



SECTION 4

CREDENTIALS

MANUAL

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Medical Executive Committee - September 7, 1996
CHI-FH Board of Directors - November 22, 1996

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CREDENTIALING MANUAL OF THE MEDICAL STAFF BYLAWS

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PURPOSE

The Credentialing Manual outlines the uniform credentialing process and the mechanism for granting appointment and reappointment to the Medical Staff as well as the process of evaluating and granting initial Clinical Privileges and renewal of Clinical Privileges for individual members of the Active Medical Staff and Allied Health Professionals. This manual is appended to the Medical Staff Bylaws of the CHI Franciscan, as outlined in Article XII, Section 3 B and is subject to the approval of the Board.

DEFINITIONS

The definitions provided in the CHI-FH Medical Staff Bylaws shall apply to the Credentialing Manual. In addition, the following shall apply:

1. **Clinical Privileges:**

Authorization granted by the Board to a practitioner to provide specific patient care services in the Hospital within defined limits based on an individual practitioner's license, education, training, experience, competence, health status, and judgment.

2. **Licensed Practitioner:**

Any individual permitted by law and by the Hospital and Medical Staff to provide patient care services within the scope of his or her license, and in accordance with individually granted Clinical Privileges.

3. **The Credentialing Process:**

The process of assessing and validating the qualifications of a licensed practitioner to provide patient care services in a hospital.

4. **Allied Health Professionals (AHP):**

Allied Health Professionals are not members of the Active Medical Staff. AHP are non-physicians (non MD, DO, DDS, DPM,) other than persons employed by CHI-FH or under contract to CHI-FH, who assist in the diagnosis and treatment of patients in CHI-FH or are authorized to perform procedures in the Hospital.

CONFIDENTIALITY OF INFORMATION AND IMMUNITY FROM LIABILITY

The protections identified in Article X of the CHI Franciscan (CHI-FH) Medical Staff Bylaws shall apply to the Credentials Manual.

**ARTICLE I. PROCEDURE FOR APPOINTMENT
TO THE ACTIVE MEDICAL STAFF**

The Board has designated the Medical Staff Office its agent to collect and verify data in the credentialing process.

- A. The Board shall appoint and reappoint applicants to the Medical Staff and grant initial, renewed, or revised Clinical Privileges, considering the Medical Executive Committee's recommendations, in accordance with the Bylaws, Rules and Regulations, and policies of the Medical Staff and of the Hospital.
- B. Appointment to the Active Staff category is granted after a review of all documents related to the applicant. Criteria for Medical Staff appointment and for Clinical Privileges are established by the Credentials Committee of the Medical Staff, are uniformly applied to all applicants, and constitute the basis for granting Medical Staff appointment and Clinical Privileges.
- C. Decisions regarding appointment and granting or denying Clinical Privileges are based on criteria that are directly related to quality of care, and are made on the basis of an applicant's credentials without regard to gender, race, creed, national origin, or any other criteria not related to professional or clinical competence.
- D. Subsequent appointments and reappointments and granting, renewing, or revising Clinical Privileges shall be for a period of not more than two (2) years.
- E. A separate credentials file is maintained for each individual requesting Medical Staff membership and/or Clinical Privileges.
- F. Upon appointment to the Medical Staff each member will be assigned to a Clinical Section (Medical Staff groups of like specialty, practice or clinical interest).
- G. Detailed Desktop Procedures are maintained in the Medical Staff Office and may be amended by the Credentials Committee in order to meet regulatory requirements or other modifications deemed to be in the best interest of the Medical Staff, Medical Staff Office, and/or organization.

SECTION 1. INITIAL APPLICATION

- A. The initial application to the Medical Staff shall be in writing or via electronic application, signed by the applicant, and submitted on a form specified by CHI-FH. CHI-FH may accept electronic signature through the approved electronic application. The application form shall require detailed information concerning the applicant's license, education, training, experience, current competence, health status, privileges requested and malpractice history.
 - 1. The-application requirements are:
 - a. Current and unrestricted Washington State license.
 - b. Current Federal Drug Enforcement Agency (DEA) Certificate where applicable.

- c. Evidence of an approved residency recognized by the Accreditation Council for Graduate Medical Education, American Osteopathic Association, American Dental Association or American Podiatric Medical Association.
 - d. Board certification or board admissibility by the professional board recognized by the American Board of Medical specialties (ABMS), the American Osteopathic Association (AOA), the American Dental Association (ADA), the American Council of Certified Podiatric Physicians & Surgeons (ACCPPS) or the Board(s) recognized by the American Podiatric Medical Association (APMA) in the clinical specialty where privileges are requested. Allied Health Professionals must demonstrate board certification or board admissibility by a nationally recognized board applicable to their specific specialty and as approved by the Credentials Committee.
 - 1) If not board certified at the time of initial appointment, it is required that board certification will be achieved within the timeframe established by the practitioner's specialty board.
 - 2) If there is no time-frame established by a practitioner's specialty board, board certification will be achieved within five (5) years of CHI-FH membership.
 - 3) This requirement applies to those providers who join the Medical Staff after March 1, 2005. Medical staff members with staff membership granted on or before March 1, 2005, shall be "grandfathered" and be exempt from this requirement.
 - 4) The Credentials Committee may, on a case-by-case basis and with due consideration of the provider's performance, recommend exceptions to the board certification requirement provision.
 - e. Verification that the practitioner requesting approval is the same practitioner identified in the credentialing documents by viewing a valid picture ID issued by a state or federal agency (e.g., driver's license or passport), through receipt and review of a notarized copy of a picture ID issued by a state or federal agency (e.g. driver's license or passport) or through review of a current picture hospital ID card
 - f. Evidence of professional liability insurance coverage, including prior acts coverage for claims made policies that meet the criteria specified by the Board. Minimum professional liability insurance coverage requirements are \$1M/\$3M.
 - g. Residence and office location sufficiently close to the hospitals to provide continuous patient care, especially in emergencies.
- B. By applying for appointment to the Medical Staff, each applicant signs a release for information that consents to the inspection of records, authorizes and requests that the Medical Staff Office at CHI-FH verify his or her credentials. The release for information is a part of the initial application for appointment and reappointment.
- C. The completed application, along with a non-refundable application fee, shall be returned to the Medical Staff Office within thirty (30) days from the date of issue. Incomplete applications and/or applications submitted without the application fee shall not be processed and shall be returned to the applicant for completion. The applicant has thirty

(30) days to resubmit the completed application. If there is no communication or the completed application is not received within that time, the application is considered withdrawn, and the applicant will be so notified.

