information is provided to the satisfaction of the requesting party. If the individual fails to provide the information requested within 30 Days of the Automatic Relinquishment, the individual's Appointment and Clinical Privileges will be deemed to have been automatically resigned.

6.F.4. Failure to Complete or Comply with Training, Educational, or Orientation Requirements:

(a) Failure to complete or comply with training, educational, or orientation requirements that are adopted by the MEC or required by the Board, including, but not limited to, those pertinent to electronic medical records, computerized Physician order entry ("CPOE"), the privacy and security of protected health information, infection control, or patient safety within 30 Days of assignment, shall result in a requirement that the individual meet with the Leadership Council to discuss why the requested input was not provided. New applicants may complete all such training prior to Appointment.

(b) Failure of the individual to either meet with the Leadership Council or complete or comply with the pertinent requirement prior to the meeting will result in the Automatic Relinquishment of the individual's Clinical Privileges until the individual demonstrates completion or compliance with the relevant requirement. If the individual fails to do so within 30 Days of the Automatic Relinquishment, the individual's Appointment and Clinical Privileges will be deemed to have been automatically resigned.

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

(a) Whenever there is a concern regarding the clinical practice or professional conduct involving any individual, a Medical Staff Leader may require the individual to attend a special meeting with one or more of the Medical Staff Leaders and/or with a standing or ad hoc committee of the Medical Staff.

(b) No legal counsel shall be present at this meeting, and no recording (audio or video) or transcript shall be permitted or made.

(c) The Notice to the individual regarding this meeting shall be given by Special Notice at least three Days prior to the meeting and shall inform the individual that attendance at the meeting is mandatory.

(d) Failure of the individual to attend the meeting shall result in the Automatic Relinquishment of all Clinical Privileges until such time as the individual does attend the special meeting. If the individual does not attend the special meeting within 30 Days of the date of relinquishment, it shall result in automatic resignation of the individual's Appointment and Clinical Privileges.

6.F.6. Request for Reinstatement:

(a) Requests for reinstatement following the expiration or lapse of a license/authorization, life support certification, controlled substance authorization, and/or insurance coverage, and failure to complete/comply with immunization, vaccination, screen tests (e.g., tuberculosis) medical records, training, educational, or orientation requirements will be processed by Medical Staff Services. If any questions or concerns are noted, Medical Staff Services will refer the matter for further review in accordance with (b) below.

(b) All other requests for reinstatement shall be reviewed by the Leadership Council. If it makes a favorable recommendation on reinstatement, the Practitioner may immediately resume clinical practice at Summit Healthcare. This determination shall then be forwarded to the Credentials Committee, the MEC, and the Board for information. If, however, the Leadership Council has any questions or concerns, those questions shall be noted and the reinstatement request shall be forwarded to the full Credentials Committee, MEC, and Board for review and recommendation.

6.G. LEAVES OF ABSENCE

6.G.1. Initiation:

(a) General. In addition to any requested mandatory leave (i.e., FMLA, ADA, etc.), as a courtesy, a Practitioner may request a leave of absence from his or her Medical Staff obligations by submitting a written request to Medical Staff Services. The request must state the beginning and ending dates of the leave, which shall not exceed 12 months, and the reasons for the leave. Except in extraordinary circumstances, this request will be submitted at least 30 Days prior to the anticipated start of the leave in order to permit adjustment of the call roster and assure adequate coverage of clinical and/or administrative activities.

The CMO shall determine whether a request for a leave of absence shall be granted. In determining whether to grant a request, the Chief of Staff and the relevant Department

Chair shall be consulted. The granting of a leave of absence, or reinstatement, as appropriate, may be conditioned upon the individual's completion of all medical records.

(b) Leaves for Health Issues. Except for uncomplicated maternity leaves, Practitioners must report to the CMO any time they are away from Medical Staff and/or patient care responsibilities for longer than 30 Days if the reason for such absence is related to their physical or mental health or otherwise to their ability to care for patients safely and competently. Failure to report such circumstances may trigger an automatic medical leave of absence.

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

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

6.G.3. Reinstatement:

(a) Individuals requesting reinstatement shall submit a written summary of their professional activities during the leave, evidence demonstrating that they continue to maintain current licensure, DEA registration (if applicable), and adequate malpractice coverage, and any other information that may be requested by Summit Healthcare. Requests for reinstatement shall then be reviewed by the Leadership Council. If the Leadership Council makes a favorable recommendation on reinstatement, the Practitioner may immediately resume clinical practice at Summit Healthcare (with all reinstatements following a leave of absence for six months or more being subject to a provisional period). This determination shall then be forwarded to the Credentials Committee, the MEC, and the Board for ratification. If, however, the Leadership Council has any questions or concerns, those questions shall be noted and the reinstatement request shall be forwarded to the full Credentials Committee, MEC, and Board for review and recommendation. If a request for reinstatement is not granted, for reasons related to clinical competence or professional conduct, the individual shall be entitled to request a hearing and appeal.

(b) If the leave of absence was for health reasons (except for uncomplicated maternity leave), the request for reinstatement must be accompanied by a report from the individual's Physician indicating that the individual is physically and/or mentally capable of resuming a hospital practice and safely exercising the Clinical Privileges requested and the request for reinstatement shall be processed as described in (a) above.

(c) Absence for longer than 12 months shall result in Automatic Relinquishment of Appointment and Clinical Privileges unless an extension is granted by the CMO. Extensions shall be considered only in extraordinary cases where the extension of a leave is in the best interest of Summit Healthcare.

(d) If an individual's current Appointment is due to expire during the leave, the individual must apply for Reappointment, or Appointment and Clinical Privileges shall lapse at the end of the Appointment period.

(e) Failure to request reinstatement from a leave of absence in a timely manner shall be deemed a voluntary resignation of Appointment and Clinical Privileges.

(f) Generally, leaves of absence are matters of courtesy, not of right. In the event that it is determined that an individual has not demonstrated good cause for a leave, or where a request for extension is not granted, the determination shall be final, with no recourse to a hearing and appeal. These terms do not apply to sabbatical leaves provided by his or her Employer.

6.H. REAPPLICATION AFTER ADVERSE CREDENTIALING DECISION, RESIGNATION, OR APPLICATION WITHDRAWAL

(a) Except as otherwise determined by the Medical Executive Committee or Governing Board in light of exceptional circumstances, a practitioner who has:

(1) received a final adverse decision; or
(2) resigned; or
(3) Withdrawn an application for appointment, reappointment, or clinical privileges

is not eligible to reapply for a period of at least one 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 set forth in this manual.

(b) 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 ow not be processed any further.

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

ARTICLE 7 - HEARING AND APPEAL PROCEDURES FOR MEDICAL STAFF MEMBERS

The hearing and appeal procedures in this Article are only applicable to Medical Staff Members and are **not** applicable to the Adjunct Professional Staff. The due process rights for members of the Adjunct Professional Staff are set forth in Article 8 of this Policy.

7.A. INITIATION OF HEARING

7.A.1. Grounds for Hearing:

(a) An individual is entitled to request a hearing whenever the MEC makes one of the following recommendations:

(1) denial of initial Appointment;

(2) denial of Reappointment;

(3) revocation of Appointment;

(4) denial of requested Clinical Privileges;

(5) revocation of Clinical Privileges;

(6) suspension of Clinical Privileges for more than 30 Days (other than precautionary suspension);

(7) a Restriction of Clinical Privileges lasting for more than 30 Days; or

(8) denial of reinstatement from a leave of absence if the reasons relate to clinical competence or professional conduct.

(b) No other recommendations shall entitle the individual to a hearing.

(c) If the Board makes any of these determinations without an adverse recommendation by the MEC, an individual would also be entitled to request a hearing. For ease of use, this Article refers to adverse recommendations of the MEC. When a hearing is triggered by an adverse recommendation of the Board, any reference in this Article to the "MEC" shall be interpreted as a reference to the "Board."

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

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

(a) determination that an applicant for Appointment fails to meet the threshold eligibility qualifications or criteria outlined in Section 2.A.1 of this Policy;

(b) ineligibility to request Appointment or Clinical Privileges, or to continue Clinical Privileges, because a relevant specialty is closed under a Medical Staff development plan or is covered under an exclusive provider agreement (see Section 4.F of this Policy);

(c) determination that an applicant for Clinical Privileges fails to meet the eligibility criteria to hold the Clinical Privilege;

(d) determination that an application is incomplete or untimely;

(e) determination that an application shall not be processed due to a misstatement or omission or refusal of Summit Healthcare to consider a request for Appointment or Clinical Privileges within one year after a determination regarding a misstatement or omission is made;

(f) change in assigned staff category or a determination that an individual is not eligible for a specific staff category;

(g) expiration of Appointment and Clinical Privileges as a result of failure to submit an application for Reappointment within the allowable time period;

(h) issuance of an Informational Letter, an Educational Letter, or any other letter of guidance, counsel, warning, or reprimand;

(i) determination that conditions, monitoring, observational proctoring, general consultations, additional training, or continuing education are appropriate for a Practitioner;

(j) voluntary acceptance of a Voluntary Enhancement Plan or Performance Improvement Plan;

(k) any requirement to complete a health assessment, diagnostic testing, a complete physical, mental or behavioral evaluation, or a clinical competency evaluation pursuant to any Bylaws-related document;

(l) conducting an Investigation into any matter or the appointment of an ad hoc investigating committee;

(m) grant of conditional Appointment or Reappointment or of an Appointment or Reappointment period that is less than two years;

(n) refusal of Summit Healthcare to consider a request for Appointment, Reappointment, or Clinical Privileges within five years of a final adverse decision regarding such request;

(o) precautionary suspension;

(p) Restriction or suspension of Clinical Privileges for less than 30 Days;

(q) Automatic Relinquishment of Appointment or Clinical Privileges or Automatic Resignation;

(r) denial of a request for a leave of absence, for an extension of a leave or for reinstatement from a leave if the reasons do not relate to clinical competence or professional conduct;

(s) removal from the on-call roster or any other reading panel;

(t) withdrawal of Temporary Privileges;

(u) requirement to appear for a special meeting; or

(v) termination of any contract with or employment by Summit Healthcare.

7.B. THE HEARING

7.B.1. Notice of Recommendation:

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

(a) a statement of the recommendation and the general reasons for it;

(b) a statement that the individual has the right to request a hearing on the recommendation within 30 Days of receipt of this Notice; and

(c) a copy of this Article.

7.B.2. Request for Hearing:

An individual has 30 Days following receipt of the Special Notice to request a hearing. The request shall be in writing to the Chief of Staff, copying the CEO, and shall include the name, address, and telephone number of the individual's counsel, if any. Failure to request a hearing

shall constitute waiver of the right to a hearing, and the recommendation shall be transmitted to the Board for final action.

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

(a) The CEO shall schedule the hearing and provide, by Special Notice to the individual requesting the hearing, the following:

(1) the time, place, and date of the hearing;

(2) a proposed list of witnesses who shall give testimony at the hearing and a brief summary of the anticipated testimony;

(3) the names of the Hearing Panel members (or Hearing Officer) and Presiding Officer, if known; and

(4) a statement of the specific reasons for the recommendation, including a list of patient records (if applicable), and a general description of the information supporting the recommendation. This statement does not bar presentation of additional evidence or information at the hearing, so long as the additional material is relevant to the recommendation or the individual's qualifications and the individual has a sufficient opportunity to review and rebut the additional information.

(b) The hearing shall begin no sooner than 30 Days after the Notice of the hearing, unless an earlier hearing date has been specifically agreed to in writing by the parties.

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

(a) Hearing Panel:

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

(1) The Hearing Panel shall consist of at least three members, at least one of whom must be a Physician, and may include any combination of:

(i) any Practitioner, provided the individual has not actively participated in the matter at any previous level; and/or

(ii) Practitioners or laypersons not connected with Summit Healthcare (i.e., Physicians not on the Medical Staff or laypersons not affiliated with Summit Healthcare).

(2) Knowledge of the underlying Peer Review matter, in and of itself, shall not preclude the individual from serving on the Panel.

(3) Employment by, or other contractual arrangement with, Summit Healthcare or an affiliate shall not preclude an individual from serving on the Panel.

(4) The Panel shall not include any individual who is in direct economic competition with the individual requesting the hearing.

(5) The Panel shall not include any individual who is demonstrated to have an actual bias, prejudice, or conflict of interest that would prevent the individual from fairly and impartially considering the matter.

(6) In addition, the Appointment of the Hearing Panel shall comply with the guidelines set forth in the conflict of interest provisions found in Article 9 of this Policy.

(b) Presiding Officer:

(1) The CEO, after consulting with the Chief of Staff, shall appoint a Presiding Officer who shall be an attorney. The Presiding Officer may not be, or represent clients who are, in direct competition with the individual who requested the hearing and may not currently represent Summit Healthcare in any legal matters. The Presiding Officer shall not act as an advocate for either side at the hearing.

(2) The Presiding Officer shall:

(i) allow the participants in the hearing to have a reasonable opportunity to be heard and to present evidence, subject to reasonable limits on the number of witnesses and duration of direct and cross-examination;

(ii) prohibit conduct or presentation of evidence that is cumulative, excessive, irrelevant or abusive or that causes undue delay;

(iii) maintain decorum throughout the hearing;

(iv) determine the order of procedure;

(v) rule on all matters of procedure and the admissibility of evidence; and

(vi) conduct argument by counsel on procedural points within or outside the presence of the Hearing Panel at the Presiding Officer's discretion.

(3) The Presiding Officer may be advised by legal counsel to Summit Healthcare with regard to the hearing procedure.

(4) The Presiding Officer may participate in the private deliberations of the Hearing Panel and be a legal advisor to it, but shall not be entitled to vote on its recommendations.

(c) Hearing Officer:

(1) As an alternative to a Hearing Panel, for matters limited to issues involving professional conduct, the CEO, after consulting with the Chief of Staff, may appoint a Hearing Officer, preferably an attorney, to perform the functions of a Hearing Panel. The Hearing Officer may not be, or represent clients who are, in direct economic competition with the individual requesting the hearing.

(2) If a Hearing Officer is appointed instead of a Hearing Panel, all references in this Article to the "Hearing Panel" or "Presiding Officer" shall be deemed to refer to the Hearing Officer.

(d) Objections:

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

(e) Compensation:

The Hearing Panel, Presiding Officer, and/or Hearing Officer may be compensated by Summit Healthcare, but the individual requesting the hearing may volunteer to share in contributing to the compensation should he or she wish to do so.

7.B.5. Counsel:

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

7.C. PRE-HEARING PROCEDURES

7.C.1. General Procedures:

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

(b) Neither party has the right to issue subpoenas or interrogatories or to depose witnesses or other individuals prior to the hearing or to otherwise compel any individual to participate in the hearing or pre-hearing process.

(c) Neither the individual who has requested the hearing, nor any other person acting on behalf of the individual, may contact Summit Healthcare employees or Practitioners whose names appear on the MEC's witness list or in documents provided pursuant to this Article concerning the subject matter of the hearing, until Summit Healthcare has been notified and has contacted the individuals about their willingness to be interviewed. Summit Healthcare will advise the individual who has requested the hearing once it has contacted such employees or Practitioners and confirmed their willingness to meet. Any employee or Practitioner may agree or decline to be interviewed by or on behalf of the individual who requested a hearing. If an employee or Practitioner who is on the MEC's witness list agrees to be interviewed pursuant to this provision, counsel for the MEC may be present during the interview. Rules of confidentiality and the Code of Conduct shall apply.

7.C.2. Time Frames:

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

(a) the pre-hearing conference shall be scheduled at least 14 Days prior to the hearing;

(b) the parties shall exchange witness lists and proposed documentary exhibits at least 10 Days prior to the pre-hearing conference; and

(c) any objections to witnesses and/or proposed documentary exhibits must be provided at least five Days prior to the pre-hearing conference.

