BANNER HEALTH

Credentialing Manual

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1. Introduction & General Terms

1.1 Applicant's Burden.

a. Every Applicant has the burden of producing sufficient information for:

i. proper evaluation of the Applicant's qualifications, and

ii. resolving any doubts about any of the qualifications required for Medical Staff membership and Clinical Privileges.

b. The burden is met once the Applicant has provided information deemed sufficient by the Medical Staff leadership, Chief Executive Officer, and the Board.

c. Applications not demonstrating compliance with the requirements for Medical Staff membership and Clinical Privileges will be deemed to be incomplete.

d. Incomplete applications will not be processed. If the Applicant fails to provide requested information within 60 days after a written request has been made, the application will be deemed withdrawn.

1.2 Complete Application. An application is complete once the Medical Staff leadership and Chief Executive Officer have determined that:

a. all relevant questions have been answered,

b. all supporting and requested documentation has been supplied, including acceptable responses from references and all information in the possession of third parties that has been deemed necessary for full and appropriate evaluation of the Applicant's qualifications, and

c. the primary source verification process has been completed, as applicable. A previously completed application may become incomplete if circumstances arise that require new, additional, or clarifying information.

1.3 Confidentiality. All credentialing, peer review, and professional review activities will be kept confidential. Disclosures of this information are prohibited except:

a. when the disclosure is made to another individual or entity as part of the peer review, credentialing, or quality assurance processes;

b. as authorized by Banner Health policy; or

c. as authorized by the Chief Executive Officer, Chief of Staff, or Banner Health legal counsel.

Breaches of confidentiality shall not constitute a waiver of any evidentiary privilege (e.g., peer review or quality assurance privileges) or other applicable legal protections.

1.4 Peer Review Protection. All oral and written communications, reports, recommendations, and actions taken as part of the credentialing, peer review, and professional review processes are confidential and privileged to the fullest extent permitted by state law. Unless explicitly stated otherwise, all credentialing, peer review, and professional review activities conducted in accordance with this policy should be considered subject to the peer review and quality assurance privileges (or their equivalent).

1.5 Indemnification of Practitioners. Practitioners will be indemnified as set forth in Policy #749 ("Indemnification for Claims Arising from Medical Staff Activities"). Individuals who serve on Medical Staff committees and in Medical Staff leadership roles may contact the Medical Staff Services Office for more information about available legal protections.

1.6 Definitions.

a. "Applicant" refers to an individual who is applying for Medical Staff membership and/or Clinical Privileges.

b. "Board" refers to the Banner Board of Directors or its designated committees and subcommittees (as set forth in the Banner Health Corporate Bylaws).

c. "Certified Mail" refers to the definition in the applicable Medical Staff Bylaws. Where the Bylaws do not include such a definition, it refers to correspondence sent via trackable/traceable methods, including (but not limited to):

   i. United States Postal Service Certified Mail, Priority Mail, Express Mail, or Delivery Confirmation;

   ii. Federal Express Service; and

   iii. United Parcel Service.

d. "Clinical Privileges" refers to the authorization granted by the Board to render specific clinical procedures and patient care services, subject to the provisions of this Policy.

e. "Credentials Committee" refers to a Medical Staff committee that handles the function of reviewing applications for initial appointment, reappointment, and Clinical Privileges. In hospitals that do not have a Credentials Committee, the term will refer to its equivalent. (For example, in a critical access hospital, the MEC may act as a Credentials Committee.)

f. "CVO" refers to the Banner Health Credentialing Verification Office.

g. "Day" refers to a calendar day.

h. "MEC" refers to the Medical Executive Committee.

i. "Practitioner" refers to an individual who currently holds Clinical Privileges as approved by the Banner Board.

j. "Practitioner Health Committee" refers to a Medical Staff committee that addresses issues of individual physician health and wellness. In hospitals that do not have a Practitioner Health Committee, the term will instead refer broadly to the applicable Medical Staff's process for managing matters of individual health for physicians and other licensed Practitioners.

k. "Special Notice" refers to the definition in the applicable Medical Staff Bylaws. Where the Bylaws do not include such a definition, it refers to hand delivery and/or Certified Mail.

1.7 Delegation of Functions.

a. Whenever a function is assigned to a particular individual or committee, that individual (or committee through its chairperson), may delegate performance of the function to one or more designees. The person who chooses to delegate a task remains responsible for selecting only qualified and appropriate designees and for ensuring the delegated task is completed.

b. If an individual who is assigned to perform a particular function is absent or unavailable, the Chief of Staff is authorized to perform the function personally or delegate it to another qualified and appropriate individual.

c. For functions that would be handled by Hospital Administration, either the Chief Medical Officer or Chief Executive Officer is authorized to perform the function personally or delegate it to another qualified and appropriate individual.

1.8 Time Limits. Unless explicitly stated otherwise, all time limits listed in this Manual are mandatory.

2. Appointment

2.1 Pre-Application.

a. Requests for applications will be submitted to the CVO.

b. If sufficient information is provided (and relevant qualifications are indicated) on the request for application, the Applicant will be provided with an application.