- D. The applicant has the burden of completing the application form and producing adequate information for proper evaluation of his or her competence, character, ethics, and if requested, health status, and other qualifications for resolving any doubts about such qualifications. In all cases, the applicant has thirty (30) days in which he/she ensures that the Medical Staff Office is in receipt of the requested information. If the information is not received within that time frame, the applicant will be notified via certified letter that the application is withdrawn. Should the applicant wish to resume the application process, he or she will submit a completed application form with all supporting documents.
- E. The Medical Staff Office shall verify from primary sources the information provided by the applicant and collect additional information wherever necessary. Verifications will include but is not limited to:
1. Verification of all current and past ten (10) years' state medical or professional license(s) and DEA certificate (if applicable) from primary sources.
 - a. WA state license and DEA certificate (if applicable) shall be verified at time of initial granting, renewal or revision of privileges and at time of expiration.
 2. Information held by the Secretary of the Department of Health and Human Services or agency designated by the Secretary; pursuant to the Health Care Quality Improvement Act of 1986 including the National Practitioner Data Bank and Medicare/ Medicaid Sanctions.
 3. Verification from primary sources of medical/professional education and training; internship; residency; fellowship; specialty board (where applicable); malpractice history, current and previous ten (10) years' hospital affiliations, professional peer references, military experience, current and past employment (if relevant), and obtain the Washington State Patrol background check.
 4. Information concerning the applicant's professional ethics, current competence, clinical judgment, clinical and technical skills, physical and mental health, and relationships with patient, peers, hospital and Medical Staff. A statement regarding whether or not the applicant has accepted voluntary or involuntary relinquishment of license, DEA registration, Medical Staff membership, voluntary or involuntary limitation, reduction, or loss of Clinical Privileges at any health care facility.
 5. Any adverse or derogatory information which could adversely affect the harmonious relationship with the Medical Staff.
- F. Upon completion of the application, verification of its contents and receipt of additional information, the credentials file with all related materials will be forwarded to the appropriate Section Chief or designee for evaluation.
1. A completed application is one where all of the information is found acceptable to the Credentials Committee. If the information is found to be unacceptable to the Credentials Committee, the application is considered incomplete.

2. The Clinical Section Chief, or the designated peer reviewer, shall review the applicant's credentials file and provide a summary of the review. The reviewer shall determine if the education, training, experience, current competence and health status and all other information in the credentials file supports the applicant's request for privileges and/or appointment to the Medical Staff of CHI-FH Hospital. The reviewer's comments and recommendations will be documented in the applicant's credentials file and in the Credentials Committee minutes.
 3. As a part of the process of evaluating an applicant the Credentials Committee may require that an applicant undergo a physical and/or mental exam by a physician or physicians satisfactory to the Credentials Committee and that results of such exam be made available to the Credentials Committee for review. Failure to obtain the requested examination within thirty (30) days after being requested to do so in writing by the Credentials Committee shall constitute an incomplete application and an automatic withdrawal of the application for appointment and Clinical Privileges, and all processing of the application shall cease.
 4. Based on the information in the applicant's credentials file, the Credentials Committee and/or Chair may:
 - a. Recommend approval.
 - b. Recommend denial.
 - c. Recommend modification of requested privileges.
 - d. Require the applicant to provide additional information to enable the committee to appropriately assess education, training, experience and other concerns regarding privileges requested, and/or require an interview.
 5. Within thirty (30) days of receipt of completed file, the Credentials Committee shall provide a written report of the review to the Medical Executive Committee.
 6. If the report is adverse to the practitioner, the report shall include the reasons for such adverse report.
 7. The Credentials Committee shall provide a written report to each campus' Operating Committee of all appointments, reappointments and/or request for privileges for their site since the last campus Operating Committee meeting.
 8. If the report is adverse to the practitioner, the report shall include the reasons for such adverse report.
- G. The Medical Executive Committee at its next regularly scheduled meeting, shall consider the written findings and recommendations of the Credentials Committee.
1. The Medical Executive Committee may:
 - a. Recommend approval of appointment/reappointment with privileges.
 - b. Recommend denial.

- c. Recommend modification or supervision of Clinical Privileges.
- 2. If the recommendation is adverse to the applicant, the applicant will be notified of the decision and the reasons for the recommendation.
- 3. The recommendation of the Executive Committee is transmitted (with or without comment) to the Quality and Value Committee of the.
- H. The Quality and Value Committee of the Board, at its next regularly scheduled meeting, shall review the reports from the Credentials Committee and the Medical Executive Committee regarding applications for appointment or reappointment and initial granting, revisions or revocation of Clinical Privileges and forward their recommendation to the Board.
- I. The Board makes the final decision on all Medical Staff applications for appointments and reappointments, and the granting, revision, or denial of Clinical Privileges. The Board is not bound by the recommendations of the Medical Executive Committee or the Quality and Value Committee.
- J. Upon the final decision of the Board, the Chief Executive Officer or a representative of the Board, shall inform the applicant in writing of the Board's decision.

SECTION 2. ACTIVE STAFF APPOINTMENT

- A. Appointees to the Active Staff category are fully licensed physicians, dentists, and podiatrists who meet the Active Staff Category qualifications of Article I, Section 1 of the Medical Staff Bylaws. Active Staff appointees select a Campus where they will vote and where they will fulfill the obligations of Active Medical Staff membership.
- B. Initial appointment on the Active Staff shall be for a provisional period of not less than twelve (12) months and not more than twenty-four (24) months. During the provisional period the practitioner's hospital practice is evaluated for compliance with applicable Medical Staff policies, rules and regulations and community standards and/or other criteria as defined in the Focused Professional Practice Evaluation process. The provisional status will be reviewed on the practitioner's birth month following a period of at least twelve (12) months and shall constitute the first reappointment to the Medical Staff.
- C. Such initial appointment to the Active Medical Staff is conditional to the applicant successfully completing training and providing demonstrated proficiency in the use of the electronic health record.

SECTION 3. AFFILIATE CATEGORY

- A. Appointees to the Affiliate category are fully licensed physicians, dentists, and podiatrists who do not meet the Active Staff Category qualifications of Article I, Section 1 of the Medical Staff Bylaws and for those who do not seek Hospital practice privileges. This category may also apply to practitioners who do not intend to admit and/or treat patients in the Hospital. Hospital privileges shall not be offered.

- B. Affiliate appointees are not eligible to admit patients to the Hospital or to exercise Clinical Privileges in the Hospital. They may attend educational meetings or committees meetings for education purposes.
- C. Affiliate appointees shall follow an abbreviated credentialing and reappointment process.

