Banner Estrella
Medical Center

Rules and Regulations, Credentialing and Privileging Policy

Allied Health Professionals

I. CATEGORIES

The Medical Executive Committee (MEC) and the Banner Board determines the categories of individuals eligible for clinical privileges or scope of care and are referred to in the Medical Staff Bylaws as Allied Health Practitioners. Allied Health Practitioners are not members of the Medical Staff and do not have voting privileges at Medical Staff meetings unless the privilege to vote is granted by policy at the time the committee appointment is made.

Allied Health Practitioners (AHPs) are healthcare professionals other than licensed physicians who are granted clinical privileges to provide direct patient care services at Banner Estrella Medical Center under a defined degree of sponsorship by a physician medical staff member who has been granted clinical privileges. These categories are:

- Clinical perfusionists
- Certified Nurse Midwives
- Nurse practitioners
- Physician assistants
- Surgical first assistants
- Private surgical scrub technicians
- Crisis counselors/social workers
- Certified registered nurse anesthetists
- Intra-operative monitoring technicians
- Radiology Practitioner Assistants

II. QUALIFICATIONS

Qualifications shall include:

- Licensure (if applicable to category): Evidence of current valid license issued by the State of Arizona
- Prescriptive Authority (if applicable to category): Evidence of current valid authority to prescribe medications
- DEA (if applicable to category): Evidence of current valid DEA
- Certification: Evidence of current board certification as required by MEC and the Board.
- Professional Liability Insurance: AHPs must maintain current professional liability insurance with liability limits in an amount as determined from time to time by the Board and with an insurance company that is acceptable to the Board.
- Professional Education and Training: Such education and training as required by the MEC and the Board.
- Clinical Performance: AHP's must have current experience, clinical results and utilization practice patterns, documenting a continuing ability to provide patient care services at an acceptable level of quality and efficiency.

- Attitude: AHP's must display a willingness and capability to work with others in a cooperative, professional manner appropriate to quality patient care
- Disability: AHP's must be free from, or exhibit adequate control of, any significant physical, mental or behavioral impairment that may adversely affect the ability to provide quality patient care.
- Professional Ethics and Conduct: AHP's must demonstrate high moral character and adherence to generally recognized standards of professional ethics.
- Communication Skills: AHP's must be able to read and understand the English language and to communicate in writing and verbally in the English language in an intelligible manner, and to prepare medical record entries and other required documentation in a legible manner.

III. BASIC RESPONSIBILITIES OF INDIVIDUAL MEMBERSHIP

Each AHP shall:

- Present to a Banner Medical Staff Services Department in the Arizona Region and present a government issued form of identification as part of the application process. Approved forms of identification are: a) state issued driver's license, b) state issued identification, c) visa, and d) passport.
- Agree to comply with the Medical Center's Disruptive Conduct Policy.
- Provide patients with quality care at the generally recognized professional level of quality and efficiency in the community—to the extent authorized by his or her license, certification, or other legal credentials—by the terms outlined in the AHP category privileges description and by the privileges granted.
- Abide by all applicable state and federal laws regulating healthcare providers, as well as by rules and regulations and all other lawful standards, policies, and rules of the Medical Center.
- Discharge functions assigned by the MEC, including but not limited to quality improvement, peer and professional review, patient care monitoring, utilization review, management, and other responsibilities.
- Cooperate with and participate in committee activities as requested by MEC.
- Submit to such physical and/or mental examination(s) or provide verification of health status as required to verify the AHP's ability to fully meet his or her responsibilities and/or to perform the requested privileges or scope of care.
- Provide evidence of freedom from infectious pulmonary tuberculosis pursuant to R9-10-207.
- Report to the Medical Staff Services Department immediately any action taken affecting licensure, certification, registration, or federal Drug Enforcement Agency registration including but not limited to probation, restriction, suspension, termination, and voluntary or involuntary relinquishment of same.
- Utilize Medical Center resources appropriately.
- Treat all individuals at or associated with the Medical Center courteously, respectfully, and with dignity at all times.
- Comply with policies, procedures, rules, regulations, and requirements that relate to the provision of services by AHP's at the Medical Center.
- Write orders and provide care, treatment, and services only as permitted by his or her licensure or certification and as outlined in the AHP privileges description and privileges granted to the AHP.
- Document in patient medical record in a complete and timely fashion to the extent authorized in the privileges granted to the AHP, if granted authority in the scope of care.
- Seek consultation, supervision, and direction whenever appropriate or necessary and

as required in the privileges granted to the AHP.

