POLICY ON MEDICAL STAFF APPOINTMENT, REAPPOINTMENT AND CLINICAL PRIVILEGES

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ARTICLE I

DEFINITIONS

A. The following definitions shall apply to terms used in this policy:

(1) "Allied Health Professional" means a person who is a licensed or certified health professional who is not a physician (M.D. or D.O.) or dentist (D.D.S. or D.M.D.).

(2) "Appointee" means any physician and dentist who has been granted Medical Staff appointment and clinical privileges by the Board to practice at the hospital.

(3) "Board" means the Board of Directors of Pawnee Valley Community Hospital, which has the overall responsibility for the conduct of the hospital.

(4) "Administrator/Chief Executive Officer" means the individual, or their designee, in charge of the operations of the hospital.

(5) "Chief Medical Officer" is the Chief Medical Officer of Hays Medical Center who shall serve as a member of the PVCH Board of Directors and medical staff committees, supporting the administrative and clinical functions of PVCH.

(6) "Clinical privileges" or "privileges" means the authorization granted by the Board to an applicant, Medical Staff appointee, other independent practitioner or advanced dependent practitioner to render specific patient care services in the hospital within defined limits.

(7) "Core privileges" means a defined grouping of privileges for a specialty or subspecialty that includes the fundamental patient care services that are routinely taught in residency and/or fellowship training for that specialty or subspecialty and that have been determined by the Medical Staff leaders and the Board to require closely related skills and experience.

(8) "Dentist" shall be interpreted to include a doctor of dental surgery ("D.D.S.") and doctor of dental medicine ("D.M.D.").

(9) "Executive Committee" means the Executive Committee of the Medical Staff unless specifically written "Executive Committee of the Board."

(10) "Federal health program" means Medicare, Medicaid or any other federal or state program providing health care benefits which is funded, directly or indirectly, by the United States government.

(11) "Good standing" means that Medical Staff appointee who is not under suspension or any restriction regarding staff appointment or admitting or clinical privileges at this hospital and/or at any other health care facility or organization.

(12) "Hospital" means Pawnee Valley Community Hospital.

(13) “Hospital Services Agreement” is the contract between PVCH and Hays Medical Center for administrative support services, including but not limited to Risk Management, Credentialing and Quality Assurance, dated March 1, 2010.

(14) "Medical Staff" means all physicians and dentists who are given privileges to treat patients at the hospital.

(15) "Organized Health Care Arrangement" means the term used by the HIPAA Privacy Rule to describe a clinically-integrated care setting in which patients typically receive health care from more than one provider (such as a hospital and its Medical Staff) and which benefits from regulatory provisions designed to facilitate compliance with the HIPAA Privacy Rule.

(16) "Patient encounters" means the number of inpatient admissions, inpatient surgeries, inpatient visits as admitting or attending physician, outpatient surgeries, physician clinic visits, anesthetic cases, radiology interpretations, pathology interpretations, emergency department patients, observation admissions, consultations, which are defined as face-to-face contacts and telemedicine.

(17) "Physicians" shall be interpreted to include both doctors of medicine ("M.D.s") and doctors of osteopathy ("D.O.s").

(18) "Professional review action" means an action or recommendation of a professional review body which is taken or made in the conduct of professional peer review activity, which is based on the competence or professional conduct of a staff appointee, and which affects or may affect adversely the clinical privileges or appointment of the staff appointee.

(19) "Professional review activity" means a peer review activity of the hospital with respect to an individual Medical Staff applicant or appointee (a) to determine whether the Medical Staff applicant or appointee may have clinical privileges with respect to his/her appointment; (b) to determine the scope or conditions of those clinical privileges and appointment; and (c) to change or modify such privileges and/or appointment.

(20) "Professional review body" means the Board of the hospital or any Board committee which conducts professional peer review activity, and includes any committee of the Medical Staff when assisting the Board in a professional peer review activity.

(21) "Resident Physician" means any M.D. or D.O. presently enrolled/employed by an ACGME/AOA accepted program for the purpose of additional training/education.

(22) "Self-government" means the duty of the Chief of Staff and committees of the Medical Staff to initiate and carry out the functions delegated by the Board and to fulfill the obligations provided for in this policy.

(23) "Unassigned patient" means any individual who comes to the hospital for care and treatment who does not have an attending physician; or whose attending physician or designated alternate is unavailable to attend the patient; or who does not want the prior attending physician to provide him/her care while a patient at the hospital.

(24) "Voluntary" or "automatic relinquishment" of Medical Staff appointment and/or clinical privileges means a lapse in appointment and/or clinical privileges deemed to automatically occur as a result of stated conditions.

B. Words used in this policy shall be read as the masculine or feminine gender, and as the singular or plural, as the content requires. The captions or headings are for convenience only and are not intended to limit or define the scope or effect of any provision of this policy.

ARTICLE II

APPOINTMENT TO THE MEDICAL STAFF

ARTICLE II - PART A: QUALIFICATIONS FOR APPOINTMENT

Section 1. General:

(a) Appointment to the Medical Staff is a privilege, which shall be extended only to professionally competent individuals who continuously meet the qualifications, standards and requirements set forth in this policy and in such policies as are adopted from time to time by the Board. All individuals practicing medicine and dentistry in this hospital, unless excepted by specific provisions of this policy, must first have been appointed to the Medical Staff.

(b) All processes described in this Article shall be subject to the confidentiality provisions described in Article III, Part G of this policy.

ARTICLE II - PART A:

Section 2. Specific Qualifications:

Only physicians and dentists who satisfy the following threshold eligibility criteria described in this policy shall be qualified for Medical Staff appointment or reappointment consideration:

(a) have a current, unrestricted license to practice in the State of Kansas;

(b) where applicable to their practice, have a current, unrestricted DEA registration and state controlled substance license;

(c) are located (office and residence) within the geographic service area of the hospital as defined by the Board, close enough to provide timely and continuous care for their patients in the hospital;

(d) possess current, valid professional liability insurance coverage in such form and in amounts satisfactory to the hospital ($1 Million/$3 Million);

(e) Graduates of U.S. medical schools must have successfully completed an accredited ACGME/AOA or an equivalent internship training program of at least one (1) year except for those specific specialties delineated below and in the core privileging document, which require a completed ACGME/AOA residency program. Foreign graduates of non-U.S. medical schools must have completed an ACGME/AOA/ABMS residency or certification program for the following specialties:

(1) Anesthesiology

(2) Dermatology

(3) Family Medicine

(4) General Dentistry

(5) General Surgery

(6) Infectious Disease

(7) Internal Medicine

(8) Medical Hematology

(9) Medical Oncology

(10) Nephrology

(11) Neurology

(12) Cardiology

(13) Gynecology

(14) Ophthalmology

(15) Oral and Maxillofacial Surgery

(16) Orthopedic Surgery

(17) Otolaryngology

(18) Pain Management

(19) Pathology

(20) Pediatrics

(21) Physical Medicine and Rehabilitation

(22) Plastic and Reconstructive Medicine

(23) Psychiatry

(24) Pulmonology

(25) Radiology

(26) Urology

(f) have never been convicted of Medicare, Medicaid, or other federal or state governmental or private third-party payer fraud or program abuse, nor have been required to pay civil penalties for the same;

(g) have never been, and are not currently, excluded or precluded from participation in Medicare, Medicaid, or other federal or state governmental health care program;

(h) have never had Medical Staff appointment, clinical privileges, or status as a participating provider denied, revoked, or terminated by any health care facility or health plan for reasons related to clinical competence or professional conduct;

(i) have never resigned appointment or relinquished privileges during a Medical Staff investigation or in exchange for not conducting such an investigation;

(j) have never been convicted of or entered a plea of guilty or no contest to any felony; or to any misdemeanor relating to controlled substances, illegal drugs, insurance or health care fraud or abuse, or violence;

(k) agree to fulfill all responsibilities regarding emergency call;

(l) have or agree to make coverage arrangements with other members of the Medical Staff for those times when the individual will be unavailable;

(m) demonstrate recent active clinical practice during at least two of the last four years.

ARTICLE II - PART A:

Section 3. Waiver of Threshold Eligibility Criteria:

(a) Any individual who does not satisfy one or more of the threshold eligibility criteria outlined above 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.

(b) A request for a waiver will be submitted to the Chief of Staff for consideration. In reviewing the request for a waiver, the Executive Committee may consider the specific qualifications of the individual in question, input from the relevant clinical peer, and the best interests of the hospital and the communities it serves. Additionally, the Executive Committee may, in its discretion, consider the application form and other information supplied by the applicant. The Executive Committee's recommendation will be forwarded to the Board. Any recommendation to grant a waiver must include the basis for such.

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

(d) No individual is entitled to a waiver or to a hearing if the Board determines not to grant a waiver. A determination that an individual is not entitled to a waiver is not a "denial" of appointment or clinical privileges.

(e) The granting of a waiver in a particular case is not intended to set a precedent for any other individual or group of individuals.

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

ARTICLE II - PART A:

Section 4. Factors for Evaluation:

Only those individuals who can document that they are highly qualified in all regards shall be appointed to the Medical Staff. The following factors shall be evaluated as part of the appointment and reappointment processes:

(a) relevant training, experience, 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 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;

(e) ability to safely and competently perform the clinical privileges requested; and

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

ARTICLE II - PART A:

Section 5. No Entitlement to Appointment:

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

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

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

(c) has had in the past, or currently has, Medical Staff appointment or privileges at any hospital or health care facility;

(d) resides in the geographic service area of the hospital as defined by the Board; or

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

ARTICLE II - PART A:

Section 6. Non-Discrimination Policy:

No individual shall be denied appointment on the basis of sex, race, creed, religion, color or national origin.

ARTICLE II - PART B: CONDITIONS OF APPOINTMENT AND REAPPOINTMENT

Section 1. Duties of Appointees:

Appointment to the Medical Staff shall require that each appointee assume such reasonable duties and responsibilities as the Medical Staff or the Board shall require.

ARTICLE II - PART B:

Section 2. Professional Conduct:

(a) Individuals appointed to the Medical Staff shall be expected to relate in a positive and professional manner to other health care professionals, and to cooperate and work collegially with the Medical Staff leadership and hospital management and personnel. Professional conduct shall also include, but not be limited to, each appointee's obligation to present himself or herself at the hospital physically and mentally capable of providing safe and competent care to his or her patients.

(b) All Medical Staff appointees shall adhere to hospital policies and federal and state laws and regulations regarding harassment in the workplace.

ARTICLE II - PART C: APPLICATION FOR INITIAL APPOINTMENT AND CLINICAL PRIVILEGES

Section 1. Pre-Application Process:

(a) The Hospital Service Agreement provides for the logistic handling of the credentialing process of the hospital.

(b) An application for appointment to the Medical Staff shall only be sent upon request to those individuals who, according to the Medical Staff Bylaws and this policy, (1) are eligible for appointment; (2) meet the threshold eligibility criteria set forth in this policy for appointment and clinical privileges consideration; (3) desire to provide care and treatment to patients for conditions and diseases for which the hospital has facilities and personnel; and (4) indicate an intention to utilize the hospital as required by the staff category to which they seek appointment.

(c) An individual requesting an application for appointment shall initially be sent (1) a letter that outlines the threshold eligibility criteria for appointment and clinical privileges consideration and explains the review process, and (2) a pre-application form which requests proof that the threshold eligibility criteria for appointment and clinical privileges consideration can be met by the individual. A completed pre-application form with copies of all required documents must be returned to the Chief Executive Officer or a designee within thirty (30) days after receipt of same if the individual desires consideration.

(d) Those individuals who meet the threshold eligibility criteria for consideration for appointment and clinical privileges shall be given an application. Individuals who fail to meet the threshold eligibility criteria shall not be given an application and shall be so notified.

ARTICLE II - PART C:

Section 2. Information:

(a) Applications for appointment to the Medical Staff shall be in writing, and shall be submitted on forms approved by the Board upon recommendation of the Executive Committee. The request for the forms shall be obtained from the office of the Chief Executive Officer or a designee.

(b) The application shall contain a request for specific clinical privileges desired by the applicant and shall require detailed information concerning the applicant's professional qualifications including:

(1) the names and complete addresses of at least three (3) physicians, dentists, or other practitioners, as appropriate, who have had recent extensive experience in observing and working with the applicant, and who can provide adequate information pertaining to the applicant's present professional competence and character. These references may be from individuals previously associated with, but not from those individuals currently associated or about to be associated with, the applicant in professional practice or personally related to the applicant. At least one (1) reference shall be from the same specialty area as the applicant;

(2) the names and complete addresses of the chiefs or chairpersons of each department of any and all hospitals or other institutions at which the applicant has worked or trained (i.e., the individuals who served as chiefs or chairpersons at the time the applicant worked in the particular department). If the number of hospitals the applicant has worked in is great or if a number of years have passed since the applicant worked at a particular hospital, the Executive Committee and the Board may take into consideration such factors;

(3) information as to whether the applicant's Medical Staff appointment or clinical privileges have ever been voluntarily or involuntarily withdrawn, denied, revoked, suspended, subjected to probationary or other conditions, reduced or not renewed at any other hospital or health care facility, or voluntarily or involuntarily relinquished, not including a voluntary personal decision by the applicant to request a lesser scope of clinical privileges upon reappointment or during the term of appointment;

(4) information as to whether the applicant has ever voluntarily or involuntarily withdrawn his/her application for appointment, reappointment and clinical privileges, or resigned from the Medical Staff before final decision by a hospital's or health care facility's governing board;

(5) information as to whether the applicant's license to practice any profession in any state, or Drug Enforcement Administration license or any state's controlled substance license is or has ever been voluntarily or involuntarily relinquished,

suspended, modified, terminated, restricted or is currently being investigated or challenged. (The submitted application shall include a list or copy and verification of all the applicant's current licenses to practice, as well as copies of Drug Enforcement Administration license, medical or dental school diploma, and certificates from all post-graduate training programs completed);

(6) information as to whether the applicant has currently in force professional liability insurance coverage, the name of the insurance company and the amount and classification of such coverage, and whether said insurance coverage covers the clinical privileges the applicant or appointee seeks to exercise at the hospital;

(7) a consent to the release of information from the applicant's present and past professional liability insurance carriers;

(8) information concerning the applicant's professional litigation experience, specifically information concerning pending claims, final judgments or settlements: (i) the substance of the allegations, (ii) the findings, (iii) the ultimate disposition, and (iv) any additional information concerning such proceedings or actions as the Executive Committee or the Board may deem appropriate;

(9) information concerning any professional misconduct proceedings and any malpractice actions involving the applicant in this state or any other state, whether such proceedings are closed or still pending;

(10) information concerning the suspension or termination for any period of time of the right or privilege to participate in Medicare, Medicaid, any other government sponsored program, or any private or public medical insurance program, and information as to whether the applicant is currently under investigation;

(11) current information regarding the applicant's ability to exercise the privileges requested and to perform the duties and responsibilities of appointment competently and safely;

(12) information as to whether the applicant has ever been named as a defendant in a criminal action and/or convicted of a crime with details about any such instance;

(13) a complete chronological listing of the applicant's professional and educational appointments, employment, or positions;

(14) information on the citizenship and/or visa status of the applicant;

(15) a copy of a government-issued photo identification;

(16) the applicant's signature; and

(17) such other information as the Board may require.