7.C.3. Witness List:

(a) At least 10 Days before the pre-hearing conference, the individual requesting the hearing shall provide a written list of the names of witnesses expected to offer testimony on his or her behalf.

(b) The witness list shall include a brief summary of the anticipated testimony.

(c) The witness list of either party may, in the discretion of the Presiding Officer, be amended at any time during the course of the hearing, provided that Notice of the change is given to the other party.

7.C.4. Provision of Relevant Information:

(a) Prior to receiving any confidential documents, the individual requesting the hearing must agree that all documents and information shall be maintained as confidential and shall not be disclosed or used for any purpose outside of the hearing. The individual must also provide a written representation that his or her counsel and any expert(s) have executed Business Associate agreements in connection with any patient Protected Health Information contained in any documents provided.

(b) Upon receipt of the above agreement and representation, the individual requesting the hearing shall be provided with a copy of the following:

(1) copies of, or reasonable access to, all patient medical records referred to in the statement of reasons, at the individual's expense;

(2) reports of experts relied upon by the MEC;

(3) copies of relevant minutes (with portions regarding other Physicians and unrelated matters deleted); and

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

The provision of this information is not intended to waive any privilege under the Arizona Peer Review protection statutes.

(c) The individual shall have no right to discovery beyond the above information. No information shall be provided regarding other Practitioners.

(d) At least 10 Days prior to the pre-hearing conference (or as otherwise agreed upon by both sides), each party shall provide the other party with its proposed exhibits. All objections to documents or witnesses shall be submitted in writing at least five Days in advance of the pre-hearing conference. The Presiding Officer shall not entertain subsequent objections unless the party offering the objection demonstrates good cause.

(e) Evidence unrelated to the reasons for the recommendation or to the individual's qualifications for Appointment or the relevant Clinical Privileges shall be excluded.

7.C.5. Pre-Hearing Conference:

The Presiding Officer shall require the individual and the MEC or their representatives (who may be counsel) to participate in a pre-hearing conference, which shall be held no later than 14 Days prior to the hearing. At the pre-hearing conference, the Presiding Officer shall resolve all procedural questions, including any objections to exhibits or witnesses. The Presiding Officer shall establish the time to be allotted to each witness's testimony and cross-examination. It is expected that the hearing shall last no more than 15 hours, with each side being afforded approximately seven and a half hours to present its case, in terms of both direct and cross-examination of witnesses. Both parties are required to prepare their case so that a hearing shall be concluded after a maximum of 15 hours. The Presiding Officer may, after considering any objections, grant limited extensions upon a demonstration of good cause and to the extent compelled by fundamental fairness.

7.C.6. Stipulations:

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

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

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

7.D. HEARING PROCEDURES

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

(a) At a hearing, both sides shall have the following rights, subject to reasonable limits determined by the Presiding Officer:

(1) to call and examine witnesses, to the extent they are available and willing to testify;

(2) to introduce exhibits;

(3) to cross-examine any witness on any matter relevant to the issues;

(4) to have representation by counsel who may call, examine, and cross-examine witnesses and present the case; and

(5) to submit proposed findings, conclusions and recommendations to the Hearing Panel as part of the Post-Hearing statement referenced in this Article, following the close of the hearing session(s).

(b) If the individual who requested the hearing does not testify, he or she may be called and questioned.

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

7.D.2. Record of Hearing:

No recording (audio or video) of the hearing shall be permitted or made. Rather, a stenographic reporter shall be present to make a record of the hearing. The cost of the reporter shall be borne by Summit Healthcare. Copies of the transcript shall be available at the individual's expense. Oral evidence shall be taken only on oath or affirmation administered by any person entitled to notarize documents in this state.

7.D.3. Failure to Appear:

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

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

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

7.D.5. Persons to Be Present:

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

7.D.6. Order of Presentation:

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

7.D.7. Admissibility of Evidence:

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

7.D.8. Post-Hearing Statement:

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

7.D.9. Postponements and Extensions:

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

7.E. HEARING CONCLUSION, DELIBERATIONS, AND RECOMMENDATIONS

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

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

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

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

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

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

7.F. APPEAL PROCEDURE

7.F.1. Time for Appeal:

(a) Within 10 Days after Notice of the Hearing Panel's recommendation, either party may request an appeal. The request shall be in writing, delivered to the CEO either in person or by certified mail, return receipt requested, and shall include a statement of the reasons for appeal and the specific facts or circumstances which justify further review.

(b) If an appeal is not requested within 10 Days, an appeal is deemed to be waived and the Hearing Panel's report and recommendation shall be forwarded to the Board for final action.

7.F.2. Grounds for Appeal:

The grounds for appeal shall be limited to the following:

(a) there was substantial failure by the Hearing Panel to comply with this Policy and/or the Medical Staff Bylaws during the hearing, so as to deny a fair hearing; and/or

(b) the recommendations of the Hearing Panel were made arbitrarily or capriciously and/or were not supported by credible evidence.

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

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

7.F.4. Nature of Appellate Review:

(a) The Board may serve as the Review Panel or the Chair of the Board may appoint a Review Panel composed of not less than three persons, either members of the Board or others, including but not limited to reputable persons outside Summit Healthcare, to consider the record upon which the recommendation before it was made and recommend final action to the Board.

(b) Each party shall have the right to present a written statement in support of its position on appeal. The party requesting the appeal shall submit a statement first and the other party shall then have ten Days to respond. In its sole discretion, the Review Panel may allow each party or its representative to appear personally and make oral argument not to exceed 30 minutes.

(c) When requested by either party, the Review Panel may, in its discretion, accept additional oral or written evidence subject to the same rights of cross-examination provided at the Hearing Panel proceedings. Such additional evidence shall be accepted only if the Review Panel determines that the party seeking to admit it has demonstrated that it is relevant, new evidence that could not have been presented at the hearing, or that any opportunity to admit it at the hearing was improperly denied.

7.G. BOARD ACTION

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

(a) Within 30 Days after the Board (i) considers the appeal as a Review Panel, (ii) receives a recommendation from a separate Review Panel, or (iii) receives the Hearing Panel's report and recommendation when no appeal has been requested, the Board shall consider the matter and take final action.

(b) The Board may review any information that it deems relevant, including, but not limited to, the findings and recommendations of the MEC, Hearing Panel, and Review Panel (if applicable). The Board may adopt, modify, or reverse any recommendation that it

receives or, in its discretion, refer the matter to any individual or committee for further review and recommendation, or make its own decision based upon the Board's ultimate legal authority for the operation of Summit Healthcare and the quality of care provided.

(c) The Board shall render its final decision in writing, including specific reasons, and shall send Special Notice to the individual. A copy shall also be provided to the MEC for its information.

7.G.2. Further Review:

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

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

No Practitioner shall be entitled to more than one hearing and one appellate review on any matter. If the Board denies initial Appointment or Reappointment or revokes the Appointment and/or Clinical Privileges of a current Practitioner, that individual may not apply for staff Appointment or for those Clinical Privileges for a period of five years unless the Board provides otherwise.

ARTICLE 8 - ADJUNCT PROFESSIONAL STAFF

8.A. PREROGATIVES AND RESPONSIBILITIES

(1) The prerogatives and responsibilities of Adjunct Professional Staff Members – which includes Advanced Practice Providers and Allied Health Professionals – are outlined in the Medical Staff Bylaws under the Adjunct Professional Staff category.

(2) Advanced Practice Providers render direct or indirect medical care under the sponsorship and/or direction of a Sponsoring Physician, while Allied Health Professionals function at Summit Healthcare under the Supervision of a Supervising Physician appointed to the Medical Staff who is responsible for the activities of the Allied Health Professional at Summit Healthcare. In addition, all Adjunct Professional Staff Members must follow the Standards of Practice outlined in Section 8.D of this Policy.

8.B. DETERMINATION OF NEED

(1) Whenever an individual in a category of the Adjunct Professional Staff that has not been approved by the Board requests Clinical Privileges at Summit Healthcare, the Board shall refer the matter to the Credentials Committee or appoint an ad hoc committee to evaluate the need for that particular category of provider and to make a recommendation to the MEC for its review and recommendation and then to the Board for final action.

(2) As part of the process of determining need, the individual shall be invited to submit information about the nature of the proposed practice, why hospital access is sought, and the potential benefits to the community by having such services available at Summit Healthcare.

(3) The Credentials Committee or ad hoc committee may consider the following factors when making a recommendation to the MEC and the Board as to the need for the services of this category of provider:

(a) the nature of the services that would be offered;

(b) any state license/authorization or regulation which outlines the Scope of Practice that the individual is authorized by law to perform;

(c) any state "non-discrimination" or "any willing provider" laws that would apply to the individual;

(d) the business and patient care objectives of Summit Healthcare, including patient convenience;

(e) the community's needs and whether those needs are currently being met or could be better met if the services offered by the individual were provided at Summit Healthcare;

(f) the type of training that is necessary to perform the services that would be offered and whether there are individuals with more training currently providing those services;

(g) the availability of supplies, equipment, and other necessary Summit Healthcare resources;

(h) the need for, and availability of, trained staff to support the services that would be offered; and

(i) the ability to appropriately supervise performance and monitor quality of care.

8.C. DEVELOPMENT OF PRIVILEGE DELINEATIONS

(1) If the Credentials Committee or ad hoc committee determines that there is a need for the particular new category of the Adjunct Professional Staff at Summit Healthcare, the committee shall recommend to the MEC and the Board Clinical Privilege delineation for the pertinent type of provider that addresses:

(a) any specific qualifications and/or training that they must possess beyond those set forth in this Policy;

(b) a detailed description of their authorized Scope of Practice or Clinical Privileges;

(c) any specific conditions that apply to their functioning at Summit Healthcare beyond those set forth in this Policy; and

(d) any Supervision requirements, if applicable.

(2) In developing such delineations, the Credentials Committee or ad hoc committee shall consult the appropriate Department Chair and consider relevant state law and may contact applicable professional societies or associations. The committee may also recommend to the Board the number of providers that are needed in a particular category.

8.D. STANDARDS OF PRACTICE APPLICABLE TO ADJUNCT PROFESSIONAL STAFF

(1) Standards of Practice for the Utilization of Adjunct Professional Staff at Summit Healthcare

(a) As a condition of being granted Appointment, all Adjunct Professional Staff Members specifically agree to abide by the standards of practice set forth in this Section. In addition, as a condition of utilizing the services of a member of the Adjunct Professional Staff at Summit Healthcare, all Medical Staff Members who serve as Sponsoring and Supervising Physicians to such individuals also specifically agree to abide by the standards set forth in this Section.

(b) The following standards of practice apply to the functioning of Allied Health Professionals at Summit Healthcare:

(i) EXERCISE OF CLINICAL PRIVILEGES. Members of the Adjunct Professional Staff may exercise those Clinical Privileges as have been granted pursuant to their approved delineation of Clinical Privileges. For Allied Health Professionals, these delineations will specify the requisite levels of Supervision that apply to their Clinical Privileges (personal, direct, or general), of which only "personal" Supervision requires the actual physical presence of the Supervising Physician.

(ii) ADMITTING PRIVILEGES. Adjunct Professional Staff are not granted inpatient Admitting Privileges and therefore may not admit patients independent of a Sponsoring/Supervising Physician. However, Adjunct Professional Staff may write inpatient admission orders on behalf of a Sponsoring/Supervising Physician who has inpatient Admitting Privileges and may examine the patient, gather data, order tests, develop an assessment and plan, and generate other documentation. Any order must be co-signed by the Sponsoring/Supervising Physician.

(iii) INPATIENT CONSULTATIONS. Adjunct Professional Staff may perform inpatient consultations in collaboration with their Sponsoring/Supervising Physicians. Adjunct Professional Staff may examine patients, gather data, order tests, and develop an assessment and plan. However, the Sponsoring/Supervising Physician must still see the patient (personally or via telemedicine) and render an opinion if deemed necessary after having a discussion with the requesting Practitioner.

(iv) EMERGENCY ON-CALL COVERAGE. Adjunct Professional Staff may not independently participate in the emergency on-call roster (formally, or

informally by agreement with their Sponsoring/Supervising Physicians) in lieu of the Sponsoring/Supervising Physician. It shall be within the discretion of the Emergency Department (e.g., the requesting Practitioner) whether it is appropriate to contact an Adjunct Professional Staff member prior to the Sponsoring/Supervising Physician. However, when contacted by the Emergency Department, the Sponsoring/Supervising Physician (or his or her covering Physician) must personally respond to all calls in a timely manner. Following discussion with the Emergency Department, the Sponsoring/Supervising Physician may direct an Adjunct Professional Staff member to see the patient, gather data, order tests, and develop an assessment and plan for further review by the Sponsoring/Supervising Physician. However, the Sponsoring/Supervising Physician must still personally see the patient when requested by the Emergency Department Physician.

(v) CALLS REGARDING SPONSORING/SUPERVISING PHYSICIAN'S HOSPITALIZED INPATIENTS. It shall be within the discretion of Summit Healthcare personnel requesting assistance whether it is appropriate to contact an Adjunct Professional Staff member or a Sponsoring/Supervising Physician. Adjunct Professional Staff members may not independently respond to calls from the floor or special care units regarding hospitalized inpatients that were specifically directed to the Sponsoring/Supervising Physician. A Sponsoring/Supervising Physician will personally respond to all calls that have been specifically directed to him or her in a timely manner if deemed necessary after having a discussion with the requesting provider.

(vi) INPATIENT ROUNDS FOR ATTENDING PHYSICIANS. Adjunct Professional Staff members are permitted to perform daily inpatient rounds; however, all inpatients must also be visited by the Sponsoring/Supervising Physician (or a designated Physician) whenever medically appropriate.

The above **do not** apply in the outpatient setting and additional exceptions to the above Standards of Practice may be granted by the MEC to a Practitioner in a particular clinical situation, upon demonstration of good cause shown.

(2) Oversight by Supervising Physician

(a) Any activities permitted to be performed at Summit Healthcare by an Allied Health Professional shall be performed only in conjunction with a Supervising Physician.

(b) Allied Health Professionals may function at Summit Healthcare only so long as (i) they are supervised by a Supervising Physician who is currently appointed to the Medical Staff, and (ii) they have a current, written Supervision agreement with the Supervising Physician. In addition, should the Appointment or Clinical Privileges of the Supervising Physician be revoked or terminated, the Allied Health Professional's Appointment and Clinical Privileges shall be Automatically Relinquished (unless the individual will be supervised by another approved Physician on the Medical Staff within 30 Days).

(c) As a condition of Clinical Privileges, an Allied Health Professional and the Supervising Physician must provide Summit Healthcare with a copy of any written Supervision agreement that may be required by the state, as well as Notice of any revisions or modifications that are made to any such agreements between them. This Notice must be provided to Medical Staff Services within three Days of any such change.

(3) Addressing Concerns Related to Adjunct Professional Staff

(a) Any question regarding the clinical practice, health, or professional conduct of an Adjunct Professional Staff member shall be reviewed in the same manner as concerns about a Medical Staff Member, as outlined in Article 6 of this Policy.

(b) Unless a conflict exists, a Physician who is the primary Sponsoring/Supervising Physician for the Adjunct Professional Staff member shall be kept apprised of the review process when such concerns exist. In such situations, the Sponsoring/Supervising Physician will be copied on all correspondence that the Adjunct Professional Staff member receives from the Medical Staff Leaders and may be invited to participate in any meetings or interventions. The Sponsoring/Supervising Physician shall maintain all such information in a confidential manner.