- Abide by the ethical principles of the profession.
- AHP's must at all times maintain the confidentiality of patient identifiable information and peer review activities and may make no voluntary disclosures of information except to persons authorized to receive it. AHP's must abide by HIPAA guidelines and policies.
- Maintain all other qualifications for privileges set forth in this policy or the applicable AHP privileges description.
- Report to Medical Staff Services Department immediately denial or loss of ability to provide services at another hospital or healthcare institution, any adverse determination by a peer review organization or denial or loss of right to participate in any federal or state program, including Medicare/State program.
- Report to Medical Staff Services Department any loss of employment by medical center or sponsoring physician.
- Wear photo identification badge above waist present for all to see.
- Pay dues as assessed by Medical Staff.

IV. CERTIFIED NURSE MIDWIFE SCOPE OF PRACTICE

A) The CNM shall at all times practice in collaboration with and under the direction of a supervising physician(s).

1) The CNM shall perform only those tasks permitted by law for his or her designated specialty, and is allowed to perform only those procedures that both they and the supervising physician have privileges to perform.
2) The CNM shall further act within the scope of practice as stated in this document and in accordance within the Rules and Regulations, Bylaws and Policies and Procedures adopted by the Women and Infants Services Department and the Medical Center.

B) All activities of the CNM at the hospital require the supervision of a physician with OB/GYN privileges.

1) Supervising physician shall be made aware and be immediately available by electronic communication or be on the hospital premises for collaboration with the CNM when the CNM has a patient in labor in the hospital.
2) A CNM's admission note must address the role of the supervising physician in the care of that particular patient and document that the supervising physician has been notified that the patient is in labor and has been made aware of all pertinent details regarding her prenatal care and labor.
3) If and when there is a change in the role of the supervision physician in the care of a particular patient:

   a) That change must be documented in the progress note by the CNM.
   b) A mutually agreed-upon plan of care must be documented in the progress notes.
   c) Under certain circumstances, contemporaneous documentation of the above elements must be provided by the supervising physician.

4) The supervising physician will round on patients within 24 hours (depending on category below) and countersign all CNM admitting notes, delivery notes, postpartum notes for complicated patients and discharge summaries.

5) The supervising physician will be in-house at the time of delivery of CNM patients. The supervising physician is not required to attend the delivery if no complications are present, but will need to be immediately available in-house. The supervising physician is required to physically check in at the Labor and Delivery desk to confirm in-house status at the time of delivery. This requirement will remain in place for 6 months for each CNM in order to assess competency and complication rates. The requirement may then be re-evaluated by the OB Department for possible removal.

C) Levels of CNM Involvement and Responsibility:

1) Primary Midwifery Care is the process whereby a CNM, who maintains primary management responsibility for the woman's care, works in collaboration with and seeks the advice or opinion of the supervising physician. Primary midwifery is intended for healthy women with uncomplicated pregnancies, uncomplicated labor, vaginal deliveries and normal postpartum recovery.
2) Physician Consultation is the process whereby a CNM and physician jointly manage the care of a woman who has become medically, gynecologically or obstetrically complicated.

    a) The scope of consultation may encompass the physical care of the patient, including delivery by the CNM, according to a mutually agreed-upon plan of care.
    b) When consultation is required, the supervising physician must physically assess the patient and document his/her evaluation and plan of care.
        (i) If the consult has been obtained prior to admission of the patient, the documentation must be included in the prenatal record. When such documentation is unavailable or has not been provided, the supervising physician shall be required to physically assess the patient and document the plan of care on admission.
        (ii) Under certain circumstances of increasing complexity or change in status, contemporaneous documentation of the above elements must be provided by the supervising physician.
3) Effective communication between the CNM and physician is essential for ongoing consultative management. The final determination of care shall be the responsibility of the physician.

<u>Consultation</u> - The following conditions (in active labor) require consultation with the supervising physician.

Consultation will consist of direct two way communication between the CNM and supervising physician to arrive at a plan of care to be carried out by the CNM. Direct communication may occur via telephone, HIPPA compliant text or email or in person and is to be documented by the CNM. The supervising physician must round on this category of patients within 24 hours.

a) Intermittent Category II fetal heart rate tracing
b) Meconium stained amniotic fluid moderate/thick resulting in fetal heart rate abnormalities;
c) Suspected Choriamnionitis
d) Gestational diabetes, non-insulin dependent, non-oral agents with estimated fetal weight (EFW) less than 4000 grams

e) Fetal demise < 20 weeks
f) Chronic hypertension, controlled
g) And the following postpartum conditions: temperature greater than 101, excessive bleeding (not controlled with oxytocin or other uterotonic agent), complicated UTI, endometritis, large or growing perineal hematoma, orthostasis, other serious medical conditions.