SECTION 4. HONORARY CATEGORY

- A. The Honorary category shall consist of physicians, dentists and podiatrists recognized for their outstanding reputation, their noteworthy contributions to CHI-FH and the community or their previous long-standing service to the Hospital. The designation as Honorary Staff shall be conferred by the Board upon the recommendation of the Medical Executive Committee.
- B. Honorary appointees are not eligible to admit patients to the Hospital or to exercise Clinical Privileges in the Hospital. They may attend Staff and Hospital educational meetings. Honorary appointees are not eligible to vote or hold office in the Medical Staff organization, or serve on standing Medical Staff committees.

SECTION 5: CONTACT INFORMATION

To facilitate contact regarding patient care and correspondence related to the business of the organized Medical Staff, regardless of staff category, members of the Medical Staff and other practitioners granted privileges are required to provide CHI Franciscan with current and accurate:

- A. Office mailing address
- B. Office contact numbers (telephone, fax, and backline)
- C. Cell phone and/or pager numbers
- D. E-mail address
- E. Home address and telephone number (for disaster plan)
- F. Detailed information for after office hours contact preferences

This information is to be provided at appointment, reappointment and within 30 days of any changes to the Medical Staff Office (MSO) and updated, as needed, thereafter with the MSO.

The Medical Staff Office will maintain the contact information in the Medical Staff data base in a secure and confidential manner. It may only be made available to those individuals or entities with a bona fide need to access the information.

ARTICLE II. PROCEDURE FOR REAPPOINTMENT

- A. Reappointment to the Medical Staff shall be made by the Board. The Board shall act on the reappointment application upon receipt of a recommendation from the Medical Executive Committee.

- B. Appraisal for reappointment or renewal or revisions of Clinical Privileges shall be uniformly applied to each applicant on the Medical Staff and shall be made for a period not to exceed two (2) years.
- C. Reappointment to the Medical Staff and the reappraisal of Clinical Privileges shall be based on information concerning the individual's professional performance, judgment, quality information, and clinical and technical skills. In addition, evidence of current ability to perform the privileges requested shall be documented in the applicant's credentials file and considered a basis for granting renewal or revision of Clinical Privileges.
- D. The Clinical Section Chief may evaluate the applicant's ability to perform the privileges requested, or may request an evaluation from someone on the Medical Staff who is a peer of the applicant. The written report of the evaluation will be incorporated into the reappointment process.

SECTION 1. APPLICATION FOR REAPPOINTMENT

- A. The Medical Staff Office will initiate the reappointment process at least six (6) months prior to the expiration of the current appointment.
- B. Application for reappointment to the Medical Staff shall be in writing or via electronic application. Each current member who is eligible for reappointment shall be responsible to complete the reappointment application and submit same in a timely manner to the Medical Staff Office.
- C. The reappointment application shall include the following information:
 1. Complete and current information regarding current license, health status changes, professional liability insurance coverage and experience, other hospital affiliation(s), previously successful and currently pending challenges to any licensure or registration (State or Drug Enforcement Administration), the voluntary or involuntary relinquishment of such licensure or registration.
 2. A signed release and immunity from civil liability statement.
 3. Completion of a new privilege form with documentation supporting any request for new privileges/procedures.
 4. Statement regarding whether or not the applicant has been involved in disciplinary actions from the any medical, dental or podiatric board or medical society.
 5. Statement regarding whether or not the applicant has been charged in any criminal proceedings.
 6. Statement as to whether or not the applicant's clinical privileging status, medical/dental/podiatric Staff status, or appointment at any health care facility, has been revoked, denied, restricted reduced, suspended, terminated or granted with stated limitations or conditions.
 7. Health statement indicating whether or not the applicant can safely perform the essential functions of the position for which he or she is requesting privileges with or without reasonable accommodation.

- D. The Staff member bears the burden of producing all information needed to evaluate the application in the same manner as stated in Article I, Section 1 in connection with the initial application.
- E. By applying for reappointment to the Medical Staff and renewal, revision of Clinical Privileges on the Medical Staff, each applicant agrees to the same conditions outlined in Article I, Section 1 of this manual.
- F. The application for reappointment shall be returned to the Medical Staff Office within thirty (30) days from date of issue. Incomplete reappointment applications will not be processed and will be returned to the applicant for completion. If there is no communication within the subsequent thirty (30) days, a certified letter will be sent informing the applicant that he/she has an additional two (2) weeks to respond, after which he/she will be dropped from Staff for failure to reapply. This will be considered an automatic resignation for failure to reapply to the Medical Staff and is not subject to fair hearing and due process and is not reportable to the National Practitioner Data Bank. Failure to return the reappointment application in sufficient time (less than three weeks) to process prior to the current expiration of privileges, shall be cause for automatic relinquishment of Medical Staff Privileges. Automatic relinquishment shall remain in effect until such time as the review, evaluation and approval by the Board has occurred. (See Bylaws Article VI, Section 3.) If an applicant is under investigation, or has been informed that he/she is under investigation which might lead to corrective action or suspension, CHI-FH is under obligation to report the withdrawal to the National Practitioner Data Bank. Resignation in lieu of formal action will not be accepted.
- G. Upon completion of the verification process of the reappointment application, the following information will be considered for reappointment and renewal or revision of Clinical Privileges:
 1. Professional ethics, competence, and clinical judgment in the treatment of patients.
 2. Physical and mental health status.
 3. Compliance with Hospital policies and Medical Staff Bylaws, Rules and Regulations and the procedural policies and the Ethical and Religious Directives for Catholic Health Facilities.
 4. Cooperation and relations with other practitioners, and general attitude toward patients, the Hospital and the public.
 5. Satisfactory completion of continuing education requirements as may be imposed by the law, this Hospital or applicable accreditation agencies.
 6. Individual's clinical and technical skills as indicated in part by the results of performance improvement or other monitoring functions.
 7. Voluntary or involuntary termination of Medical Staff membership or voluntary or involuntary limitation, reduction, or loss of Clinical Privileges at this or another health care facility.
 8. Other reasonable indicators of continuing qualifications including information found in the individual's credentials file.