(c) Because the Sponsoring/Supervising Physician is responsible for the care provided by an Adjunct Professional Staff member at Summit Healthcare, the conduct of the Sponsoring/Supervising Physician may also be referred for review under Article 6 of this Policy if he or she is found to have failed to follow the standards of practice set forth in Section 8.D above or has otherwise failed to meet the standards set forth in Medical Staff policy.

8.E. PROCEDURAL RIGHTS FOR THE ADJUNCT PROFESSIONAL STAFF

8.E.1. General:

Adjunct Professional Staff members shall not be entitled to the hearing and appeals procedures set forth in Article 7 of this Policy. Rather, any and all procedural rights to which these Practitioners are entitled are set forth in this Article.

8.E.2. Grounds for Hearing and Notice of Rights:

(a) Adjunct Professional Staff members are entitled to request a hearing whenever the MEC makes one of the following recommendations:

(1) denial of requested Clinical Privileges;

(2) revocation of Clinical Privileges;

(3) suspension of Clinical Privileges for more than 30 Days (except for precautionary suspension); or

(4) Restriction of Clinical Privileges for more than 30 Days.

(b) If the Board makes any of the above determinations without an adverse recommendation by the MEC, an Adjunct Professional Staff member would also be entitled to request a hearing under this Article. In this instance, all references in this Article to the MEC will be interpreted as a reference to the Board.

(c) The individual will receive Special Notice of the recommendation. The Special Notice will include a general statement of the reasons for the recommendation and will advise the individual that he or she may request a hearing.

(d) If the individual wants to request a hearing, the request must be in writing, directed to the CEO or CMO, within 30 Days after receipt of the Special Notice.

(e) The hearing will be convened as soon as is practical, but no sooner than 30 Days after the request for the hearing, unless an earlier hearing date has been specifically agreed to by the parties.

(f) The individual shall have the right to receive copies of the documentation relied upon by the MEC; however, prior to receiving any confidential documents, the individual requesting the hearing must sign a confidentiality agreement under which the individual agrees that all documents and information shall be maintained as confidential and within the protected peer review process and shall not be disclosed or used for any purpose outside of the hearing. The individual must also provide a written representation that his

or her counsel has executed Business Associate agreements in connection with any patient information contained in any documents provided.

8.E.3. Hearing Committee:

(a) If a request for a hearing is made in a timely manner, the CEO, in conjunction with the Chief of Staff, shall appoint a Hearing Committee composed of up to three individuals (including, but not limited to, individuals appointed to the Medical Staff, Adjunct Professional Staff, Summit Healthcare management, individuals not connected to Summit Healthcare, or any combination of these individuals) and a Presiding Officer, who may be legal counsel to Summit Healthcare. The Hearing Committee shall not include anyone who previously participated in the recommendation, any relatives or practice partners, or any competitors of the affected individual.

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

8.E.4. Hearing Process:

(a) A record of the hearing will be maintained by a stenographic reporter or by a recording of the proceedings. Copies of the transcript will be available at the individual's expense.

(b) The hearing will last no more than six hours, with each side being afforded approximately three hours to present its case, in terms of both direct and cross-examination of witnesses.

(c) At the hearing, a representative of the MEC will first present the reasons for the recommendation. The Adjunct Professional Staff member will be invited to present information to refute the reasons for the recommendation.

(d) Both parties will have the right to present witnesses. The Presiding Officer will permit reasonable questioning of such witnesses.

(e) The Adjunct Professional Staff member and the MEC may be accompanied at the hearing by legal counsel. However, while counsel may be present at the hearing, counsel will not call, examine, or cross-examine witnesses or present the case.

(f) The Adjunct Professional Staff member will have the burden of demonstrating, by clear and convincing evidence, that the recommendation of the MEC was arbitrary, capricious, or not supported by substantial evidence. The quality of care provided to patients and the smooth operation of Summit Healthcare will be the paramount considerations.

(g) The Adjunct Professional Staff member and the MEC will have the right to prepare a post-hearing memorandum for consideration by the Hearing Committee. The Presiding Officer will establish a reasonable schedule for the submission of such memoranda.

8.E.5. Hearing Committee Report:

(a) Within 20 Days after the conclusion of the proceeding or submission of the post-hearing memoranda, whichever date is later, the Hearing Committee will prepare a written report and recommendation. The Hearing Committee will forward the report and recommendation, along with all supporting information, to the CEO. The CEO will send a copy of the written report and recommendation by Special Notice to the Adjunct Professional Staff member and to the MEC.

(b) Within ten days after notice of such recommendation, the Adjunct Professional Staff member and/or the MEC may make a written request for an appeal. The request must include a statement of the reasons, including specific facts, which justify an appeal.

(c) The grounds for appeal will be limited to an assertion that there was substantial failure to comply with this Policy during the hearing, so as to deny a fair hearing, and/or that the recommendation of the Hearing Committee was arbitrary, capricious, or not supported by substantial evidence.

(d) The request for an appeal will be delivered to the CEO in writing within 30 Days of the receipt of the findings of the Hearing Committee.

(e) If a written request for appeal is not submitted timely, the appeal is deemed to be waived and the recommendation and supporting information will be forwarded to the Board for final action. If a timely request for appeal is submitted, the CEO will forward the report and recommendation, the supporting information and the request for appeal to the Board. The Chair of the Board will arrange for an appeal.

8.E.6. Appellate Review:

(a) An Appellate Review Committee appointed by the Chair of the Board will consider the record upon which the adverse recommendation was made. The Board may serve as the Appellate Review Committee or the Chair of the Board may appoint an Appellate Review Committee composed of not less than three persons, either members of the Board or others, including but not limited to reputable persons outside Summit Healthcare.

(b) New or additional written information that is relevant and could not have been made available to the Hearing Committee may be considered at the discretion of the Appellate Review Committee. This review will be conducted within 30 Days after receiving the request for appeal.

(c) The Adjunct Professional Staff member and the MEC will each have the right to present a written statement on appeal.

(d) At the sole discretion of the Appellate Review Committee, the Adjunct Professional Staff member and a representative of the MEC may also appear personally to discuss their position.

(e) Upon completion of the review, the Appellate Review Committee will provide a report and recommendation to the full Board for action. The Board will then make its final decision based upon the Board's ultimate legal responsibility to grant privileges and to authorize the performance of clinical activities at Summit Healthcare.

(f) The Adjunct Professional Staff member will receive Special Notice of the Board's action. A copy of the Board's final action will also be sent to the MEC for information.

ARTICLE 9 - CONFLICT OF INTEREST GUIDELINES FOR CREDENTIALING, PRIVILEGING, AND PEER REVIEW ACTIVITIES

9.A.1. General Principles:

(a) All those involved in credentialing, privileging, and Peer Review activities (referred to collectively as "Medical Staff Functions" in this Article) must be sensitive to potential conflicts of interest ("COI") in order to be fair to the individual whose qualifications are under review, to protect the individual with the potential conflict, and to protect the integrity of the review processes.

(b) It is also essential that peers participate in Medical Staff Functions in order for these activities to be meaningful and effective. Therefore, whether and how an individual can participate must be evaluated reasonably, taking into consideration common sense and objective principles of fairness.

(c) A potential conflict of interest depends on the situation and not on the character of the individual. To promote this understanding, any individual with a potential conflict of interest shall be referred to as an "Interested Member."

(d) No Practitioner has a right to compel the disqualification of another individual based on an allegation of conflict of interest. Rather, that determination is within the discretion of the Medical Staff Leaders or Board chair, guided by this Article.

(e) The fact that any individual chooses to refrain from participation, or is excused from participation, in any Medical Staff Function shall not be interpreted as a finding of an actual conflict that inappropriately influenced the review process.

(f) **Appendix C** to this Policy is a chart that outlines the conflict of interest guidelines that are applicable to Medical Staff Functions at Summit Healthcare. The remainder of this Article is intended to supplement **Appendix C** and expand upon the guidelines that are summarized in the chart.

9.A.2. Process for Identifying Conflicts of Interest:

(a) Self-Disclosure. Any individual involved in Medical Staff Functions must disclose all personal conflicts of interest relevant to those activities to the committee chair or CMO.

(b) Identification by Others. Any individual who is concerned about a potential conflict of interest on the part of any other individual who is involved in Medical Staff Functions should inform the committee chair or CMO.

(c) Identification by Individual under Review. An individual who is the subject of review during any Medical Staff Functions is obligated to notify the committee chair or CMO of any known or suspected conflicts of interest by others who are involved in such activities.

Any potential conflict of interest that is not raised timely by the individual under review shall be deemed waived.

9.A.3. Implementation of Conflict of Interest Guidelines in Appendix C:

This section describes how to implement the Conflict of Interest Guidelines found in **Appendix C** of this Policy:

- Paragraph (a) identifies the three COI situations that require special treatment and rules during the performance of Medical Staff Functions, irrespective of the Interested Member's level of participation in the process (e.g., individual reviewer, PRC member, MEC member);
- Paragraph (b) describes the other common situations that raise COI issues during the performance of Medical Staff Functions; and
- Paragraph (c) describes how to apply the guidelines in **Appendix C** to the common COI situations outlined in (b) at each level of the review processes.

(a) Three COI Situations That Require Special Treatment and Rules, Irrespective of an Interested Member's Level of Participation:

(1) EMPLOYMENT OR CONTRACTUAL ARRANGEMENT WITH SUMMIT HEALTHCARE. Because Medical Staff Functions are performed on behalf of Summit Healthcare, the interests of those who are employed by, or under contract with, Summit Healthcare are aligned with Summit Healthcare's interest in seeing that those activities are performed effectively, efficiently, and lawfully. As such, employment by, or other contractual arrangement with, Summit Healthcare or any of its affiliated entities does not, in and of itself, preclude an Interested Member from participating in Medical Staff Functions.

(2) SELF OR FAMILY MEMBER. While Interested Members may provide information to other individuals involved in the review process, an Interested Member should not otherwise participate in the review of his or her own application or the review of the care he or she provided or in any such activities involving an immediate family member (spouse or domestic partner, parent, child, sibling, or in-law).

(3) RELEVANT TREATMENT RELATIONSHIP. As a general rule, an Interested Member who has provided professional health services to a Practitioner whose application or provision of care is under review should not participate in the review process regarding the Practitioner. However, if the patient-Physician relationship has terminated and the review process does not involve the health condition for which the Practitioner sought professional health services, the Interested Member may participate fully in all Medical Staff Functions.

Furthermore, even if a current patient-Physician relationship exists, the Interested Member may provide information to others involved in the review process if:

(i) the information was not obtained through the treatment relationship, or

(ii) the information was obtained through the treatment relationship, but the disclosure was authorized by the Practitioner under review through the execution of a HIPAA-compliant authorization form.

(b) Other Common Situations That Raise COI Issues During the Performance of Medical Staff Functions:

Participation by any Interested Member who is in one of the following situations – as it relates to the Practitioner under review – will be evaluated under the guidelines outlined in Paragraph (c) and **Appendix C**:

(1) SIGNIFICANT FINANCIAL RELATIONSHIP (e.g., when the Interested Member and other Practitioners: are members of a small, single specialty group; maintain a significant referral relationship; are partners in a business venture; or, are individuals practicing in a specialty for which a policy matter – such as clinical privileging criteria – is being considered);

(2) DIRECT COMPETITOR (e.g., Practitioners in the same specialty, but in different groups);

(3) CLOSE FRIENDSHIPS;

(4) HISTORY OF PERSONAL CONFLICT (e.g., former partner, ex-spouse, or where there has been demonstrated animosity);

(5) PERSONAL INVOLVEMENT IN THE CARE THAT IS SUBJECT TO REVIEW (e.g., where the Interested Member provided care in the case under review, but is not the subject of the review);

(6) ACTIVE INVOLVEMENT IN CERTAIN PRIOR INTERVENTIONS WITH THE INDIVIDUAL UNDER REVIEW (e.g., where the Interested Member was involved in the development of a prior Performance Improvement Plan or in a review involving the individual under review. This situation does not include participation in initial education or Collegial Intervention efforts (e.g., sending an Educational Letter; meeting collegially with a colleague and sending a follow-up letter)); and/or

(7) FORMALLY RAISED THE CONCERN ABOUT ANOTHER INDIVIDUAL (e.g., where the Interested Member's concern triggered the review of another Practitioner, as evidenced by the Interested Member's written report regarding the concern (i.e.,

sent a written concern to a Medical Staff Officer or CMO, or filed a report through Summit Healthcare's electronic reporting system)).

(c) Application of the Guidelines in Appendix C to the Performance of Medical Staff Functions:

(1) INITIAL REVIEWERS IN CREDENTIALING AND PEER REVIEW ACTIVITIES

An Interested Member may participate as an initial reviewer (e.g., a Department Chair) so long as a check and balance is provided by subsequent review by a Medical Staff committee. This includes, but is not limited to, the following:

(i) participation in the review of applications for initial and renewed Appointment and Clinical Privileges (which is subsequently reviewed by the Credentials Committee and/or MEC); and
(ii) participation as a case reviewer in Peer Review activities (which is subsequently reviewed by the Leadership Council, PRC, Investigating Committee, and/or MEC).

(2) CREDENTIALS COMMITTEE, LEADERSHIP COUNCIL, AND PRC MEMBERS

As a general rule, an Interested Member may fully participate as a member of the Credentials Committee, Leadership Council, and PRC because these committees do not possess any disciplinary authority and do not make any final recommendation that could adversely affect the Appointment or Clinical Privileges of a Practitioner, which is only within the authority of the MEC and Board.

However, the chairs of these committees always have the discretion to recuse an Interested Member if they determine that the Interested Member's presence or participation would inhibit full and fair discussion of the issue, would skew the recommendation or determination of the committee, or would otherwise be unfair to the Practitioner under review.

(3) MEC

As a general rule, an Interested Member may fully participate as a member of the MEC when it is approving routine and favorable recommendations regarding the granting of initial Appointment, Reappointments, and Clinical Privileges.

However, an Interested Member should be recused from the MEC when that committee is considering a matter that could result in an adverse professional review action affecting the Appointment or Clinical Privileges of a Practitioner. The

Interested Member's participation in MEC meetings will be governed by the guidelines regarding recusal that are set forth in **Appendix C**.

(4) INVESTIGATING COMMITTEES

Once an Investigation has been initiated by the MEC, additional steps to manage conflicts of interest should be taken as a precaution. Therefore, an Interested Member should not be appointed as a member of an investigating committee and should not participate in the committee's deliberations or decision-making, but may be interviewed and provide information if necessary for the committee to conduct a full and thorough Investigation.

(5) HEARING PANEL

An Interested Member should not be appointed as a member of a Hearing Panel and should not participate in the Panel's deliberations or decision-making.

(6) BOARD

As a general rule, an Interested Member may fully participate as a member of the Board when it is approving routine and favorable recommendations regarding the granting of initial Appointment, Reappointments, and Clinical Privileges.

However, an Interested Member should be recused from the Board when the Board is considering action that will adversely affect Appointment or Clinical Privileges of a Practitioner. The Interested Member's participation in Board meetings will be governed by the guidelines regarding recusal that are set forth in **Appendix C**.

ARTICLE 10 - DISASTER PLAN RULES

10.A. DISASTER PLAN

A plan for handling mass casualties and illnesses shall be developed by a multi-disciplinary committee with Medical Staff and Summit Healthcare representation, and approved by the MEC.

10.B. MEDICAL STAFF DISASTER DRILL ASSIGNMENTS

Staff Physicians will be asked to participate periodically in disaster drills and will be assigned to posts, either in Summit Healthcare, or in designated casualty stations. It is the Physicians' duty to report to their assigned stations.