Collaboration - The following conditions require collaboration with the supervising physician.

Consultation will consist of direct two way communication via telephone or in person between the CNM and the supervising physician. The supervising physician reviews the patient's medical record, evaluate the patient in-house within 1 hour of admission, and documents his/her knowledge of the patient's diagnosis and hospital course. The plan of care may be carried out by the CNM.

a) Dysfunctional labor
b) Gestational age greater than 42 weeks
c) Intrauterine fetal demise > 20 weeks in current or previous pregnancy
d) Pre-eclampsia without severe features / gestational hypertension
e) Maternal fever greater than 100.4
f) Preterm labor <36 weeks gestation
g) Uterine anomalies
h) Symptomatic anemia or hematocrit <21% / hemoglobin <7g
i) Evidence of syphilis at any stage
j) Oligohydramnios or polyhydramnios, documented by ultrasound
k) Evidence of fetal abnormality
l) Intrauterine growth restriction (IUGR) (<5%) or history of IUGR in previous pregnancy
m) Diet controlled gestational diabetes
n) Patients with no prenatal care
o) Risk for shoulder dystocia (with onset of second stage labor)
p) Drug addiction
q) EFW greater than 4500 grams in a non-diabetic patient
r) Gestational diabetes, non-insulin dependent, non-oral agents with estimated fetal weight (EFW) greater than 4000 grams
s) During labor:
    1. Recurrent Category II heart rate changes
    2. Arrest of active phase in which change in cervical dilation has not been demonstrated after 4 hours of an adequate uterine contraction plan.
    3. Prolonged 2nd stage of labor.
    4. Prolonged rupture of membranes > 18 hours.
    5. Elevated temperature (>38 degrees C) or evidence of chorioamnionitis.

t) During Delivery:
    1. Significant lacerations
    2. Need for manual removal of placenta, or if placenta is retained after 30 minutes.
    3. Post-partum or intrapartum hemorrhage

This is not an all-inclusive list and other conditions may arise that require consultation, including a change in maternal or fetal status.

Consultation In House - The following conditions (in active labor) require consultation with the supervising physician and for the physician to be in-house and immediately available Trial of Labor After Cesarean (TOLAC):

1) The physician assumes full admission and management responsibility of all TOLAC patients and is required to remain on campus during the active phase of labor.
2) The CNM may document progress notes in the medical record; however, the Admission History and Physical and Informed Consent for a TOLAC are the responsibility of the physician. Order may be given only by the physician.
3) The CNM may perform routine exams, AROM, and placement of internal monitors of a patient undergoing a TOLAC, in collaboration with the physician.
4) The CNM may perform the delivery of the patient undergoing a TOLAC, at the discretion of the physician, who shall be present on the unit and immediately available for assistance. Delivery notes completed by the CNM must be co-signed by the physician.

Referral - The following conditions require referral of care to the supervising physician.

Referral will consist of the transfer of the care of the pregnant patient to the supervising physician, who will be directly responsible for the management of the condition(s). The CNM may continue to provide nursing care, labor and delivery support and delivery to the patient and may assist in subsequent C-section as first or second-assist, depending on OR experience and training. This category of patients require the supervising physician to evaluate the patient on-site at the time of change of care management.

a) Heart disease (Not including MVP)
b) Insulin or oral dependent gestational diabetics or diabetics class B or greater
c) Manual extraction of retained placenta
d) Maternal renal disease with renal compromise
e) Maternal-fetal isoimmunization
f) Multiple gestation
g) Operative (forceps) vaginal delivery
h) Other severe medical disorders
i) Patients who refuse care by a nurse-midwife
j) Placenta previa
k) Suspected partial placental abruption
l) Premature labor greater than 23 weeks gestation and less than 36 weeks gestation
m) Premature rupture of membranes less than 36 weeks gestation
n) Pre-eclampsia with severe features/eclampsia
o) Uncontrolled maternal seizure disorder
p) Suspected fetal macrosomia, defined as an estimated fetal weight over 4500g in diabetic or 5000g in non-diabetic
q) Category III fetal heart rate tracing
r) Thromboembolic disorders
s) Uncontrolled hypertension, any cause
t) Chronic renal disease
u) Conditions requiring cesarean section such as:
    1. active genital herpes lesion
    2. breech presentation or other malpresentation
    3. complete placental abruption
    4. arrest of dilatation or descent
    5. prolapsed cord