9. Current professional liability insurance status, pending malpractice challenges, including claims, lawsuits, judgments and settlements.
 10. Information from the National Practitioner Data Bank; Medical Board; Medicare or Medicaid sanctions or reports.
 11. Ongoing Professional Practice Evaluation data.
- H. The Medical Staff Office will provide reappointment profile(s) reflecting statistical and clinical activity data, performance evaluation, improvement and peer review information to support the renewal of Clinical Privileges. The information will be considered at the time of reappointment. The information may include but is not limited to:
1. Outcomes of performance improvement activities.
 2. Non-use of privileges for high-risk procedure or treatment over a period of two (2) years.
 3. Hospital utilization review data; infection control, drug usage review and blood usage review statistics.
 4. Any unfavorable outcomes that have been attributed to the practitioner's knowledge, skill, or judgment based on findings and conclusions of peer review actions.
 5. Ongoing Professional Practice Evaluation data.
- I. The Medical Staff Office will forward the reappointment application and accompanying documents for evaluation and review by the Chief of Section and then to the Credentials Committee.
- J. Review by the Chief of Section, the Credentials Committee, the Medical Executive Committee and approval by the Board will follow the same procedure outlined in Article I, Section 1, paragraphs F through J of this manual.
- K. In the event of an adverse decision by the Board, the Chief Executive Officer or a Board designee, shall promptly notify the practitioner of its decision by certified mail, return receipt requested, and inform him/her of the right to appeal under the provisions of Article VII, Panel Review Hearing of the Medical Staff Bylaws.
1. Any Active Medical Staff member has a right to a hearing/appeal pursuant to the Hospital's Fair Hearing Plan.
 2. Adverse actions that affect a practitioner's appointment or status as a member of the Active Medical Staff or the exercise of Clinical Privileges are as follows:
 - a. Denial of Staff appointment/reappointment.
 - b. Revocation of Staff appointment.
 - c. Denial or restriction of requested Clinical Privileges.
 - d. Reduction in Clinical Privileges.

- e. Revocation of Clinical Privileges.
 - f. Mandatory consultation requirements.
- L. **Limitation on Reapplication for Membership.** No practitioner whose application for Medical Staff membership or reappointment on the Medical Staff has been denied, or whose membership has been finally terminated by corrective action or suspension shall be permitted to submit another application requesting such membership for a period of at least two (2) years from date of final action. The Board may, on a case by case basis and for good reason, make exceptions to this provision.

SECTION 2. LEAVE OF ABSENCE (LOA)

- A. A member of the Active Medical Staff or Allied Health Professional Staff may, for good cause, be granted a leave of absence by the Board for a definite stated period of time not to exceed one (1) year. An absence for longer than one (1) year will constitute an automatic resignation of Medical Staff/Allied Health Professional Staff appointment and termination of Clinical Privileges unless an exception is made by the Board.
1. A request for a leave of absence, and the reason for the leave, including military duty, shall be made in writing to the President of the Medical Staff, the Chief Executive Officer of CHI-FH, or the Chief Medical Officer or their designee at least 30 days prior to the anticipated start of the leave unless the leave is precipitated by urgent circumstances.
 2. Even if a practitioner has been granted a Leave of Absence by their employer, it is still necessary to separately request a leave of absence from the Medical Staff.
 3. The request shall state the beginning and ending dates, if known.
 4. Concurrence of the Clinical Section Chief is recommended.
 5. A Medical Staff appointee or Allied Health Professional must request a leave of absence in writing if
 - a. The provider will be away from Medical Staff and/or patient care responsibilities for longer than 120 calendar days.
 - b. The provider will be away from Medical Staff and/or patient care responsibilities for longer than 30 calendar days and the reason for the leave of absence is related to physical or mental health.
 6. During this leave, the provider may not exercise any clinical privileges/scope of practice and will be excused from Medical Staff and Allied Health Professional responsibilities (e.g. meeting attendance, committee service, emergency service call obligations) during this period.
 7. Required expired items that come due during the leave of absence will not be required until reinstatement of privileges or scope of practice (e.g. annual TB health testing, current malpractice certificate, alternate coverage arrangements).

8. If a provider is incapacitated, their designee may submit the leave of absence request on behalf of the provider.
9. The Medical Executive Committee will consider the leave of absence request at its next regularly scheduled meeting and shall recommend approval or denial to the Board.
10. A leave of absence request submitted in lieu of potential corrective action or suspension will not be considered.
11. In the event that a leave of absence request is denied, the practitioner can either continue their Medical Staff/Allied Health Professional Staff appointment with privileges, or resign from the Medical Staff/Allied Health Professional Staff.
12. Before a leave of absence is granted, the practitioner must have completed all medical records and fulfilled any other Medical Staff/Allied Health Professional Staff obligation required as a condition of membership on the Medical Staff.
13. Prior to returning from leave, the provider must submit a request for reinstatement with a written summary of professional activities during their leave. The provider must also provide current documentation of expired items along with any other information requested by the hospital.
14. At the conclusion of the leave of absence, the individual shall be reinstated, through the reappointment process. Practitioner shall document professional activity during leave of absence period. Temporary Clinical Privileges are only granted as a courtesy and shall only be considered if the practitioner meets any of the following circumstances:
 - a. To fulfill an important patient care need, or
 - b. When a practitioner with a complete, clean application is awaiting review and approval of the Medical Executive Committee and the Board. or
 - c. If leave of absence was for health reasons, the request for reinstatement must also be accompanied by health assessment documentation from the provider's physician indicating the provider is physically and/or mentally capable of resuming a hospital practice and can safely exercise the clinical privileges/scope of practice requested.

ARTICLE III. CLINICAL PRIVILEGES

SECTION 1. CLINICAL PRIVILEGES

- A. Every practitioner at CHI-FH by virtue of Medical Staff membership or otherwise, in connection with such practice, shall be entitled to exercise those Clinical Privileges specifically granted to him or her by the Board, except as provided in Sections 2 and 3 of this Article III.
- B. Every application for initial appointment or reappointment must contain a request for Clinical Privileges (excluding the Affiliate Category) submitted on the appropriate delineation of privilege form. The evaluation of such requests shall be based upon the

applicant's current license, relevant education and training, evidence of ability to perform the requested privileges, experience, demonstrated competence, peer and/or facility recommendations, data from professional practice review by an organization(s) that currently privileges the applicant, references and other relevant information. When renewing privileges, review of the practitioner's performance within the organization is performed. The applicant shall have the burden of establishing his or her qualifications and competency for the Clinical Privileges requested.