(c) The history of malpractice verdicts and the settlement of malpractice claims, as well as pending claims, will be evaluated as a criterion for appointment, reappointment, and the granting of clinical privileges. However, the mere presence of verdicts, settlements or claims shall not, in and of themselves, be sufficient to deny appointment or particular clinical privileges. The evaluation shall consider the extent to which verdicts, settlements or claims evidence a pattern of care that raises questions concerning the individual's clinical competence, or whether a verdict, settlement or claim in and of itself, represents such deviation from standard medical practice as to raise overall questions regarding the applicant's clinical competence, skill in the particular clinical privilege, or general behavior.

(d) The applicant's signature shall constitute agreement:

(1) that the applicant has received and had an opportunity to read a copy of the bylaws of the hospital, and the bylaws, rules and regulations of the Medical Staff as are in force at the time of application, and agrees to be bound by the terms thereof in all matters relating to consideration of the application without regard to whether or not appointment to the Medical Staff and/or clinical privileges are granted;

(2) that any misrepresentation or misstatement in, or omission from, the application, whether intentional or not, shall constitute cause for the hospital to

stop processing the application. If appointment or reappointment has been granted prior to the discovery of a misrepresentation, misstatement or omission, appointment and privileges may be deemed to be automatically relinquished. In either situation, there shall be no entitlement to a hearing or appeal. Rather, the individual shall be informed in writing of the nature of the misstatement, misrepresentation or omission and permitted to provide a written response. The Executive Committee shall review the individual's response and provide a recommendation to the Board whether the application should be processed further;

(3) that the hearing and appeal procedures set forth in this policy shall be the sole and exclusive remedy with respect to any professional review action taken at this hospital;

(4) authorize the release of all information necessary for an evaluation of the individual's qualifications for initial or continued appointment, reappointment, and/or clinical privileges;

(5) not to sue the hospital, its officers, directors, or members, the Medical Staff or anyone acting by or for the hospital and its Medical Staff for any matter relating to the application for appointment, reappointment, or clinical privileges, or relating to the evaluation of the applicant's qualifications on any matter related to appointment, reappointment or clinical privileges.

(6) extend absolute immunity to the fullest extent of the law to the hospital, its Medical Staff and all individuals acting by or for the hospital and/or its Medical Staff for all matters relating to appointment, reappointment and clinical privileges or the individual's qualifications for the same.

ARTICLE II - PART C:

Section 3. Basic Responsibilities and Requirements of Applicants and Appointees:

As a condition of consideration for appointment or reappointment, and as a condition of continued appointment, every applicant and appointee for Medical Staff appointment or reappointment specifically agree to the following:

(a) to provide continuous and timely care and supervision to all patients for whom the individual has responsibility;

(b) to abide by all bylaws, policies and rules and regulations of the Medical Staff and hospital in force during the time the individual is appointed;

(c) to accept committee assignments, emergency service call obligations, care of unassigned patients, consultation requests, participation in quality improvement and peer review activities, and such other reasonable duties and responsibilities as shall be assigned;

(d) to comply with clinical practice protocols and guidelines that are established by, and must be reported to, regulatory or accrediting agencies or patient safety organizations, including those related to national patient safety initiatives and core measures, or clearly document the clinical reasons for variance;

(e) to comply with clinical practice protocols and guidelines pertinent to his or her medical specialty, as may be adopted by the Medical Staff or the Medical Staff leadership, or clearly document the clinical reasons for variance;

(f) to inform the Chief Executive Officer and the Chief of Staff 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, at the time the change occurs, and shall include, but not be limited to, changes in licensure status or professional liability insurance coverage, the filing of a lawsuit against the practitioner, changes in the practitioner's Medical Staff status at any other hospital, exclusion or preclusion from participation in Medicare or any sanctions imposed, and any changes in the individual's ability to safely and competently exercise clinical privileges or perform the duties and responsibilities of appointment because of health status issues, including impairment due to addiction;

(g) to constructively participate in the development, review, and revision of clinical protocols and pathways pertinent to his or her medical specialty, including those related to national patient safety initiatives and core measures;

(h) to immediately submit to a blood and/or urine test, or to a complete physical and/or mental evaluation, if at least two Medical Staff leaders (or one Medical Staff leader and one members of the Administrative team) are concerned with the individual's ability to safely and competently care for patients. The health care professional(s) to perform the testing and/or evaluations will be determined by the Medical Staff leadership;

(i) to appear for personal interviews in regard to an application for initial appointment or reappointment, if requested;

(j) to use the hospital sufficiently to allow continuing manner the current competence;

(k) to refrain from illegal fee splitting or other illegal inducements relating to patient referral;

(l) to refrain from delegating responsibility for hospitalized patients to any individual who is not qualified or not adequately supervised;

(m) to refrain from deceiving patients as to the identity of any individual providing treatment or services;

(n) to seek consultation whenever necessary;

(o) to participate in monitoring, performance improvement and evaluation activities of clinical departments;

(p) to complete in a timely manner the medical and other required records for all patients as required by this policy, the rules and regulations, and other applicable policies of the hospital;

(q) to participate in an Organized Health Care Arrangement with the hospital, to abide by the terms of the hospital's Notice of Privacy Practices with respect to health care delivered in the hospital, and to provide patients with a Notice of Organized Health Care Arrangement as a supplement to their own Notice of Privacy Practices;

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

(s) to pay promptly any applicable Medical Staff assessments;

(t) to satisfy continuing medical education requirements by participating in continuing medical education programs for the benefit of the individual and for the benefit of other professionals and hospital personnel;

(u) to work cooperatively with Medical Staff appointees, allied health professionals, nurses and other hospital personnel;

(v) to undergo a tuberculin test, unless contraindicated, as a condition of initial appointment, with the results reported to the Infection Control Nurse or designee. The Medical Staff shall follow the guidelines of the Associate Health Policy pertaining to seasonal flu vaccinations;

(w) to comply with all health screening, drug testing and immunization requirements set forth by hospital policy prior to becoming eligible to begin exercising clinical privileges and engaging in any patient care at the hospital;

(x) to promptly notify the Chief Executive Officer, or a designee, of any change in eligibility for payments by third-party payors or for participation in Medicare, including any sanctions imposed or recommended by the Federal Department of Health and Human Services, and/or the receipt of a PRO citation and/or quality denial letter concerning alleged quality problems in patient care; and

(y) to abide by generally recognized ethical principles applicable to the applicant's or appointee's profession.

ARTICLE II - PART C:

Section 4. Burden of Providing Information:

(a) Individuals seeking appointment and reappointment have the burden of producing information deemed adequate by the hospital for a proper evaluation of current competence, character, ethics, and other qualifications and for resolving any doubts.

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

(c) An application shall be complete when all questions on the application form have been answered, all supporting documentation has been supplied, and all information has been verified from primary sources. An application shall become incomplete if the need arises for new, additional, or clarifying information at any time. Any application that continues to be incomplete thirty (30) days after the individual has been notified of the additional information shall be deemed to be withdrawn.

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

ARTICLE II - PART C:

Section 5. Grant of Immunity and Authorization to Obtain Information:

The following statements, which shall be included on the application form and which form a part of this policy, are express conditions applicable to any Medical Staff applicant, any appointee to the Medical Staff, and to all others having or seeking clinical privileges at the hospital. By requesting an application and/or applying for appointment, reappointment or clinical privileges, the individual expressly accepts the following conditions set forth in this Section during the processing and consideration of the application, whether or not appointment or clinical privileges are granted, and throughout the term of any appointment or reappointment period and thereafter. These conditions shall also apply should appointment, reappointment, or clinical privileges be revoked, reduced, restricted, suspended, and/or otherwise affected as part of the hospital's professional review activities, and as applicable to any third-party inquiries received about the individual's tenure at the hospital after the individual leaves the Medical Staff.

(a) Immunity:

To the fullest extent permitted by law, the individual releases from any and all liability, and extends absolute immunity to the hospital, any member of the Medical Staff, their

authorized representatives and appropriate third parties, with respect to any acts, communications or documents, reports, statements, recommendations and/or disclosures involving the individual, concerning the following:

(1) applications for appointment or clinical privileges, including temporary privileges;

(2) evaluations concerning reappointment or changes in clinical privileges;

(3) proceedings for suspension or reduction of clinical privileges or for revocation of Medical Staff appointment, or any other disciplinary sanction;

(4) precautionary suspension;

(5) hearings and appellate reviews;

(6) medical care evaluations;

(7) utilization reviews;

(8) other activities relating to the quality of patient care or professional conduct;

(9) matters or inquiries concerning the applicant's or appointee's professional qualifications, credentials, clinical competence, character, mental or emotional stability, physical condition, ethics or behavior; and/or

(10) any other matter that might directly or indirectly relate to the individual's competence, to patient care, or to the orderly operation of this or any other hospital or health care facility.

(b) Authorization to Obtain Information:

The individual specifically authorizes the hospital and its authorized representatives, including Medical Staff leaders, to consult with any third party who may have information bearing on the individual's professional qualifications, credentials, clinical competence, character, mental or emotional stability, physical condition, ethics, behavior, or any other matter reasonably having a bearing on the applicant's or appointee's satisfaction of the criteria for initial and continued appointment to the

Medical Staff. This authorization also covers the right to inspect or obtain any and all communications, reports, records, statements, documents, recommendations and/or disclosures of third parties that may be relevant to such questions. The individual also specifically authorizes third parties to release this information to the hospital and its authorized representatives upon request.

(c) Authorization to Release Information:

The individual specifically authorizes the hospital and its authorized representatives to release such information to other hospitals, health care facilities and their agents, managed care organizations, government regulatory and licensure boards or agencies and their agents, who solicit such information for the purpose of evaluating the individual's professional qualifications for appointment, clinical privileges, and/or participation at the requesting organization/facility, and any licensure or regulatory matter.

(d) Hearing and Appeal Procedures:

The individual agrees that the hearing and appeal procedures set forth in this policy will be the sole and exclusive remedy with respect to any professional review action taken by the hospital.

(e) Authorization for Criminal Background Check:

The individual agrees to sign consent forms to permit a consumer reporting agency to Consumer reporting agency to conduct a criminal background check and report the results to the Hospital.

ARTICLE II - PART D: PROCEDURE FOR INITIAL APPOINTMENT

Section 1. Submission of Application:

(a) The application for Medical Staff appointment shall be submitted by the applicant to the Chief Executive Officer or designee. It must be accompanied by payment of such processing fees as shall be determined from time to time. After reviewing the application to determine that all questions have been answered, and after reviewing all references and other information or materials deemed pertinent, and after verifying the

information provided in the application with the primary sources, the Chief Executive Officer's Office or designee shall transmit the complete application and all supporting materials to the Chief of Staff or designee.

(b) An application shall be deemed to be complete when all questions on the application form have been answered, all supporting documentation has been supplied and all information verified. An application shall become incomplete if the need arises for new, additional or clarifying information anytime during the evaluation. Any application that continues to be incomplete ninety (90) days after the applicant has been notified of the additional information required shall be deemed to be withdrawn. It is the responsibility of the applicant to provide a complete application, including adequate responses from references. An incomplete application will not be processed.

ARTICLE II - PART D:

Section 2. Chief of Staff Procedure:

(a) The Chief of Staff shall provide the Executive Committee with a written report within fifteen (15) days concerning the applicant's qualifications for the requested clinical privileges. As part of the process of making this report, the Chief of Staff has the right to meet with the applicant to discuss any aspect of the application, qualifications and requested clinical privileges.

(b) The Chief of Staff shall evaluate the applicant's education, training, experience and conduct and make inquiries with respect to the same to the applicant's past or current department chairperson(s), residency training director, and others who may have knowledge about the applicant's education, training, experience, and ability to work with others.

(c) The Chief of Staff shall be available to the Executive Committee to answer any questions that may be raised with respect to that Chief of Staff's report and findings.

ARTICLE II - PART D:

Section 3. Executive Committee Procedure:

(a) After determining that the applicant is qualified for appointment and privileges, the Executive Committee may require the applicant to undergo a physical and/or mental examination by a physician or physicians satisfactory to the Executive Committee. The results of any such examination shall be made available to the committee for its consideration. Failure of an applicant to undergo such an examination within a reasonable time after being requested to do so in writing by the Executive Committee shall constitute a voluntary withdrawal of the application for appointment and clinical privileges, and all processing of the application shall cease.

(b) The Executive Committee shall have the right to require the applicant to meet with the committee to discuss any aspect of the applicant's application, qualifications, or clinical privileges requested.

(c) The Executive Committee may use the expertise of an outside consultant, if additional information is required regarding the applicant's qualifications.

(d) If, after considering the report of the outside consultant, the Executive Committee's recommendation for appointment is favorable, the Executive Committee shall recommend provisional appointment.. All recommendations to appoint, including provisional appointment, must specifically recommend the clinical privileges to be granted, which may be qualified by any probationary or other conditions or restrictions as deemed appropriate by the committee.

(e) If the recommendation of the Executive Committee is delayed longer than ninety (90) days, the Chairperson of the Executive Committee shall send a letter to the applicant, with a copy to the Chief Executive Officer and Governing Board, explaining the reasons for the delay.