V. SPONSORING PROCEDURES

AHP's must have a designated sponsoring physician medical staff member acceptable to and in good standing on the medical staff. A copy of the sponsoring agreement will be submitted with the AHP's application and will be signed by both parties wherein the primary sponsoring physician accepts responsibility for the services provided by the AHP under his/her sponsorship and agrees that the AHP will not exceed the scope of practice.

VI. APPLICATION PROCESS

AHP's employed by the Medical Center: Employment by Banner as an AHP is contingent upon successful completion of the credentialing and privileging processes administered by the Banner CVO and medical staff organization of the Medical Center.

If the AHP begins employment prior to completion of the credentialing process, the AHP cannot exercise the requested clinical privileges (including functioning under standardized protocols/procedures) until the credentialing process has been successfully completed. During this interim period, the AHP may function as a registered nurse (for advanced practice registered nurses). The applicant will be informed by the Medical Staff Services Department as soon as possible if an unfavorable recommendation is made by the department chair, the Credentials Committee, the MEC or the Banner Board. It will be the responsibility of the employed AHP to notify the Human Resources Department.

AHP's employed or sponsored by a physician member of the medical staff organization: AHP's will be instructed to obtain application materials from the Banner CVO. Exercise of privileges or scope of care may not begin until the credentialing process has been successfully completed. The applicant will be informed by the Medical Staff Services Department as soon as possible if an unfavorable recommendation is made by the department chair, the Credentials Committee, the MEC or the Banner Board.

VII. STAFF DUES

The Medical Executive Committee shall establish the amount of annual Allied Health Professional dues. Notice of dues shall be given at the time of reappointment at which time two years must be paid. A practitioner's reappointment will not be considered complete unless dues are paid in full. All new staff members must pay one year's worth of dues with the application and will be billed for the second year one year later. Failure to render payment shall result in non-processing of a new application or reappointment. Provider Staff dues are non-refundable.

VIII. VERIFICATION PROCEDURES AND EVALUATION AND DECISION-MAKING PROCESS

Verification procedures will be carried out by the Medical Staff Services Department, or designated centralized verification organization, in accordance with the Medical Center's procedure. The applicant has the burden of producing adequate information for a proper evaluation of qualifications and to resolve any doubts about any qualification required for staff membership. Applications not demonstrating compliance with the requirements for Allied Health Staff membership and privileges will be deemed to be incomplete. Incomplete applications will not be processed. If information is not obtained from the applicant within ninety (90) days after a written request has been made, the application will be deemed withdrawn.

After review by the department chair, the AHP application is forwarded to the

Credentials Committee and MEC.

IX. TEMPORARY PERMISSION TO PROVIDE PATIENT CARE SERVICES

Upon recommendation of the Department Chair or designee, the Chief of Staff and the CEO or their respective designee, temporary privileges may be granted in the following circumstances:

- Pendency of Application: Temporary privileges for the purpose of fulfilling an important patient care need may be granted to an applicant who has submitted a complete application that has been verified and raises no concerns, has been approved by the Department Chairman and Credentials Committee, and is awaiting review and approval of the Medical Executive Committee and the Board.

  Temporary privileges may be granted to an applicant for an initial period not to exceed 60 days. One extension may be granted for an additional period not to exceed 60 days. Any such renewal shall be made by the department chairman when the information available continues to support a favorable determination regarding the practitioner's application for membership and privileges. Under no circumstances may such privileges be granted or renewed if the application is still pending because the applicant has not responded in a satisfactory manner to a request for clarification of a matter or for additional information. Temporary privileges may be terminated by the CEO or Chief of Staff if it is discovered that any information or action raises a question about a practitioner's professional qualifications or ability to perform privileges or scope of care requested.