- C. Periodic renewal or revision of Clinical Privileges and the increase or curtailment of same shall be based upon the direct observation of care provided, review of records of patients treated in this or other hospitals, and review of the records of the Medical Staff which document the evaluation of the member's participation in the delivery of medical/ surgical care and information gathered in the performance improvement process of the Hospital.
- D. Once the electronic health record system is satisfactorily implemented; exercise of clinical privileges will be restricted to those practitioners who have successfully completed training and demonstrated proficiency in the use of the electronic health record.
- E. If applying for Clinical Privileges in a service line or program that is operated as a closed panel, a practitioner must demonstrate that he/she meets the objective qualifications and complies with the objective requirements applicable to the closed panel.
- F. If applying for Clinical Privileges in a service line or program that is subject to an exclusive or semi-exclusive contract, a practitioner must demonstrate that he/she is a member, employee or subcontractor of the group or person that holds the exclusive or semi-exclusive contract.
- G. Professional Practice Evaluation consists of two phases:
 - 1. Focused Professional Practice Evaluation (FPPE)
 - a. FPPE consists of an evaluation that will be conducted as set forth by the Medical Staff FPPE Policy and Procedure #80.50 to confirm current competence for the following circumstances:
 - 1) New Appointments: All practitioners initially appointed; provisional status as outlined in the Medical Staff Bylaws.
 - 2) New Privilege Requests: All practitioners requesting new privileges not previously requested; when the new requested privilege is significantly different from current practice.
 - 3) Below Threshold/Peer Review: Any instance a practitioner shows below standard performance or if the results of an Ongoing Professional Practice Evaluation (OPPE) indicate a potential issue with physician performance.
 - 4) Low Activity: When a privilege/procedure is used infrequently.
 - b. FPPE may consist of:

- 1) Monitoring and proctoring of performance as dictated by the CHI-FH Credentials Committee's review of the applicant's request for membership and privileges. All proctoring must abide by CHI-FH Professional Proctoring Policy.
 - 2) Focused review of cases, by volume, outcome, complication rates, returns to the hospital, post discharge surveillance data- all compared to peer group comparisons, and adjusted where possible for acuity.
 - 3) FPPE is completed and used for advancement at the time of provisional to full active appointment or whenever any of the above-stated circumstances occur.
2. Ongoing Professional Practice Evaluation (OPPE) shall be carried out as set forth by the Medical Staff OPPE Policy and Procedure #80.00 and may consist of:
- a. Ongoing review of cases, by volume, outcome, complication rates, returns to the hospital, average length of stay, average cost by case, post discharge surveillance data- all compared to peer group comparisons, and adjusted where possible for acuity
 - b. Review of participants peer review experience, grievances, incident reports, litigation/claims, patient satisfaction data, and CMS Core Metric report cards.
 - c. OPPE may be performed concurrent with the reappointment cycle but must meet the timelines as set forth by the Medical Staff OPPE Policy and Procedure. The data used is presented to the section chief, the Chief Medical Officer (or designee), and available to the Credentials Committee.

SECTION 2. TEMPORARY CLINICAL PRIVILEGES

- A. Temporary privileges shall only be considered if the practitioner meets either of the following circumstances:
 1. To fulfill an important patient care need;
 2. When an applicant with a complete, clean application is awaiting review and approval of the Medical Executive Committee and the Board.
- B. Temporary privileges may be considered only when the application is complete, all required documentation has been received and verified and there are no significant questions or unfavorable action concerning the applicant's qualifications.
- C. Upon review and recommendation of the peer reviewer, if applicable, the Chief of Section, the Chief Executive Officer or designee, may grant temporary admitting and Clinical Privileges to the applicant for a period not to exceed one hundred-twenty (120) consecutive days. In exercising such privileges, the applicant shall act under the supervision of the Clinical Section Chief in the specialty where privileges have been extended. Granting of such temporary privileges shall have no bearing on final acceptance or rejection for Medical Staff appointment or granting of Clinical Privileges.

- D. Special requirements of supervision and reporting may be imposed by the Clinical Section Chief and/or the Credentials Committee on any practitioner granted temporary privileges. Temporary privileges shall be immediately terminated by the Chief Executive Officer, or designee, upon notice of the practitioner's failure to comply with any such special conditions.
- E. The Chief Executive Officer or designee, may at any time, upon the recommendation of the Executive Committee or the Clinical Section Chief, terminate a practitioner's temporary privileges effective with the discharge of the practitioner's patient(s) in the Hospital. However, where it is determined that the life or health of such patient would be endangered by continued treatment by the practitioner, the termination may be imposed by any person entitled to impose summary suspension pursuant to Article VI, Section 2 of the Medical Staff Bylaws, and shall be immediately effective. The Clinical Section Chief or in his absence the President of the Medical Staff shall assign a member of the Medical Staff to assume responsibility for the care of such patient(s) until discharge from the Hospital. The wishes of the patient shall be considered in the selection of such substitute practitioner(s).
- F. Temporary privileges are granted as a courtesy. Should temporary privileges be denied, revoked, or modified, the practitioner will not be entitled to any of the corrective action and due process rights of an Active Medical Staff member.

SECTION 3. LOCUM TENENS

After review and recommendation of an application and verification of its contents by the Chief of Section or designee, the Chief Executive Officer or designee may permit a physician or Allied Health Professional serving as a locum tenens for a member of the Active Medical Staff or Allied Health Professional Staff, to attend patients without applying for Medical Staff membership for a period not to exceed ninety (90) consecutive days in a twelve (12) month period. Under extraordinary circumstances, this timeframe may be extended by the Board on a case by case basis in sequential 90 day increments.

- A. Locum tenens may be extended or renewed only once by providing the Medical Staff Office with a letter explaining the "extraordinary circumstances" prior to the expiration of the coverage rotation. Letter of explanation shall come from the practitioner office requesting the locum tenens coverage. All other extensions or renewals to the medical or allied health medical staffs will require completion of a full application.
- B. If at any time professional liability coverage is terminated, locum tenens membership and privileges will be terminated.
- C. With the appropriate training and qualifications, a locum tenens practitioner may act as a "proctor" for the duration of his/her locum tenens appointment.

SECTION 4. VISITING CONSULTANT PRIVILEGES

Under extraordinary circumstances an appropriately trained practitioner shall be permitted to consult, assist in the care of, and to treat or teach by demonstration. The Chief Executive Officer or designee shall make a recommendation upon review of an application and verification of its contents. This is usually limited to seventy-two (72) hours in any one calendar year but may be extended by the Board. This category of privileges is intended to allow utilization of nationally and

internationally recognized consultants whose services and skills may benefit the patient and are not readily available in this community. It is not intended to bypass the standard credentialing and privileging of those planning to practice in CHI-FH. Concurrent care must be provided by an appropriately credentialed member of the Active Medical Staff who is ultimately responsible for the admission, discharge and follow-up care.