10.C. MEDICAL AUTHORITY

(1) All policies regarding patient care will be a joint responsibility of the Medical Disaster Officer, the Chief of Staff, and the CEO or designated administrative representative on the scene.

(2) In the event of a disaster, the following responsibilities will be assigned:

(i) Medical Disaster Officer. Will be the Physician on duty in the Emergency Department at the time the Code D is activated. This Physician is responsible for the assignment of all available Physicians to treatment areas. The Medical Disaster Officer position may be assigned to any appropriate Physician as deemed necessary by the ED Physician, to enable the ED Physician to care for patients already in the department.

(ii) Triage Officer. The back-up Emergency Physician and/or Triage RN on duty will be the Triage Officer. The Triage Officer evaluates incoming patients, decides on their disposition, and communicates the need for additional Triage staff to the Medical Disaster Officer.

(iii) The Chief of Staff may be asked to evaluate in-house patients and coordinate with the patient's Physician for possible discharge so as to allow for more efficient use of staff and facilities.

(3) All Staff Physicians specifically agree to relinquish direction of the professional care of their patients to the Medical Disaster Officer or designee.

(4) Triage Physician responsibilities shall be to:

(i) Organize the triage area.

(ii) Briefly evaluate all incoming victims and assign them priority designations.

(ii) Authorize discharge or transfer of inpatients if such is deemed necessary to accommodate disaster casualties.

ARTICLE 11 - DISRUPTIVE AND INAPPROPRIATE BEHAVIORS

Summit Healthcare is committed to providing a work environment that is free of all forms of discrimination, harassment and retaliation. Actions, words, jokes or comments based on an individual's gender, pregnancy, race, color, age, religion, national origin, physical or mental disability or any other legally protected characteristic will not be tolerated. Summit Healthcare does not, and will not, tolerate harassment, including sexual harassment, of or by its employees, patients, members of the Medical Staff, members of the Adjunct Professional Staff, or other individuals in the work environment. Summit Healthcare also prohibits retaliation because an employee has engaged in a protected activity. In addition, harassment can be a violation of local, state, and federal law.

It is also the policy of Summit Healthcare that all individuals within its facilities shall be treated courteously, respectfully, and with dignity. To that end, Summit Healthcare requires all individuals, employees, Physicians, and other practitioners to conduct themselves in a professional and cooperative manner in Summit Healthcare facilities or at Summit Healthcare events.

If a Practitioner at a Summit Healthcare facility fails to conduct himself or herself appropriately, the matter shall be addressed in accordance with this Policy. If the Practitioner is also a Summit Healthcare employee, other Summit Healthcare policies, including Human Resources policies, will also apply.

It is Summit Healthcare's intention that investigations undertaken, proceedings held, actions taken, and data created or produced pursuant to this Policy are:

(a) confidential, privileged and subject to all applicable peer review and quality improvement program protections under state and federal laws;

(b) not subject to subpoena, discoverable or admissible in evidence in any judicial, administrative, arbitration or mediation proceeding; and

(c) undertaken by a peer review body, the Leadership Council or quality improvement program committee, as appropriate, at the direction of the MEC.

11.A. DEFINITION OF SEXUAL HARASSMENT

(1) Sexual harassment includes unwelcome sexual advances, requests for sexual favors or other sexual conduct which:

(a) Is explicitly or implicitly a term or condition of employment, promotion or job benefits;

(b) Serves as the basis for an employment decision; or

(c) Any other verbal or physical conduct of a sexual nature that has the effect of unreasonably interfering with an employee's work performance or which creates an intimidating, hostile or offensive work environment.

(2) Some of the specific prohibited conduct includes, but is not limited to:

(a) Unwelcome sexual advances, including verbal overtures, as well as uninvited physical contact;

(b) Threats against, or promises to, an individual to induce him or her to perform sexual favors;

(c) Intimidation by way of suggesting a desire for unwelcome sexual relations or physical contact;

(d) Continued invitations to social events outside the workplace after it is made clear that such suggestions are unwelcome;

(e) Use of offensive terms of a sexual nature, or degrading language related to an individual's sex, race, religion, age or other legally protected class;

(f) Jokes or remarks of a sexual, religious or racial nature; and

(g) Sexually offensive materials or pictures in the workplace.

11.B. DEFINITION OF DISRUPTIVE CONDUCT

Disruptive Conduct is behavior or conduct on the part of any Practitioner that impedes patient care, is considered lower than the standards of Summit Healthcare or disruptive to the orderly operation of Summit Healthcare or its Medical Staff, including the inability of the Practitioner to work harmoniously with others. Examples of Disruptive Conduct include, but are not limited to:

(1) Threatening or abusive language directed at Summit Healthcare personnel, patients, visitors, Physicians, or other Practitioners; degrading or demeaning comments regarding Summit Healthcare personnel, patients, visitors, Physicians or other Practitioners;

(2) Profanity or similarly offensive language while in a Summit Healthcare facility;

(3) Inappropriate physical contact or gestures with another individual that is offensive, threatening, demeaning or intimidating;

(4) Interfering with patient safety or refusal to abide by Medical Staff requirements as delineated in the Medical Staff Bylaws, policies or rules and regulations;

(5) Attacks leveled at other Practitioners which are personal, irrelevant, or go beyond the bounds of fair professional comment;

(6) Abusive behavior to patients, yelling at them or refusing to listen to their legitimate questions and requests;

(7) Imposing idiosyncratic requirements on nursing staff which have nothing to do with better patient care but serve only to burden the nurses with "special" techniques and procedures;

(8) Non-constructive criticism, addressed to its recipient in such a way as to intimidate, undermine confidence, belittle, or to impute stupidity, or incompetence; and

(9) Impertinent and inappropriate comments written (or "cute" illustrations drawn) in patient medical records or other official documents impugning the quality of care in Summit Healthcare or attacking particular Physicians, nurses, or Summit Healthcare policy.

11.C. EXPECTATION OF COOPERATION

Practitioners shall cooperate with requests for information made in connection with enforcement of this Policy. Failure to cooperate, including a failure to agree in writing to abide by the standards of conduct expected of all Practitioners as defined by this Policy, shall be construed as a voluntary resignation of Appointment and Clinical Privileges.

11.D. PROCEDURE FOR REVIEW AND EVALUATION OF COMPLAINTS OF HARASSMENT OR DISRUPTIVE CONDUCT BY PRACTITIONERS (SEE APPENDIX F FOR A FLOW CHART DESCRIBING THIS PROCESS)

(1) COMPLAINTS: Reports of Harassment or Disruptive Conduct from a person who observes or who believes he/she has been the victim of Harassment or Disruptive Conduct shall be made in writing and/or through Summit Healthcare's reporting system which is forwarded to Quality Management for validation. The complaints shall include a factual description of the incident, including quotations of any offending language used and/or a description of any offensive behavior in objective terms.

(2) EMPLOYEE-RELATED COMPLAINTS: Employee-related complaints are those that are related to actions of employed Practitioners, or where the alleged conduct has an impact on a Summit Healthcare employee or Summit Healthcare work environment.

All employee reports of Harassment or Disruptive Conduct shall be submitted to Quality Management for validation and forwarded to the Leadership Council for resolution in a confidential manner. While no promise of confidentiality shall be made to the complainant, every effort shall be made to maintain confidentiality except as legally or otherwise necessary. If the complaint is made or received through the Human Resources Department, it will be promptly forwarded to Quality Management for validation. Any employee initiating a complaint will not be subject to any form of intimidation, harassment or reprisal as a result of making a complaint. The person making the complaint will be informed in writing that the complaint will be promptly reviewed by Summit Healthcare and Medical Staff leadership. The complainant will also be informed that he/she should report any further events to Quality Resource as well as any intimidation, harassment or retaliation that might be a result of making the complaint.

(3) COMPLAINTS FROM OTHERS: All reports of Harassment or Disruptive Conduct involving a Practitioner, other than those that are "employee-related," shall be submitted either through Summit Healthcare reporting system or to Quality Management for validation. The Human Resources Director may be asked to participate as a consultant for employed providers only. The person making the complaint will be informed in writing that the complaint will be promptly reviewed by Summit Healthcare and Medical Staff leadership. The complainant will also be informed that he/she should report any further events to Quality Resource as well as any intimidation, harassment or retaliation that might be a result of making the complaint.

11.E. REVIEW AND EVALUATION OF COMPLAINT

(1) INITIAL PROCESS: Upon receipt of the occurrence report or complaint in the web-based program (i.e., RL System or written report), Quality Management (QM) shall investigate and validate the occurrence report or complaint. If validated, the information is forwarded to the Leadership Council for further handling. If the occurrence is not validated, the information is forwarded to the Leadership Council and the Practitioner's name is removed from the tracking mechanism of the occurrence and the occurrence is not included in trending for that provider. The Leadership Council will coordinate a plan and process to review pertinent information, notify and interview the alleged Practitioner and interview other appropriately identified witnesses, as appropriate. A Practitioner has no right to have legal counsel present during the interview process. In the event a

Practitioner member brings legal counsel to the interview, the Leadership Council will immediately terminate the interview. This provision has no effect on the due process rights set forth in this Policy. The CMO should be included in the planning process if the alleged Practitioner is an employed Practitioner.

In evaluating the complaint, the Leadership Council may ask the alleged Practitioner to provide information regarding the complaint. He/she shall also be informed that retaliation, even subtle retaliation, will not be tolerated. In the event the alleged Practitioner retaliates against the complainant, the alleged Practitioner may be barred from Summit Healthcare facilities by the Chief of Staff, after consultation with the Leadership Council pending further investigation. In addition, in the event the complaint is sufficiently egregious, the alleged Practitioner may be barred from all Summit Healthcare facilities by the Chief of Staff after consultation with the Leadership Council pending resolution of the matter.

After completion of the interviews and other applicable inquiry, the Leadership Council and, if employee-related and recommended or requested the Human Resources Director or designee, shall determine whether the report is credible. The CMO should be included in the evaluation process if the alleged Practitioner is an employed Practitioner. If the report is determined not to be credible and if the alleged Practitioner had been informed of the complaint, he/she shall be informed that the complaint was not substantiated. The Leadership Council shall coordinate appropriate feedback to the employee or person who made the complaint.

(2) PLAN TO RESOLVE COMPLAINT: The Leadership Council, the Human Resources Director (in employee-related cases and recommended or requested), and the Department Chair shall confer and develop a plan for resolution of the complaint. In developing the plan, the decision makers shall consider whether the alleged conduct may be a product of an impairment or another health problem (and therefore subject to resolution under the Wellness Article of this Policy), whether the alleged conduct may constitute Harassment or Disruptive Conduct, the severity of the conduct, the impact on patient care, the nature and type of previous conduct allegations, previous actions taken by Summit Healthcare against the alleged Practitioner, and other pertinent information. The Leadership Council shall determine whether informal action under this Policy or formal action is warranted. Any single egregious occurrence may result in the occurrence being forwarded to the MEC or formal action.

11.F. RESOLUTION OF COMPLAINT AND DISCIPLINARY ACTION

(1) INFORMAL ACTION:

(i) FIRST EVENT ("COFFEE CUP"): If a single occurrence warrants informal action under this Policy, a member of the Leadership Council shall meet with the Practitioner to discuss the complaint. This Policy and any other applicable policies shall be discussed with the Practitioner. The conversation shall be documented, a copy of which shall be filed in the Practitioner's Confidential File. In cases where the conduct is sufficiently egregious to warrant greater intervention, the Practitioner shall be told that a single further incident of Harassment or Disruptive Conduct will result in initiation of formal review pursuant to this Policy. A letter to the Practitioner describing these expectations may be sent to the practitioner and shall be filed in the Practitioner's Confidential File. If employee-related and the Human Resources Director or designee has not been involved in the planning process, the Leadership Council will inform the Human Resources Director that the issue has been addressed.

(ii) SECOND EVENT ("COLLEGIAL INTERVENTION"): If additional incidents of Harassment or Disruptive Conduct are reported, they will be evaluated according to the process described above.

If substantiated, a member of the Leadership Council and Department Chair shall discuss the matter informally with the Practitioner. The conversation shall be documented in a letter to the Practitioner, a copy of which shall be filed in the Practitioner's Confidential File. The letter shall state that the Practitioner is required to correct the inappropriate behavior and cooperate with the resolution of the problem that his/her behavior caused. If employee-related and the Human Resources Director has not been involved in the planning process, the Leadership Council will inform the Human Resources Director that the issue has been addressed.

(iii) THIRD EVENT: If additional incidents of Harassment or Disruptive Conduct are reported, they will be evaluated according to the process described above.

If confirmed, the Chief of Staff, the CEO and/or the CMO, and the Department Chair shall meet with and advise the Practitioner that such conduct is intolerable and must stop. A member of the Board may participate in the meeting. This shall be followed with a letter reiterating the conditions applicable to continued appointment, a copy of which shall be filed in the Practitioner's Confidential File.

The MEC shall be informed. If employee-related and the Human Resources Director has not been involved in the planning process, the Leadership Council will inform the Human Resources Director that the issue has been addressed.

(iv) SUBSEQUENT EVENT: A single additional confirmed incident shall result in initiation of formal review pursuant to this Policy.

(2) FORMAL ACTION: If formal action is deemed to be warranted by the Chief of Staff after consultation with the Leadership Council at any time, the matter shall be referred to the MEC for action pursuant to Article 6 of this Policy. Suspension of the Practitioner may be appropriate if warranted.

11.G. TRENDING OF OCCURRENCES

The resolution of complaint and review steps will start over with the first step if there are no other offenses within two (2) full reappointment terms.

ARTICLE 12 - MEDICAL STAFF PROFESSIONAL CODE OF CONDUCT

The Medical Staff and Adjunct Professional Staff of Summit Healthcare shall, through positive behavior and communication, promote honesty, trust, respect and teamwork in order to achieve an environment that fosters quality healthcare.

We value diversity and view this as an opportunity for growth. We will commit to create an atmosphere of respect, compassion, and ethical behavior toward our patients, their families and each other.

It is expected that all members of the Medical Staff and Adjunct Professional Staff adhere to the Medical Staff Bylaws, Rules and Regulations, Practitioner Procedural Manual, and Summit Healthcare policies and procedures (as applicable). This is a summary of expectations that members are expected to follow:

12.A. INTERPERSONAL RELATIONSHIPS

(1) Conduct actions in a professional and ethical manner at all times toward patients, families, employees, staff members, etc.;

(2) Communicate respectfully with patients, families and members of the healthcare team;

(3) Be respectful of the rights, privacy, and cultural diversity of patients, families, and others; and

(4) Address disagreements about patient care or other issues that impact the working environment using conflict management skills promptly, directly, and privately.

12.B. PATIENT-CENTERED CARE

(1) Assume 24-hour responsibility for the inpatient under our care; when off duty, or on vacation, assure that our patients are adequately cared for by another Practitioner;

(2) When terminating or transferring care of a patient to another Physician, provide prompt, pertinent, and appropriate medical documentation to assure continuation of care;

(3) Provide patient care that is professional and within the scope of Clinical Privileges, education, and training; and

(4) Respond professionally and in a timely manner when called upon by fellow practitioners to provide appropriate consultation or clinical services.

12.C. SAFETY

(1) Participate in quality measures identified to improve patient safety;

(2) Participate in the organization's efforts to improve safety from a systems perspective by identifying and reporting potential performance improvement initiatives; and

(3) Protect from loss or theft, and not share, log-ins and passwords to any hospital system that contains patient identifiable information or other confidential hospital information.

12.D. PROFESSIONAL PRACTICE

Maintain complete and accurate patient medical records and keep all such information confidential; follow all regulations for release of information.