  Locum Tenens: To a practitioner who will be serving to fulfill an important patient care need, but only after receipt of a complete application for appointment and evidence of the following information: appropriate and current licensure that is not currently being challenged or previously had a successful challenge, certification requirements as required by the respective scope of practice, adequate professional liability insurance, DEA registration (if applicable), acceptable education and training (via Student Clearinghouse profile), criminal background check, National Practitioner Data Bank report, one current competency reference, documentation required to meet criteria for any special privileges being requested and identification verification (verification may be shared from another Banner facility if current within the past six months). The locum tenens lasts for 90 days in length upon approval of the Department Chairman. A locum tenens may not be granted privileges more than once (plus one 90 day extension) in any 12 month period. The individual must fully and completely agree to abide by the provisions of the Bylaws, Allied Health Rules and Regulations, as well as the appropriate Department Rules and Regulations.

X. AHP REAPPOINTMENT PROCESS

All AHP's shall be reappointed to the AHP staff at least every 24 months. The Medical Staff Services Department or their designee shall send an application for reappointment and notice of the date on which privileges or scope of care expires. Failure to return the satisfactorily completed forms shall be deemed a voluntary resignation. Inadequacies or verification problems shall be reported to the reapplicant who will have the burden of producing adequate information and resolve any concerns.

Relevant findings from quality review, timely and accurate completion of medical records, cooperativeness in working with practitioners and hospital personnel, general attitude towards patients and the Medical Center and compliance with Rules and

Regulations, policies and procedures of the medical staff and Medical Center will be considered in the reappointment process.

During the reappointment process, the department chair or his or her designee is permitted access to performance evaluations (maintained in Human Resources files) that occurred during the previous two-year period of time immediately preceding the reappointment (applicable to Medical Center–employed AHP's only). Copies of employment-related performance evaluations are not maintained in credentials files. Peer review data maintained in credentials files (e.g., NPDB query) is not available for individuals performing employment-related performance evaluations.

After review by the Department Chair, the reapplication of AHP's is reviewed by the Medical Executive Committee and the Banner Board.

XI. LEAVE OF ABSENCE

AHP's may request a leave of absence for up to one year by giving written notice to the Medical Staff Services Department. During the leave, the privileges or scope of care, and requirement of sponsoring physician, and payment of dues are suspended. The Department Chair will consider the request and forward its recommendation to the Credentials Committee, MEC and the Banner Board for final action.

Reinstatement must be requested in writing. A written summary of his/her relevant activities during the leave must be provided and if the term of appointment has expired during the leave of absence, the reappointment process must be completed. AHP must provide evidence of current clinical competency, sponsoring physician member of the medical staff, licensure, DEA registration and professional liability insurance. The Department Chair will consider the request and forward its recommendation to the Medical Executive Committee and the Banner Board for final action.

XII. REVIEW OF SPECIFIC CONDUCT OR CARE/CORRECTIVE ACTION

Whenever the activities or professional conduct of an AHP adversely affect or are reasonably likely to adversely affect patient safety or the delivery of quality patient care or are disruptive to the organization's operations, the matter will be reviewed by the PRC. The review and/or investigation may involve an interview of the AHP involved the sponsoring physician medical staff member and other individuals or groups.

If additional review is necessary, the PRC may designate an ad hoc or external body to investigate the matter. Additionally, the matter may be handled by the employing organization as described in organization-specific policies and procedures (applicable only to AHP's employed by the Medical Center).

Automatic relinquishment of privileges

The privileges or scope of care and status as an AHP shall terminate immediately, without right to due process, in the event that the employment of the AHP with the Medical Center is terminated for any reason. If the AHP loses his/her sponsoring physician, privileges will be suspended immediately until the AHP can provide documentation of new sponsorship by another physician who is credentialed and in good standing at the Medical Center. If documentation of a new sponsoring physician is not provided within 30 days following suspension, the practitioner shall be deemed to have voluntarily resigned from staff and must reapply.

Automatic suspensions

Automatic suspension shall be immediately imposed whenever any of the following actions occur:

a) **License**
   - Revocation: Whenever a practitioner's license to practice in this State is revoked, Allied Health Staff appointment and clinical privileges are immediately and automatically revoked.

   - Restriction: Whenever a practitioner's license is limited or restricted in any way, those clinical privileges that are within the scope of the limitation or restriction are similarly immediately and automatically restricted.

   - Suspension: Whenever a practitioner's license is suspended, Allied Health Staff appointment and clinical privileges are automatically suspended for the term of the licensure suspension.

   - Probation: Whenever a practitioner is placed on probation by a licensing authority, his or her membership status and clinical privileges shall become subject to the same terms and conditions of the probation.