SECTION 5. EMERGENCY PRIVILEGES

- A. For the purposes of this section, an "emergency" is defined as a condition which would result in serious permanent harm to a patient, or in which the life of a patient is in immediate danger and any delay in administering treatment would add to that danger.
- B. In the case of an emergency, any member of the Medical Staff, to the degree permitted by his/her license, shall be permitted and assisted to do everything possible to save the life of a patient, using every facility of the Hospital necessary, including the calling for any consultation necessary or desirable. When an emergency situation no longer exists, such practitioner must relinquish care of the patient if not already privileged to continue care. The wishes of the patient shall be considered where feasible in the selection of a Staff member to continue care.
- C. If there is a need for emergency, specialized care not normally available at the facility, any practitioner who is not credentialed but possesses skills and expertise to administer treatment for a patient in immediate danger may request to do everything possible to save the life of a patient.
- D. The Chief Medical Officer or designee shall review the practitioner's credentials and privileges from the facility where he practices and make a recommendation.

SECTION 6. RESIDENT SCOPE OF PRACTICE

- A. Resident Scope of Practice may be requested by submitting an application to the Medical Staff Office. Residents are not afforded membership on the Active Medical Staff but may, through the residency program, request and be granted a scope of practice valid only during rotations at CHI-FH facilities.
- B. Resident scope of practice may be granted to qualified practitioners not licensed in the State of Washington under limited circumstances:
 - 1. When a current affiliation agreement exists between the Residency Training Program and CHI Franciscan.
 - 2. The resident is enrolled in a training program approved by the Accreditation Council for Graduate Medical Education (ACGME) or the American Osteopathic Association (AOA) or the American Podiatric Medical Association.
- C. Residents must provide:
 - 1. Evidence of professional liability insurance as required by the Board.

2. A current Washington State license (if applicable), OR if a uniformed service member, must have a current license in good standing from another State.
 3. A profile verifying educational degrees (AMA, AOA or DASG Profile).
- D. Residents may only function under the direct supervision of the Program Preceptor and within the scope of practice approved for the rotation. Residents and teaching physicians must abide by the Teaching Physician Medical Record Documentation and Billing Policy.
- E. Residents are afforded the same courtesies as Medical Staff members except they may not vote or hold office. When completing a CHI-FH rotation, a resident's scope of practice to provide any and all care shall automatically cease without prejudice and without entitlement to due process procedures. This resignation or withdrawal is not reportable to the National Practitioner Data Bank. The resident may apply for Medical Staff membership by following procedures outlined beginning with Article I of this manual.
- F. Residents may be considered only when all required documentation has been received and verified and there are no significant questions concerning the applicant's qualifications.
- G. As a process of monitoring and evaluating all resident programs, the Credentials Committee will serve as the Oversight Committee. The Credentials Committee shall have the authority to review and make a recommendation to the Medical Executive Committee regarding all residents and policy issues regarding CHI-FH residency programs.

SECTION 7. FELLOW PRIVILEGES

- A. Physicians in a fellowship program may apply for membership and privileges by submitting an application to the Medical Staff Office and are afforded membership of the Medical Staff. Fellows shall follow the credentialing procedures outlined beginning with Article I of this manual.

SECTION 8. STUDENT SCOPE OF PRACTICE

- A. Student Scope of Practice may be requested by submitting an application to the Medical Staff Office. Students are not afforded membership on the Active Medical Staff but may, through the application process request and be granted scope of practice during rotations at CHI-FH facilities.
- B. Student scope of practice may be granted to qualified students not licensed in the State of Washington under limited circumstances:
1. When a current affiliation agreement exists between the Student University Training Program and CHI Franciscan.
 2. The student is enrolled in a training program approved by the Accreditation Council for Graduate Medical Education (ACGME) or the American Osteopathic Association (AOA) or the American Podiatric Medical Association.
- C. Students must provide:

1. Evidence of professional liability insurance as required by the Board.
 2. A current Washington State license (if applicable), OR if a uniformed service member, must have a current license in good standing from another State.
- D. Students may only function under the direct supervision of the Program Preceptor and within the scope of practice approved for the rotation.
- E. When completing a student rotation at CHI-FH, the student's scope of practice to provide any and all care shall automatically cease without prejudice and without entitlement to due process procedures. This completion of rotation is not reportable to the National Practitioner Data Bank.
- F. Students may be considered only when all required documentation has been received and verified and there are no significant questions concerning the applicant's qualifications.
- G. As a process of monitoring and evaluating all student programs, the Credentials Committee will serve as the Oversight Committee. The Credentials Committee shall have the authority to review and make recommendation(s) to the Medical Executive Committee regarding all students, policies and issues regarding CHI-FH student programs.

SECTION 9. REQUEST FOR ADDITIONAL CLINICAL PRIVILEGES

- A. Requests for additional privileges may be made at any time. The request shall be made in writing on the appropriate privilege form. The request shall state in detail the specific additional Clinical Privileges desired and the appointee's relevant recent training and experience which justify increased privileges. The request for additional privileges will be processed in the same manner as an initial application. Each applicant agrees to the same conditions outlined in Article 1, Section 1 of this manual.
- B. Proctoring for new procedures. The appropriate section chair or Medical Director or the Credentials Committee may require proctoring for a new privilege. This requirement will be based upon the complexity of the subject procedure, risks involved, and similarity or dissimilarity to procedures for which the provider is currently privileged. At the completion of each proctored case, the proctoring provider will be required to complete and submit a proctor report regarding the competence of the proctored provider in the subject procedure.
- C. Recommendation for an increase in Clinical Privileges made to the Board shall be based upon:
1. Relevant recent training and/or education;
 2. Observation of patient care provided;
 3. Review of records of patients treated in this or other hospitals;
 4. Results of the Hospital's quality improvement and assessment activities;
 5. Focused Professional Practice Evaluation; and

6. Any other reasonable indicators of the individuals continuing qualifications for the privileges in question.

SECTION 10: PROCTOR QUALIFICATIONS

A proctor must be a practitioner who has recognized proficiency or documented expertise in the specialty area being proctored. In order to be eligible to be a proctor at CHI Franciscan, practitioners must meet one of the following criteria:

- A. Be a member of the CHI Franciscan Active Medical Staff in good standing and credentialed and privileged at CHI Franciscan for the procedure/privilege being proctored.
- B. Apply for and be granted “Locum Tenens Appointment” in accordance with Article III, Section 3 of the Credentials Manual or “Visiting Consultant Privileges” in accordance with Article III, Section 4 of the Credentials Manual of the CHI Franciscan Medical Staff Bylaws and meet CHI-FH credentialing and privileging standards. Proctors must hold the privilege for the procedure/privilege they will proctor at an accredited health care facility. Proctors who meet this criterion must be approved by the Chief Medical Officer or designee prior to the proctoring.
- C. Proctoring may be performed outside of CHI Franciscan facilities but must be approved by the Chief Medical Officer or designee in advance (facility and proctor). Proposed proctors must hold the privilege for the procedure/privilege they will proctor at their own health care facility.