2.2 Application Forms. An application for Medical Staff membership and/or Clinical Privileges will be submitted by the Applicant in a manner and format approved by the Board.

2.3 References.

a. Each Applicant will provide the names of at least three health care professionals in the same discipline, preferably in the same specialty, with the same or similar qualifications. Banner Health may request additional references at any time.

b. These will be licensed health care professionals who can attest to the Applicant's current clinical competency (within the past 24 months, at minimum), ethical character, and ability to work cooperatively with others.

c. Relatives are not acceptable.

2.4 Effect of Application. By signing the application, an Applicant:

a. attests to the correctness and completeness of all information furnished;

b. acknowledges that any material misstatement in or omission from the application may result in ineligibility for appointment and Clinical Privileges;

c. signifies a willingness to undergo a physical or mental health evaluation upon the request of a Practitioner Health Committee or other Medical Staff peer review committee;

d. agrees to abide by the terms of the Medical Staff Bylaws, Rules and Regulations, and the policies of the Medical Staff and the Hospital, including (but not limited to) Policy #5988 ("Medical Staff – Professional Conduct");

e. agrees to maintain an ethical practice and to provide continuous care to the Applicant's patients;

f. authorizes and consents to representatives of the Medical Staff and Hospital consulting with any individual who or entity which may have information bearing

on the Applicant's qualifications, and consents to the inspection of all records and documents that may be material to evaluation of such qualifications;

g. authorizes and consents to the sharing of information in accordance with Banner Health policies and procedures;

h. agrees to exhaust all hearing and appeal rights under the Medical Staff Bylaws and Fair Hearing Plan before initiating legal action;

i. releases from any liability Banner Health, the Board, Hospital employees, Medical Staff members, and all others who review, act on, or provide information regarding the Applicant's qualifications for staff appointment and Clinical Privileges; and

j. agrees to adhere to the compliance policies of Banner Health, the Hospital, and the Medical Staff, as well as any laws, regulations, and standards of conduct applicable to the profession, participation in any federal health program, and activities at the Hospital.

If an Applicant refuses to agree to these terms, the application will be deemed incomplete.

2.5 Sharing of Information. By applying for and exercising Clinical Privileges at a Banner facility, Practitioners agree to comply with all applicable peer review and quality assurance processes. Further, Practitioners acknowledge that peer review and quality assurance information may be shared with other entities in accordance with Banner's policies and procedures.

2.6 Processing the Application. The application will be processed in accordance with the applicable Medical Staff Bylaws. Incomplete applications will not be processed. In addition, Banner Health may choose to pause processing an application, at any time, if concerns arise. Except where the Medical Staff Bylaws state otherwise, the following application process will apply:

a. Once the application is submitted, it will be processed further by the CVO. This phase of the credentialing process will include collecting and verifying references, licensure, and other evidence of qualification. Additional verifications will be conducted if determined to be necessary. The CVO may communicate with Applicants regarding any issues that arise (e.g., problems with missing information).

b. Once this phase is completed, the CVO will determine whether an application is ready to be released to the applicable Medical Staff Services Office(s). The CVO's decision to release an application to a Medical Staff Services Office is purely procedural and does not indicate that an Applicant has been deemed eligible for appointment and Clinical Privileges. It means only that the CVO has determined

that there is sufficient information to proceed with the next phase of the credentialing process.

c. Upon receipt of the application, the Medical Staff Services Office will conduct an initial review and mark the file as either an expedited or non-expedited application in accordance with applicable Banner Health policy.

d. Applications will generally be reviewed as follows, except where the applicable Medical Staff Bylaws state otherwise:

   i. A department chair will review the application and make a recommendation to the Credentials Committee.

   ii. The Credentials Committee will review the file and assess whether the Applicant meets all applicable criteria for appointment and Clinical Privileges. The Credentials Committee will make a recommendation to the MEC.

   iii. The MEC will review the recommendation of the Credentials Committee and then make a recommendation to the Board. As part of this process, the MEC may consider the options set forth in Section 2.7.

e. The Credentials Committee, the MEC, or the Board may choose, at any time, to treat an expedited application as a non-expedited application. Such determination is not a denial or reduction of Clinical Privileges and does not entitle the Applicant to any kind of due process or hearing.

2.7 Optional Recommendations. The MEC may make any recommendation or take any action consistent with the applicable Medical Staff Bylaws. The following list of recommendations is provided as guidance:

a. Appointment with Stipulation. The MEC may choose to offer a Stipulation Agreement to the Applicant. Further details are provided in Section 2.8.

b. Conditional Appointment. The MEC may recommend that an Applicant be offered a conditional appointment or reappointment. Further details are provided in Section 2.9.

c. Shortened Appointment. The MEC may recommend an appointment period that is shorter in duration than the maximum time permitted by regulatory agencies. Shortened reappointments do not qualify as a reduction or limitation of appointment or Clinical Privileges.

d. Deferral. The MEC may choose to defer the application for further consideration at a future meeting.

