CREDENTIALS POLICY FOR MEDICAL STAFF AND ADVANCED PRACTICE PROVIDERS

Monongalia County General Hospital Company

Mon Health Marion Neighborhood Hospital

Preston Memorial Hospital Corporation

Stonewall Jackson Memorial Hospital Company

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GENERAL

1.A. PREAMBLE

All Medical Staff and Advanced Practice Providers commit to working cooperatively and professionally with each other, Hospital employees, and management, to promote safe, appropriate patient care. Medical Staff Leaders will strive to address professional practice issues fairly, reasonably, and collegially in a manner that is consistent with quality care and patient safety. All definitions for this Policy are found in the definitions set forth in the Medical Staff Bylaws.

1.B. CONFIDENTIALTY, CONFLICT OF INTEREST, AND PEER REVIEW PROTECTION

1.B.1. Confidentiality:

(a.) All professional review activity and recommendations will be strictly confidential. The Medical Staff and Advanced Practice Providers or other Providers granted privileges who have access to credentialing, privileging, or peer review information agree to maintain the confidentiality of this information. No disclosures of any such information (discussions or documentation) may be made outside of the meetings of the peer review committees, except:

(1.) To another authorized individual and for the purpose of conducting professional review activity; or

(2.) As authorized by System, Hospital or Medical Staff policy; or

(3.) As authorized, in writing, by legal counsel to the System.

(b.) Any breach of confidentiality may result in appropriate sanctions.

1.B.2. Conflict of Interest:

(a.) When performing a function outlined in this policy, the Organization Manual, or any other Medical Staff or Hospital policy, if any member of the Medical Staff or any Advanced Practice Provider has or reasonably could be perceived as having a conflict of interest or a bias in any matter involving another individual, the individual with a conflict will not participate in the general discussion on the matter.

However, the individual may provide relevant information and may answer any questions concerning the matter. Thereafter, the individual will be excused from the meeting and will not vote on the matter.

(b.) Any Member of the Medical Staff or any Advanced Practice Provider with knowledge of the existence of a potential conflict of interest or bias on the part of any other Medical Staff Member or any other Advanced Practice Provider, they may call the conflict to the attention of the Chief of Staff (or to the Vice Chief of Staff if the Chief of Staff is the person with the potential conflict), or the applicable Department Chief or Committee Chairperson, or designee. The Chief of Staff (or if the Chief of Staff is the individual with the potential conflict, Vice Chief of Staff or the applicable Department Chief or Committee Chairperson, or designee, will make a final determination as to whether the provisions in this policy should be triggered.

(c.) The fact that a Department Chief, or designee, Medical Staff member, or Advanced Practice Provider is in the same specialty as one whose performance is being reviewed, does not automatically create a conflict. The evaluation of whether a conflict of interest exists will be interpreted reasonably by the persons involved, taking into consideration common sense and objective principles of fairness. No Medical Staff or Advanced Practice Provider has a right to compel a determination that a conflict exists based on an allegation of conflict of interest.

(d.) The fact that a committee member, Medical Staff Leader, or Advanced Practice Provider chooses to refrain from participation, or is excused from participation, will not be interpreted as a finding of actual conflict.

1.B.3. Peer Review Protection:

(a.) All professional review activity will be performed by the peer review committees. Peer review committees include, but are not limited to:

(1.) All standing and ad hoc committees of the Medical Staffs and Hospitals; and

(2.) All departments and sections; and

(3.) Hearing and appellate review panels; and

(4.) The Board of Directors and its committees; and

(5.) any individual acting for or on behalf of any such entity, including but not limited to Department Chiefs, Section Chiefs, Committee Chairpersons, Committee members, Officers of the Medical Staff, Chief Medical Officer, Clinical Affairs Medical Directors, and experts or consultants retained to assist in peer review activities.

(6.) All reports, recommendations, actions, and minutes made or taken by peer review committees are confidential and covered by the provisions of applicable law.

1.D. INDEMNIFICATION

The System shall provide a legal defense for, and shall indemnify, all Medical Staff Officers, Department Chiefs, Committee Chairpersons, committee members, and authorized representatives when acting in those capacities, to the fullest extent permitted by law, in accordance with the Medical Staff and Hospital Bylaws.

ARTICLE 2

QUALIFICATIONS, CONDITIONS AND RESPONSIBILITIES

2.A. QUALIFICATIONS

2.A.1. Nature of Medical Staff Membership

Membership on the Medical Staff is a privilege which shall be extended only to professionally competent physicians, dentists, oral surgeons, and podiatrists who continuously meet the qualifications, standards and requirements set forth in this Policy. Appointment and membership on the Medical Staff shall confer on the Medical Staff Member only such clinical privileges and prerogatives as have been granted by the Board of Directors in accordance with this Policy and shall include staff category and department assignments.