ARTICLE II - PART D:

Section 4. Executive Committee Report:

(a) Not later than ninety (90) days from its receipt of the application and all required and requested information, the Executive Committee shall send its recommendation and written findings to the Governing Board. The completed application and all supporting

documentation shall accompany the Executive Committee's findings and recommendation.

(b) The Chairperson of the Executive Committee shall be available to the Governing Board to answer any questions that may be raised with respect to the Executive Committee's findings and recommendation.

(c) If the recommendation of the Executive Committee would entitle the applicant to request a hearing, it shall be forwarded to the Chief Executive Officer who shall promptly notify the applicant in writing, certified mail, return receipt requested. The Chief Executive Officer shall then hold the application until after the applicant has exercised or waived the right to a hearing, after which the Chief Executive Officer shall forward the recommendation of the Executive Committee, together with the complete application and all supporting documentation to the Board for further action.

ARTICLE II - PART D:

Section 5. Board Action:

(a) The Board may delegate to a committee, consisting of at least two (2) Board members, action on appointment, reappointment, and clinical privileges if there has been a favorable recommendation from the Executive Committee and there is no evidence of any of the following:

(1) a current or previously successful challenge to any license or registrant;

(2) an involuntary termination, limitation, reduction, denial, or loss of appointment or privileges at any other hospital or other entity; or

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

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

(b) When there has been no delegation to the Board Committee, upon receipt of a recommendation that the applicant be granted appointment and clinical privileges, the Board may:

(1) appoint the applicant and grant clinical privileges as recommended; or

(2) refer the matter back to the Executive Committee or to another source inside or outside the hospital for additional research or information; or

(3) state clear and convincing reasons for rejecting or modifying the recommendation.

(c) If the Board determines to reject a favorable recommendation, it should first discuss the matter with the Chairperson of the Executive Committee. If the Board's determination remains unfavorable to the applicant, the Chief Executive Officer shall promptly send special notice to the applicant that the applicant is entitled to request a hearing.

(d) Notice of any final decision by the Board to grant, deny, revise or revoke appointment and/or clinical privileges shall be forwarded by the Chief Executive Officer, certified mail, return receipt requested, to the applicant within seven (7) days after the Board's determination, and shall be disseminated to appropriate individuals and, as required, reported to appropriate entities.

ARTICLE II - PART D:

Section 6. 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 II - PART E: PROVISIONAL STATUS

Section 1. Nature and Duration of Provisional Period:

All initial appointments to the Medical Staff (regardless of the category) and all initial grants of clinical privileges, whether at the time of appointment, reappointment, or during the term of

appointment, shall be provisional for a period of twelve (12) months from the date of the appointment or longer if recommended by the Executive Committee.

ARTICLE II - PART E:

Section 2. Focused Professional Practice Evaluation:

(a) During this provisional period, the individual shall be evaluated by the Chief of Staff, and by the relevant committees of the Medical Staff and the hospital as to the individual's clinical competence, general behavior and conduct in the hospital. The assessment shall constitute a focused professional practice evaluation and may include chart review, monitoring of the individual's practice patterns, proctoring, external review, and information obtained from other physicians and hospital employees. The numbers and types of cases to be reviewed shall be determined by the Executive Committee.

(b) Continued appointment and/or clinical privileges after the provisional period shall be conditioned on an evaluation of the factors set forth in Section 3(c) of this Part.

(c) Provisional clinical privileges shall be adjusted to reflect clinical competence at the end of the provisional period or sooner, if warranted.

ARTICLE II - PART E:

Section 3. Duties During Provisional Period:

(a) During the provisional period, an appointee must demonstrate all of the qualifications, may exercise all of the prerogatives, and must fulfill all the obligations attendant to his/her staff category.

(b) Each appointee must arrange, or cooperate in the arrangement of the required numbers and types of cases to be reviewed and/or observed by the clinical department chairperson and/or designated proctors.

(c) Failure of the provisional appointee to admit, treat or attend patients during the provisional period sufficient to permit observation and assessment, or failure of the appointee, during the provisional period, to fulfill all requirements of appointment relating to meeting attendance, completion of medical records, and/or cooperation with

monitoring or proctoring conditions as outlined in this policy, shall render the provisional appointee ineligible for continued appointment and clinical privileges unless the failure to meet such requirements is based upon good cause. In the absence of good cause, the appointment and all clinical privileges shall expire at the end of the provisional period. The individual may be permitted to reapply for initial appointment in accordance with this policy, provided the individual can demonstrate a greater interest in or intention to use the hospital in the future.

(d) Any Medical Staff member who desires to transfer to another staff category and request clinical privileges must meet the qualifications, standards and requirements for appointment and clinical privileges as set forth in this policy. If approved for another category, the applicant will be subject to a twelve (12) month provisional period, during which time the required number of patient encounters for the medical staff category being applied for must be met. *(See Medical Staff Bylaws, Article II - Categories of the Medical Staff.)* If not met, the appointee will be automatically transferred to the appropriate category for the remainder of the appointment or reappointment period, unless disapproved by the Executive Committees and the Board.

ARTICLE II - PART F: CLINICAL PRIVILEGES

Section 1. General:

(a) Medical Staff appointment or reappointment shall not confer any clinical privileges or right to practice at the hospital.

(b) Each individual who has been appointed to the Medical Staff shall be entitled to exercise only those clinical privileges specifically granted by the Board.

(c) The grant of clinical privileges shall also require that a complete history and physical examination in all medical cases be documented within twenty-four (24) hours after admission of the patient and noted in the patient's medical record along with the reason for admission. An updated medical record entry documenting an examination for any changes in the patient's condition shall be required when the medical history and physical examination are completed within thirty (30) days before admission. All history and physical examinations shall be signed by the practitioner who performed the history

and physical examination within twenty-four (24) hours after admission. Detailed requirements regarding history and physical examination of patients shall be those set forth in the Medical Staff Rules and Regulations, which are herein incorporated by reference into this policy.

(d) The grant of clinical privileges shall carry with it acceptance of the obligations of such privileges including, but not limited to, on-call coverage for purposes of providing medical screening examinations and treatment in the hospital's Emergency Department to fulfill the hospital's responsibilities under the Emergency Medical Treatment and Labor Act, 42 U.S.C. § 1395 dd. and/or other applicable requirements or standards. Appointees to the medical staff shall adhere to hospital policies and procedures and medical staff schedules concerning on-call coverage in the Emergency Department. Appointees shall have the obligation to adhere to all relevant provisions of the hospital's Code of Conduct and to participate in the hospital's Corporate Compliance Program.

(e) In order for a request for privileges to be processed, the applicant must satisfy all applicable threshold eligibility criteria.

(f) Requests for clinical privileges that are subject to an exclusive contract shall not be processed except as consistent with applicable contracts.

(g) Clinical privileges shall be voluntarily relinquished only in the manner that provides for the orderly transfer of such obligations.

(h) The clinical privileges recommended to the Board shall be based upon consideration of the following:

(1) education and relevant training, successful completion of an approved training program, experience, demonstrated current competence, including medical/clinical knowledge, technical and clinical skills, clinical judgment, interpersonal and communication skills, professionalism with patients, families, and other members of the health care team and peer evaluations relating to these criteria;

(2) appropriateness of utilization patterns;

(3) ability to perform the privileges requested competently and safely;

(4) ability to meet all current criteria for the requested clinical privileges;

(5) availability of qualified physicians or other appropriate practitioners to provide medical coverage for the applicant in case of the applicant's illness or unavailability;

(6) adequate levels of professional liability insurance coverage with respect to the clinical privileges requested;

(7) the hospital's available resources and personnel;

(8) any previously successful or currently pending challenges to any licensure or registration, or the voluntary or involuntary relinquishment of such licensure or registration;

(9) information resulting from ongoing and focused professional practice evaluation, performance improvement and other peer review activities, if applicable;

(10) any information concerning professional review actions or voluntary or involuntary termination, limitation, reduction, or loss of appointment or clinical privileges at another hospital;

(11) practitioner-specific data as compared to aggregate data, when available;

(12) morbidity and mortality data, when available;

(13) professional liability actions, especially any such actions that reflect an unusual pattern or excessive number of actions; and

(14) other relevant information, including a written report and findings by the Chief of Staff.

(i) The applicant shall have the burden of establishing qualifications for and competence to exercise the clinical privileges requested.

(j) The reports of the Chief of Staff shall be forwarded to the Executive Committee and processed as a part of the initial application for staff appointment.

ARTICLE II - PART F:

Section 2. Privilege Modifications and Waivers:

(a) Scope: This section applies to all requests for modification of clinical privileges (increases and relinquishments) during the term of appointment, resignation from the Medical Staff, and waivers of eligibility criteria for privileges.

(b) Submitting a Request: Requests for privilege modifications and waivers must be submitted in writing to the Medical Staff Office.

(c) Waivers:

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

(2) If the individual is requesting a waiver of the requirement that each member apply for the full core privileges in his or her specialty, the request must indicate the specific patient care services within the core that the member does not wish to provide, state a good cause basis for the request, and include evidence that the individual does not provide the patient care services at issue in any health care facility.

(3) By applying for a waiver related to limiting the scope of core privileges, the individual nevertheless agrees to participate in the general on-call schedule for the relevant specialty and maintain sufficient competency to assist the Emergency Medicine physicians in assessing and stabilizing patients who require services within that specialty. If, upon assessment, a patient needs a service that is no longer provided by the individual pursuant to the waiver, the individual

shall arrange for another individual with appropriate clinical privileges to care for the patient or, if such an individual is not available, arrange for the patient's transfer.

(4) Requests for waivers in accordance with this section will be processed in the same manner as requests for waivers of appointment criteria, as described in Article 2, Part A, Section 3 of this policy and the factors outlined in paragraph (e) of this Section shall be considered as part of that process.

(d) Increased Privileges:

(1) Requests for increased privileges must state the specific additional clinical privileges requested and provide information sufficient to establish eligibility, as specified in applicable criteria.

(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.

(e) Factors for Consideration: The Medical Staff leaders and Board may consider the following factors, among others, when deciding whether to recommend or grant a modification or waiver related to privileges:

(1) the hospital's mission and ability to serve the health care needs of the community by providing timely, appropriate care within its facilities;

(2) whether sufficient notice has been given to provide the smooth transition of patient care services;

(3) fairness to the individual requesting the modification or waiver, including past service and the other demands placed on the individual;

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

(5) the expectations of other members of the Medical Staff who are in different specialties but who rely on the specialty in question in the care of patients who present to the Emergency Department;

(6) any perceived inequities in modifications or waivers being provided to some, but not others;

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

(8) how the request may affect the hospital's ability to comply with applicable regulatory requirements, including the Emergency Medical Treatment and Active Labor Act.

(f) Effective Date: If the Board grants a modification or waiver related to privileges, it shall specify the date that the modification or waiver will be effective. Failure of a member to request privilege modifications or waivers in accordance with this section shall, as applicable, result in the member retaining Medical Staff appointment and clinical privileges and all associated responsibilities.

(g) Procedural Rights: No individual is entitled to a modification or waiver related to privileges or to a hearing or other process if a modification or waiver is not granted.

ARTICLE II - PART F:

Section 3. Clinical Privileges for New Procedures:

(a) Requests for clinical privileges to perform either a procedure not currently being performed at the hospital or a significant new technique to perform an existing procedure ("new procedure") shall not be processed until (1) a determination has been made that the procedure shall be offered by the hospital and (2) criteria to be eligible to request those clinical privileges have been established.

(b) The Executive Committee shall make a preliminary recommendation as to whether the new procedure should be offered to the community. Factors to be considered by the Executive Committee include, but are not limited to, whether there is empirical evidence of improved patient outcomes and/or other clinical benefits to patients, whether the new procedure is being performed at other similar hospitals and the experiences of those institutions, and whether the hospital has the resources, including space, equipment, personnel, and other support services, to safely and effectively perform the new procedure, and clinical indications for when the new procedure is appropriate and whether proficiency for the new procedure is volume-sensitive and if the requisite volume would be available.

(c) If it is recommended that the new procedure be offered, the Executive Committee shall conduct research and consult with experts, including those on the Medical Staff and those outside the hospital, and develop recommendations regarding (1) the minimum education, training, and experience necessary to perform the new procedure, and (2) the extent of monitoring and supervision that should occur if the privileges are granted. The Executive Committee may also develop criteria and/or indications for when the new procedure is appropriate. The Executive Committee shall forward its recommendations to the Board for final action.

ARTICLE II - PART F:

Section 4. Clinical Privileges That Cross Specialty Lines:

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

(b) The Executive Committee shall conduct research and consult with experts, including those on the Medical Staff (e.g., individuals on the Medical Staff with special interest and/or expertise) and those outside the hospital (e.g., other hospitals, residency training programs, specialty societies).

(c) The Executive Committee may or may not recommend that individuals from different specialties be permitted to request the privileges at issue. If it does, the Committee may develop recommendations regarding:

(1) the minimum education, training, and experience necessary to perform the clinical privileges in question;

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

(3) the extent of monitoring and supervision that should occur if privileges would be granted;

(4) the manner in which the procedure would be reviewed as part of the hospital's ongoing performance improvement activities (including an assessment of outcomes data for all relevant specialties); and

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

The Executive Committee shall forward its recommendations to the Board for final action.

ARTICLE II - PART F:

Section 5. Clinical Privileges for Dentists and Oral Surgeons:

(a) The scope and extent of surgical procedures that a dentist may perform in the hospital shall be delineated and recommended in the same manner as other clinical privileges.

(b) Surgical procedures performed by dentists shall be under the overall supervision of the Chief of Staff. A medical history and physical examination of the patient shall be made and recorded by a physician who holds an appointment to the Medical Staff before dental surgery shall be scheduled for performance, and a designated physician shall be responsible for the medical care of the patient throughout the period of hospitalization.

(c) Oral surgeons who admit patients without underlying health problems may perform a complete admission history and physical examination and assess the medical risks of the procedure on the patient if they are deemed qualified to do so by the Executive

Committee. "Oral surgeons" shall be interpreted to refer to licensed dentists who have successfully completed a postgraduate program in oral and maxillofacial surgery accredited by the American Association of Oral and Maxillofacial Surgery and/or the Commission on Dental Education of the American Dental Association.