2.8 Appointment with Stipulation. Stipulation Agreements set forth expectations for conduct and/or performance, which may include refraining from the misuse of alcohol and drugs.

a. Stipulation Agreements may be offered at any time before or during the term of appointment. When a Stipulation Agreement is offered to an initial Applicant, processing of the application will pause for a period of up to 60 days in order to permit the Applicant to review and consider the terms of the Stipulation Agreement.

b. If an individual refuses to sign a Stipulation Agreement, the matter will return to the MEC for consideration. The following next steps are provided as guidance:

i. The MEC will assess whether there have been any new developments or whether any new questions or complaints have emerged about the individual under review.

ii. The MEC will conduct any additional fact-finding necessary to inform its decision-making.

iii. The MEC will consider whether the following actions are appropriate:

1. requiring a Focused Professional Practice Evaluation ("FPPE") for behavior or clinical concerns in accordance with Policy #755 ("Medical Staff Focused Professional Practice Evaluation");

2. requiring the individual to attend an external course relevant the concerns at issue;

3. notifying the Applicant of any penalties for continued misconduct; and/or

4. taking actions on Clinical Privileges, which could be reportable to either the state licensure boards or to the National Practitioner Data Bank (e.g., denying, suspending, restricting, or terminating Clinical Privileges).

c. If an individual is approaching the end of an appointment cycle, the MEC may recommend a shortened reappointment in order to provide the individual with sufficient time to review an offered Stipulation Agreement.

2.9 Conditional Appointment. Certain Medical Staff Bylaws recognize the concepts of conditional appointments and reappointments. These enable the MEC to make appointment or reappointment contingent upon an individual's compliance with certain specific conditions. Conditions may relate to behavior (such as mandating strict compliance with Policy #5988 ("Medical Staff – Professional Conduct")) or to clinical issues (such as medical record documentation requirements). These conditions will not be a reduction or limitation of membership or Clinical Privileges. Penalties for

noncompliance will be set forth in the offer of conditional appointment and/or reappointment and will generally be more severe than those associated with a Stipulation Agreement.

2.10 Board Action. All MEC recommendations relating to Medical Staff membership and/or Clinical Privileges are subject to final approval by the Banner Board of Directors.

2.11 Pended Applications. At times, an application may be placed into Pended status. Pended Applications may only be processed in accordance with the Banner Health Policy on Pended Applications.

2.12 No Entitlement or Right to Membership. No individual is entitled to hold appointment or Clinical Privileges solely because:

a. the individual is employed by Banner Health or one of its Hospitals;

b. the individual is contracted with, or part of a group that is contracted with, Banner Health or one of its Hospitals;

c. the individual is licensed to practice a health care profession;

d. the individual is a member of any particular professional organization;

e. the individual previously held appointment or Clinical Privileges at a Banner facility;

f. the individual resides in the geographic service area of a Banner hospital.

2.13 Photo Identification and Badging. Prior to exercising Clinical Privileges, all Practitioners are individually responsible for obtaining a Banner Health photo identification badge. Practitioners who do not meet this requirement are not eligible to exercise Clinical Privileges. Practitioner identification will be verified as part of the credentialing and privileging process.

3. Eligibility and Qualifications

3.1 Threshold Eligibility Criteria. An individual will continuously meet the following criteria (as applicable) in order to hold Medical Staff membership and/or Clinical Privileges:

a. meet all eligibility requirements set forth in the applicable Medical Staff Bylaws;

b. meet all applicable privileging requirements as set forth in Delineation of Privilege Forms ("DoPs");

c. hold a current, unrestricted license to practice in the state that is not subject to any restrictions, probationary terms, or conditions not generally applicable to all licensees;

d. have current, valid professional liability insurance coverage as set forth in Section 3.3, below;

e. have an appropriate coverage arrangement, as determined by the applicable Credentials Committee, to provide coverage when the Practitioner is unavailable; and

f. not currently be excluded or precluded from participation in Medicare, Medicaid, or any other federal or state governmental health care program.

3.2 Waiver of Threshold Eligibility Criteria. Except where the applicable Medical Staff Bylaws state otherwise, the Credentials Committee (as applicable) and MEC may consider waivers of threshold eligibility criteria using the following process, subject to final approval by the Board:

a. Waivers must be requested in writing by the Applicant and must, at a minimum, state why the Applicant's qualifications are equivalent to (or exceed) existing threshold eligibility criteria.

b. The Credentials Committee will determine if the Applicant's qualifications meet or exceed existing threshold eligibility criteria. The Applicant bears the burden to resolve any doubts about this (in accordance with Article 1 of this Manual).

c. In reviewing the waiver request, the Credentials Committee may consider the best interests of the Hospital and the communities it serves. If the Credentials Committee chooses to recommend a waiver, the recommendation will include a list of reasons justifying the decision. Recommendations for a waiver will then be forwarded, in writing, to the MEC for review.

d. The MEC may choose to recommend the requested waiver, deny the requested waiver, or return the matter to the Credentials Committee for reconsideration. If the

MEC chooses to recommend the requested waiver, the request will be forwarded to the Board for final action along with a list of reasons justifying the decision. Waivers will be limited to exceptional circumstances.

e. No Applicant is entitled to a waiver. If a waiver request is denied at any level, such denial does not entitle the Applicant to any kind of hearing or due process. Waivers are exceptions to established rules that will only be granted under exceptional circumstances. If an Applicant remains ineligible for appointment and/or Clinical Privileges because of the refusal to grant a waiver, this determination of ineligibility is neither a disciplinary action nor a matter that is reportable to the National Practitioner Data Bank.

f. Granting a waiver in a particular case is not intended to set a precedent for any future Applicant or group of Applicants. Waivers are always granted based on case-specific information that may change over time.