12.E. DISRUPTIVE AND INAPPROPRIATE BEHAVIORS

Disruptive Physician and Inappropriate Behaviors are defined and addressed in Article 11 of this Policy.

ARTICLE 13 - PRACTITIONER WELLNESS

13.A. PURPOSE

(1) To establish the steps to be taken in the event a Practitioner is suspected of having a drug, alcohol, psychological, medical or other impairment. This policy creates a process that allows Practitioner impairment issues to be addressed quickly, appropriately and in a fashion consistent with the best interests of patient care, confidentiality and so as to qualify for peer review immunity under state and federal law.

(2) For purposes of this Article, "Impairment" shall mean the presence of a psychological or physical condition or the usage of drugs or alcohol in a fashion which interferes with a Practitioner's ability to render safe and appropriate medical care to Summit Healthcare patients. Impairment may include, but not limited to, drug or alcohol use or addiction, disruptive behavior, physical illness, aging issues and inappropriate workplace behavior.

13.B. PROCESS (SEE APPENDIX G FOR A FLOW CHART DESCRIBING THIS PROCESS)

(1) Any individual working or practicing at Summit Healthcare who has a good faith belief that a Practitioner is treating Summit Healthcare patients while impaired shall immediately contact his or her supervisor. Patients and visitors may notify any employee, who will in turn contact their supervisor.

(2) A supervisor who receives such a report should immediately contact the Chief of Staff or designee, and the CEO or designee. Additionally, within twenty-four (24) hours of the incident, the person raising the concern and the involved supervisor will submit a written report to the CEO and the Chief of Staff, documenting the basis for the allegation, the facts and circumstances which led to the allegation, the names of persons who observed the incident and all other material facts, and, in the case of the supervisor, whether he or she concurs with the concerns raised in the report.

(3) The Administrator on call and/or the Chief of Staff will come to Summit Healthcare to meet with the Practitioner. Pending their arrival, the supervisor will privately request the Practitioner refrain from treating Summit Healthcare patients. The Administrator on call and/or the Chief of Staff will meet with the Practitioner privately to discuss the allegation and assess the Practitioner's condition.

(4) The Administrator on call and/or the Chief of Staff may request the Practitioner submit to a blood test or urinalysis. The Practitioner's refusal to comply with such request will be deemed grounds for immediate investigative suspension. They may also request that

the Practitioner leave the premises, refrain from treating patients for up to forty-eight (48) hours under an administrative leave and make appropriate coverage arrangements for the Practitioner's hospital patients as a result of such decision. The Administrator on-call and the Chief of Staff will complete written reports within twenty-four (24) hours of the incident, including their observations, conclusions and the basis for their decision(s).

(5) Where the Administrator on call and/or the Chief of Staff have a good faith basis to believe a Practitioner was hospitalized, or otherwise treating patients while impaired, they shall immediately contact the Leadership Council.

(6) The Leadership Council will immediately convene a meeting with the Practitioner. They will review the written incident reports and use best efforts to meet with the individuals who generated the reports. The purpose of this meeting shall be to conduct a good faith, reasonable investigation of the facts of the situation and to assess the need for referral of the Practitioner for an evaluation and any related treatment. The Practitioner shall have the right to see the materials submitted to the Leadership Council.

(7) If in the reasonable belief of the Leadership Council, the Practitioner requires a psychological, medical or other assessment, the following process will be implemented:

(i) The Practitioner will be required to immediately contact the Arizona State Licensing Board or such other appropriate evaluation program as determined by the Leadership Council for any appropriate evaluation(s) warranted by the circumstances ("Program").

(ii) The Practitioner will agree to voluntarily refrain from exercising his or her Clinical Privileges pending enrollment in, cooperation with and completion of the Program evaluation process, completion of any indicated treatment, receipt of a release to return to practice by the Program and the Leadership Council.

(iii) The Practitioner will execute a Support Agreement with the Leadership Council.

(8) If the Practitioner refuses to cooperate and comply with these steps, the Leadership Council may recommend to the MEC that the Practitioner be subject to corrective action, including summary suspension, which will entitle the Practitioner to the rights under the fair hearing plans outlined in Articles 7 and 8 of this Policy.

(9) The Practitioner will share all information from the Program, including the evaluation and treatment process, requests and recommendations with the Leadership Council. The Leadership Council will meet with the Practitioner to determine how any treatment, prescriptions, or recommendations issued by the Program will be implemented, supplemented and/or supported by the Leadership Council. Before resumption of

Clinical Privileges, the Practitioner will execute an Assistance Agreement describing this implementation and the relative rights and responsibilities involved.

(10) Summit Healthcare shall not file a report with the National Practitioner Data Bank or State Licensing Boards regarding Practitioners with suspected impairment(s) who cooperate with the Leadership Council and complete the steps outlined in this policy unless otherwise compelled to do so by applicable law. In cases of suspected medication diversion, the Chief Compliance Officer shall be immediately notified so that a determination can be made regarding any reporting requirements under federal and state law.

(11) Physician Impairment issues, including reports, Leadership Council minutes, test results, Program and Leadership Council documents, shall be treated as confidential and privileged matters, as required by applicable peer review laws.

(12) Summit Healthcare has a zero tolerance policy regarding retaliation against persons who reported suspected Impairment or otherwise participated in the Practitioner Wellness process as articulated herein. Individuals who retaliate, or who are suspected of retaliating, against such persons may be subject to immediate corrective actions, including but not limited to investigative or summary suspension.

ARTICLE 14 - PEER REVIEW POLICY & PROCEDURE

14.A. POLICY STATEMENT

To ensure that Summit Healthcare, through the activities of its Medical Staff, assesses the ongoing professional performance of individuals granted Clinical Privileges, used the results of such assessments to improve care, and, when necessary, performs focused performance evaluation.

14.B. CONFIDENTIALITY, IMMUNITY, AND COMPLIANCE WITH STATE LAW

All written records of interviews, reports, statements, minutes, memoranda, and all physical and electronic materials related to research, discipline or medical study utilized in the course of the Peer Review activities described in this policy and procedure is the property of Summit Healthcare Association and its Medical Staff at the time of the Peer Review and is confidential to the full extent provided by Health Insurance Portability and Accountability Act (HIPAA) and Arizona state law, including, but not limited to, Arizona Revised Statute 36-445.01. (i.e., Peer Review is protected to all but the Federal government, Centers of Medicare & Medicaid Services ("CMS"), the Arizona Board of Medical Examiners, and the Arizona Board of Osteopathic Examiners in Medicine and Surgery).

Participants in the Peer Review activities described in this policy and procedure who furnish information or opinions related to research, discipline or medical study enjoy immunity from liability to the full extent provided by Arizona state law, including, but not limited to, Arizona Revised Statute 36-445.02.

This policy and procedure is intended to comply with the requirements of Arizona Revised Statute 36-445 for the organization of hospital Medical Staff peer review.

14.C. DEFINITIONS

(1) *Peer Review:* "Peer Review" is the evaluation of an individual practitioner's professional performance and includes the identification of opportunities to improve care and utilization of resources. Peer review differs from other quality improvement processes in that it evaluates the strengths and weaknesses of an individual practitioner's

performance, rather than appraising the quality of care rendered by a group of professionals or a system.

Peer review is conducted using multiple sources of information, including 1) the review of individual cases, 2) the review of aggregate data for compliance with general rules of the Medical Staff, and 3) clinical standards and use of rates in comparison with peers or established benchmarks or norms.

The individual's evaluation is based on generally recognized standards of care. Through this process, practitioners receive feedback for the personal improvement or confirmation of personal achievement related to the effectiveness of their professional, technical, and interpersonal skills in providing patient care.

(2) *Scope of Peer Review:* All Summit Healthcare Association patient cases are candidates for Peer Review. Patient cases are routinely selected for Peer Review through systematic assessment of data and the use of Peer Review Indicators. Reviews are conducted concurrently or retrospectively on any Physician providing care to that patient and are not limited to the attending Physician on the case.

(3) *Peer:* A "peer" is defined as a member of the Medical Staff, in good standing, practicing in the same profession who has expertise in the appropriate subject matter. The level of subject matter expertise required to provide meaningful evaluation of a practitioner's performance determines what "practicing in the same profession" means on a case by case basis. For example, for quality issues related to general medical care, a Physician (i.e., MD or DO) reviews the care of another Physician. For specialty-specific clinical issues (e.g., evaluating the technique of a specialized surgical procedure) as identified by the Peer Review Committee, a peer is an individual who is well-trained and competent in an applicable specialty. *Physicians are required to actively participate in Medical Peer Review (Credentialing Procedures Manual Section 3.13.6). Allied Health Professionals are subject to the same peer review policy concurrently with their Supervising Physician. Case(s) are to be reviewed by another Physician and/or Allied Health Professional at the discretion of the Peer Review Committee.

(4) *Peer Review Committee:* The Peer Review Committee is designated to perform the initial review by the MEC. A quorum of the Peer Review Committee must be present for Peer Review decisions to be made. If a conflict of interest is present for any member of the Peer Review Committee, the individual will be excused. (See definition for Conflict of Interest/Medical Staff Conflict of Interest). A function of the Peer Review Committee is to determine level of technical expertise needed for Peer Review.

(i) *Membership.* Committee membership will consist of one representative from each Medical Staff Department, and one Adjunct Member-At-Large and other Members-At-Large as nominated by and approved by the MEC, and Summit Healthcare CMO, unless otherwise designated for specific circumstances by the MEC. The Medical

Staff Treasurer shall serve as an ex-officio member of the Peer Review Committee. Each Department will elect its own representative from among its membership.

(ii) *Term* of Committee membership shall be as follows:

(a) Department Representative – a two (2) year renewable term;

(b) Member-at-Large – a three (3) year renewable term; and

(c) Adjunct Member-at-Large – a three (3) year renewable term.

(iii) *Chair.* The Peer Review Committee Chair will be appointed by the MEC. The Peer Review Committee Chair must be a member of the Active Medical Staff in good standing and have served on the Committee at least two (2) years. The Peer Review Committee Chair shall serve a two (2) year renewable term.

If the Chief of Staff involvement in peer review is needed, the Chief of Staff or designee shall be called upon to provide direction.

(5) *Early Intervention:* The QM staff may ask the Peer Review Committee Chair and the appropriate Department Chair for early intervention with a Physician in place of, or in addition to peer review activity when the Physician is new to the policies and procedures of Summit Healthcare, the issue is a new issue to a member of the Medical Staff, or it is deemed that early intervention might keep an issue from escalating into a major problem. The early intervention may be done by the Chief of Staff, the Department Chair, or their designee, or combination of as needed. Documentation of an Early Intervention will be reported to the Peer Review Committee for informational purposes and will be held in Medical Staff Services. The Early Intervention may be considered at time for reappointment/provisional review.

(6) *Ongoing Professional Practice Evaluation (OPPE):* OPPE is the routine monitoring and evaluation of current competency for current Medical Staff. These activities comprise the majority of the functions of the ongoing peer review process and the use of data for reappointment and are overseen by the Credentialing Committee.

(7) *Performance Improvement Plan (PIP):* PIP activities comprise what is typically called proctoring or focused review, depending on the nature of the circumstances. A PIP is not a formal investigation. Examples of PIP's include the following but are not all inclusive:

(i) Additional education/CME with proof of completion;

(ii) Prospective monitoring/review of next (set by MEC) cases;

(iii) Retrospective review/proctoring for identified issues;

(iv) Concurrent Proctoring for identified issues;

(v) Participation in formal evaluation/assessment program. Enrollment should be within set time frame and be completed with the time frames set by MEC. A release will be granted for MEC communication with the program;

(vi) Additional Training in identified area. Program will be approved by MEC and completed by date set; and

(vii) Educational Leave of Absence.

(8) *Conflict of Interest:* A member of the Medical Staff requested to perform peer review has a conflict of interest if he or she is not able to render an unbiased opinion. An automatic conflict of interest results if the Physician is the provider under review. Relative conflicts of interest are either due to a provider's involvement in the patient's care not related to the issues under review or because of a relationship with the Physician involved as a direct competitor, partner, or key referral source. It is the obligation of the individual reviewer to disclose to the peer review committee the potential conflict. The Medical Staff Conflict of Interest Guidelines in this Policy will be utilized to determine on a case-by-case basis whether a relative conflict is substantial enough to prevent the individual from participating. When either an automatic or substantial relative conflict is determined to exist, the individual may not participate or be present during Peer Review Committee discussions or decision other than to provide specific information requested as described in the Peer Review Process.

(9) *Physician Occurrence Report:* A Physician occurrence report is a report documented within the web-based event reporting system. All Physician occurrence reports are immediately evaluated under the auspices of this policy and are protected by Arizona State Law.

14.D. GUIDELINES

(1) All peer review information is privileged and confidential in accordance with Medical Staff and hospital bylaws, state and federal laws, and regulations pertaining to confidentiality and non-discoverability.

(2) The involved practitioner receives provider-specific feedback on a routine basis.

(3) The Medical Staff uses the provider-specific peer review results in making its recommendations to Summit Healthcare regarding the credentialing and privileging process and, as appropriate, in its performance improvement activities.

(4) Summit Healthcare keeps provider-specific peer review and other quality information concerning a practitioner in a secure, locked file. Provider-specific peer review information consists of information related to:

(i) Performance data for all dimensions of performance measured for that individual Physician;

(ii) The individual Physician's role in sentinel events, significant events, or near misses; and

(iii) Correspondence to the Physician regarding commendations, comments regarding practice performance, or corrective action in the form of a PIP.

(5) Only the final determinations of the peer review activities and any subsequent actions are considered part of an individual provider's quality assessment. Any written or electronic documents related to the review process, other than the final committee decisions, are considered working notes of the committee and are to be destroyed by policy after the committee decision has been made. Working notes include potential issues identified by hospital staff, questions and notes of the Physician reviewers, requests for information from the involved Physicians, and any written responses to the committee.

(6) Peer review information in the individual provider quality file is available only to authorized individuals who have a legitimate need to know this information based upon their responsibilities as Medical Staff leaders or hospital employees. However, access to the information is only to the extent necessary to carry out their assigned responsibilities. The Quality Management (QM) Department ensures that only authorized individuals have access to individual provider quality files, and that the files are reviewed under the supervision of the Chief Quality Officer or designee. Only the following individuals have access to provider-specific peer review information, and only for purposes of quality improvement:

(i) The specific provider;

(ii) Medical Staff Officers;

(iii) The Medical Staff Peer Review Committee;

(iv) Medical staff department chairs (for members of their departments only);

(v) Members of the medical executive, credentials, and quality committees;

(vi) The Chief Quality Officer and staff supporting the peer review process;

(vii) Medical staff services professionals, to the extent that access to this information is necessary for the re-credentialing process or formal corrective action;

(viii) Individuals surveying for accrediting bodies with appropriate jurisdiction (e.g., federal or state regulatory bodies);

(ix) Individuals with a legitimate purpose for access as determined by the Board; and

(x) The CEO or designee, when information is needed to take immediate formal corrective action for purposes of summary suspension by the CEO.

(7) No copies of peer review documents are created and distributed unless authorized by the MEC, the Board, or by the Chief of Staff for purposes of deliberations regarding corrective action on specific cases.

14.E. CIRCUMSTANCES REQUIRING PEER REVIEW

Peer review is conducted on an ongoing basis and reported to the appropriate committee for review and action. Additional evaluations are conducted when there is a sentinel event, a near miss, or an unusual individual case. (Rev. 04/2013)

14.F. PARTICIPANTS IN THE PEER REVIEW PROCESS

Participants in the review process are selected by the Peer Review Committee. Clinical support staff will participate in the review process if deemed appropriate. Additional support staff participate if such participation is included in their job responsibilities, such as the CEO, Chief Nursing Officer (CNO), Risk Manager, Chief Quality Officer, or any administrator over employed or contracted providers. The Peer Review Committee considers and records the views of the person whose care is under review prior to making a final determination regarding the care provided by that individual providing that individual responds in six (6) working days from receipt of hand delivered notification or certified letter. If clinical support staff is unable to had deliver the notification within five (5) working days, a certified letter shall be sent.