2.A.2 Threshold Eligibility Criteria – Medical Staff

To be eligible to apply for appointment and clinical privileges, an individual must:

(a.) Have a current, unrestricted license to practice in this state that is not subject to any restrictions, probationary terms, or conditions not generally applicable to all licenses, and have never had a license to practice revoked, restricted, or suspended by any state licensing agency; and

(b.) Document their experience, background, training, demonstrated ability, and physical and mental health status with sufficient adequacy to demonstrate to the Medical Staff and the Board of Directors they will provide care to patients at the generally recognized professional level of quality, in an efficient manner, considering patients' needs, and the available Hospital facilities and resources, consistent with the utilization standards in effect at the Hospital; and

(c.) As determined based on documented references, adhere strictly to the ethics of their respective professions, to work cooperatively with others, and to be willing to participate in the discharge of Staff responsibilities; and

(d.) Maintain professional liability insurance coverage in form and in amounts satisfactory to the Hospital, with additional tail insurance coverage to cover any

future claims arising from the individual's practice at the Hospital after termination of the policy: and

(e.) Where applicable to the Practitioner, have a current unrestricted DEA registration. DEA registration is not required for a pathologist or a radiologist whose clinical privileges are not affected by the lack of a DEA certificate; and

(f.) Be located (office and residence) within the geographic services area of the Hospital, as defined by the Board of Directors, close enough to fulfill their Medical Staff responsibilities, and to provide timely and continuous care for their patients in Hospital; and

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

(h.) Have never been, and are not currently, excluded from participation in Medicare, Medicaid, or any other federal or state governmental health care program; and

(i.) Have never had a medical staff appointment, clinical privileges, or status as a participating provider denied, revoked, or terminated by any health care facility or health plan for reasons related to clinical competence or professional conduct, and have never resigned appointment or relinquished privileges during a medical staff investigation or in exchange for not conducting such an investigation; and

(j.) Have never been convicted of, or entered a plea of guilty or no contest, to any felony, or to any misdemeanor relating to controlled substances, illegal drugs, insurance or health care fraud or abuse, or related to the practitioner's suitability to practice medicine; and

(k.) Agree to fulfill all responsibilities regarding emergency call; and

(l.) Demonstrate willingness and capability to abide by all Medical Staff and Hospital Bylaws, Rules and Regulations, policies, and procedures, including but not limited to adherence to generally recognized standards of professional and personal ethics and conduct; and

(m.) Have coverage arrangements with other members of the Medical Staff for those times when the individual will be unavailable; and

(n.) Have successfully completed a residency training program approved by the Accreditation Council for Graduate Medical Education ("ACGME") or the American Osteopathic Association ("AOA") in the specialty in which the

applicant seeks clinical privileges, or an oral and maxillofacial surgery training program accredited by the Commission on Dental Accreditation of the American Dental Association ("ADA"), or a podiatric surgical residency program accredited by the Council on Podiatric Medical Education of the American Podiatric Medical Association, (This requirement is applicable only to those individuals who apply for initial staff appointment on or after July 1, 2021); and

(o.) Demonstrate recent clinical activity in their primary area of practice during at least two (2) of the last four (4) years or engaged in medical education related activities (i.e., residency, fellowship); and

(p.) Demonstrate current clinical privileges are not currently suspended at any other Hospital; and

(q.) Is not applying for privileges in a service which is currently under a moratorium, unless they are either directly employed by Hospital or employed or contracted through a group which has a contract to provide the clinical services to the Hospital; and

(r.) Be qualified for membership on the Medical Staff and demonstrate their willingness to participate in the discharge of Medical Staff obligations and responsibilities; and

(s.) When the Medical Executive Committee or Board of Directors has reason to question the physical and/or mental health status of an applicant, the applicant shall be required to submit to an evaluation of his/her physical and/or mental health status by a physician or physicians acceptable to the Medical Executive Committee or Board of Directors, as a prerequisite to further consideration of his/her application for appointment or reappointment, to the exercise of previously granted privileges, or to maintenance of his/her Staff appointment.