3.3 Professional Liability Insurance Coverage. Practitioners will hold current, valid professional liability insurance coverage in the amounts specified by the Banner Board. This insurance policy will cover the Practitioner's professional activities in the applicable hospital.

For example, if a Practitioner's insurance coverage:

a. only applies to activities performed in the course of employment, and

b. the Practitioner's employer directs the Practitioner to refrain from practice, then

c. the Practitioner will be deemed *not* to have current professional liability insurance coverage.

Failure to satisfy this threshold eligibility criterion may trigger an automatic suspension (and other consequences) as set forth in the applicable Medical Staff Bylaws.

3.4 Automatic Suspension. Failure to satisfy one or more threshold eligibility criteria may trigger an automatic suspension (and other consequences) as set forth in the applicable Medical Staff Bylaws.

4. Clinical Privileging

4.1 General.

a. Individuals will meet all applicable eligibility requirements, including those requirements set forth in Medical Staff Rules and Regulations and facility DoPs, in order to hold Clinical Privileges.

b. Practitioners are individually responsible for complying with Banner Health privileging requirements. Practitioners will not practice outside the scope of the Clinical Privileges that have been granted to them by the Board. If there are concerns that a Practitioner has performed a procedure without necessary Clinical Privileges, this will immediately be referred for review under the applicable peer review and quality assurance processes. In addition, the Medical Staff Services Office will notify the Banner Health Compliance team of the issue.

c. All requests for Clinical Privileges will be processed in accordance with the Medical Staff Bylaws and with the procedures outlined in Articles 2 and 5. If Applicants request modifications to their Clinical Privileges during an appointment period, the request will be handled through the Medical Staff Services Office. Requests to add or modify Clinical Privileges are not effective unless and until recommended by the MEC and approved by the Board and will generally follow the normal process for reviewing clinical privileging requests (as set forth in Section 2.6).

d. Requests to resign Clinical Privileges (either in part or in full) will be effective immediately. Practitioners may wish to consider the impact, if any, on existing coverage arrangements.

e. All requests for Clinical Privileges, including requests to modify Clinical Privileges before the standard reappointment cycle, will be processed on appropriate DoPs.

4.2 Delineation of Privilege Forms.

a. Specific privileging criteria will be set forth on DoPs.

b. Medical Staff leadership (e.g., department chairs and section chairs) are encouraged to review DoPs periodically and identify opportunities for improvement.

c. If concerns arise regarding the content of a particular DoP form (e.g., if a member of the perioperative department has concerns that a form is vague), these concerns should be referred to the Credentials Committee. The Committee may then assign a subgroup to review the DoP form and make recommendations on whether to revise it.

4.3 Clinical Privileges for New Procedures and/or New Technologies.

a. Unless the Medical Staff Bylaws specify otherwise, requests for Clinical Privileges that involve new procedures and/or new technologies will follow this process.

b. Requests for Clinical Privileges to perform either a treatment, procedure, or therapy not currently being performed at the Hospital or a new technique to perform an existing treatment, procedure, or therapy ("New Procedure") will not be processed until a determination has been made that the New Procedure will be offered by the hospital and criteria for the associated Clinical Privilege(s) have been adopted.

c. Any individual proposing that the New Procedure should be offered at the Hospital will prepare and submit information to the Chief Medical Officer and Chief Executive Officer addressing the following:

   i. clinical indications for when the New Procedure is appropriate;

   ii. whether there is empirical evidence of improved patient outcomes with the New Procedure

   iii. whether the New Procedure is being performed at other similar hospitals and the experiences of those institutions;

   iv. relevant Medicare national and local coverage determinations;

   v. whether the New Procedure is investigational;

   vi. whether the New Procedure has a favorable safety profile; and

   vii. whether the New Procedure has received any regulatory approval.

d. The Chief Medical Officer will meet with the Chief of Staff to discuss next steps. The following process is provided as a guideline, and the Chief Medical Officer and Chief of Staff may agree to modify the process (including adding steps, where appropriate).

   i. A subgroup of Credentials Committee members will be assigned to review the request. They will solicit input from all departments with relevant expertise.

   ii. The subgroup will then assess whether the New Procedure is already covered by existing DoPs. If the New Procedure is not covered by an existing DoP, the subgroup will provide a draft DoP to the Credentials Committee for review.

   iii. The subgroup will assess whether proficiency for the New Procedure is volume-sensitive and if the requisite volume is available at the Hospital.

iv. The subgroup will assess whether additional training or proctoring is needed for the New Procedure.

v. The subgroup will make recommendations to the Credentials Committee, which will then make a recommendation to the MEC.

vi. The MEC will review the matter and forward its recommendations to the Board for final action.