(d) The dentist or oral surgeon shall be responsible for the dental care of the patient, including the dental history and dental physical examination as well as all appropriate elements of the patient's record. Dentists and oral surgeons may write orders within the scope of their license and consistent with the Medical Staff Rules and Regulations, and in compliance with the hospital and Medical Staff bylaws and this policy.

ARTICLE II - PART F:

Section 6. Supervision of Allied Health Professionals:

Any physician who employs an allied health professional to perform clinical activities/functions in the hospital shall be responsible for the direction and supervision of the on-site and/or day-to-day patient care activities of that allied health professional. All physicians employing such individuals are advised to consult the hospital's Policy on Allied Health Professionals for details concerning the use of dependent non-physician practitioners in the hospital. Allied health professionals are limited to the same specialty area of practice as the supervising physician.

ARTICLE II - PART F:

Section 7. Residents:

Resident physicians shall not hold appointments to the Medical Staff and shall not be granted specific clinical privileges. Rather, they shall be permitted to perform only those clinical functions set out in curriculum requirements, affiliation agreements, and/or training protocols approved by the Executive Committee or its designee, and the Graduate Medical Education Committee of the hospital. 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. The applicable program director shall be responsible for verifying and evaluating the qualifications of each physician in training.

ARTICLE II - PART F:

Section 8. Telemedicine Privileges:

(a) Telemedicine is the exchange of medical information from one site to another via electronic communications for the purpose of improving patient care, treatment, and services. The Board will determine the clinical services to be provided through telemedicine after considering the recommendations of the Executive Committee.

(b) A qualified individual may be granted telemedicine privileges, but need not be appointed to the Medical Staff or Allied Health Staff. The number of telemedicine practitioners credentialed shall be limited to thirty-five (35) per specialty.

(c) Requests for initial or renewed telemedicine privileges shall be processed through one of the following options, as determined by the Chief Executive Officer in consultation with the Chief of Staff:

(1) A request for telemedicine privileges may be processed through the same process for Medical Staff and Allied Health Staff applications, as set forth in this Policy. In such case, the individual must satisfy all qualifications and requirements set forth in this Policy, except those relating to geographic location, coverage arrangements, and emergency call responsibilities.

(2) If the individual requesting telemedicine privileges is practicing at a distant hospital that participates in Medicare or a telemedicine entity (as that term is defined by Medicare), and the hospital or telemedicine entity deemed status with an appropriate accreditation organization, a request for telemedicine privileges may be processed using an alternative process that relies on the credentialing and privileging decisions made by the distant hospital or telemedicine entity. In such cases, the hospital must ensure through a written agreement, that the distant hospital or telemedicine entity complies with all applicable Medicare regulations and accreditation standards. The distant hospital or telemedicine entity must provide:

(i) confirmation that the practitioner is licensed in the state where the hospital is located;

(ii) a current list of privileges granted to the practitioner;

(iii) information indicating that the applicant has actively exercised the relevant privileges during the previous 12 months and has done so in a competent manner;

(iv) a signed attestation that the applicant satisfies all of the distant hospital or telemedicine entity's qualifications for the clinical privileges granted;

(v) a signed attestation that all information provided by the distant hospital or telemedicine entity is complete, accurate, and up-to-date; and

(vi) any other attestations or information required by the agreement or requested by the hospital.

The information received about the individual requesting telemedicine privileges shall be provided to the Executive Committee for review and recommendation and to the Board for final action. Notwithstanding the process set forth in this subsection, the hospital may determine that an applicant for telemedicine privileges is ineligible for appointment or clinical privileges if the applicant fails to satisfy the threshold eligibility criteria set forth in this Policy.

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

(e) Individuals granted telemedicine privileges shall be subject to the hospital's performance improvement, ongoing and focused professional practice evaluations and peer review activities. The results of the peer review activities, including any adverse events and complaints filed about the practitioner providing telemedicine services from patients, other practitioners or staff, shall be shared with the hospital or entity providing telemedicine services.

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

ARTICLE II - PART F:

Section 9. Core Privileges:

(a) Application Process Requirements: Individuals requesting clinical privileges at the hospital are required to apply for core privileges in their specialties. The scope of core privileges for each specialty shall be recommended by the Chief of Staff, Executive Committee, and Board. Core privileges (and the eligibility criteria related to them) may be revised if recommended by the Executive Committee and Board.

(b) Rules Governing Exercise of Core Privileges: Individuals who have been granted core privileges shall be required to do the following:

(1) provide emergency call coverage for patients requiring emergency care within the scope of their core privileges (See Emergency Department Rules and Regulations for specifications); and

(2) provide consultations for patients requiring consults within the scope of their core privileges.

(c) Exemption from Core Privileges:

(1) Any individual who wishes to be exempt from a particular privilege(s) within the core for a specialty must apply for an exemption in writing, documenting the good cause basis for the request.

(2) After considering the recommendations from the Executive Committee, the Governing Board shall make a recommendation in support of or against such exemption. The factors for exemption consideration shall be the same factors as those set forth for privilege waivers in Article II - Part F, Section 2(e) of this policy.

(d) Special Privileges Beyond the Core: Individuals who have requested and been granted special privileges in addition to the core privileges for their specialty shall be required to provide such services on an emergency and consultative basis as may be requested.

ARTICLE II - PART G: VOLUNTARY RELINQUISHMENT OF PRIVILEGES

Section 1. Request to Relinquish Clinical Privileges:

(a) A Medical Staff appointee who desires to voluntarily relinquish any one (1) or more of the clinical privileges granted at any time during the appointment period may submit a written request to the Chief of Staff specifying the clinical privilege(s) to be relinquished. Said relinquishment of privileges shall not be effective until acknowledged in writing by the Board.

(b) The procedure set forth in this Part shall not apply to situations where the appointee has been deemed by the hospital to have automatically relinquished privileges pursuant to this policy, the Medical Staff bylaws, rules and regulations or the hospital bylaws or policies.

(c) Likewise, voluntary relinquishment of clinical privileges while under an investigation or in return for not conducting an investigation shall be considered a "surrender" of such privileges, and shall be so reported when so required.

ARTICLE II - PART G:

Section 2. Procedure for Relinquishment of Clinical Privileges:

(a) Upon the receipt of a request to relinquish one (1) or more clinical privileges, the Chief of Staff and/or the Executive Committee shall review the request and forward a recommendation to the Board for final action. The Chief of Staff and/or the Executive Committee may request a meeting with the appointee involved if the decrease of the clinical privileges would create a deficiency in available hospital services. A report of such meeting shall be submitted to the Board with the recommendation of the Chief of Staff and/or the Executive Committee.

(b) The Board shall act on the request and its decision shall be reported in writing by the Chief Executive Officer to the appointee and the Executive Committee. The decision of the Board shall specify a specific date on which relinquishment of clinical privilege(s) shall become effective.

(c) Failure to request relinquishment of any clinical privileges pursuant to this Part or to adhere to the effective date specified by the Board for the relinquishment of the clinical privileges in question shall constitute grounds for professional review action pursuant to this policy.

(d) A request to resign all clinical privileges must (a) specify the desired date of resignation, at least 30 days from the date of the request; and (b) provide evidence that the individual has completed all medical records and will be able to appropriately discharge or transfer responsibility for the care of any hospitalized patient. After consulting with the Chief Medical Officer, the Chief Executive Officer will act on the request.

ARTICLE II - PART H: PROCEDURE FOR TEMPORARY CLINICAL PRIVILEGES

Section 1. Temporary Clinical Privileges for Applicants:

(a) Temporary privileges shall not routinely be granted to applicants. Such privileges may only be granted on a case-by-case basis when a specific and urgent patient care need exists that requires immediate authorization to practice at the hospital, including:

(1) the care of a specific patient; or

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

(3) the proctoring medical staff appointee.

(b) Temporary privileges may also be granted when an applicant for initial appointment is awaiting review by the Executive Committee and/or the Board, and has no current or previously successful challenges to his or her license or registration, and has not been subject to involuntary termination of Medical Staff appointment, or involuntary limitation, reduction, denial, or loss of clinical privileges at another health care facility. The Chief Executive Officer, or designee, shall verify information regarding the individual's licensure, DEA certification, relevant training and experience, current clinical competence and judgment, character, ethical standing, behavior, ability to exercise the privileges requested competently and safely, lack of Medicare/Medicaid/other government health care program exclusion/sanctions and professional liability

insurance coverage, and shall query the National Practitioner Data Bank before making a final decision to grant temporary privileges.

(c) Temporary privileges shall be granted for a specific period of time, as warranted by the situation. In no situation, however, shall the initial grant of temporary privileges be for a period exceeding thirty (30) days. Temporary privileges may be extended for two separate thirty (30) day intervals, upon approval of the governing body. In exercising such privileges, the applicant shall act under the monitoring and supervision of the Chief of Staff or appropriate designee of the clinical specialty in which the applicant has requested primary privileges.

(d) Prior to temporary privileges being granted, the applicant must agree in writing to be bound by the bylaws, policies, rules and regulations, procedures and protocols of the Medical Staff and the hospital.

(e) Temporary privileges shall expire at the end of the time period for which they are granted or at any earlier time determined by the Chief Executive Officer or the Board in accordance with this policy.

ARTICLE II - PART H:

Section 2. Supervision Requirements:

In exercising temporary privileges, the individual shall act under the supervision of the Chief of Staff. Special requirements of supervision and reporting may be imposed by the Chief of Staff concerned on any individual granted temporary clinical privileges. Temporary privileges shall be immediately terminated by the Chief Executive Officer or a designee upon notice of any failure by the individual to comply with such special conditions.

ARTICLE II - PART H:

Section 3. Locum Tenens:

(a) The Chief Executive Officer, or designee, may grant an individual serving as a locum tenens for an appointee of the Medical Staff temporary admitting and clinical privileges

to attend patients of that appointee for a period not to exceed thirty (30) days at one interval and may be used for a period not to exceed six (6) months. After a period of six (6) months, the credentialing and privileging of the individual serving as a locum tenens shall be processed through the Medical Executive Committee and Board of Directors. This shall be done in the same manner and upon the same conditions as set forth in Section l of this Part, provided that the Chief Executive Officer, or designee, shall first obtain such individual's signed acknowledgment that the individual has received and had an opportunity to read copies of the hospital bylaws, this policy and Medical Staff bylaws, rules and regulations which are then in force, and agrees to be bound by the terms thereof.

(b) The individual serving as a locum tenens must complete a request for Locum Tenens clinical privileges form and must have in force and effect a current license to practice in this state, a DEA license, if applicable; professional liability insurance in an amount and terms acceptable to the hospital, documentation of education, residency training, current demonstrated experience, including the individual's current primary place of clinical medical practice.

ARTICLE II - PART H:

Section 4. Termination of Temporary Clinical Privileges:

(a) The Chief Executive Officer may, at any time after consulting with the Executive Committee terminate temporary admitting privileges. Clinical privileges shall then be terminated when the individual's inpatients are discharged from the hospital. However, where it is determined that the care or safety of such patients would be endangered by continued treatment by the individual granted temporary privileges, a termination of temporary clinical privileges may be imposed by the Chief Executive Officer, the Chief Medical Officer, or the Chief of Staff, and such termination shall be immediately effective.

(b) The Chief Medical Officer or the Chief of Staff shall assign to a Medical Staff appointee responsibility for the care of such individual's patients until they are discharged from the hospital, giving consideration wherever possible to the wishes of the patient in the selection of the substitute.

(c) The granting of any temporary admitting and clinical privileges is a courtesy on the part of the hospital and any or all temporary privileges may be terminated if a clinical question or concern has been raised. Neither the granting, denial, or termination of such privileges shall entitle the individual concerned to request the procedural rights provided in this policy.

(d) Temporary privileges shall be automatically terminated at such time as the Executive Committee recommends not to appoint the applicant to the staff. Similarly, temporary clinical privileges shall be modified to conform to the recommendation of the Executive Committee that the applicant be granted clinical privileges different from the temporary privileges.

ARTICLE II - PART I: EMERGENCY CLINICAL PRIVILEGES

(1) For the purpose of this section, an "emergency" is defined as the 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 or danger.

(2) In an emergency, any practitioner who is not currently appointed to the Medical Staff may be permitted by the hospital to exercise clinical privileges to the extent permitted by his or her license regardless of that individual's clinical status.

(3) When the emergency situation no longer exists, the patient shall be assigned by the Chief of Staff to an appointee with appropriate clinical privileges. The wishes of the patient shall be considered in the selection of a substitute physician.

ARTICLE II - PART J: DISASTER PRIVILEGES

(1) When the disaster(s) plan has been implemented and the immediate needs of patients in the facility cannot be met, the Chief Executive Officer 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 shall be granted on a case-by-case basis after verification of identify and licensure.

(a) A volunteer's identity may be verified through a valid, government-issued photo identification (i.e., driver's license or passport).

(b) A volunteer's license may be verified in any of the following ways: (i) current hospital picture ID card that clearly identifies the individual's professional designation; (ii) current license to practice; (iii) primary source verification of the license; (iv) identification indicating that the individual has been granted authority to render patient care in disaster circumstances or is a member of a Disaster Medical Assistance Team, the Medical Recourse Corps, the Emergency System for Advance Registration of Volunteer Health Professionals, or other recognized state or federal organizations or groups; or (v) identification by a current hospital employee or Medical Staff member who possesses personal knowledge regarding the individual's ability to act as a volunteer during a disaster.

(3) Primary source verification of a volunteer's license shall begin as soon as the immediate situation is under control and must be completed within seventy-two (72) hours from the time the volunteer begins to provide service at the hospital.

(4) In extraordinary circumstances when primary source verification cannot be completed within seventy-two (72) hours, it should be completed as soon as possible. In these situations, there must be documentation of the following: (a) the reason primary source verification could not be performed in the required time frame; (b) evidence of the volunteer's demonstrated ability to continue to provide adequate care; and (c) an attempt to obtain primary source verification as soon as possible. If a volunteer has not provided care, then primary source verification is not required.

(5) The Medical Staff shall oversee the care provided by volunteer licensed independent practitioners. This oversight will be conducted through direct observation, mentoring, clinical record review, or other appropriate mechanism developed by the Medical Staff and hospital.