2.A.3. Threshold Eligibility Criteria –Advanced Practice Providers

The Advanced Practice Providers shall consist of any individual, other than a licensed physician, podiatrist, dentist, or oral surgeon, who are granted privileges to practice at the Hospital and are directly involved in patient care. Such individuals may be employed by physicians on the Medical Staff, but whether or not so employed, must be under the supervision and direction of a Medical Staff physician who maintains clinical privileges

at the Hospital to perform procedures in the same specialty area the Advanced Practice Provider is practicing in (with the exception of CRNAs, who may be supervised by an anesthesiologist or other physician deemed competent to supervise the administration of anesthesia as defined in the Medical Staff Rules and Regulations).

To be eligible to apply for initial appointment or reappointment as an Advanced Practice Provider, the applicant must:

(a.) Have a current, unrestricted license to practice in this state that is not subject to any restrictions, probationary terms, or conditions not generally applicable to all licenses, and have never had a license to practice revoked, restricted, or suspended by any state licensing agency; and,

(b.) Document their experience, background, training, demonstrated ability, and physical and mental health status with sufficient adequacy to demonstrate to the Medical Staff and the Board of Directors they will provide care to patients at the generally recognized professional level of quality, in an efficient manner, considering patients' needs and the available Hospital facilities and resources, consistent with the utilization standards in effect at the Hospital; and

(c.) As determined based on documented references, adhere strictly to the ethics of their respective professions, to work cooperatively with others, and to be willing to participate in the discharge of Advance Practice Provider responsibilities; and

(d.) Maintain professional liability insurance coverage in form and in amounts satisfactory to the Hospital, with additional tail insurance coverage to cover any future claims arising from the individual's practice at the Hospital after termination of the policy; and

(e.) Unless granted an exception by the Medical Executive Committee, have a current unrestricted DEA registration; and

(f.) Be located (office and residence) within the geographic services area of the Hospital, as defined by the Board of Directors, close enough to fulfill their responsibilities, and to provide timely and continuous care for their patients in Hospital; and

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

(h.) Have never been, and are not currently, excluded from participation in Medicare, Medicaid, or any other federal or state governmental health care program; and

(i.) Have never had an Advance Practice Provider appointment, clinical privileges, or status as a participating provider denied, revoked, or terminated by any health care facility or health plan for reasons related to clinical competence or professional conduct, and have never resigned appointment or relinquished privileges during an Advanced Practice Provider investigation or in exchange for not conducting such an investigation; and

(j.) Have never been convicted of, or entered a plea of guilty or no contest, to any felony, or to any misdemeanor relating to controlled substances, illegal drugs, insurance or health care fraud or abuse, or related to the Advanced Practice Provider's suitability to practice medicine; and

(k.) Demonstrate willingness and capability to abide by all applicable Medical Staff and Hospital Bylaws, Rules and Regulations, policies, and procedures, including but not limited to adherence to generally recognized standards of professional and personal ethics and conduct; and

(l.) Have successfully completed a training program approved by the State to meet licensure requirements; and

(m.) Demonstrate recent clinical activity in their primary area of practice during the last three (3) years, or meet the requirements that the designated lead Department Chairperson, or designee, stipulate to assess competence; and

(n.) Demonstrate current clinical privileges are not currently suspended at any other Hospital; and

(o.) Is not applying for privileges in a service which is currently under a moratorium, unless they are either directly employed by Hospital or employed or contracted through a group which has a contract to provide the clinical services to the Hospital; and

(p.) Be qualified as an Advance Practice Provider and demonstrate their willingness to participate in the discharge of obligations and responsibilities; and

(q.) When the Medical Executive Committee or Board of Directors has reason to question the physical and/or mental health status of an applicant, the applicant shall be required to submit to an evaluation of his/her physical and/or mental health status by a physician or physicians acceptable to the Medical Executive

Committee or Board of Directors, as a prerequisite to further consideration of his/her application for appointment or reappointment, to the exercise of previously granted privileges, or to maintenance of his/her staff appointment; and

(r.) Be certified by their respective national certifying agency; and

(s.) As required by professional practice, have a written or collaborative agreement in which their primary supervising physician is a member of the Medical Staff at the Hospital of appointment to provide the requisite supervision. The agreement must meet all applicable requirements of applicable law and Hospital policy.

2.A.4. Specialty Status

(a.) Except as expressly set forth in Section 2.A.4.c. below, obtaining and maintaining specialty board certification is required for all Medical Staff . However, physicians and dentists who have recently completed their residency training may become members of the Medical Staff if they have satisfied all of the requirements to sit for the certifying exam as defined by their specialty board and thereafter obtain certification within the earlier of (i) the time frame mandated by the American Board of Medical Specialties "ABMS", AOA, or ADA or (ii) within 5 years of the completion of residency training. If a physician or dentist fails to obtain board certification in the required time frame, such physician or dentist will be ineligible for Medical Staff privileges, and physicians and dentists who are members of the Medical Staff will be deemed to have voluntarily relinquished his or her privileges effective as of the expiration of the time frame stated in this subsection.