In the event of a conflict of interest or circumstances that would suggest a biased review beyond that described above, the MEC replaces, appoints, or determines who participates in the process so that bias does not interfere in the decision-making process.

14.G. THRESHOLD FOR INTENSIVE REVIEW

(1) If the results of individual case reviews for a Physician exceed the thresholds established by the Medical Staff described below, the Physician involved is contacted by certified mail that he/she is to be reviewed for exceeding thresholds (as written below) and has 6

days to provide any documentation to be attached to the review process documents. If the supporting documentation addresses the concerns raised, the Physician is notified by mail that the concerns were addressed.

(2) If the review is to proceed, the involved Physician will be invited, with a 14-Day notice, to attend the Peer Review Committee to give input into the discussion of cases where the threshold is met or exceeded. The Peer Review Committee will review the findings to determine whether further intensive review is needed to identify a potential pattern of care.

(3) Thresholds:

(i) Any single egregious case.

(ii) Within any 6-month period of time, any one of the following criteria:

(a) Two cases with Physician clinical judgment or decision-making; diagnoses, or with issues identified with technical skills; and

(b) Four cases with identified issues related to communication, documentation, follow through and other related issues.

(iii) Radiologists only: Within any 12-month period of time, 1% of imaging studies scored as a 3B (discrepancy in interpretation/should be made most of the time and likely to be clinically significant) by the Imaging PI Committee.

14.H. PEER REVIEW FOR SPECIFIC CIRCUMSTANCES

In the event that a decision is made by the MEC to investigate a practitioner's performance or circumstances warrant the evaluation of one or more providers with privileges, the MEC or its designee shall appoint a panel of appropriate medical professionals to perform the necessary peer review activities as ordered by the MEC.

14.I. PEER REVIEW TIME FRAMES

Peer review is conducted by the Medical Staff in a timely manner. The goal is for routine cases to be completed within 90 days from the date the chart is reviewed by the QM Department and for complex cases to be completed within 120 days. Exceptions are based on Case complexity or reviewer availability.

14.J. OVERSIGHT AND REPORTING

Direct oversight of the peer review process is delegated by the MEC to the Quality Initiative subcommittee: the Peer Review Committee. A report is generated for MEC and the Board at least quarterly.

14.K. PEER REVIEW INDICATORS

(1) Routine Peer Review Indicators. The Medical Staff Departments, from time to time, establish Routine Peer Review Indicators to be used to select cases for review. These Routine Peer Review Indicators are established to ensure that cases are selected in sufficient numbers and sufficient detail to effectively assess and evaluate all aspects of the quality of patient care provided to the patients of Summit Healthcare. Routine Peer Review Indicators are automatically sent for review and do not typically proceed through the Peer Review Committee.

(2) Physician Occurrence Report and Patient Grievance. The Peer Review Committee screens and approves all validated occurrence reports and patient grievances for peer review. All occurrence reports and patient grievances that are not validated have the Physician's identification removed from the report and the report is not used for trending purposed for that Physician.

(3) Extraordinary Peer Review Indicators. The occurrence of any of the following, in connection with a patient case, constitutes an Extraordinary Peer Review Indicator.

(i) A Sentinel Event (A sentinel event is an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof.)

(ii) A significant Near Miss (The risk of a sentinel event including any process variation for which a recurrence would carry a significant chance of a serious adverse outcome.)

(iii) The request for a review from at least two of the following: the Chief of Staff or designee, Risk Management, the Corporate Compliance Officer, the Department Chair, the CMO, and/or the Chief Quality Officer. (Clinical issues that are brought to the attention of an Administrator are discussed with the Peer Review Committee prior to being sent for Peer Review).

The MEC, may from time to time, establishes additional Extraordinary Peer Review Indicators to be used to select cases for review.

(4) Expedited Review of Cases with Extraordinary Peer Review Indicators. For case(s) identified by or reported to Quality Management staff with significant concerns and/or the potential for patient harm, an Expedited Review Pathway, which is on file in Medical Staff Services and Quality Management Office, shall be followed. Any case involving Extraordinary Peer Review Indicators, at the discretion of the Chief of Staff or designee and Department Chair or designee, receives review at the next scheduled Department meeting. The Physician(s) whose care is the subject of any such case is provided prompt notice that such case has been referred to the Department meeting for expedited review and is asked to be present at the Department meeting. In the event of Department meeting cancellation or untimely meeting, the case may be referred to the next MEC for review or special MEC or Department meeting may be called in order to provide for expedited review.

14.L. Peer Review Results

(1) A Peer Quality Review Form is completed for each peer review done.

(2) All patient cases that are sent to a Physician reviewer for Peer Review are classified according to the following criteria:

(a) No further follow-up needed.

(b) Department review of identified issues and actions needed.

(c) Cases referred to Department Peer Review combines the peer review process with a comprehensive review of the system issues surrounding the care in question. Cases may be reviewed at the Division level at the discretion of the Department Chair with the Department Chair to be in attendance during the peer review process.

(d) Cases referred to the Department Peer Review with nursing issues requests that the CNO and appropriate Nursing Director be present for the review.

(e) Reviewing Physicians must submit, in writing, concerns regarding the course of patient management when completing a peer review as well as when referring a case to the Department meeting for review.

(f) At the reviewing Physician's discretion, the patient case may be referred to the Department meeting for Educational Purposes.

14.M. Department Peer Review and Referral Procedure to MEC

(1) The Quality Management Department provides written notification to the Physician being reviewed as well as the Physician Reviewer at least 14 days prior to the scheduled department meeting that the case is being reviewed and their attendance is requested.

(2) The Department Chair makes every effort to have both the reviewer and the Physician whose case is to be reviewed by the Department, attend the meeting at which it will be discussed. Departmental review may be postponed once if either party is unable to attend and requests a postponement. The Department Chair arranges for cases to go to Department and is responsible for notifying both the Physicians involved. The involved Physician submits any reviewing concerns in writing prior to the scheduled Department review.

(3) The Department Chair and membership may request closure of the peer review, actions in the form of an educational letter or a collegial intervention related to the issues identified, recommend a Performance Improvement Plan (PIP) be created if warranted, and/or request further review by the Peer Review Committee or MEC.

(4) Cases are not reviewed more than once for the same concern or involved Physician by each Department. Cases, however, are reviewed more than once if different medical disciplines and/or Physicians are involved.

(5) The actions of the Department are reported to the Peer Review Committee. The Peer Review Committee may close the case, recommend a Performance Improvement Plan (PIP) be created if warranted, and/or the case may be sent to the MEC. The MEC is solely responsible for approval and implementation of PIPs. All actions taken are reported back to the Peer Review Committee for closure.

(6) If a PIP is implemented and the Physician being reviewed disagrees with the PIP, he/she has 60 days to submit a written request for further review to the MEC. If the MEC deems it appropriate, the case is referred to an outside reviewer for additional evaluation. Results of the MEC review is communicated to the Physician being reviewed within 30 Days.

14.N. Recording and Use of Peer Review Results

(1) Upon completion of the Peer Review, the patient case medical record and the completed Peer Review Form are returned to the QM Department for completion.

(2) Peer Review final results are aggregated with identified issues and submitted to the Credentialing Committee with documentation of completed actions.

(3) Peer Review results are kept a minimum of 7 years or in the case of a pediatric patient, the Peer Review is kept until the patient is 21 years old plus 3 years. (Per advice of legal counsel).

14.O. EXTERNAL PEER REVIEW

External Peer Reviews are requested by the Chief of Staff and/or Peer Review Committee for situations such as: absence of peer reviewer with same technical specialty, conflict of interest, personal conflict, and/or the Physician reviewers do not feel qualified to evaluate the situation. In addition, external peer review may be utilized at the discretion of the Chief of Staff and/or the Peer Review Committee for issues where a threshold for intensive review has been met (Threshold for Intensive Review).

(1) Quality Management Department attempts to meet any specific directions provided by the Chief of Staff and/or the Peer Review Committee Chairperson.

(2) All external peer review reports receive a final review at the appropriate department and actions taken are as above for internal peer review. If an external review is requested by the Chief of Staff or the Peer Review Committee, the results of the external review will go to the committee that requested it. The involved Physician will be invited to attend that meeting as per the guidelines above (i.e., 2-week notice).

ARTICLE 15 – MEDICAL STAFF GRAND ROUND CASE STUDY POLICY & PROCEDURE

15.A Policy Statement

The purpose of the Grand Round Case Study ("Grand Round") is to provide a safe venue for Medical & Adjunct Professional Staff to identify areas of improvement, and promote professionalism, ethical integrity and transparency in assessing and improving patient care. The Grand Round also provides a forum to discuss and provide education on quality improvement and medico legal issues to participants, while fostering a climate of openness and discussion about medical errors. The Grand Round also promotes leadership, research, and scholarly activity and incorporates into a learning opportunity the six core ACGME competencies of

i. Patient care;
ii. Medical knowledge;
iii. Practice-based learning and improvement;
iv. Interpersonal and communication skills;
v. Professionalism; and
vi. System-based practice

15.B Confidentiality, Immunity, and Compliance with State Law

Grand Rounds are a function of the Medical Staff's Quality Improvement and Peer Review process. All written records of interviews, reports, statements, and all physical and electronic materials related to research or medical study utilized in the course of the Peer Review activities described in this policy and procedure is the property of Summit Healthcare Association and its Medical Staff, and is confidential to the full extent provided by Health Care Quality Improvement Act (HCQIA) and Arizona state law, including, but not limited to, Arizona Revised Statutes 36-45 et. Seq. and 34-2401 et. Seq.

Participants in the Grand Round Case Study activities described in this policy and procedure who furnish information or opinions related to research, discipline or medical study enjoy immunity from liability to the full extent provided by Arizona State and Federal regulations.

15.C Definitions

A. *Moderator*: Department Chair, Chief of Staff, or designee
B. *"Near Miss" or "Good Catch":* An event that might have resulted in patient harm but the problem did not reach the patient because of timely intervention by healthcare providers or the patient or family, or due to good fortune.

C. *Scope of Grand Round Case Study*. All Summit Healthcare Association patient cases (inpatient and ambulatory) are candidates for Grand Rounds.

15.D Guidelines

15.D.1 Participants

A. Anyone involved in the case with direct knowledge of the systems and events relevant to the discussion are invited and expected to attend. This may include other physicians, Adjunct Professional Staff, nurses, pharmacists, therapists, lab personnel, and representatives of ancillary departments.
B. Department specific Grand Rounds: All applicable non-telemedicine Medical Staff Department members (Medical Staff and Adjunct Professional Staff) are invited
C. General Medical Staff Grand Rounds: All non-telemedicine Medical Staff and Adjunct Professional Staff members are invited.
D. Administrative Leadership member(s) and other Summit Healthcare staff as appointed by the Moderator.

15.D.2 Case Selection

A. Cases should be selected from the entire practice population. Cases (inpatient or outpatient), should involve:
    i. A poor or unintended outcome which might have been due to or worsened by error or system problems, or
    ii. "near-misses," where there was an error or misstep in care delivery that could have led to a poor patient outcome,
    iii. An interesting and unique case that may provide new learning and inquiry;
    iv. Clinical indicators

B. Presenter should complete the Grand Round Preparation Worksheets (**Appendix H**) and review in advance with the Department Chair (for Department specific Grand Rounds) or the Chief of Staff (for Grand Rounds presented at a General Medical Staff meeting).

15.D.3 Preparation

A. The Grand Round Preparation Worksheet (**Appendix H**) & PowerPoint template should be used to create the presentation
B. An electronic copy of the final PowerPoint presentation to be provided to Quality Management.

15.D.4 Ground Rules

A. Follow the format
B. Focus on systems of care rather than individual errors – No finger-pointing
C. Confidentiality – Avoid patient identifiers (no names, dates, record numbers) and do no discuss casually outside the conference
D. Add the following statement to all documents: "**Privileged & Confidential: Subject to Quality Improvement and Peer Review Protections, ARS 36-445 et. seq. and ARS 36-2401 et. Seq, and HCQIA."**
E. Information to be in electronic format with no handouts or copies

15.D.5 Conference Format

A. PowerPoint Presentation limited to 30 minutes
B. Case Presentation by Physician/Adjunct Professional Staff member
    i. Overview of the case
    ii. Review timeline of events
    iii. Describe how the patient care issues(s) caused potential or actual harm to the patient, family, or a healthcare professional
    iv. Identify any evidence-based literature that is applicable
    v. Identify the ACGME competency the patient care issue related to
    vi. Identify the nature of the patient care issue
    vii. Identify the "Take Home Points"
    viii. Recommend any clinical or system changes that should be considered to prevent this patient care issue from occurring in the future
C. Moderator facilitates the discussion of the case and Take Home Points – 15 minutes

15.D.6 Scheduling & Reporting

A. Grand Rounds may or may not be scheduled in conjunction with a Medical Staff Department or General Medical Staff Meeting.
B. The QM Department will facilitate scheduling of Grand Rounds, not to exceed 1 hour, unless approved by the Moderator
C. Participants will be provided a 14-day advance notice of the Grand Rounds.
D. Grand Rounds will not be postponed due to participant(s) unavailability unless granted by the Moderator.
E. Attendance will be taken and counted toward the individual's Medical Staff Department meeting attendance.
F. A summary report of conducted Grand Rounds will be provided to the Peer Review Committee and Medical Staff Executive Committee, at least annually.

15.D.7 Recording and Use of Grand Round Case Study Results

A. Minutes are not taken during Grand Rounds and are considered to be conducted under Executive Session.
B. Grand Round participation will be tracked for credentialing or recredentialing purposes.

Grand Round information may be utilized during individual peer review as outlined in the Medical Staff's Peer Review policy.

ARTICLE 16 - 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 this Policy 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.

16.A. 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.

16.B. 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 Summit Healthcare. 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. Summit Healthcare 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.

16.C. 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.

16.D. 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 patient's 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.

(1) In the case of a consultant, this could be accomplished by the active attending Physician's assessment of the consultation services.

(2) In the case of an admitting Physician, the department chair and/or designee could review cases concurrent to care.

(3) Additional review parameters to be assigned based on any concerns for past practice patterns.

16.E. 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

16.F. DURATION OF PROCTORING PERIOD

Each Practitioner granted Clinical Privileges must be proctored for at least six (6) months 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:

(1) Recent training program graduate from another facility.

(2) Practitioner with experience at another Medical Staff of at least two (2) years.

Specialty	Minimum Requirement
All Telemedicine specialties	No observation requirements.
Emergency Medicine	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.
Family Medicine	• 5 case reviews for all ages. • FM with OB/GYN: 3 observed cases with 3 additional case reviews. • FM with Level II Nursery – 2 cases concurrently reviewed and 5 cases retrospectively reviewed.
Medical Specialties	All Medical Specialties (except Pathology): • Three (3) cases observed. For medical management – retrospective review; for procedures – concurrent observations
OB/GYN	• 3 Cesarean Sections with Physician assists • 2 Cesarean Sections cart 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
Pathology	• 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
Pediatrics	• 5 case reviews for all ages • Level II Nursery – 2 cases concurrently reviewed and 5 cases retrospectively reviewed
Radiology	• Five (5) direct observations and five (5) chart reviews
Surgical Specialties	All Surgical Specialties: • New Physicians 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 Board Certified*: 2 observations and 2 chart reviews NOT Board Certified: 4 observations and 2 chart reviews 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. *Board Certified: Must be a recognized board by either the ABMS, AOA, ADA or American Board of Podiatry.