ARTICLE III

ACTIONS AFFECTING MEDICAL STAFF APPOINTEES

ARTICLE III - PART A: PROCEDURE FOR REAPPOINTMENT

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

ARTICLE III - PART A:

Section 1. Application:

(a) Each current appointee who is eligible to be reappointed to the Medical Staff shall be responsible for completing the reappointment application form. The reappointment application shall be submitted to the applicant by certified mail at least four (4) months prior to the expiration of the appointee's current appointment period and shall be returned to the Medical Staff Office at Hays Medical Center within thirty (30) days of receipt. Failure to submit an application by that time may result in automatic expiration of the appointee's appointment and clinical privileges at the end of the then current appointment period.

(b) Reappointment, if granted by the Board, shall be for a period of not more than two (2) years, with re-appointments staggered in a manner established by the Medical Staff Office.

(c) Except as provided below, if an application for reappointment is submitted timely but the Board has not acted on it prior to the end of the current term of appointment, the individual's appointment and clinical privileges shall expire at the end of that current term of appointment. Subsequent Board action may be to grant reappointment and renewal of clinical privileges.

(d) In those situations where the Board has not acted on a pending application for reappointment and there is an important patient care need that mandates an immediate authorization to practice, including, but not limited to, an inability to meet on-call coverage requirements, or denying the community access to needed medical

services, the Chief Executive Officer and or Chief Medical Officer shall have the authority to grant the individual temporary privileges until such time as the Board acts on the application. Prior to granting temporary privileges the Chief Executive Officer and or Chief Medical Officer shall consult with the Chief of Staff. The temporary privileges will be only for a period not to exceed sixty (60) days.

(e) In the event the application for reappointment is the subject of an investigation or hearing at the time reappointment is being considered, a conditional reappointment for a period of less than one (1) year may be granted, pending the completion of that process.

(f) The application shall be reviewed by the Medical Staff Office to determine that all questions have been answered and that the individual satisfies all eligibility criteria for reappointment and for the clinical privileges requested.

ARTICLE III - PART A:

Section 2. Factors to be Considered:

(a) Each recommendation concerning reappointment of an individual currently appointed to the Medical Staff shall be based upon such appointee's:

(1) ethical behavior, clinical competence and clinical judgment in the treatment of patients;

(2) attendance at Medical Staff and committee meetings, and participation in staff duties;

(3) compliance with the bylaws, policies and rules and regulations of the Medical Staff and the hospital;

(4) behavior at the hospital, including cooperation with Medical Staff and hospital personnel as it relates to patient care, the orderly operation of this hospital, and general attitude toward patients, the hospital and its personnel;

(5) use of the hospital's facilities for patients, taking into consideration the individual's comparative utilization patterns;

(6) ability to perform the clinical privileges requested competently and safely;

(7) capacity to satisfactorily treat patients as indicated by the results of the hospital's quality assessment/performance improvement activities or other reasonable indicators of continuing qualifications, taking into consideration practitioner-specific information compared to aggregate information concerning other individuals in the same or similar specialty (provided that other practitioners shall not be identified);

(8) satisfactory completion of such continuing education requirements as may be imposed by law, this hospital or applicable accreditation agencies;

(9) current professional liability insurance status and pending malpractice challenges, including claims, lawsuits, judgments and settlements;

(10) current licensures, including currently pending challenges to any license or registration;

(11) voluntary or involuntary termination of Medical Staff appointment or voluntary or involuntary limitation, reduction, or loss of clinical privileges at another hospital, not including a voluntary personal decision by the applicant to request a lesser scope of clinical privileges upon reappointment or during the term of appointment;

(12) relevant findings from the hospital's quality assessment/performance improvement activities;

(13) any focused professional practice evaluations;

(14) any verified complaints received from patients and/or staff; and

(15) other reasonable indicators of continuing qualifications.

(b) Eligibility for Reappointment:

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

(1) completed all medical records;

(2) completed all continuing medical education requirements;

(3) satisfied all Medical Staff and Allied Health Staff responsibilities, including payment of any dues, fines, and assessments;

(4) continued to meet all qualifications and criteria for appointment and the clinical privileges requested;

(5) paid any applicable reappointment processing fee; and

(6) had sufficient patient contacts to enable the assessment of current clinical judgment and competence for the privileges requested. Any member seeking reappointment who has minimal activity at the Hospital must submit such information as may be requested (such as a copy of his or her confidential quality profile from his or her primary Hospital, clinical information from his or her private office practice, or a quality profile from a managed care organization or insurer) before the application will be considered complete and processed further.

ARTICLE III - PART A:

Section 3. Chief of Staff Procedure:

(a) No later than three (3) months prior to the end of the current appointment period, the Chief Executive Officer or a designee shall send to the Chief of Staff a current list of all appointees who have clinical privileges, together with a description of the clinical privileges each holds, accompanied by copies of their applications.

(b) No later than fifteen (15) days after receipt of the applications, the Chief of Staff or designee shall provide the Executive Committee with a written report concerning each individual seeking reappointment. The Chief of Staff or designee shall include in each written report, when applicable, the reasons for any changes recommended in staff category, in clinical privileges, or for non-reappointment. The Chief of Staff or designee shall be available to the Executive Committee to answer any questions that may be raised with respect to any such report.

ARTICLE III - PART A:

Section 4. Executive Committee Procedure:

(a) The Executive Committee, after receiving the reports from each Chief of Staff, shall review all pertinent information available, including all information provided from other committees of the Medical Staff and from hospital management, for the purpose of determining its recommendations for staff reappointment, for change in staff category, and for the granting of clinical privileges for the ensuing appointment period.

(b) After determining that the appointee is qualified for reappointment and privileges, the Executive Committee may require an individual currently seeking reappointment to undergo a physical and/or mental examination by a physician or physicians satisfactory to the Executive Committee either as part of the reapplication process or at anytime during the appointment period to aid it in determining whether clinical privileges should be granted or continued. The results of such examination shall be available for the Executive Committee's consideration. Failure of an individual seeking reappointment to undergo such an examination within a reasonable time after being requested to do so in writing by the Executive Committee shall constitute a voluntary relinquishment of all clinical privileges until such time as the Executive Committee has received the examination results and has had a reasonable opportunity to evaluate them and make a recommendation thereon.

(c) The Executive Committee shall have the right to require the individual to meet with the committee to discuss any aspect of the individual's reappointment application, qualifications, or clinical privileges requested.

(d) The Executive Committee may use the expertise of the Chief of Staff, or any member of the medical staff, or an outside consultant, if additional information is required regarding the individual's qualifications for reappointment.

(e) If, after considering the report of the Chief of Staff concerned, the Executive Committee's recommendation is favorable, it shall recommend reappointment and the specific clinical privileges to be granted, which may be qualified by any probationary or other conditions or restrictions, as deemed appropriate by the committee.

(f) If it becomes apparent to the Executive Committee that it is considering a recommendation to deny reappointment or a requested change in staff category, or to reduce clinical privileges, the chairperson of the committee may notify the individual of the general tenor of the possible recommendation and invite the individual to meet with the committee or a designee prior to any final recommendation being made. At the meeting, the individual should be informed of the general nature of the information supporting the recommendation contemplated and shall be invited to discuss, explain or refute it. This meeting is not a hearing, and none of the procedural rules for hearings shall apply. The committee shall indicate as part of its report whether such a meeting occurred and shall include a summary of the meeting with its minutes.

(g) At its next regular meeting after receipt of the written findings and recommendation of the Chief of Staff, the Executive Committee shall:

(1) adopt the findings and recommendation of the Chief of Staff; or

(2) refer the matter back to the Chief of Staff for further consideration and preparation of responses to specific questions raised by the Executive Committee prior to its final recommendation; or

(3) set forth in its report and recommendation clear and convincing reasons, along with supporting information, for its disagreement with the Chief of Staff's recommendation. Thereafter, the Executive Committee's recommendation shall be forwarded, together with the Chief of Staff's findings and recommendation, through the Chief Executive Officer to the Board.

(h) The Executive Committee shall transmit its written reports and recommendations concerning the reappointment, clinical privileges and, where applicable, change in staff category, of each person currently holding a Medical Staff appointment, to the Board, through the Chief Executive Officer, for reappointment consideration and further action.

(i) Any recommendation by the Executive Committee that would entitle the affected individual to request the procedural rights provided in this policy shall be forwarded to the Chief Executive Officer who shall promptly notify the affected individual by certified mail, return receipt requested. The Chief Executive Officer shall then hold the

recommendation until after the individual has exercised or has waived the right to a hearing as provided in this policy, after which time, the Chief Executive Officer shall forward the recommendation of the Executive Committee, together with all supporting documentation to the Board. The Chairperson of the Executive Committee shall be available to the Board to answer any questions that may be raised with respect to the recommendation.

(j) In the event the Board determines to consider modification of the action of the Executive Committee and such modification would entitle the appointee to request a hearing in accordance with this policy, it shall notify the affected individual, through the Chief Executive Officer, and shall take no final action until the individual has exercised or has waived the procedural rights provided in this policy.

(k) Notice of any final decision by the Board to grant, deny, revise, renew, not renew appointment and clinical privileges shall be forwarded by the Chief Executive Officer, certified mail, return receipt requested, to the Medical Staff member within seven (7) days after the Board's determination, and shall be disseminated to appropriate individuals and, as required, reported to appropriate entities.

ARTICLE III - PART A:

Section 5. Meeting with Affected Individual:

If, during the processing of an individual's reappointment request, it becomes apparent to the Executive Committee or its Chairperson that the committee is considering a recommendation that would deny reappointment, deny a requested change in staff category or clinical privileges, or reduce clinical privileges, the Chairperson of the Executive Committee may notify the individual of the general tenor of the possible recommendation and ask if the individual desires to meet with the committee prior to any final recommendation by the committee. At such meeting, the affected individual shall be informed of the general nature of the evidence supporting the action contemplated, and shall be invited to discuss, explain or refute it. This interview shall not constitute a hearing and none of the procedural rules provided in this policy with respect to hearings shall apply. Minutes of the discussion in the meeting shall not be kept. However, the committee shall indicate as part of its report to the Governing Board whether such a meeting occurred, and shall include a summary of the meeting.

ARTICLE III - PART A:

Section 6. Conditional Reappointments:

(a) Recommendations for reappointment and renewed privileges may be contingent upon an individual's compliance with certain specific conditions. These conditions may relate to behavior (e.g., code of conduct) or to clinical issues (e.g., general consultation requirements, proctoring, completing of CME requirements). Unless the conditions involve grounds for a hearing as set forth in Article IV - Part A, Section 1 of this policy, the imposition of such conditions shall not entitle an individual to request the procedural rights set forth in Article IV of this policy.

(b) In addition, reappointments may be recommended for periods of less than two (2) years in order to permit closer monitoring of an individual's compliance with any conditions that may be imposed. A recommendation for reappointment for a period of less than two (2) years shall not, in and of itself, entitle an individual to the procedural rights set forth in Article IV.

ARTICLE III - PART A:

Section 7. Time Periods for Processing:

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

ARTICLE III - PART B: PEER REVIEW PROCEDURES FOR QUESTIONS

INVOLVING MEDICAL STAFF APPOINTEES

Section 1. Informal Proceedings/Collegial Intervention:

(a) Nothing in this policy or other parts of the Medical Staff Bylaws shall preclude collegial efforts to address questions or concerns relating to an individual's practice and conduct at the hospital. This policy specifically encourages collegial steps where there is a reasonable likelihood that such steps may correct a pattern/concern before it requires

formal investigation. The goal of such efforts is to arrive at voluntary, responsive actions by the individual.

(b) All efforts of Medical Staff leaders and hospital management in this regard are intended to be, and are, part of the hospital's ongoing and focused professional practice evaluations, performance improvement and professional peer review activities.

(c) Collegial intervention efforts involve reviewing, counseling and educating colleagues when questions arise concerning their clinical practice or professional conduct and include, but are not limited to:

(1) educating and advising colleagues of all applicable policies, such as policies regarding appropriate behavior (Code of Conduct Policy), emergency call obligations, and the timely and adequate completion of medical records;

(2) following up on any questions or concerns raised about the clinical practice and/or professional conduct of staff appointees and recommending activities such as proctoring, monitoring, consultation, and letters of guidance; and

(3) sharing comparative quality, utilization, and other relevant information, including any variations from clinical protocols or guidelines, in order to assist individuals to conform their practices to appropriate norms.

(d) The relevant Medical Staff leader(s) shall determine whether it is appropriate to include documentation of collegial intervention efforts in the individual's confidential file. If documentation of collegial efforts is included in the individual's file, the individual shall be given the opportunity to review it and respond in writing. The response, if any, shall be maintained in the individual's confidential file, along with the original documentation.

(e) Collegial intervention efforts are encouraged, but are not mandatory, and shall be within the discretion of the appropriate medical staff leaders and hospital management, depending on the circumstances. Such efforts shall be considered to be confidential peer review activities, but shall not in and of themselves give rise to any procedural rights.

(f) The Chief of Staff and Chief Medical Officer shall determine whether to direct that a matter be handled in accordance with another policy, such as the Code of Conduct Policy or the policy on practitioner health (Physician Health Process), or to direct it to the Executive Committee for further determination.

ARTICLE III - PART B:

Section 2. Ongoing and Focused Professional Practice Evaluation

<<<<<Describe our ongoing and focus practice evaluation process when decided upon>>>>>

ARTICLE III – PART B:

Section 3 Initial Review Procedure:

(a) Whenever a serious concern or question has been raised or where collegial efforts have not resolved an issue regarding:

(1) the clinical competence or clinical practice of any Medical Staff appointee;

(2) the care or treatment of a patient or patients or management of a case by any Medical Staff appointee;

(3) the known or suspected violation by any Medical Staff appointee of applicable ethical standards or the bylaws, policies, rules or regulations of the hospital or the Medical Staff, including, but not limited to, the hospital's quality assessment/performance improvement, risk management, and utilization review programs;

(4) 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; and

(5) any other matter concerning an appointee's qualifications for appointment; the Chief of Staff, Chief Medical Officer and or Chief Executive Officer shall make sufficient inquiry to satisfy themselves that the concern or question raised is credible. If so, it shall be submitted in writing to the Executive Committee.