SECTION 11: CHAPERONES

If a requirement is imposed, either by the practitioner’s licensing board, or by other disciplinary action, for a practitioner to have a chaperone present when seeing patients, it will be the responsibility of the provider to ensure their practice complies with the requirement.

SECTION 12: ONE TIME PRIVILEGES

- A. One time privileges to care for a specific patient may be granted by the Chief Medical Officer or designee to a practitioner who is not on the Medical/Allied Health staff of CHI Franciscan, and who does not intend to pursue appointment.
- B. The practitioner’s one time privileges shall automatically terminate effective with discharge of the patient, however, where it is determined that the life or health of such patient would be endangered by continued treatment by the practitioner, termination may be imposed by any person entitled to impose a summary suspension pursuant to Article VI, Section 2 of the Medical Staff Bylaws, and shall be effective immediately. If one time privileges are denied, revoked, or modified, the practitioner will not be entitled to any of the corrective action and due process rights of an Active Medical Staff member.
- C. One time privileges will be granted for the care of one patient per calendar year only.

SECTION 13: DISASTER CREDENTIALING

- A. In the event that the CHI-FH Incident Command System is implemented, privileges may be granted to volunteer medical staff and Allied Health Professionals in accordance with the CHI-FH Emergency Management Disaster Credentialing Procedure, Policy #504.70.
- B. The decision whether or not to authorize the use of volunteer staff and the degree to which they will be allowed to practice in the event of a community wide disaster will be at the sole discretion of the Hospital President or his/her designee. To the degree permitted by his/her license, the volunteer, licensed independent practitioners may be granted privileges to do everything possible to save the life of a patient, using every facility of the Hospital necessary, including the calling for any consultation necessary or desirable. Based on the oversight of each volunteer, licensed independent practitioner, the Hospital determines within 72 hours of the practitioner's arrival if granted disaster privileges should continue. When there is no longer a need for the volunteer staff, such practitioner must relinquish their privileges.
- C. Primary source verification of licensure of individuals who receive disaster privileges shall begin as soon as the immediate situation is under control or within 72 hours from the time the volunteer, licensed independent practitioner presents to the organization. In the extraordinary circumstance that primary source verification cannot be completed within 72 hours, it will be done as soon as possible. In this extraordinary circumstance, there must be documentation of why it could not be performed in the required timeframe, evidence of a demonstrated ability to continue to provide adequate care and evidence of the Hospital's attempts to perform primary source verification as soon as possible. Primary source verification of licensure would not be required if the volunteer practitioner has not provided care, treatment and services under the disaster privileges. Verification will be processed according to Article III, Section 2 (Temporary Privileges) of the Credentials Manual.
- D. Privileges may be terminated at any time without any reason or cause. Volunteer staff shall have no right to appeal the decision. The wishes of the patient shall be considered where feasible in the selection of a Staff member to continue care.

SECTION 15 VIRTUAL HEALTH SERVICES PRIVILEGES

- A. Virtual Health Services involves the use of electronic communication or other communication technologies to provide or support clinical care at a distance.
- B. Practitioners requesting privileges for t virtual health services shall follow the procedure outlined in Article II, Section 6 D, "Remote Provider and Virtual Health Privileges" of the Medical Staff Bylaws.

SECTION 16 WAIVED/NON-WAIVED TESTING

By virtue of their medical training, the medical staff providers may perform waived testing that falls within his or her specialty and does not involve an instrument. Medical staff providers may perform additional waived and non-waived testing based on their medical specialty training if the additional testing privileges are documented.

**ARTICLE IV. RELINQUISHMENT OF APPOINTMENT
AND/OR CLINICAL PRIVILEGES**

SECTION 1. AUTOMATIC RELINQUISHMENT OF APPOINTMENT AND/OR CLINICAL PRIVILEGES

Automatic relinquishment of appointment and/or Clinical Privileges is not reportable to the National Practitioner Data Bank and is not subject to due process. A practitioner's resignation must be submitted in writing to the President of the Medical Staff or designee, and must specify the effective date of the resignation. This action will be formally accepted only after all medical record obligations have been satisfied. If relinquishment of either membership or privilege(s) is done in an attempt to avoid a corrective action or in lieu of formal action due to performance and/or disciplinary issues, the action will be reportable to the National Practitioner Data Bank via the State of Washington, Department of Health, in accordance with statutory requirements.

SECTION 2. DENIAL, REVOCATION, LIMITATION, SUSPENSION, REDUCTION OF CLINICAL PRIVILEGES

Whenever, on the basis of information and belief, the Chief Executive Officer, the President of the Medical Executive Committee or their designated representative(s), has cause to question:

- A. The clinical competence of any Medical Staff appointee;
- B. The care or treatment of a patient or patients or management of a case by any Medical Staff appointee;
- C. The known or suspected violation by any Medical Staff appointee of applicable ethical standards or the Bylaws, policies, Rules and Regulations of the Hospital or its Board or Medical Staff, including but not limited to the Hospital's quality assessment, risk management, and utilization review programs; or
- D. Behavior or conduct on the part of any Medical Staff appointee that is considered lower than the standards of the Hospital or disruptive to the orderly operation of the Hospital or its Medical Staff, including the inability of the appointee to work harmoniously with others;

He/She has the authority to suspend all or any portion of the Clinical Privileges of the practitioner. Such summary suspension shall become effective immediately upon imposition, in accordance with Article VI, Sections 1 and 2, of the Medical Staff Bylaws.

ARTICLE V. ALLIED HEALTH PROFESSIONALS

SECTION 1. ALLIED HEALTH PROFESSIONALS - GENERAL

- A. Allied Health Professionals are not members of the Active Medical Staff, and accordingly, have none of the rights of Active Medical Staff members.
- B. Allied Health members consist of Categories I, II and III professionals.