4.4 Clinical Privileges that Cross Specialty Lines.

a. Unless the Medical Staff Bylaws specify otherwise, requests for Clinical Privileges that have previously only been exercised by Practitioners in other specialties will follow this process.

b. The individual requesting these Clinical Privileges will prepare and submit a written report to the Chief of Staff and Credentials Committee that addresses the following:

i. recommended qualifications for exercising these Clinical Privileges safely, including necessary education, training, and experience (including a discussion of how these compare with existing standards for those Clinical Privileges);

ii. plans for addressing any complications that may arise when exercising these Clinical Privileges (e.g., where complications would require a Practitioner of another specialty to intervene);

iii. the impact, if any, on Emergency Department call responsibilities; and

iv. recommended number of procedures for Initial FPPE.

c. The Chief of Staff will meet with the Chief Medical Officer to discuss next steps. The following process is provided as a guideline, and the Chief of Staff and Chief Medical Officer may agree to modify the process (including adding steps, where appropriate).

d. A subgroup of Credentials Committee members will be assigned to review the request. They will solicit input from all departments with relevant expertise.

e. The subgroup will make recommendations to the Credentials Committee, which will then make a recommendation to the MEC.

f. The MEC will review the matter and forward its recommendations to the Board for final action.

4.5 Telemedicine Privileging. Requests for Clinical Privileges by distant-site telemedicine Practitioners will be processed through one of the following options.

a. The request for Clinical Privileges may be processed through the same pathway as all other Medical Staff privileging requests. In such cases, the telemedicine Practitioner will satisfy all of the qualifications and requirements set forth in the Medical Staff Bylaws and this Credentialing Manual, except for those relating to geographic location.

b. The Chief of Staff and Chief Executive Officer may authorize the MEC to rely on the privileging decisions of another Banner Health Medical Staff. The following conditions apply:

   i. There will be a current written agreement between the participating Banner Health Hospitals; and

   ii. The MEC retains the discretion to recommend that any particular application follow the same pathway as all other Medical Staff privileging requests.

c. The Chief of Staff, Chief Executive Officer, and Chief Clinical Officer may authorize the MEC to rely on the privileging decisions of a distant site (as permitted by The Joint Commission standards). The following conditions apply:

   i. There will be a current written agreement between the Hospital and the distant site;

   ii. The written agreement will outline a process for the distant site to share quality information, including relevant ongoing professional practice evaluation data, with Banner Health;

   iii. The written agreement will state that the distant site will provide additional peer review and/or quality assurance information whenever requested by the Hospital;

   iv. The written agreement will satisfy all relevant Joint Commission requirements and will be compliant with state and federal law; and

   v. The MEC retains the discretion to recommend that applications follow the same pathway as all other Medical Staff privileging requests.

4.6 Focused Professional Practice Evaluation (Initial). All initial grants of Clinical Privileges are subject to a period of Initial FPPE. This will be conducted in accordance with Policy #755 (“Medical Staff Focused Professional Practice Evaluation”).

5. Reappointment

5.1 General.

a. Each appointment cycle will last for three years, except where the Medical Staff Bylaws set forth a shorter time frame and/or the MEC recommends a shortened appointment.

b. Reappointments will be processed in accordance with the Medical Staff Bylaws. In general, the reappointment process will follow a similar pathway as the appointment process set forth in Article 2. Failure to complete the reappointment documentation before the end of the appointment cycle will result in a voluntary resignation of appointment and Clinical Privileges.

c. At reappointment, the CVO will process the application once a single acceptable peer reference has been received. In all other respects, such peer reference will satisfy the conditions set forth in Section 2.3.

5.2 Information Gathering.

a. The Medical Staff committees, Medical Staff Services Office, and/or CVO will collect and review relevant information regarding the individual's professional activities, performance, conduct, and clinical skills. This will include all findings from the peer review, quality assurance, and utilization review processes. In addition, information may be collected regarding:

i. continuing education activities or other training or research programs;

ii. clinical activity at Banner Health;

iii. information from Risk Management;

iv. timely and accurate completion of medical records;

v. cooperativeness in working with other Practitioners and hospital personnel;

vi. evaluations from the department chair(s) and section chief(s), as applicable;

vii. professionalism and interactions with others in the Hospital;

viii. results from patient satisfaction and employee surveys (if applicable); and

ix. adherence to the policies of Banner Health, the Hospital, and the Medical Staff, as well as any laws, regulations, and standards of conduct applicable to the profession, participation in any federal health program, and activities at the Hospital.

b. Information will also be sought from other sources, such as:

i. National Practitioner Data Bank reports;

ii. peer references;

iii. information regarding professional liability insurance coverage;

iv. verification of licensures, certifications, and other qualifications;

v. Board Certification information;

vi. continuing medical education;

vii. reports of adverse actions or incidents at other hospitals;

viii. any other information which may be relevant to an evaluation of an individual's qualifications and competency.