(b) If any of the inquiring individuals set forth in this Section believe it to be in the best interest of the hospital and the appointee concerned, they may, but are not required to, discuss the matter with the affected appointee.

(c) No action taken pursuant to this Section shall constitute an investigation.

ARTICLE III - PART B:

Section 4. Initiation of Investigation:

(a) When a concern or question involving clinical competence or behavior/conduct is referred to, or raised by, the Executive Committee, that committee shall review the matter and determine whether to discuss the matter with the appointee concerned, direct that the matter be handled pursuant to another policy, such as the Code of Conduct Policy or the policy on practitioner health (Physician Health Process), or to begin an investigation. Notification to the individual may be delayed if, in the Executive Committee's judgment, informing the individual immediately would compromise the investigation or disrupt the operation of the hospital or Medical Staff. The Executive Committee may also, by formal resolution, initiate an investigation on its own motion. If the Board wishes to begin such an investigation, it shall also formally resolve to do so, but may delegate the actual investigation.

(b) The Chief of Staff shall promptly notify the Executive Committee and the Chief Executive Officer in writing of all such requests and investigations, and shall keep them fully informed of all action taken in connection with an investigation.

ARTICLE III - PART B:

Section 5. Investigative Procedure:

Upon resolving to initiate an investigation, the Executive Committee shall meet as soon as possible:

(a) If the concern states sufficient information to warrant a recommendation, the Executive Committee, at its discretion, may make such a recommendation, with or without a personal interview with the individual being investigated.

(b) If the concern does not state sufficient information to warrant a recommendation, the Executive Committee shall immediately investigate the matter, appoint a subcommittee to do so, or appoint an ad hoc investigating committee consisting of up to three (3) persons, who may or may not hold appointments to the Medical Staff. This ad hoc investigating committee shall not include partners, associates, relatives or any individual who is in direct economic competition or who has a conflict of interest with the individual being investigated. The investigating committee shall make a reasonable effort to complete its investigation and report within forty-five (45) days after the determination to initiate the investigation, provided an outside review is not necessary. When an outside review is necessary, the investigating committee will make a reasonable effort to complete the investigation and issue its report within thirty (30) days of receiving the results of the outside review.

(c) The Executive Committee, its subcommittee or the ad hoc investigating committee shall have available to it the full resources of the Medical Staff and the hospital, as well as the authority to use outside consultants, if needed. An outside consultant or agency may be used whenever a determination is made by the hospital and investigating committee that:

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

(2) the individual under review is likely to raise, or has raised, questions about the objectivity of other practitioners on the Medical Staff; or

(3) the individuals with the necessary clinical expertise on the Medical Staff would not be able to conduct a review without risk of all allegations of bias, even if such allegations are unfounded.

(d) The investigating committee may require a physical and/or mental examination of the individual being investigated by a physician(s) or other health care professional(s) satisfactory to the committee, and shall require that the results of such examination be made available for the committee's consideration. The individual being investigated shall execute a release 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.

(e) The individual being investigated shall have an opportunity to meet with the investigating committee before it makes its report. Prior to the meeting, the individual shall be informed of the general questions being investigated. At this meeting, the individual shall be invited to discuss, explain or refute the questions that gave rise to the investigation. This interview shall not constitute a hearing, and none of the procedural rules provided in this policy with respect to hearings shall apply. Neither the individual being investigated nor the hospital shall have the right to be represented by legal counsel at this meeting. A summary of that meeting shall be made by the investigating committee and included with its report to the Executive Committee.

(f) The investigating committee will make a reasonable effort to complete the investigation and issue its report within thirty (30) days of the commencement of the investigation, provided that an outside review is not necessary. When an outside review is necessary, the investigating committee will make a reasonable effort to complete the investigation and issue its report within 30 days of receiving the results of the outside review. These time frames are intended to serve as guidelines and, as such, will not be deemed to create any right for an individual to have an investigation completed within such time periods. In the event the investigating committee is unable to complete the investigation and issue its report within these time frames, it will inform the individual and the Executive Committee of the reasons for the delay and the approximate date on which it expects to complete the investigation.

(g) At the conclusion of the investigation, the investigating committee will prepare a report with its findings, conclusions, and recommendations.

(h) In making its recommendations, the investigating committee will strive to achieve a consensus as to what is in the best interests of patient care and the smooth operation of the Hospital, while balancing fairness to the individual, recognizing that fairness does not

require that the individual agree with the recommendation. Specifically, the committee may consider:

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

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

(3) any information or explanations provided by the individual under review.

(i) If a subcommittee or ad hoc investigating committee is used, the Executive Committee may accept, modify or reject the recommendation it receives from an investigating committee.

ARTICLE III - PART B:

Section 6. Procedure Thereafter:

(a) At the conclusion of the investigation, the Executive Committee may:

(1) determine that no action is justified;

(2) issue a written warning;

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

(4) impose terms of probation;

(5) impose a requirement for monitoring or consultation;

(6) impose conditions for continued appointment;

(7) recommend additional training or education;

(8) recommend reduction of clinical privileges;

(9) recommend suspension of clinical privileges for a term;

(10) recommend revocation of staff appointment and/or clinical privileges; or

(11) make such other recommendations as it deems necessary or appropriate.

(b) If the action of the Executive Committee does not entitle the individual to request a hearing, the action shall take effect immediately without action of the Board and without the right of appeal to the Board. A report of the action taken and reasons therefore shall be made to the Board through the Chief Executive Officer, and the action shall stand unless modified by the Board.

(c) If the action of the Executive Committee does entitle the individual to request a hearing, the Executive Committee shall forward its recommendation to the Board, and the Chairperson of the Executive Committee shall be available to the Board to answer any questions that may be raised with respect to the recommendation.

(d) After reviewing the findings and recommendation of the Executive Committee, and, if necessary, meeting with the Chairperson of the Executive Committee, the Board shall:

(1) adopt the recommendation of the Executive Committee; or

(2) refer the matter back to the Executive Committee for its further investigation and preparation of responses to specific questions raised by the Board prior to its final decision; or

(3) set forth in its report and recommendation clear and convincing reasons, along with supporting information, for its disagreement with the Executive Committee's recommendation, prior to its final decision

(e) Any recommendation by the Executive Committee that would entitle the affected individual to request a hearing shall be forwarded to the Chief Executive Officer who shall promptly notify the affected individual by certified mail, return receipt requested. The Chief Executive Officer shall then hold the recommendation until after the individual has exercised or has waived the right to a hearing as provided in this policy, after which the Chief Executive Officer shall forward the recommendation of the Executive Committee, together with all supporting information, to the Board (or its committee). The Chairperson of the Executive Committee shall be available to the Board (or its committee) to answer any questions that may be raised with respect to the recommendation.

(f) In the event the Board determines to consider modification of the action of the Executive Committee and such modification would entitle the individual to request a hearing in accordance with this policy, the Chief Executive Officer shall notify the affected individual in writing, certified mail, return receipt requested, and no final action shall be taken until the individual has completed or has waived the right to a hearing.

(g) 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 the hospital's performance improvement activities or pursuant to applicable policies, as appropriate.

ARTICLE III - PART C: PRECAUTIONARY SUSPENSION OR RESTRICTION OF CLINICAL PRIVILEGES

Section 1. Grounds for Precautionary Suspension or Restriction:

(a) The Chief of Staff, the Chief Medical Officer, the Chairperson of the Executive Committee, the Chief Executive Officer, or the Chairperson of the Board shall each have the authority to afford the affected individual an opportunity to voluntarily refrain from exercising privileges pending an investigation or to suspend or restrict all or any portion of the clinical privileges of a Medical Staff appointee or other individual whenever failure to take such action may result in an imminent danger to the health and/or safety of any individual . Such precautionary suspension or restriction is an interim precautionary step in the professional review activity related to the ultimate professional review action that may be taken with respect to the suspended individual, but is not a complete professional review action in and of itself. It can be imposed at any time, including, but not limited to, immediately after the occurrence of an event that causes concern for patient safety; following a pattern of occurrences that raises concern; or following a recommendation of the Executive Committee that would entitle the individual to request a hearing and appeal. Precautionary suspension or restriction shall not imply any final finding of responsibility for the situation that caused the suspension.

(b) Such precautionary suspension or restriction shall become effective immediately upon imposition, shall immediately be reported in writing to the Chief Executive Officer, Chief Medical Officer, the Chief of Staff, and the Chairperson of the Executive Committee, and

shall remain in effect unless or until modified by the Chief Executive Officer or the Board.

(c) The individual who is placed on precautionary suspension or restriction shall be given written notice of such action within forty-eight (48) hours of the imposition of the suspension or restriction. The written notice shall include a description of the reason(s) for the precautionary suspension or restriction, including the patient names and medical record numbers involved, if any.

ARTICLE III - PART C:

Section 2. Executive Committee Procedure:

(a) Within a reasonable time, not to exceed 14 days of the imposition of the suspension, the Executive Committee will review the reason for the suspension.

(b) As part of this review, the individual will be invited to meet with Executive Committee. In advance of the meeting, the individual may submit a written statement and other information to the Executive Committee.

(c) At the meeting, the individual may provide information to the Executive Committee and should respond to questions that may be raised by Executive Committee members. The individual may also propose ways, other than precautionary suspension, to protect patients, employees or others while the matter is being reviewed.

(d) After considering the reasons for the suspension and the individual's response, if any, the Executive Committee will recommend to the Chief Executive Officer whether the precautionary suspension should be continued, modified, or lifted. The Executive Committee may also determine whether to begin an investigation.

(e) If the Executive Committee decides to continue the suspension, the Chief Executive Officer will send the individual written notice of its decision, including the basis for it.

(f) There is no right to a hearing based on the imposition or continuation of a precautionary suspension. The procedures outlined above are deemed to be fair under the circumstances.

ARTICLE III - PART C:

Section 3. Care of Patients:

(a) Immediately upon the imposition of a precautionary suspension or restriction, the Chief of Staff, shall assign to another individual with appropriate clinical privileges responsibility for care of the individual's hospitalized patients, or aid in implementing the precautionary restriction, as appropriate. The assignment shall be effective until such time as the patients are discharged. The wishes of the patient shall be considered in the selection of the assigned appointee.

(b) It shall be the duty of all Medical Staff appointees to cooperate with the Chief of Staff, the Executive Committee and the Chief Executive Officer in enforcing precautionary suspensions or restrictions.

ARTICLE III - PART D: AUTOMATIC RELINQUISHMENT

Section 1. Failure to Complete Medical Records:

The elective and emergency admitting clinical privileges of any individual shall be deemed to be automatically relinquished for failure to complete medical records in accordance with applicable rules and regulations governing the same, after notification by the Health Information Management Department of such delinquency. Such relinquishment shall continue until all the records of the individual's patients are no longer delinquent. Failure to complete the medical records that caused relinquishment of clinical privileges within sixty (60) days from the relinquishment of such privileges shall constitute a voluntary relinquishment of all clinical privileges and resignation from the Medical Staff.

ARTICLE III - PART D:

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

(a) Any action taken by any licensing board, professional liability insurance company, court or government agency regarding any of the matters set forth below or failure to satisfy any of the threshold eligibility criteria set forth in this policy must be promptly reported to the Chief Executive Officer.

(b) An individual's appointment and clinical privileges will be automatically relinquished if any of the following occur:

(1) Licensure: Revocation, expiration, suspension, or the placement of Conditions or restrictions on an individual's license.

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

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

(4) Medicare and Medicaid Participation: Termination, exclusion, or preclusion by government action from participation in the Medicare-Medicaid or other federal or state health care programs.

(5) Criminal Activity: 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; or (iv) violence against another.

(c) An individual's appointment and clinical privileges shall be automatically relinquished, without entitlement to the procedural rights outlined in this policy, if the individual fails to satisfy any of the other threshold eligibility criteria set forth in this policy.

(d) Automatic relinquishment shall take effect immediately upon notice to the hospital and continue until the matter is resolved, if applicable. If an individual engages in any patient contact at the hospital after the occurrence of an event that results in automatic relinquishment, without notifying the hospital of that event, then the relinquishment shall be deemed permanent.

(e) Failure to resolve the underlying matter leading to an individual's clinical privileges being automatically relinquished within ninety (90) days of the date of relinquishment shall result in automatic resignation from the Medical Staff.

(f) Requests for reinstatement shall be reviewed by the Chairperson of the Executive Committee, the Chief of Staff, Chief Medical Officer and Chief Executive Officer. If all these individuals make a favorable recommendation on reinstatement, the individual may immediately resume clinical practice at the hospital. This determination shall then be forwarded to the Executive Committee and the Board for ratification. If, however, any of the individuals reviewing the request have any questions or concerns, those questions shall be noted and the reinstatement request shall be forwarded to the Executive Committee and Board for review and recommendation, and final action.

ARTICLE III - PART D:

Section 3. Failure to Comply with Request for Fitness for Practice Evaluation:

(a) Failure of an applicant to undergo a requested fitness for practice evaluation or to execute any of the required releases (i.e., to allow the Medical Staff leaders, or the relevant committee, to discuss with the health care professional(s) the reasons for the evaluation and to allow the health care professional to report the results to the Medical Staff leaders or relevant committee) shall be considered a voluntary withdrawal of the application.

(b) Failure of an appointee to undergo a requested fitness for practice evaluation or to execute any of the required releases (i.e., to allow the Medical Staff leaders, or the relevant committee, to discuss with the health care professional(s) the reasons for the evaluation and to allow the health care professional to report the results to the Medical Staff leaders or relevant committee) will result in the automatic relinquishment of appointment and privileges.

ARTICLE III - PART D:

Section 4. Failure to Satisfy Continuing Education Requirements:

(a) Failure to complete mandated continuing education requirements shall be deemed to constitute a voluntary relinquishment of Medical Staff appointment and clinical privileges, and shall be sufficient grounds for refusing to consider the individual for reappointment. Such failures shall be documented and specifically considered by the

Executive Committee when making recommendations for reappointment and by the Board when making its final decisions.

(b) Any appointee who is ineligible for reappointment for failure to satisfy continuing education requirements shall be entitled to meet with a committee to be designated by the Board before final action is taken. This meeting with the Board committee shall not be conducted under the procedural rules provided in this policy.