   - Expiration of License: Whenever a practitioner's license to practice in this state expires, the practitioner's Allied Health Staff appointment and clinical privileges shall immediately be suspended and the practitioner will be considered to have voluntarily resigned if the license is not renewed within 30 days of the license expiring.

b) **DEA or Controlled Substance Registration** – Whenever a practitioner's DEA or other controlled substance registration is revoked, restricted, suspended, or has expired, the practitioner's right to prescribe medications covered by the registration is similarly revoked, restricted, or suspended.
c) **Professional Liability Insurance** – A practitioner's appointment and clinical privileges shall immediately be suspended for failure to maintain the minimum amount of professional liability insurance required by the Banner Board. Reinstatement may be requested during a period of 30 calendar days following suspension upon proof of adequate insurance. Thereafter, practitioners shall be deemed to have voluntarily resigned from staff and must reapply.
d) **Exclusion from Federal (Medicare) /State Programs** – The CEO with notice to the Chief of Staff will immediately and automatically suspend privileges of an Excluded Practitioner. The CEO may restore limited privileges to an Excluded Practitioner upon his/her signing an agreement whereby he/she agrees (a) not to provide items or services to patients enrolled in Medicare/State Programs and (b) to indemnify the Medical Center and the Medical Staff for any liability they might have solely as a result of a breach of this agreement. An "Excluded Provider" is a practitioner whose name is on the then current "list of Excluded Individuals/Entries" maintained by the Office of the Inspector General, Department of Health and Human Services or who has been barred from participation in any Medicare/State Program. A "Medicare/State Program" is any federal or state program, including Medicare, Medicaid, AHCCCS, Indian Health Service, or TriCare program.
e) **Failure to respond to requests for information or to satisfy special appearance requirements** – A practitioner who fails without good cause to respond when contacted by an officer of the medical staff, department chairman, or Professional Review Committee member, after three attempts by the physician's preferred method

of communication, or to appear at a meeting where his or her special appearance is required, may be automatically suspended from exercising all clinical privileges. Privileges may be reinstated upon response or appearance as determined by the Chief of Staff or designee. Failure to comply within 90 days of the request to respond or appear shall result in revocation of staff membership and privileges. Thereafter, the affected practitioner must reapply for staff membership and privileges.

f) **Failure to pay staff dues** – A practitioner who fails to pay staff dues shall automatically be suspended. If the dues are paid within 30 calendar days of notification of suspension, the practitioner shall be reinstated. Thereafter, the AHP shall be deemed to have resigned voluntarily from the staff and must reapply.

g) **Failure to execute releases and/or provide documents** – A practitioner who fails to execute a general or specific release and/or provide documents during term of appointment when requested by the Chief of Staff, Department Chairman or designee or the Professional Review Committee shall automatically be suspended. If the release is executed and/or documents provided within 30 calendar days of the notice of suspension, the practitioner will be reinstated. Thereafter, such practitioner shall be deemed to have voluntarily resigned from staff and must reapply.

h) **Failure to establish freedom from infectious TB** – A practitioner's appointment and clinical privileges shall be immediately suspended for failure to provide evidence of freedom from infectious TB as required by law and Hospital policy. Reinstatement may be requested during a period of 30 calendar days following suspension if evidence of freedom from infectious TB is provided. Thereafter, practitioners shall be deemed to have voluntarily resigned from staff and must reapply.

i) **Certification** (specialty, BLS, ACLS, PALS, NRP, etc.) – A practitioner's appointment and clinical privileges shall be immediately suspended for failure to maintain certification as required. Reinstatement may be requested during a period of 30 calendar days following suspension if evidence of certification is provided. Thereafter, practitioners shall be deemed to have voluntarily resigned from staff and must reapply.

j) **Eligibility criteria** - A practitioner's appointment and clinical privileges shall be immediately suspended for failure to meet eligibility criteria for the applicable category. Reinstatement may be requested during a period of 30 calendar days following suspension if evidence of meeting eligibility criteria for the applicable category is provided. Thereafter, practitioners shall be deemed to have voluntarily resigned from staff and must reapply.

k) **Failure to Participate in an Evaluation** – A practitioner who fails to participate in an evaluation of his/her qualifications for Allied Health membership and/or privileges shall automatically be suspended. If, within 30 days of the suspension, the practitioner agrees in writing to participate in the evaluation and does participate constructively, the practitioner shall be reinstated. Thereafter, such practitioner shall be deemed to have resigned voluntarily from the staff and must reapply for membership and privileges.