6. Updating Information/Misstatements/Omissions

6.1 General.

a. In order for the credentialing and privileging processes to function effectively, Applicants need to provide the Medical Staff with correct information about their competencies and qualifications. As described in Section 1.1 ("Applicant's Burden"), this includes supplying a complete application and sufficient information for the Medical Staff and Board to evaluate the Applicant's credentials. If Applicants provide outdated, incorrect, or misleading information on an application form, this undermines key safety processes and disrupts the Medical Staff's ability to uphold a culture of safety.

b. Therefore, an application will immediately become incomplete upon the discovery of any misstatement or omission. Practitioners will be notified in writing of the suspected misstatement or omission and will be given an opportunity to provide an explanation (addressing the reason for the omission or misstatement) via written response.

c. The written response will be directed to the Credentials Committee (or an equivalent body, at the Chief of Staff's discretion). The Credentials Committee will then decide whether to continue processing the application.

d. If the Credentials Committee determines that the misstatement or omission was both significant and intentional, the Applicant will be deemed ineligible to apply for

Clinical Privileges. (The Credentials Committee may refer this assessment to the Medical Executive Committee.)

e. There may be situations where the misstatement or omission is discovered after an Applicant has been granted appointment and/or Clinical Privileges. Under these circumstances, the matter will be referred to the MEC for review. Where authorized by the applicable Medical Staff Bylaws, the Practitioner will also be placed on an automatic suspension. If the MEC determines that the misstatement or omission was significant, the Applicant will be deemed ineligible to hold appointment and/or Clinical Privileges and will be immediately removed from the Medical Staff.

f. No action taken pursuant to this Article will entitle an Applicant or Practitioner to a hearing or appeal.

6.2 Duty to Notify. Practitioners are required to notify the Medical Staff Services Office immediately of:

a. any change in their professional licensure;

b. any adverse action taken against their clinical privileges by any other Medical Staff or health care facility;

c. any request, by a Medical Staff or other health care facility, that they refrain from practice while a clinical or behavioral concern is reviewed;

d. any change in their professional liability insurance coverage that would place them out of compliance with the requirements set forth in Article 3; and

e. any arrest, indictment, criminal charge, conviction, guilty plea, or plea of *nolo contendere* involving crimes that relate (in any way) to the Practitioner's qualifications, competence, functions, or duties as a health care professional (including, but not limited to, crimes involving substance use or abuse, fraud, assault, child abuse, and sexual offenses/sexual misconduct).

7. Evaluations

7.1 General.

a. An evaluation by an external or internal source may be required in instances where there are concerns or doubts about an applicant's ability to perform privileges requested.

b. This Article provides tools and guidance intended to supplement existing material in the applicable Medical Staff Bylaws. Some Medical Staff Bylaws use "assessment" (or similar terms) to refer to an evaluation.

c. This Article describes three general categories of evaluation: FPPEs, Competency Evaluations, and Fitness for Practice Evaluations. These are provided as examples and are in no way intended to serve as an exhaustive list. Many other forms of evaluation, such as ongoing professional practice evaluation, will occur in accordance with the Medical Staff Bylaws and Banner Health policies.

7.2 Focused Professional Practice Evaluations.

a. FPPEs will occur in accordance with Banner Policy #755 ("Medical Staff Focused Professional Practice Evaluation").

b. There are two kinds of FPPE: (i) Initial FPPE and (ii) FPPE to Review Concerns.

c. FPPE to Review Concerns is a kind of FPPE used when a question arises regarding a currently privileged Practitioner's ability to provide safe, quality patient care.

d. FPPE may include chart review, monitoring clinical practice patterns, simulation, proctoring, external peer review, and discussion with other individuals involved in the care of each patient (for example, consulting physicians, assistants at surgery, nursing, and administrative personnel). Further information is set forth in Policy #755.

7.3 Competency Evaluations. Except where stated otherwise by the Medical Staff Bylaws, a Competency Evaluation refers to an evaluation of a Practitioner's current ability to perform one or more Clinical Privileges. It is designed to evaluate a Practitioner's current competence in response to concerns regarding the provision of safe, high-quality patient care.

a. If a Competency Evaluation is required, this will often be part of a FPPE to Review Concerns.

b. At times, a Competency Evaluation may consider issues relating to a Practitioner's health status. In such circumstances, Medical Staff leaders should consider whether a Fitness for Practice Evaluation would be a better assessment tool.

7.4 Fitness for Practice Evaluations. Except where stated otherwise by the Medical Staff Bylaws, a Fitness for Practice Evaluation refers to a broad evaluation of a Practitioner's qualifications, competency, capabilities, and professional performance. A Fitness for Practice Evaluation is similar to, but broader than, a Competency Evaluation.

a. A Fitness for Practice Evaluation is intended to assess whether a Practitioner is qualified to hold all Clinical Privileges requested and to discharge all Medical Staff duties and prerogatives in a manner that upholds a culture of safety and the provision of high-quality patient care.

b. Fitness for Practice Evaluations may include an evaluation of a Practitioner's physical and mental health status.

c. Fitness for Practice Evaluations are case-specific and may vary depending on the Practitioner's specialty, qualifications, credentials, and Clinical Privileges held or requested. They may also vary depending on concerns or issues indicated by a Practitioner's credentialing, peer review, and/or quality files.

d. Medical Staff leaders are encouraged to consult with Banner Legal (and Banner Risk, as appropriate) when determining the scope of a Fitness for Practice Evaluation.