16.G. 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.

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

(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 Appointment or Clinical Privileges.

(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 medial staff with that expertise are determined to have a conflict of interest regarding the Practitioner under review as described above.

(4) New technology – when a Medical Staff member requests permission to use new technology or perform a procedure new to Summit Healthcare and the Medical Staff does not have the necessary subject matter expertise to adequately evaluate the quality of care involved.

(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 Board may require external professional practice evaluation in any circumstances deemed appropriate by either of these bodies.

16.H. RESPONSIBILITIES

(1) Responsibilities of the Proctor

Proctor(s) must be members in good standing of the Active Medical Staff of Summit Healthcare 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:

(a) Use appropriate methods and tools approved by the MEC for that specialty.

(b) Ensure the confidentiality of the proctoring results and forms and deliver the completed proctoring forms to the Medical Staff Services Office.

(c) Submit a summary proctor report at the conclusion of the FPPE period.

(d) 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.

(e) 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.

(f) 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.

(i) 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.

(ii) 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.

(2) Responsibility of the Practitioner Being Proctored

The Practitioner being proctored shall:

(i) 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.

(ii) Provide the proctor with information about the patient's clinical history, pertinent physical findings, pertinent lab and x-ray results, the planed 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.

(iii) 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.

(iv) Inform the proctor of any unusual incident(s) associated with his/her patients.

(3) Responsibilities of the Department Chair

Each Medical Staff department chair shall be responsible for:

(i) Assignment of proctors as noted above.

(ii) 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.

(iii) Identifying the names of Medical Staff members eligible to serve as proctors as noted above.

(iv) 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.

(4) Responsibilities of the Medical Staff Services Office

The Medical Staff Services Office shall:

(i) 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

(1) The name, address and telephone numbers of the Practitioner being proctored and the proctor

(2) A copy of this Proctoring Policy and Procedure

(3) Proctoring forms to be completed by the Proctor

(b) Develop a mechanism (in coordination with Information Services Department) for tracking all admissions or procedures performed by the Practitioner being proctored.

(c) Provide information to appropriate hospital departments about Practitioners being proctored including the name of the proctor and a supply of proctoring forms as needed.

(d) 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.

(e) Periodically submit a report to Credentials Committee and MEC of proctorship activity for all Practitioners being proctored.

(f) At the conclusion of the proctoring period, submit a summary proctor report to the Credentials Committee and MEC.

(5) Responsibilities of the Credentials Committee

The Credentials Committee shall:

(i) Have the responsibility of monitoring compliance with this policy and procedure.

(ii) 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.

(iii) Make recommendations to the MEC regarding Clinical Privileges based on information obtained from the proctoring process.

16.I. 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 Clinical Privileges. Furthermore, whenever a Practitioner's privileges are limited, revoked, or in any way constrained, Summit Healthcare 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.

16.J. 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

(a) 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:

(i) National Practitioner Data Bank (NPDB)

(ii) Medical License(s) in state(s) where currently practicing

(iii) Letter of good standing from current institution

(iv) OIG and Sanctions screenings

(v) 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.

(b) The proctor/preceptor is responsible to Summit Healthcare, 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.

(c) Procedure

(i) 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 Board.

(ii) For new procedures (where new equipment and/or techniques will be utilized), specific credentialing criteria for the procedure must be submitted and go through Summit Healthcare'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.

(iii) 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.

(iv) 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 he or she is proctoring/preceptoring.

(v) The Chief of Staff or his or 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.

(vi) Prior to the initiation of the proctoring/direct preceptorship process, the applicant for new privileges must agree in writing to hold harmless Summit Healthcare, 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.

(vii) The Chief of Staff or his/her designee shall notify the proctor/preceptor, the Practitioner and the appropriate Summit Healthcare 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.

(viii) 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.

(ix) 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.

ARTICLE 17 - 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:

(a) Dates of affiliation with Summit Healthcare;

(b) Medical Staff status;

(c) Practicing specialty;

(d) 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:

  (1) the imposition of condition or limitation to clinical privileges;

  (2) probation;

  (3) additional training requirements;

  (4) reprimand or the imposition of any observation/supervision requirement not related to the customary, initial appointment requirements;

  (5) a Performance Improvement Plan; or

  (6) the termination/revocation of privileges;*

(e) Resignation of staff membership and/or privileges to avoid discipline, revocation, or termination;*

(f) Final disciplinary actions taken by the MEC and/or the Board;*

(g) Clinical data from the most relevant reappointment/assessment, if available, to include number of admissions, consultations, and/or procedures; and

(h) 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.

* The events described in (d), (e), and (f) above will be disclosed using a ten-year look back period, meaning any of these events that occurred more than ten years prior to receiving the affiliation request will not be disclosed.

ARTICLE 18 - STUDENT, INTERN, RESIDENT, AND FELLOW ROTATIONS

18.A REGISTRATION

Students, medical students, residents, and fellows rotating through the Medical Center from accredited schools in the United States or Canada in hospital-recognized program must be registered through [Human Resources] and approved by the Governing Board. This includes advance practice nursing (nurse anesthetists and nurse practitioners) and physician assistant ("APP students"). Medical students, residents, fellows, and APP students are not subject to the credentialing process outlined in these documents, are not entitled to due process rights under the Medical Staff Bylaws and are not granted membership or Clinical Privileges.

The terms "APP students", "medical students", "subinterns", "interns", "externs", "residents", and "fellows" are hereby referred to collectively as "medical trainees". Supervising physicians must notify the appropriate nursing director if medical trainees will be rotating in procedural areas (Operating Room, Labor & Delivery, Emergency Department, Outpatient Surgery Center, and Cardiac Catheterization Laboratory).

Supervising physicians will ensure that patients understand and agree that medical trainees will participate in their care and/or observe/participate in procedures.

Summit Healthcare does not have a formal GME program and will not assist in finding Practitioners willing to precept medical trainees. It is the sole responsibility of the medical trainee to find a Practitioner willing to participate in the GME program and assume accompanying responsibilities. Individual members of the Medical Staff may serve as the documented preceptor ("supervising physician/surgeon") for no more than four (4) medical trainees at once.

The rotation must be approved as an official rotation of the sponsoring educational institution. A contract with the sponsoring educational institution is required.

Only Medical Staff members with clinical privileges may precept medical trainees.

Medical trainees must successfully complete training on Summit Healthcare's electronic medical record before the start of the assigned rotation. The [Human Resources Office] will ensure that training is complete.

The faculty GME report of the quality and scope of activity of medical trainees will be communicated to the Medical Executive Committee on a periodic basis.

18.B CARE PROVIDED BY MEDICAL TRAINEES

Medical trainees provide care under the supervision of designated member(s) of the Medical Staff. Medical trainees may not provide patient care beyond the scope of privileges held by the supervising member of the Medical Staff.

Medical Staff members who supervise medical trainees are responsible for reviewing all notes, orders, histories, physicals, consultations, operative reports, discharge summaries, and all other patient care documentation. Medical Staff members must comply with the documentation requirements below.

Medical trainees may perform histories and physicals, assist with procedures, make rounds, and carry out other clinical and educational assignments as directed by the supervising physician. Medical trainees may assist with evaluating patients in the Emergency Department, however this assistance does not relieve supervising physicians of the requirement to respond to the Emergency Department and evaluate patients.

Performance of medical trainees will be evaluated by the supervising physician. Failure to satisfactorily perform assigned duties shall be reported to the Chief of Staff and to the sponsoring academic institution. In the event that medical trainees do not respond appropriately to directions, demonstrate misconduct, or commit actions which place patients at risk, the supervising physician, the appropriate clinical department chair, the Chief of Staff, or the Chief Executive Officer may summarily terminate the rotation. The medical trainee has no review rights if such action is taken.

Decisions about progressive involvement and independence in specific patient care activities of medical trainees are the responsibility of the supervising physician and must not exceed upon the guidelines of the sponsoring education institution. However, duties performed by medical trainees are in addition to and not substitutes for required responsibilities of members of the Medical Staff. Questions or concerns about the knowledge or skills of individual medical trainees should be directed to the supervising physician.

18.C FELLOWS

Fellows shall be considered equivalent to residents (see 10.4 below) for the purposes of these Practitioner Procedural Policy, hospital policy, and the Medical Staff Bylaws unless they have applied for and been granted Medical Staff membership and Clinical Privileges.

18.D RESIDENTS

Residents evaluate and treat patients only under the direction and supervision of a member of the Medical Staff with clinical privileges. The supervising physician assumes complete responsibility for the care rendered by the resident and must countersign, time, and date all dictations and medical record entries. Countersignature is to be made in the record within 24 hours. Supervising physicians must be physically present during the critical or key portions of all medical and surgical services provided by residents.[1]

18.D.1. Residents are allowed to:

(a) Perform Histories and Physicals.

(b) Scrub in and participate in surgery (and other procedures) at the discretion of the supervising surgeon after verification that resident understands and complies with aseptic technique and standard operating room etiquette.

(c) Make entries in the medical record, including:

(i) Operative and procedure notes.

(ii) Therapeutic and diagnostic orders.

(iii) Discharge summaries.

(iv) Progress notes.

Supervising physicians must personally document that they performed the service or were physically present during the critical or key portions of the service furnished by residents, and that they participated in the management of the patient.[2]

All procedures performed by the resident will be directly supervised by the supervising physician. In sterile areas, this means that the supervising physician must be scrubbed in at all times while the resident is scrubbed in, except as clarified below. Residents may not admit patients or function as supervising physicians.

Provided patient safety is assured, PGY-4 level (and more senior) residents of surgical training programs may, at the discretion of the supervising surgeon, remain scrubbed in while the supervising surgeon breaks scrub if:

- The "critical portions" (see below for definition) of the procedure have been completed; and
- The supervising surgeon:
  - Remains within the immediate vicinity, to explicitly include the main OR, PACU, pre-operative holding area, OR physician lounge, and the surgery waiting room;
  - Is not scrubbed into another surgical case; and

- Is immediately available.

The supervising surgeon's responsibility cannot be delegated. The supervising surgeon must be an active participant throughout the key or critical components of the operation. The overriding goal is the assurance of patient safety[3].

The critical portions of an operation, as defined by the American College of Surgeons[4] , are those segments of the operation where essential technical expertise and surgical judgment are required in order to achieve an optimal patient outcome. For the purposes of these Practitioner Procedural Policy, the critical portions begin at the Time Out and initial incision and continue until the point at which all that remains to be completed is closing surgical incisions and establishing/securing drainage equipment.

18.E MEDICAL STUDENTS

Medical Students must be under the direction and supervision of a member of the Medical Staff at all times.

18.E.1 Medical students are allowed to do the following in conjunction with the supervising physician if permitted by the sponsoring educational institution:

(a) Perform Histories and Physicals. An H&P performed by a medical student does not take the place of an H&P performed and documented by a supervising physician

(b) Scrub in and participate in surgery (and other procedures) at the discretion of the supervising surgeon, only after completing an orientation by the supervising surgeon and/or OR personnel.

(c) Document progress notes in the medical record.

Medical students may not dictate or document operative notes or discharge summaries. All procedures performed by medical students must be directly supervised by the supervising physician. In sterile areas, this means that the supervising physician must be scrubbed in at all times while the medical student is scrubbed in. All medical record entries will be co-signed, timed, and dated by the supervising physician at the time they are completed.

18.F APP STUDENTS

APP students must be under the direction and supervision of a member of the Medical Staff and/or a member of the Adjunct Professional Staff (CRNA/NP/PA).

18.F.1 APP students are allowed to do the following in conjunction with the supervising physician/CRNA/NP/PA if permitted by the sponsoring educational institution:

(a) Perform Histories and Physicals. An H&P performed by an APP student does not take the place of an H&P performed and documented by a supervising physician/CRNA/NP/PA.

(b) Scrub in and participate in surgery (and other procedures) at the discretion of the supervising surgeon, only after completing an orientation by the supervising surgeon and/or OR personnel.

(c) Document progress notes in the medical record.

APP students may not dictate or document operative notes or discharge summaries. All procedures performed by APP students must be directly supervised by the supervising physician/CRNA/NP/PA. In sterile areas, this means that the supervising physician must be scrubbed in at all times while the APP student is scrubbed in. All medical record entries will be co-signed, timed, and dated by the supervising physician/CRNA/NP/PA at the time they are completed.

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[1] Page 3, Centers for Medicare and Medicaid Services, Guidelines for Teaching Physicians, Interns, and Residents, https://www.cms.gov/Outreach-and-Education/Medicare-Learning-NetworkMLN/MLNProducts/Downloads/Teaching-Physicians-Fact-Sheet-ICN006437.pdf

[2] Page 7, Centers for Medicare and Medicaid Services, Guidelines for Teaching Physicians, Interns, and Residents, https://www.cms.gov/Outreach-and-Education/Medicare-Learning-NetworkMLN/MLNProducts/Downloads/Teaching-Physicians-Fact-Sheet-ICN006437.pdf

[3] Statement on Principles, American College of Surgeons, https://www.facs.org/aboutacs/statements/stonprin

[4] Statement on Principles, American College of Surgeons, https://www.facs.org/aboutacs/statements/stonprin

ARTICLE 19 - CONFIDENTIALITY

All Peer Review activity defined in this Policy and recommendations made shall be strictly confidential. Individuals participating in, or subject to, Peer Review activities shall make no disclosures of any such information (discussions or documentation) outside of committee meetings, except:

(a) when the disclosures are to another authorized Practitioner or authorized Summit Healthcare employee and are for the purpose of researching, investigating, or otherwise conducting legitimate Peer Review activities;

(b) when the disclosures are authorized by a Medical Staff or Summit Healthcare policy; or

(c) when the disclosures are authorized, in writing, by the CEO or by legal counsel to Summit Healthcare.

Any breach of confidentiality may result in a professional review action and/or appropriate legal action. Such breaches are unauthorized and do not waive the Peer Review privilege. Any Practitioner who becomes aware of a breach of confidentiality must immediately inform the CEO, the CMO, or the Chief of Staff.

ARTICLE 20 - AMENDMENTS

This Policy may be amended pursuant to Article 8 of the Medical Staff Bylaws.

ARTICLE 21 - ADOPTION

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

Adopted by the Medical Staff: 02/21/2023

Approved by the Board: 02/28/2023

APPENDIX A - CREDENTIALING FEES

Initial application and reappointment fees as established by the Medical Executive Committee and approved by the Board are as follows:

(1) Initial Application fees:

a.	Active & Active Outpatient Medical Staff	$125.00
b.	Affiliate Medical Staff	$200.00
c.	Consulting Medical Staff	$200.00
d.	Telemedicine Medical Staff	$200.00
e.	Adjunct Professional Staff	$125.00

(Exception:

Registered Nurse First Assistant, Advanced Surgical Technologist, Certified Surgical Technologist, Clinical Psychologist, and Behavioral Health Counselor/Therapist (LCSW, LMFT, LPC) $62.50

(2) Reappointment fees:

a. Active & Active Outpatient Medical Staff

Attendance at held Medical Staff meetings (i.e., General Medical Staff, Department/Division Meetings, as listed in the Medical Staff Governing Documents.):

50% or more per 2 year reappointment term	No reappointment fee
less than 50% per 2 year reappointment term	$100.00

b.	Consulting Medical Staff	$100.00
c.	Telemedicine Medical Staff	$100.00
d.	Adjunct Professional Staff	
	Less than 10 patient encounters per year	$100.00
	More than 10 patient encounters per year	No reappointment fee

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

APPENDIX B - MINIMAL CLINICAL ACTIVITY REAPPOINTMENT GUIDELINES

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

Specialty	Proposed Minimum Reappointment Clinical Activity
Anesthesiology/CRNA	Management and participation in 100 general/regional anesthesiology patients within the past 24 months with acceptable outcomes.
Emergency Medicine	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.
Family Medicine Specialties (FM, GYN, Pediatrics, etc.)	For inpatient privileges: Documentation/attestation of management of at least 20 inpatients during the past 24 months with acceptable outcomes.
Medicine Specialties	For inpatient privileges: Documentation/attestation of management of at least 20 inpatients during the past 24 months with acceptable outcomes.
General Surgery	Document successfully performed/managed at least 200 inpatients or outpatient surgical procedures during the past 24 months with acceptable outcomes.
Obstetrics	Documentation/attestation of management of at least 30 obstetric procedures/cases during the past 24 months with acceptable outcomes.
Ophthalmology	Management and participation in 50 inpatient or outpatient ophthalmology patients within the past 24 months with acceptable outcomes.
Orthopedic Surgery	Management and participation in 100 orthopedic surgery patients within the past 24 months with acceptable outcomes.
Otolaryngology (ENT)	Documentation/attestation of the performance of at least 100 otolaryngology (ENT) surgical procedures during the past 24 months with acceptable outcomes.
Pain Management	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.