l) **Failure to Complete Assessments and Provide Results** – A practitioner who fails to complete a required educational assessment and/or training program and//or health (including psychiatric/psychological health) assessment and follow-up treatment or to provide a report of such findings shall automatically be suspended. If the report is provided within 30 calendar days of the notice of suspension, the practitioner shall be reinstated. Thereafter, such practitioner shall be deemed to have resigned voluntarily resigned and must reapply for membership and privileges.

m) **Failure to complete CPOE training** - For categories that are required to complete CPOE training, failure to complete training within 6 months of appointment to the staff will result in automatic relinquishment of membership and privileges.
n) **Failure to provide evidence of flu vaccine or exemption** - The clinical privileges of a practitioner who provides care services at the Medical Center shall be immediately suspended for failure to provide evidence of annual influenza vaccination or of an exemption. When granted an exemption, failure to wear a protective mask as required by Banner Policy will result in immediate suspension. The practitioner will be reinstated once the flu season has officially ended.

XIII. NON-REVIEWABLE ACTIONS

a) Imposition of supervision pending completion of an investigation to determine if corrective action is warranted.
b) Issuance of a warning or letter of admonition or reprimand.
c) Termination or limitation of temporary permission to provide patient care services.
d) Any recommendation voluntarily imposed or accepted by an AHP.
e) Denial of membership for failure to complete an application for membership or permission to provide patient care services.
f) Removal of membership for failure to complete the minimum supervisory requirements.
g) Removal of membership and permission to provide patient care services for failure to submit an application for reappointment within the allowable time period.
h) Any requirement to complete an educational assessment or training program.
i) Any requirement to complete a health and/or psychiatric psychological assessment and follow-up treatment recommended by the designated or approved healthcare professional.
j) Removal of permission to provide patient care services for lack of a sponsoring physician.
k) Temporary suspension for failure to timely complete medical records.
l) Any limitation imposed by employer.

XIV. ADVERSE ACTION REVIEW AND APPELLATE REVIEW

An AHP shall have the right to dispute any action that revokes, suspends, terminates, restricts, or reduces the clinical privileges or scope of care that the AHP has been given permission to provide at the Medical Center unless the action revokes, suspends, terminates, restricts, or reduces the clinical privileges of an entire classification of AHP's rather than being focused on an individual AHP. If the AHP is a hospital employee and a limitation is imposed by the Medical Center, Human Resources will provide a review pursuant to hospital policy; a review will not be provided pursuant to this policy.

The AHP rights of hearing and appeal are as follows:

AHP's who are subject to Adverse Action (other than Nonreviewable or Automatic Actions defined in Sections II & III) shall be afforded an Adverse Action Review and appeal process in accordance with these Rules & Regulations. Adverse Action includes: denial of a request to provide any patient care services within the applicable privileges or scope of care or revocation, suspension, reduction, limitation or termination of permission to provide any patient care services within the applicable privileges or scope of care. AHP's are not entitled to due process rights set forth in the Medical Staff Bylaws, and none of the procedural rules set forth therein shall apply.

Notice of Adverse Recommendation or Action
Within fifteen (15) days after Adverse Action is taken against an AHP, the AHP shall be notified in writing of the specific reasons for the Adverse Action and the AHP's rights per these Rules & Regulations**.**

Request for Review of Adverse Recommendation or Action
The AHP may request an Adverse Action Review following the procedure set forth in these Rules & Regulations. If the AHP does not deliver a written request for an Adverse Action Review to the Chief Executive Officer within ten (10) days following the AHP notice of the Adverse Action, the Adverse Action shall be final and non-appealable.

Composition of the Review Committee
A committee consisting of the Chief Nursing Officer, the Chief of the applicable Medical Staff Department and Professional Practice Director, or their respective designees, will consider the request and serve as the Review Committee.

Notice of Time and Place for Review
The AHP shall be given ten (10) days prior written notice of the time, place and date of the Adverse Action Review and a list of witnesses, if any, who will be called to support the Adverse Action.

Statements in Support
The sponsoring Medical Staff member and the AHP shall be entitled to submit a written statement in support and/or to introduce all relevant documentation by supplying two (2) copies of the statement and/or documentation to the Medical Staff Services Department at least three (3) days prior to the review.

Rights of Parties
During the Adverse Action Review, the parties will be given an opportunity to present relevant evidence, call witnesses and make arguments in support of their positions. Neither the AHP, Medical Center, nor the sponsoring Medical Staff member shall be entitled to legal counsel at the Adverse Action Review or Appellate Review.