7.5 Automatic Suspensions.

a. Failure to participate in an evaluation may trigger an automatic suspension (and other consequences) as set forth in the applicable Medical Staff Bylaws.

b. In addition to Section 7.5.a, or as an alternative, a Medical Executive Committee or Practitioner Health Committee may require a Practitioner to provide documents or other reports describing the outcomes of an evaluation. Failure to provide these requested documents may trigger an automatic suspension (and other consequences) as set forth in the applicable Medical Staff Bylaws.

8. Leaves of Absence

8.1 Initiating a Leave of Absence. A leave of absence of up to one year may be requested by submitting a request to the Chief of Staff and Chief Medical Officer. The request should, when possible, be in writing, state the beginning and ending dates, and the reasons for the leave. If the Practitioner is requesting the leave for health or wellness reasons, the reasons for the leave may instead be communicated to a Practitioner Health Committee.

a. A leave of absence cannot extend past the end of the Practitioner's current appointment term.

b. The Medical Staff leave process is separate and distinct from any kind of employment or HR leave of absence process. Employed Practitioners will need to request a Medical Staff leave of absence in addition to an any applicable employment leave of absence.

c. Practitioners will request a leave of absence if they will be away from Medical Staff responsibilities for more than 60 days. Failure to follow the 60-day requirement will be referred to the peer review process as a professionalism concern.

d. Practitioners who are on a military leave of absence (relating to service in the United States Armed Forces) for more than one year will automatically be granted an extension of their leave until their active duty is completed. Practitioners on a military leave of absence will still monitor the expiration dates of their appointment and Clinical Privileges (as these generally cannot be extended due to accreditation standards). An extended leave of absence may be requested at the same time as the reappointment application is filed.

e. Automatic Medical Leave of Absence

i. There may be situations where a Practitioner is unable to request a leave of absence due to a medical issue. Under those circumstances, Medical Staff leadership (as described below) may consider the process for triggering an automatic medical leave of absence.

ii. Specifically, if the Practitioner is unable to be contacted in a timely manner and the Chair of the Practitioner Health Committee (or an equivalent individual, as determined by the Chief of Staff in accordance with the Medical Staff Bylaws), has received credible information indicating that the Practitioner will be away from patient care responsibilities due to a reported health issue, then the Chair of the Practitioner Health Committee, in consultation with the Chief of Staff, may instruct the Medical Staff Services Office to place the Practitioner on an automatic medical leave of absence.

iii. The Medical Staff Services Office will provide Special Notice to the Practitioner (as described by the applicable Medical Staff Bylaws) that this has occurred.

iv. After Special Notice is sent, the Practitioner has seven days in which to contact the Medical Staff Services Office and ask for the automatic medical leave of absence to be lifted. If such a request is received within the seven-day window, the Medical Staff Services Office will immediately reinstate the Practitioner. However, if there is concern that the Practitioner is not safe to exercise Clinical Privileges, Medical Staff leadership may consider other precautionary actions as authorized by the Medical Staff Bylaws.

v. If the Practitioner does not make such a request within seven days after the Special Notice is sent, the Practitioner will automatically be deemed to have requested a medical leave of absence. To return from this leave of absence, the Practitioner will need to follow the process outlined in Section 8.3.

vi. An automatic medical leave of absence is not a disciplinary action and is treated similarly to any other leave of absence. It is separate and distinct from the Medical Staff Investigation process. Placing someone on an automatic medical leave of absence does not necessarily constitute or trigger the beginning of a Medical Staff Investigation.

8.2 Practitioner Responsibilities during a Leave of Absence. During a leave of absence, Practitioners will not exercise Clinical Privileges. Practitioners are excused from other Medical Staff responsibilities (e.g., attending meetings).

a. Practitioners are responsible for monitoring the dates when their appointment and Clinical Privileges will expire. Any questions about this should be directed to the Medical Staff Services Office. If a Practitioner's appointment and/or Clinical Privileges expire during a leave of absence, this may result in the Practitioner having to apply as a new Applicant (as set forth in Section 9.1).

b. As part of the recredentialing and privileging process, it is necessary to confirm that the Applicant is able to perform the essential functions of a Practitioner in their area of practice, including all Clinical Privileges requested, in a safe and competent manner. If there are health problems which could affect the Applicant's ability to perform the Privileges requested, the Joint Commission requires the Medical Staff to evaluate the Applicant's condition. Practitioners who are on a medical leave of absence due to a health issue may wish to consider this when submitting an application for reappointment.