Pathology	Management and participation in 100 clinical pathology cases within the past 24 months with acceptable outcomes.
Plastic Surgery	Management and participation in 100 plastic surgery patients within the past 24 months with acceptable outcomes.
Podiatry	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.
Radiology	Documentation/attestation of management of at least 20 invasive/interventional radiologic procedures during the past 24 months with acceptable outcomes.
Radiation Oncology	Documentation/attestation of radiation oncological inpatient/outpatient or consultative services for at least 50 patients during the past 24 months with acceptable outcomes.
Urology	Documentation/attestation of urological inpatient/outpatient or consultative services for at least 100 patients during the past 24 months with acceptable outcomes.
Vascular Surgery	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 Practitioners 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) Change of Medical Staff category.

APPENDIX C - CONFLICT OF INTEREST GUIDELINES

Potential Conflicts	Levels of Participation								
	Provide Information	Initial Reviewer Application/ Case	Committee Member					Hearing Panel	Board
			Credentials	Leadership Council	PRC	MEC	Investigating Committee		
Employment/contract relationship with Summit Healthcare	Y	Y	Y	Y	Y	Y	Y	Y	Y
Self or family member	Y	N	R	R	R	R	N	N	R
Relevant treatment relationship*	Y	N	R	R	R	R	N	N	R
Significant financial relationship	Y	Y	Y	Y	Y	R	N	N	R
Direct competitor	Y	Y	Y	Y	Y	R	N	N	R
Close friends	Y	Y	Y	Y	Y	R	N	N	R
History of conflict	Y	Y	Y	Y	Y	R	N	N	R
Provided care in case under review (but not subject of review)	Y	Y	Y	Y	Y	R	N	N	R
Involvement in prior PIP or review	Y	Y	Y	Y	Y	R	N	N	R
Formally raised the concern	Y	Y	Y	Y	Y	R	N	N	R

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

Y – (Yellow "Y") means the Interested Member may generally serve in the indicated role. It is legally permissible for Interested Members to serve in these roles because of the check and balance provided by the multiple levels of review and the fact that the Credentials Committee, Leadership Council, and PRC have no disciplinary authority.

In addition, the Chair of the Credentials Committee, Leadership Council, or PRC always has the authority and discretion to recuse a member in a particular situation if the Chair determines that the Interested Member's presence would (i) inhibit the full and fair discussion of the issue before the committee, (ii) skew the recommendation or determination of the committee, or (iii) otherwise be unfair to the Practitioner under review.

N – (Red "N") means the Interested Member should not serve in the indicated role.

R – (Red "R") means the Interested Member should be recused, in accordance with the guidelines on the next page.

* Special rules apply both to the provision of information and participation in the review process in this situation. See Section 9.A.3 of this Policy

RULES FOR RECUSAL	
STEP 1 Confirm the conflict of interest	The Committee Chair or Board Chair should confirm the existence of a conflict of interest relevant to the matter under consideration.
STEP 2 Participation by the Interested Member at the meeting	The Interested Member may participate in any part of the meeting that does not involve the conflict of interest situation. When the matter implicating the conflict of interest is ready for consideration, the Committee Chair or Board Chair will note that the Interested Member will be excused from the meeting prior to the group's deliberation and decision-making. Prior to being excused, the Interested Member may provide information and answer any questions regarding the following: (i) any factual information for which the Interested Member is the original source; (ii) clinical expertise that is relevant to the matter under consideration; (iii) any policies or procedures that are applicable to the committee or Board or are relevant to the matter under consideration; (iv) the Interested Member's prior involvement in the review of the matter at hand (for example, an Investigating Committee member may describe the Investigating Committee's activities and present the Investigating Committee's written report and recommendations to the MEC prior to being excused from the meeting); and (v) how the committee or Board has, in the past, managed issues similar or identical to the matter under consideration.
STEP 3 The Interested Member is excused from the meeting	The Interested Member will then be excused from the meeting (i.e., physically leave the meeting room and/or disconnect from any telephone or other electronic connection) prior to the committee's or Board's deliberation and decision-making.
STEP 4 Record the recusal in the minutes	The recusal should be documented in the minutes of the committee or Board. The minutes should reflect the fact that the Interested Member was excused from the meeting prior to deliberation and decision-making. As set forth in the Medical Staff Bylaws, once a quorum has been established, the business of the meeting may continue and actions taken will be binding regardless of whether any subsequent recusal of members causes the number of individuals present at the meeting to fall below the number required for a quorum.

APPENDIX D – Advance Practice Providers

Those individuals currently practicing as Advanced Practice Providers at Summit Healthcare are as follows:

- Advance Practice Nurse (i.e. Nurse Practitioner, Certified Registered Nurse Anesthetist, Certified Nurse Midwife, etc.)
- Clinical Psychologist
- Behavioral Health Counselor/Therapist (LCSW, LMFT, LPC)

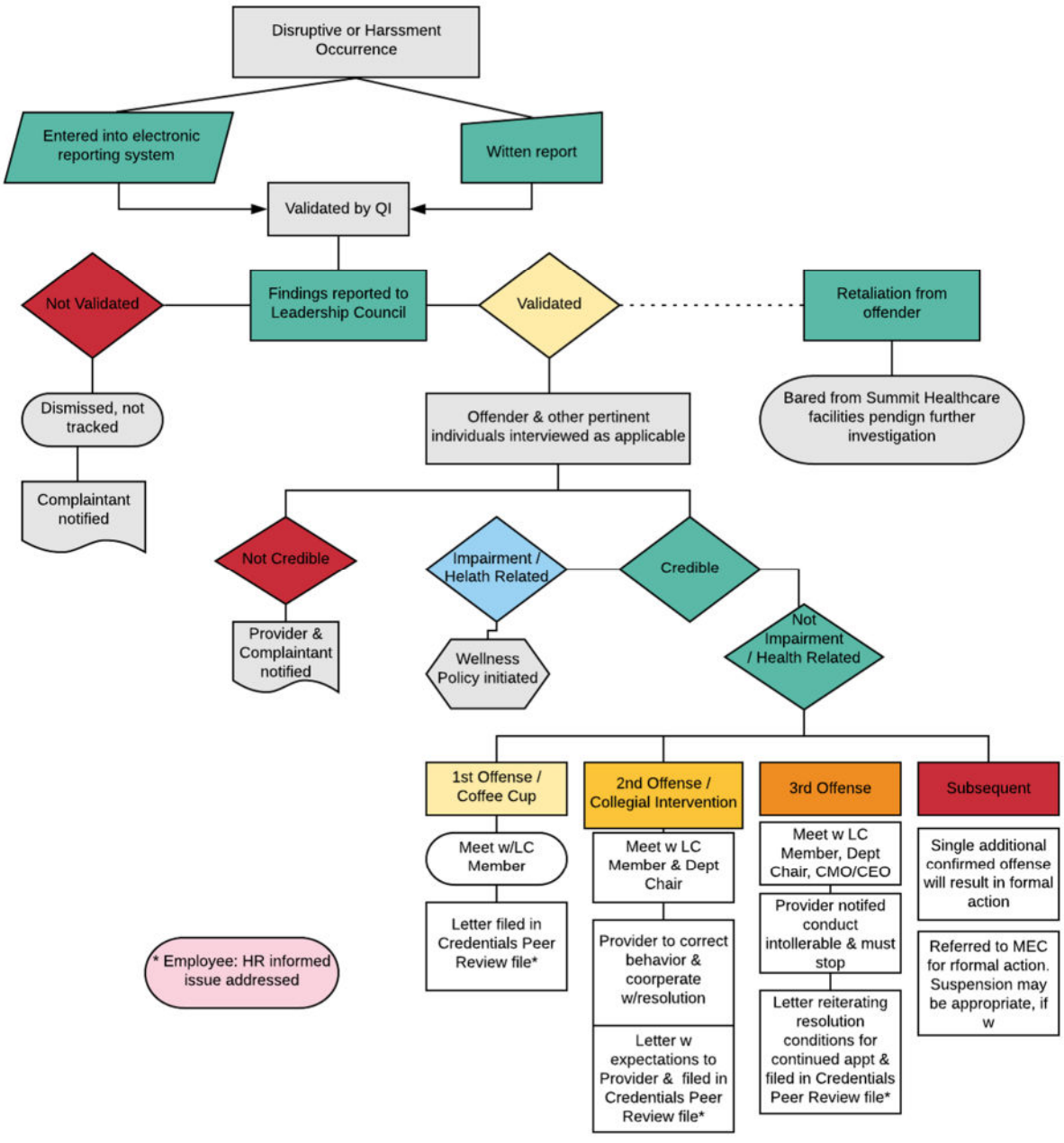
APPENDIX E – Allied Health Professionals

Those individuals currently practicing as Allied Health Professionals at Summit Healthcare are as follows:

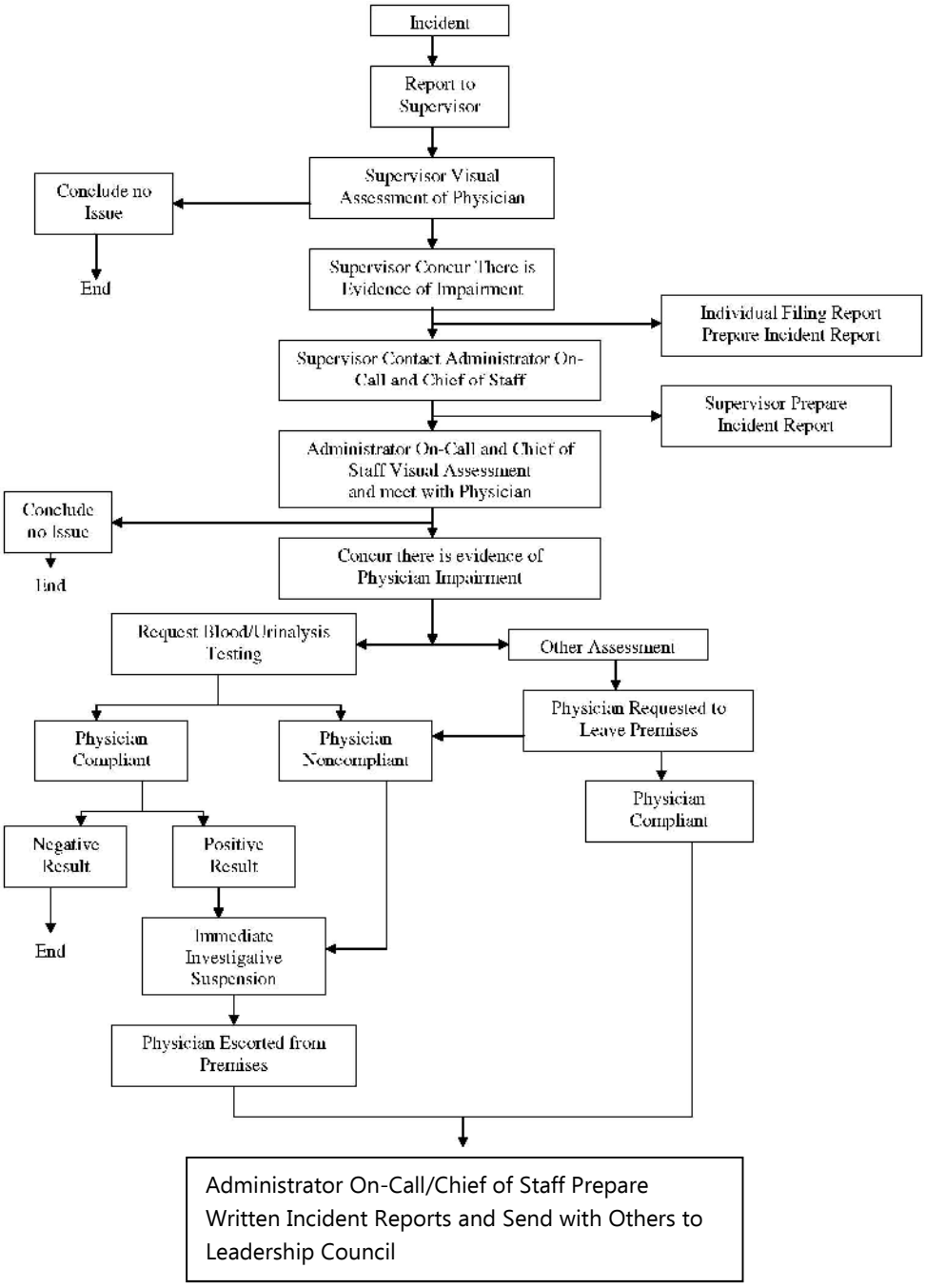
- Physician Assistant
- Registered Nurse First Assistant
- Advanced Surgical Technologist
- Certified Surgical Technologist

APPENDIX F - DISRUPTIVE & INAPPROPRIATE BEHAVIOR FLOW CHART

*Please refer to text for policy specifics



APPENDIX G - PRACTITIONER WELLNESS FLOW CHART



APPENDIX H - Medical Staff Grand Round Case Study Preparation Worksheet

Use this worksheet to develop your PowerPoint presentation

Date of M&M Presentation:	
Presenter:	Moderator:
Medical Staff Involved	Other Key Staff Involved

Brief Overview of the Case
• **Rationale for selection of case** • **Diagnosis** • **Complication(s)**

Outline the Timeline of Events

Restate the complication and identify all potential causes of the complication(s) *(perform root cause analysis and fishbone diagram to help)*

Describe how the complications could (or should) have been prevented, ameliorated, or managed

What Does the Evidence-Based Literature Review Tell Us?

In view of the ACGME competencies, did the issue(s) occur as a problem related to: (Check all that apply)			
ACGME Competency	**Yes**	**No**	**Describe**
Medical Knowledge			
Patient Care provided or not provided			
Communication and Interpersonal Skills			
Professionalism			
Practice-based learning and improvement			
Systems-based Practice			

Did the issue occur as problem related to: (Check all that apply)			
Problem Area	**Yes**	**No**	**Describe**
Documentation			
Practitioner Care			
Nursing Care			
Care from other health care professionals			
Patient and/or family			
Specific other system-based practice, policy, protocol, etc.			
Communication			

Identify the knowledge gaps
1. **What is known?** 2. **What is not known?**

Describe in detail what issue(s) you have identified and the key take home points you will make relative to that issue

Explain what can be done to change clinical or system practice so that this type of situation does not reoccur in the future.

What will be the Take Home Points