Burden Of Proof
The Medical Staff has the initial obligation to present evidence in support of the adverse action or recommendation. Thereafter, the AHP has the burden of demonstrating, by a preponderance of the evidence, that the adverse action or recommendation lacks any substantial factual basis or is otherwise arbitrary, unreasonable, or capricious.

Action on Committee Review
Upon completion of the review, the Review Committee shall consider the information and evidence presented, make a recommendation, which shall include the basis therefore, and forward it to the Chief of Staff. The AHP and the Medical Staff shall be provided with a copy of the Committee's recommendation.

Duty To Notify Of Noncompliance
If the AHP believes that there has been a deviation from the procedures required by this Adverse Action Review Plan or applicable law, the AHP must promptly notify the Chief of Staff of such deviation, including the Adverse Action Review Plan, these Rules & Regulations or applicable law citation. If the Chief of Staff agrees that a deviation has occurred and is substantial and has created demonstrable prejudice, he/she shall correct

such deviation.

Request for Appellate Review
If the AHP is dissatisfied with the Committee's recommendation, the AHP may submit a written request for an Appellate Review, provided that the Chief Executive Officer receives such request within ten (10) days following the AHP's receipt of the Committee's recommendation. The request must identify the Grounds for Appeal and must include a clear and concise statement of the facts in support of the request. Grounds for Appeal include: that the Adverse Action Review failed to comply with these Rules & Regulations or applicable state law and that such noncompliance created demonstrable prejudice or that the Review Committee's recommendation was not supported by substantial evidence. If the request for an Appellate Review is not requested properly and/or timely, the Committee's recommendation shall become final and non-appealable.

Interview with Medical Executive Committee
Upon a proper and timely request for an Appellate Review, the AHP shall be given an interview with the MEC or a subcommittee thereof consisting of at least three (3) members. The AHP shall be given at least five (5) days prior written notice of the time, place and date of the Appellate Review. At the appeal, the parties shall be allowed to present written and/or oral arguments as to why the Committee's recommendation should be reversed or modified.

Final Determination by the Medical Executive Committee
The MEC shall make a final determination on the Adverse Action, which shall be provided to the parties. The decision of the MEC shall not be subject to further appeal.

The final decision will be submitted to the Medical Staff Subcommittee of the Board.

XV. ONGOING PROFESSIONAL PRACTICE EVALUATION (OPPE)

As outlined in the Ongoing Professional Practice Evaluation Policy. It is the responsibility of the AHP to return the completed OPPE form(s) to the Medical Staff Office within 30 days of receipt. If not received, the AHP's membership and privileges will be suspended. Reinstatement may be requested during a period of 30 calendar days following suspension if the completed forms are provided. Thereafter, practitioners shall be deemed to have voluntarily resigned from staff and must reapply.

XVI. FOCUSED PROFESSIONAL PRACTICE EVALUATION (FPPE)

Within six months after a practitioner's initial appointment or initial granting of privileges, the provider will have three cases retrospectively or concurrently reviewed by a peer in good standing with the same privileges at BEMC. These reviews, on a prescribed form, will be submitted directly to the Medical Staff Office for review by the Department Chairman or designee. Results of any unfavorable review will be reported to the Medical Executive Committee for review and action. Additional cases may be required if deemed necessary by the Department Chairman or the Medical Executive Committee.

It is the responsibility of the AHP to return the completed FPPE form(s) to the Medical Staff Office within 30 days of receipt of the final notice. If not received, the AHP's membership and privileges will be suspended. Reinstatement may be requested during a period of 30 calendar days following suspension if the completed forms are provided. Thereafter, practitioners shall be deemed to have voluntarily resigned from staff and must reapply.

For those practitioners with fewer than three (3) cases during the FPPE period, a peer reference attesting to the provider's current competency may be accepted as FPPE.

For those practitioners where data is not available, the department chairman may review case volume in relation to any deviation from the standard of care through quality monitoring or from PRC referrals.

APPROVED: MEC – 6/1/16
Board – 7/14/16
REVISED: MEC – 8/3/16
Out for Comment – 8/26/16
Board – 9/7/16
REVISED: Medical Executive Committee – 4/5/17
Out to Medical Staff for comment – 4/25/17
Board – 5/11/17
REVISED: MEC – 5/3/17
Out for Comment – 5/22/17
Board – 6/7/17
REVISED: MEC – 8/2/17
Out for Comment – 8/7/17
Board – 8/10/17