8.3 Return from Leaves of Absence. To return from a leave of absence, Practitioners will submit a request to the Chief of Staff and Chief Medical Officer. As part of this request, Practitioners will include a written statement listing anything that occurred during the leave which could affect their ability to exercise Clinical Privileges safely

and at a high level of competency and any significant changes to the material on their application form.

a. The Chief of Staff and Chief Medical Officer will review the request for reinstatement. Either of them may request additional information, including a Competency Evaluation and/or Fitness for Practice Evaluation (described further in Article 7). In addition, the Chief of Staff may require the Practitioner to meet with a Practitioner Health Committee (or its equivalent) prior to or after reinstatement.

b. If the Chief of Staff and Chief Medical Officer agree, the Practitioner may be reinstated immediately. However, if either has concerns, the MEC will be asked to assign an *ad hoc* committee of three individuals, plus the Chief of Staff and Chief Medical Officer, to review the request and vote on whether to recommend reinstatement. If this *ad hoc* committee votes against reinstatement, the matter will be escalated to the full MEC, which will then make a recommendation to the Board.

9. Miscellaneous

9.1 Reinstatement.

a. This section applies in situations where an individual has automatically or voluntarily resigned from the Medical Staff (e.g., following an automatic suspension or the expiration of a leave of absence). These individuals may request reinstatement via the process outlined below. The reinstatement process is subject to the discretion of (and may be extended by) the Medical Staff leadership and Chief Executive Officer.

b. In order to be reinstated, Applicants will show that they meet the requirements set forth in Section 1.1 ("Applicant's Burden"). The following guidelines may be considered when processing a request for reinstatement following automatic or voluntary resignation.

Time Since Resignation	**Process**
1 to 20 days	Once the Medical Staff Services Office confirms that all necessary information is complete and current (e.g., the Practitioner still holds a valid professional license), the individual may be immediately reinstated.
21 to 119 days	The individual will be asked to submit a written statement to the Chief of Staff and Chief Medical Officer requesting reinstatement. This will include a full summary of all of the individual's activities since leaving staff (as relevant to the individual's practice), an explanation of why the individual is returning from resignation, and an attestation that no problems exist which could affect the individual's ability to exercise Clinical Privileges safely and at a high level of competence. The Chief of Staff will discuss the request with the Chief Medical Officer and then decide whether to grant reinstatement. If both agree, the individual may be reinstated once the Medical Staff Services Office confirms that all necessary information is complete and current (e.g., the Practitioner still holds a valid professional license). If either the Chief of Staff or Chief Medical Officer has any concerns, the individual will be required to apply as an initial Applicant (pursuant to the standard process).
120 days or more	The individual will apply as an initial Applicant.

c. The Time Since Resignation is measured according to the date when the request for reinstatement is made. Example: A Practitioner requests reinstatement 118 days

after resignation. The reinstatement process follows the requirements set forth on the "21 to 119 days" row. It takes five days to complete the full reinstatement process. At the conclusion of that process, the individual has been resigned for 123 days. As long as the requirements of the "21 to 119 days" row have been met, there is no need for the individual to apply as an initial Applicant. However, the full reinstatement process is always subject to the discretion of (and may be extended by) the Medical Staff leadership and Chief Executive Officer.

9.2 Delays. As a general rule, applications should be processed within 180 days. However, the processing time may extend beyond this if concerns arise about an Applicant's qualifications, competency, or professionalism.

9.3 Application Following Adverse Decision. If an individual was denied Medical Staff appointment or terminated from the Medical Staff, and this adverse action was upheld in a fair hearing (or accepted without a fair hearing), then the individual is ineligible to apply for (or hold) appointment or Clinical Privileges at any Banner Health facility for a period of ten years from the date of notice of the final adverse decision.

If an individual resigned while under Investigation, then the individual is ineligible to apply for appointment or Clinical Privileges for a period of three years from the date of resignation.

9.4 Precedence of Medical Staff Bylaws. If there appears to be a conflict between this Credentialing Manual and the provisions of the Medical Staff Bylaws, the applicable Medical Staff Bylaws language will govern the issue.

10. Amendment

10.1 Amendment. This Credentialing Procedures Manual may be amended or repealed, in whole or in part, following the amendment process outlined in the Medical Staff Bylaws.

10.2 Approval (July Facilities). This Credentialing Procedures Manual was approved and adopted by resolution of the Banner Health Board of Directors for the following facilities on July 11, 2024:

Banner Behavioral Health Hospital
Banner Boswell Medical Center
Banner Del E. Webb Medical Center
Banner Estrella Medical Center
Banner Heart Hospital
Banner Ocotillo Medical Center
Banner Thunderbird Medical Center
Banner—University Medical Center Phoenix
Banner—University Medical Center South Campus
Banner—University Medical Center Tucson

10.3 Approval (August Facilities). This Credentialing Procedures Manual was approved and adopted by resolution of the Banner Health Board of Directors for the following facilities on August 8, 2024:

Banner Baywood Medical Center
Banner Casa Grande Medical Center
Banner Churchill Community Hospital
Banner Fort Collins Medical Center
Banner Gateway Medical Center
Banner Goldfield/Ironwood Medical Center
Banner Lassen Medical Center
Banner Payson Medical Center
Community Hospital
East Morgan County Hospital
Banner McKee Medical Center
Banner North Colorado Medical Center
Ogallala Community Hospital
Page Hospital
Platte County Memorial Hospital
Sterling Regional Medical Center
Washakie Medical Center
Wyoming Medical Center