- C. Every Allied Health Professional shall be covered by and furnish evidence of professional liability insurance coverage in the same amounts as required by Active Medical Staff members as described in Article 1, Section 1,A,4.
- D. The Hospital retains the right, either through the Chief Executive Officer or upon recommendation of the Medical Executive Committee to suspend or terminate any or all of the privileges or functions of any Allied Health Professional without recourse on the part of such person(s) or others to the hearing procedure of the Medical Staff Bylaws, policies and procedures.
- E. Category I, II and III Allied Health Professionals who are to be terminated or curtailed shall be notified in writing by the Chief Executive Officer or designee of the reasons for such action and, if they so request, within thirty (30) days, shall be entitled to have such action reviewed by the Medical Executive Committee. At any review meeting, the practitioner shall be allowed to be present and participate without a vote. The Medical Executive Committee can recommend to accept, reject or modify the decision to terminate or curtail subject to review and final decision by the Board.

SECTION 2. CATEGORY I ALLIED HEALTH PROFESSIONALS

- A. Category I Allied Health Professionals will consist of health care providers, other than Active Medical Staff members, who are licensed in the State of Washington to practice independently. They may be privileged to admit and/or provide specific medical care to patients within their scope of practice and Clinical Privileges approved by the Board. This includes but is not limited to certain Advanced Registered Nurse Practitioners and Clinical Psychologists (Ph.D.). See "Allied Health Professionals Functional Descriptive Summaries" in the Credentialing Guidelines for Allied Health Professionals.
- B. Category I Allied Health Professionals shall have their application processed in the same manner as applicants of the Active Medical Staff. Application for Clinical Privileges shall be processed in accordance with policies for clinical privileging.
- C. Temporary privileges for Category I Allied Health Professionals will be processed in the same manner as for Medical Staff members.
- D. Category I Allied Health Professionals with admitting privileges are required to obtain and document clinical guidance from an appropriately credentialed Active Medical Staff member prior to major diagnostic or therapeutic interventions or within twenty-four (24) hours of admission, whichever comes first, except in the case of uncomplicated labor and delivery. Medical Staff consultation is required prior to transfer of a newborn or other patient to another facility.
 - 1. Mental Health Psychiatric Nurse Practitioners may independently participate in the management and care of the inpatient and exercise independent judgment in area of competence without consultation from an active medical staff member.
 - a. The mental health nurse practitioner will contact the sponsoring/supervising physician for the following situations:
 - 1) Severe Acuity – for example
 - a) Medical complication
 - b) Pain medication management

- c) Suicide attempt involving high lethality – guns, hanging, carbon monoxide, jumping from bridge
 - d) Suicide attempt during hospitalization
 - 2) Prolonged stay (beyond average length of stay)
 - 3) Disgruntled and/or severely angry patient or family
 - 4) Patients placed in restraints or seclusion.

- E. Category I Allied Health Professionals may, as a condition of continued privileges, be required to attend meetings involving the clinical review of patient care in which they participate.

- F. Category I Allied Health Professionals who are not granted admitting privileges shall:
 - 1. Exercise independent judgment in their area of competence. However, a member of the Active Medical Staff shall have the ultimate responsibility for the patient's general medical condition;
 - 2. Participate directly in the management and care of the patients under the general supervision or direction of an Active Medical Staff member;
 - 3. Record reports and progress notes on the patients' records and write orders for treatments to the extent established in the Rules and Regulations and Credentialing Manual of the Medical Staff Bylaws provided that such orders are within the scope of their license, certificate, or other legal credentials and granted privileges.
 - 4. May not admit patients to nor discharge them from the Hospital.

SECTION 3. CATEGORY II AND III ALLIED HEALTH PROFESSIONALS

- A. This category of Allied Health Professionals includes Advanced Professionals (Category II) and non-CHI-FH employed Professional/Technical providers (Category III).

- B. Professionals in this group must remain under the control and active supervision of specific members of the Active Medical Staff to ensure adequate overall patient protection. The sponsor shall present a written statement of the clinical duties and responsibilities to the section and to the Executive Committee for review and approval. The requested privileges must be approved prior to utilizing said individual within the Hospital. The sponsor shall complete such forms as may be requested by the Medical Executive Committee or Designee.

- C. Temporary privileges for this category of Allied Health Professionals will be processed in the same manner as for Active Medical Staff members.

- D. The sponsor of a Category II or III Allied Health Professional shall assume full responsibility, and shall be fully accountable for the conduct of said individual within the Hospital. Further, it is the responsibility of the sponsor of Category II and III Allied Health Professional to acquaint said individual with the applicable rules and regulations of the Medical Staff and the Hospital as well as appropriate members of the Active Medical Staff and Hospital personnel with whom the Allied Health Professional will have contact in the Hospital.

- E. The clinical duties and responsibilities of a Category II or III Allied Health Professional within the Hospital shall terminate if the Active Medical Staff appointment of the sponsor is terminated for any reason or if the sponsor's Clinical Privileges are curtailed to the extent that the professional services of said individual within the Hospital are no longer necessary to assist the sponsor unless a new sponsor is identified and approved in accordance with the terms of this Credentials Manual.
- F. "Credentialing Guidelines for Allied Health Professionals" have been incorporated into the Credentials Manual.

SECTION 4. OTHER HEALTH PROFESSIONALS

CHI-FH employed Health Professionals who would otherwise fall into Category III Allied Health Providers, but who are employed by entities within CHI-FH are processed, supervised and evaluated through the Human Resources mechanisms. This category includes, but is not limited to, surgical technicians; vascular technicians, EEG technicians, and Registered Nurses.

ARTICLE VI. CONFIDENTIALITY OF MEDICAL STAFF CREDENTIALS FILES

- A. It is the policy of CHI-FH to protect the confidentiality of credentials files in accordance with all applicable legal requirements. A policy to this effect will be on file in the Medical Staff Office.
- B. Medical Staff members who have access to credentialing information/files shall agree in writing to protect the confidentiality of information in credentials files and other Medical Staff records, and to use that information only for purposes that promote peer review and quality improvement efforts.

ARTICLE VII. AMENDMENTS

An amendment to these Rules and Regulations may be made under provisions of Article XII, Section 2, of the Medical Staff Bylaws.

ARTICLE VIII. ADOPTION

After adoption by the Active Medical Staff as an amendment to the Bylaws, last revised in 1996, this Credentialing Manual, together with appended Bylaws, Rules and Regulations, shall replace any previous edition and shall become effective when approved by the Board.

ADOPTED by the Active Medical Staff on September 7, 1996.

APPROVED by the Board on November 22, 1996.