(c) If reappointment is refused by the Board, the individual shall be eligible to reapply for staff appointment and clinical privileges and the application shall be processed in the same manner as if it were an initial application.

ARTICLE III - PART D:

Section 5. Failure to Provide Requested Information:

If at any time an appointee fails to provide required information pursuant to a formal request by the Executive Committee or the Chief Executive Officer, the appointee's clinical privileges shall be deemed to be automatically relinquished until the required information is provided to the satisfaction of the requesting party.

ARTICLE III - PART D:

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

Failure to complete and/or comply with training or educational requirements that are adopted by the Executive Committee and/or required by the Board, including, but not limited to, those pertinent to electronic medical records or patient safety, will result in the automatic relinquishment of all clinical privileges. Any relinquishment will continue in effect until documentation of compliance is provided to the satisfaction of the requesting party. If the requested information is not provided within 60 days of the date of relinquishment, it shall result in automatic resignation from the Medical Staff.

ARTICLE III - PART D:

Section 7. Failure to Attend Special Conference:

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

(b) The written notice to the individual regarding this conference shall be given by certified mail, return receipt requested, at least three (3) days prior to the conference and shall inform the individual that attendance at the conference is mandatory.

(c) Failure of the individual to attend the conference shall be reported to the Executive Committee. Unless excused by the Executive Committee upon a showing of good cause, such failure shall result in automatic relinquishment of all or such portion of the individual's clinical privileges as the Executive Committee may direct. Such relinquishment shall remain in effect until the matter is resolved.

ARTICLE III - PART D:

Section 8. Use of Signature Stamp and/or Computer Key Electronic Signature:

The elective and emergency admitting clinical privileges of any individual shall be deemed to be automatically relinquished for a period of twenty-nine (29) days for violation of the terms of the Declaration Concerning Use of Signature Stamp and/or Declaration of Confidentiality and Intent (Electronic Medical Record Policy on Access) executed by the individual after notification by the Health Information Management Department of such violation. Such relinquishment shall continue until a new Declaration has been executed. Relinquishment and reinstatement will be reported to the Executive Committee.

ARTICLE III - PART D:

Section 9. Procedure for Leave of Absence:

(a) Individuals appointed to the Medical Staff may, for good cause, be granted leaves of absence by the Board for a definitely stated period of time. Absence for longer than the period of time granted shall constitute automatic resignation of Medical Staff appointment and clinical privileges unless an exception is made by the Board upon recommendation of the Executive Committee.

(b) Requests for leaves of absence shall be made to the Chief of Staff and shall state the beginning and ending dates of the requested leave. The Chief of Staff shall transmit the request together with a recommendation to the Chief Executive Officer for action by the Board or its designee. The Chief Executive Officer shall also notify the Executive Committees of all such requests. Best efforts shall be used to make the determination within thirty (30) days of the receipt of the individual's written leave request.

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

(d) At the conclusion of the leave of absence, the individual may be reinstated, upon filing a written statement with the Chief Executive Officer at least forty-five (45) days prior to the expiration of the leave of absence, or an earlier time, summarizing the professional activities undertaken during the leave of absence. The individual shall also provide such other information as may be requested by the hospital at that time.

(e) If the leave of absence was for health/medical reasons, the request for reinstatement must be accompanied by a report from the individual's attending physician indicating that the appointee is physically and/or mentally capable of resuming a hospital practice and exercising the clinical privileges requested. The appointee shall also provide such other information as may be requested by the hospital at that time. All information shall be forwarded by the Chief Executive Officer to the Executive Committee. After considering all relevant information, the Executive Committee shall then make a recommendation regarding reinstatement to the Board for final action.

(f) In acting upon the request for reinstatement, the Board may approve reinstatement either to the same or a different staff category, and may limit or modify the clinical privileges to be extended to the individual upon reinstatement.

(g) Absence for longer than one (1) year shall result in automatic relinquishment of Medical Staff appointment and clinical privileges unless an extension is granted by the Chief Executive Officer in consultation with the Chief of Staff. Extensions shall be considered

only in extraordinary cases where the extension of a leave is in the best interest of the Medical Staff and the hospital.

(h) If an individual's current appointment is due to expire during the leave, the individual's appointment and clinical privileges shall lapse at the end of the appointment period, and the individual shall be required to apply for reappointment.

(i) 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.

ARTICLE III - PART E: CONFIDENTIALITY AND REPORTING

(1) Actions taken and recommendations made pursuant to this policy shall be treated as confidential in accordance with applicable legal requirements and such policies regarding confidentiality as may be adopted by the Board provided that reports of actions taken shall be made by the Chief Executive Officer to such governmental agencies as may be required by law.

(2) All records and other information generated in connection with and/or as a result of performance improvement and/or professional review activities shall be confidential. Individuals or committee members participating in, or subject to, credentialing and peer review activities shall agree to make no disclosures of any such information outside of credentialing and/or peer review committee meetings, except (i) as authorized, in writing, by the Chief Executive Officer or by legal counsel to the hospital; (ii) when the disclosures are to another authorized member of the Medical Staff or authorized hospital employee, or are for the purpose of conducting legitimate credentialing and peer review activities; and (iii) when the disclosures are authorized by Medical Staff or hospital policy.

(3) Any breach of confidentiality by an individual or committee member may result in a professional review action, and/or may result in appropriate legal action to ensure that confidentiality is preserved, including application to a court of law for injunctive or other relief.

ARTICLE III - PART F: PEER REVIEW PROTECTION

All minutes, reports, recommendations, communications, and actions made or taken pursuant to this policy are deemed to be covered by the provisions of Kan. Stat. Ann. §65-442 (1976); §65-4915 (1996); or the corresponding provisions of any subsequent federal or state statute providing protection to peer review or related activities. Furthermore, the committees and/or panels charged with making reports, findings, recommendations or investigations pursuant to this policy shall be considered to be acting on behalf of the hospital and its Board when engaged in such professional review activities and thus shall be deemed to be "professional review bodies" as that term is defined in the Health Care Quality Improvement Act of 1986.

ARTICLE IV

HEARING AND APPEAL PROCEDURES

ARTICLE IV - PART A: INITIATION OF HEARING

Section 1. Grounds for Hearing:

(a) An applicant or an individual holding a Medical Staff appointment shall be entitled to request a hearing whenever one (1) of the following adverse professional review recommendations has been made by the Executive Committee or the Professional Affairs Committee of the Board:

(1) denial of initial Medical Staff appointment;

(2) denial of Medical Staff reappointment;

(3) revocation of Medical Staff appointment;

(4) denial of requested initial clinical privileges;

(5) revocation of clinical privileges;

(6) denial of requested additional clinical privileges;

(7) decrease of clinical privileges;

(8) suspension or restriction of clinical privileges for more than thirty (30) days ;

(9) imposition of mandatory concurring consultation requirement (i.e., the consultant must approve the course of treatment in advance); or

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

(b) No other professional review recommendations except those enumerated in (a) of this section shall entitle the individual to request a hearing.

(c) The affected individual shall also be entitled to request a hearing before the Board enters a final decision, in the event the Board should determine, without a similar

adverse recommendation from the Executive Committee, to take any action set forth in (a) above.

(d) Residents in training at the hospital shall not be entitled to the hearing and appeal rights set forth in this policy. All resident grievances shall be addressed pursuant to those procedures outlined in the resident contract and/or the resident's training manual.

ARTICLE IV - PART A:

Section 2. Actions Not Grounds for Hearing:

None of the following actions shall constitute grounds for a hearing, but 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 confidential file;

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

(b) imposition of conditions, monitoring, or a general consultation requirement (i.e., the individual must obtain a consult but need not get prior to approval for the treatment);

(c) termination of temporary privileges;

(d) automatic relinquishment of appointment or privileges;

(e) imposition of a requirement for additional training or continued education;

(f) precautionary suspension;

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

(h) determination that an application is incomplete;

(i) determination that an application will not be processed due to a misstatement, misrepresentation; or omission; or

(j) determination of ineligibility based on a failure to meet threshold eligibility criteria, or a lack of need or resources, or because of an exclusive contract.

ARTICLE IV - PART B: THE HEARING

Section 1. Notice of Recommendation:

When a recommendation is made which, according to this policy entitles an individual to request a hearing prior to a final decision of the Board, the affected individual shall promptly be given notice by the Chief Executive Officer, in writing, certified mail, return receipt requested. This notice shall contain:

(a) a statement of the adverse professional review recommendation made and the general reasons for it;

(b) a statement that the individual has the right to request a hearing on the adverse recommendation within thirty (30) days of receipt of this notice; and

(c) a copy of this Article.

ARTICLE IV - PART B:

Section 2. Request for Hearing:

An individual shall have thirty (30) days following the date of the receipt of such notice within which to request the hearing. The request shall be in writing to the Chief Executive Officer and will include the name, address and telephone number of the individual's counsel, if any. Failure to request a hearing within the time and in the manner required by this policy shall constitute a waiver of the right to the hearing, and the recommendation shall become effective immediately upon final Board action.

ARTICLE IV - PART B:

Section 3. Notice of Hearing and Statement of Reasons:

(a) The Chief Executive Officer shall schedule the hearing and shall give written notice, certified mail, return receipt requested, to the person who requested the hearing. The notice shall include:

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

(2) a proposed list of witnesses, as known at that time, but which may be modified, who will give testimony or present evidence at the hearing in support of the Executive Committee or the Board, and a brief summary of the anticipated testimony;

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

(4) a statement of the specific reasons for the adverse recommendation, including a list of patient records (if applicable), and information supporting the recommendation. This statement and the list of supporting patient record numbers and other supporting information, may be revised or amended at any time, even during the hearing, so long as the additional material is relevant to the recommendation or the individual's qualifications and the individual has had sufficient time, up to thirty (30) days, to study this additional information and rebut it.

(b) The hearing shall begin as soon as practicable, but no sooner than thirty (30) days after the notice of the hearing, unless an earlier hearing date has been specifically agreed to in writing by the parties.

ARTICLE IV - PART B:

Section 4. Witness List:

(a) The individual requesting the hearing shall provide a written list of the names and addresses of the individuals expected to offer testimony or evidence on the affected individual's behalf within ten (10) days after receiving notice of the hearing, and shall include a brief summary of the nature of the anticipated testimony.

(b) The witness list of the hospital in support of the adverse recommendation of the Executive Committee (or the Board) shall include a brief summary of the nature of the anticipated testimony. The Presiding Officer shall have the authority to limit the number of witnesses, especially character witnesses or witnesses whose testimony is merely cumulative, as set forth in Section 5 of this Part.

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

ARTICLE IV - PART B:

Section 5. Hearing Panel, Presiding Officer and Hearing Officer:

(a) Hearing Panel:

(1) When a hearing is requested, the Chief Executive Officer, acting for the Board and after considering the recommendations of the Chief of Staff (and that of the Chairperson of the Board, if the hearing is occasioned by a Board determination) shall appoint a Hearing Panel which shall be composed of not less than three (3) members, one (1) of whom shall be designated a chairperson. The Hearing Panel shall be composed of Medical Staff appointees who shall not have actively participated in the consideration of the matter involved at any previous level or of physicians or laypersons not connected with the hospital or any combination of such persons. Knowledge of the underlying peer review matter, in and of itself, shall not preclude an individual from serving as a member of the Hearing Panel. Employment by, or other contractual arrangement with, the hospital or an affiliate shall not preclude an individual from serving on the Hearing Panel.

(2) The Hearing Panel shall not include any individual who is in direct economic competition with the individual requesting the hearing, or any individual who is professionally associated with, related to, or involved in a referral relationship with, or who has demonstrated actual bias, prejudice or conflict of interest that would prevent the individual from fairly and impartially considering the matter involving the individual requesting the hearing.

(b) Presiding Officer:

(1) In lieu of a Hearing Panel Chairperson, the Chief Executive Officer may appoint a Presiding Officer who may be an active or retired attorney. The Presiding Officer shall not act as a prosecuting officer or advocate for either side at the hearing.

(2) If no Presiding Officer has been appointed, a Chairperson of the Hearing Panel shall be appointed by the Chief Executive Officer to serve as the Presiding Officer, and shall be entitled to one (1) vote.

(3) The Presiding Officer (or Hearing Panel Chairperson) shall:

(i) act to insure that all participants in the hearing 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, applicable to both sides, as may be necessary to avoid cumulative or irrelevant testimony or to prevent abuse of the hearing process;

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

(iii) maintain decorum throughout the hearing;

(iv) determine the order of procedure throughout the hearing;

(v) rule on all questions which pertain to matters of procedure and to the admissibility of evidence;

(vi) act in such a way that all information relevant to the appointment or clinical privileges of the individual requesting the hearing is considered by the Hearing Panel in formulating its recommendations; and

(vii) conduct argument by counsel on procedural points outside the presence of the Hearing Panel unless the Panel wishes to be present.

(4) The Presiding Officer may be advised by legal counsel to the hospital with regard to the hearing procedure.

(5) 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) <u>Hearing Officer</u>:

(1) As an alternative to the Hearing Panel described in subparagraph (a) of this Section, the Chief Executive Officer, after consulting with the Chief of Staff (and Chairperson of the Board if the hearing was occasioned by a Board determination) may instead appoint a Hearing Officer to perform the functions that would otherwise be carried out by the Hearing Panel. The Hearing Officer shall preferably be an attorney at law.

(2) 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 advocate to either side at the hearing. If the Hearing Officer is an attorney, he or she shall not represent clients in direct economic competition with the affected individual.

(3) In the event 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 instead to the Hearing Officer.

(4) Any objection to any member of the Hearing Panel, or the Hearing Officer or Presiding Officer, shall be made in writing to the Chief Executive Officer within ten (10) days of receipt of notice. 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 Chief Executive Officer shall rule on the objection and give notice to the parties. The Chief Executive Officer may request that the Presiding Officer make a recommendation as to the validity of the objection.

ARTICLE IV - PART C: HEARING PROCEDURE

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

Section 1. Discovery:

(a) There is no right to discovery in connection with the hearing. However, prior to receiving any confidential documents, the individual requesting the hearing must agree that all documents shall be maintained as confidential and shall not be disclosed or used

for any purpose outside of the hearing. The individual must also provide a written representation that his/her legal counsel and/or 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 will 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 Executive Committee;

(3) redacted copies of relevant committee meeting minutes; and

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

(c) The provision of information to the individual requesting the hearing is not intended to waive any privilege under the state peer review protection statute. The individual shall have no right to discovery beyond the information outlined in this Section. No information shall be provided pertaining to other practitioners.

(d) Prior to the pre-hearing conference, on dates set by the Presiding Officer or agreed upon by counsel for both sides, each party shall provide the other party with a list of proposed exhibits. All objections to documents or witnesses to the extent then reasonably known, shall be submitted in writing 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) Prior to the pre-hearing conference, on dates set by the Presiding Officer, the individual requesting the hearing shall, upon specific request, provide the Executive Committee (or the Board) copies of any expert report or other documents relied upon by the individual.

(f) Neither the individual requesting the hearing, nor any other person on behalf of the affected individual, shall contact hospital employees whose names appear on the Executive Committee's witness list or in documents concerning the subject matter of the

hearing, unless specifically agreed upon by counsel. Any employee may agree or decline to be interviewed by or on behalf of the individual who requested the hearing.

ARTICLE IV - PART C:

Section 2. Pre-Hearing Conference:

The Presiding Officer shall require the individual or a representative (who may be counsel for the individual) and the hospital's Executive Committee (or the Board) to participate in a pre-hearing conference. 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 fifteen (15) hours, with each side being afforded approximately seven and a half hours to present its case, in terms of direct and cross-examination of witnesses. Both parties are required to prepare their case so that the hearing shall be concluded after a maximum of fifteen (15) hours. The Presiding Officer may, after considering any objections, grant limited extensions of time upon a demonstration of good cause and to the extent compelled by fundamental fairness. The Presiding Officer may specifically require that:

(1) all documentary evidence be exchanged by the parties prior to this conference. Any objections to the documents shall be made at this conference and shall be resolved by the Presiding Officer;

(2) evidence unrelated to the reasons for the adverse recommendation be excluded;

(3) the names of all witnesses and a brief statement of their anticipated testimony be exchanged by the parties, if not previously provided;

(4) the time granted to each witness' testimony and cross-examination be agreed upon, or determined by the Presiding Officer, in advance; and

(5) witnesses and documentation not provided and agreed upon in advance of the hearing shall be excluded from the hearing, except upon a showing of good cause.

ARTICLE IV - PART C:

Section 3. 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) stipulations agreed to by the parties.

ARTICLE IV - PART C:

Section 4. Stipulations:

The parties and 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.

ARTICLE IV - PART C:

Section 5. Failure to Appear:

Failure, without good cause, of the individual requesting the hearing to appear and proceed at such a hearing shall be deemed to constitute a waiver and voluntary acceptance of the pending adverse professional review recommendations or actions, which shall then be forwarded to the Board for final action.

ARTICLE IV - PART C:

Section 6. Record of Hearing:

The Hearing Panel shall maintain a record of the hearing by a stenographic reporter present to make a record of the hearing. The cost of such reporter shall be borne by the hospital, but copies of the transcript shall be provided to the individual requesting the hearing at that individual's expense. Oral evidence shall be taken only on oath or affirmation administered by any person entitled to notarize documents in this State.

ARTICLE IV - PART C:

Section 7. Rights of Both Sides:

(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 available and willing to testify;

(2) to introduce exhibits;

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

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

(5) to submit a written statement at the close of the hearing; and

(6) to submit proposed findings, conclusions and recommendations to the Hearing Panel.

(b) Any individual requesting a hearing who does not testify in his or her own behalf may be called and questioned.

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

ARTICLE IV - PART C:

Section 8. Admissibility of Evidence:

The hearing shall not be conducted according to rules of evidence. Hearsay evidence shall not be excluded merely because it constitutes 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.

ARTICLE IV - PART C:

Section 9. Post-Hearing Statement:

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

ARTICLE IV - PART C:

Section 10. Official Notice:

The Presiding Officer shall have the discretion to take official notice of any matters, either technical or scientific, relating to the issues under consideration that could have been judicially noticed by the courts of the State of Kansas. Participants in the hearing shall be informed of the matters to be officially noticed and such matters shall be noted in the record of the hearing. Either party shall have the opportunity to request that a matter be officially noticed or to refute the noticed matter by evidence or by written or oral presentation of authority. Reasonable additional time shall be granted, if requested, to present written rebuttal of any evidence admitted on official notice.

ARTICLE IV - PART C:

Section 11. Postponements and Extensions:

Postponements and extensions of time beyond any time limit set forth in this policy may be requested by anyone, but shall be permitted only by the Presiding Officer or the Chief Executive Officer, on a showing of good cause.

ARTICLE IV - PART C:

Section 12. Observers:

The hearing shall be restricted to those individuals involved in the proceeding. Appropriate administrative personnel may be present as requested by the Chief Executive Officer or the Chief of Staff.

ARTICLE IV - PART D: HEARING CONCLUSION, DELIBERATIONS, AND RECOMMENDATIONS

Section 1. Order of Presentation:

The Executive Committee or the Board, depending on whose recommendation prompted the hearing initially, shall first present evidence in support of its adverse professional review recommendation. Thereafter, the individual who requested the hearing shall present evidence.

ARTICLE IV - PART D:

Section 2. Basis of Recommendation:

(a) The Hearing Panel shall recommend in favor of the Executive Committee (or the Board) unless it finds that the individual who requested the hearing has proved that the adverse recommendation that prompted the hearing was arbitrary, capricious, or not supported by credible evidence.

(b) The recommendation of the Hearing Panel shall be based on the evidence produced at the hearing. This evidence may consist of the following:

(1) oral testimony of witnesses;

(2) post-hearing statements;

(3) any information regarding the individual who requested the hearing so long as that information has been admitted into evidence at the hearing and the person who requested the hearing had the opportunity to comment on and, by other evidence, refute it;

(4) any and all applications, references, evaluations, and accompanying documents;

(5) other documented evidence, including medical records; and

(6) any other information presented at the hearing.

ARTICLE IV - PART D:

Section 3. Adjournment and Conclusion:

The Presiding Officer may, without special notice, adjourn the hearing and reconvene the same at the convenience and with the agreement of the participants. Upon conclusion of the presentation of evidence by the parties and/or questions by the Hearing Panel, the hearing shall be closed.

ARTICLE IV - PART D:

Section 4. Deliberations and Recommendation of the Hearing Panel:

Within twenty (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 memoranda, whichever is later), the Hearing Panel shall conduct its deliberations outside the presence of any other person except the Presiding Officer, and shall render a recommendation, accompanied by a report, which shall contain a concise statement of the reasons for the recommendation.

ARTICLE IV - PART D:

Section 5. Disposition of Hearing Panel Report:

The Hearing Panel shall deliver its report and recommendation to the Chief Executive Officer who shall forward it, along with all supporting documentation, to the Board for further action. The Chief Executive Officer shall also send a copy of the report and recommendation, certified mail, return receipt requested, to the individual who requested the hearing, and to the Executive Committee for information and comment.

ARTICLE IV - PART E: APPEAL PROCEDURE

Section 1. Time for Appeal:

(a) Within ten (10) days after notice of the Hearing Panel's recommendation, either party may request to appeal the recommendation. The request shall be in writing, and must include a statement(s) of the reasons for appeal and the specific facts or circumstances, which justify further review. Such written request shall be delivered to the Chief Executive Officer either in person or by certified mail, return receipt requested.

(b) If appellate review is not requested in writing within ten (10) days as provided herein, the parties shall be deemed to have waived the right to appeal, and the Hearing Panel's report and recommendation shall be forwarded to the Board for final action.

ARTICLE IV - PART E:

Section 2. Grounds for Appeal:

The grounds for appeal shall be limited to the following:

(a) there was substantial failure to comply with this policy and/or the hospital or 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, capriciously or with prejudice; and/or

(c) the recommendations of the Hearing Panel were not supported by credible evidence.

ARTICLE IV - PART E:

Section 3. Time, Place and Notice:

Whenever an appeal is requested as set forth in the preceding sections, the Chairperson of the Board shall, as soon as arrangements can reasonably be made, taking into account the schedules of all participants, schedule and arrange for an appellate review. The affected individual shall be given notice of the time, place and date of the appellate review. When a request for appellate review is from an appointee who is under a suspension then in effect, the appellate Review Panel shall be convened not more than fourteen (14) days from the date of receipt of the request for an appeal unless the individual agrees to a longer period. The time for appellate review may be extended by the Chairperson of the Board for good cause.

ARTICLE IV - PART E:

Section 4. Nature of Appellate Review:

(a) The Chairperson of the Board shall appoint a Review Panel composed of not less than three (3) persons, either members of the Board or others, including but not limited to reputable persons outside the hospital, to consider the record upon which the recommendation before it was made, or the Board may hear the appeal as a whole body.

(b) The Review Panel may in its discretion accept additional oral or written evidence subject to the same rights of cross-examination or confrontation provided at the Hearing Panel proceedings. Such additional evidence shall be accepted only if the party seeking to

admit it can demonstrate that it is new, relevant evidence or that any opportunity to admit it at the hearing was denied.

(c) Each party shall have the right to present a written statement in support of its position on appeal. In its sole discretion, the Review Panel may allow each party or its representative to appear personally and make oral argument not to exceed thirty (30) minutes. The Review Panel shall recommend final action to the Board.

(d) The Board may affirm, modify or reverse the recommendation of the Review Panel or, in its discretion, refer the matter for further review and recommendation, or make its own decision based upon the Board's ultimate legal responsibility to grant appointment and clinical privileges.

ARTICLE IV - PART E:

Section 5. Appellate Review in the Event of Board Modification or

Reversal of Hearing Panel Recommendation:

In the event the Board determines to modify or reverse the recommendation of a Hearing Panel in a matter in which the individual did not request appellate review pursuant to Section 1 of this Part, and such action would adversely affect the individual, the Board shall notify the affected individual through the Chief Executive Officer that he or she may appeal the proposed modification or reversal. The Board shall take no final professional review action until the individual has exercised or has waived the procedural rights provided in this Part.

ARTICLE IV - PART E:

Section 6. Final Decision of the Board:

Within thirty (30) days after receipt of the Review Panel's recommendation, the Board shall render a final decision in writing, including specific reasons, and shall deliver copies within seven (7) days thereafter to the affected individual and to the Chairperson Executive Committees, in person or by certified mail, return receipt requested.

ARTICLE IV - PART E:

Section 7. Further Review:

Except where the matter is referred for further action and recommendation in accordance with Section 4 of this Part, the final decision of the Board following the appeal shall be effective immediately and shall not be subject to further review. If the matter is referred pursuant to Section 4 of this Part for further action and recommendation, such recommendation shall be promptly made to the Board in accordance with the instructions given by the Board. This further review process and the report back to the Board shall in no event exceed thirty (30) days except as the parties may otherwise stipulate.

ARTICLE IV - PART E:

Section 8. Right to One Hearing and One Appeal Only:

No applicant or Medical Staff appointee shall be entitled to more than one (1) hearing and one (1) appeal on any matter which may be the subject of an appeal. If the Board determines to deny initial Medical Staff appointment or reappointment to an applicant, or to revoke or terminate the Medical Staff appointment and/or clinical privileges of a current appointee, that individual may not apply for staff appointment or for those clinical privileges at this hospital for a period of five (5) years unless the Board provides otherwise.

ARTICLE V

HOSPITAL EMPLOYEES

(a) Except as provided below, the employment of an individual by the hospital or one of its affiliates will be governed by applicable employment policies and manuals and he terms of the individual's employment relationship or written contract. To he extend that applicable employment policies or manuals, or the terms of any employment contract, conflict with this Policy, the employment policies, manuals and descriptions and terms of the individual's employment relationship or written contract will apply.

(b) A request for appointment, reappointment or clinical privileges, submitted by an applicant or appointee who is employed by the Hospital or one of its affiliates, will be processed in accordance with the terms of this Policy. A report regarding each practitioner's qualifications will be made to appropriate management personnel to assist with employ decisions.

(c) If a concern about an employed member's clinical competence, conduct or behavior arises, the concern may be reviewed and addressed in accordance with this Policy, in which event a report will be provided to appropriate management personnel. However, nothing herein will require the individual's employer to follow this Policy.

ARTICLE VI

AMENDMENTS

(a) This policy may be amended by a majority vote of the members of the Executive Committee present and voting at any meeting of that committee where a quorum exists. Notice of all proposed amendments shall be posted on the Medical Staff bulletin board at least fourteen (14) days prior to the Executive Committee meeting. Any Medical Staff appointee shall have the right to submit written comments to the Executive Committee regarding the amendment. No such amendment shall be effective unless and until it has been approved by the Board.

(b) Neither party may unilaterally amend this policy. However, this policy may be amended by the Board on its own motion, provided that any such proposed amendment is first submitted to the Executive Committees for their review, comment and/or recommendation at least thirty (30) days prior to any final action by the Board on such amendment. Instances where such action by the Board may be warranted shall include:

(1) action to comply with changes in federal and state laws that affect this hospital and the hospital corporation, including any of its entities;

(2) requirements imposed by the hospital's general and professional liability or Director's and Officer's insurance carrier;

(3) action to comply with applicable licensing, legal, regulatory, Joint Commission or other applicable accreditation standards, and Medicare/Medicaid Conditions of Participation for hospitals;

(4) to make the hospital operation safer, more efficient and/or cost-effective; and

(5) when the Medical Staff fails to comply with its obligations under the Medical Staff Bylaws, Rules and Regulations and applicable policies.

ARTICLE VII

ADOPTION

This policy on Medical Staff Appointment, Reappointment and Clinical Privileges is adopted and made effective upon approval of the Board, superseding and replacing any and all other Medical Staff bylaws, rules and regulations, policies, manuals or hospital policies pertaining to the subject matter thereof.

Adopted by the Medical Staff of Pawnee Valley Community Hospital this 23rd day of June, 2010.

/s/

Matt Heyn

Hospital Chief Executive Officer

/s/

David W. Sanger, MD

Chief of Staff

Approved by the Board of Pawnee Valley Community Hospital this 28th day of June, 2010.

John H. Jeter, MD

Chairperson

Board of Directors

EC Approval: 10/14/14; 1/12/16; 7/19/16

Board Approval: 10/27/14; 1/27/16; 7/27/16