Except as expressly set forth in Section 2.A.4.a. below, all Medical Staff are required to maintain board certification in accordance with the requirements of ABMS, AOA, or ADA. If a physician or dentist fails to maintain his or her specialty board certification, such physician or dentist will be deemed to have voluntarily relinquished his or her privileges on the day of expiration of certification.

(b.) The Board of Directors may grant waivers of the requirements in (a) above after recommendations for granting such a waiver have been made by the relevant

Department Chief and the Medical Executive Committee. When granting a waiver, the Board of Directors shall document the circumstances and conditions of the Waiver. A decision by the Board of Directors not to grant a waiver shall not create a basis for the rights to a hearing or appellate review provided in the Bylaws, including those provided in Articles 11 and 12.

(c.) The requirements of the above paragraph do not apply to any Medical Staff or Advanced Practice Provider who was granted privileges on or before July 1, 2021, and has remained a member of the Medical Staff or credentialed as an Advanced Practice Provider continuously since such date.

2.A.5 Waiver of Criteria

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

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

(c.) The individual Hospital Medical Executive Committees will review the recommendation of the Credentials Committee and make recommendations to their respective Boards regarding whether to grant or deny the request for a waiver. Any recommendation to grant a waiver must include the basis for such.

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

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

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

(g.) Any member of a Hospital's Medical Staff or any Advanced Practice Provider that has been granted a waiver of threshold eligibility criteria prior to the adoption of this Credentials Policy, shall have the waiver grandfathered and shall maintain their Medical Staff or Advanced Practice Provider membership under the present credentialing criteria and guidelines by the Hospital for which the waiver was granted.

(h.) The grandfathering clause does not automatically apply to other Hospitals for which a request for waiver of threshold eligibility has not already been reviewed or approved by that Hospital's Board of Directors. A provider with an approved waiver at one Hospital that wishes to apply for Medical Staff or Advanced Practice Provider membership at an additional Hospital must request an additional waiver of threshold eligibility criteria for the new Hospital. At that time, the new Hospital's Medical Executive Committee will consider the specific qualifications of the individual in question, input from the relevant Department Chief, and the best interests of the Hospital and the communities it serves. The Medical Executive Committee's recommendation will be forwarded to the Hospital-specific Board of Directors. Any recommendation to grant a waiver must include the basis for such.

2.A.6 Factors for Evaluation:

Only those individuals who can document that they are highly qualified in all regards will be appointed to the Medical Staff or as an Advanced Practice Provider. The following factors will be evaluated as part of the appointment and reappointment processes (if applicable based on staff type):

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

(b.) Board eligible or board certified in their primary area of practice at the Hospital,

(c.) Adherence to the ethics of their profession, continuous professional development, an understanding of and sensitivity to diversity, and responsible attitude towards patients and their profession,

(d.) Good reputation and character,

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

(f.) Ability to safely and competently perform the clinical privileges requested; and

(g.) Recognition of the importance of, and willingness to support, Hospital's commitment to quality care and a recognition that interpersonal skills, good citizenship, and collegiality are essential to the provision of quality patient care,

2.A.7 No Entitlement to Appointment:

No individual is entitled to receive an application or to be appointed or reappointed to the Medical Staff or as an Advanced Practice Provider or to be granted particular clinical privileges merely because he or she:

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

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

(c.) is certified by any particular specialty or professional board;

(d.) has had in the past, or currently has, appointment or privileges at any hospital or health care facility;

(e.) resides in the geographic service area of the Hospital; or

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

2.A.8 Nondiscrimination:

Medical Staff clinical privileges or Advanced Practice Provider clinical privileges shall not be denied on the basis of any criterion unrelated to the efficient delivery of patient care at the generally recognized professional level of quality in the Hospital, including, but not limited to, gender, race, creed, color and national origin.

2.B GENERAL CONDITIONS OF APPOINTMENT AND REAPPOINTMENT

2.B.1. Basic Responsibilities and Requirements:

As a condition of consideration for appointment or reappointment, and as a condition of continued appointment, every member of the Medical Staff and Advanced Practice Provider specifically agrees to the following:

(a.) To provide continuous and timely care to all patients for whom the individual has responsibility at the generally recognized professional level of quality and efficiency;

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

(c.) To accept and discharge committee assignments, emergency service call obligations, care of unassigned patients, consultation requests, participation in quality and performance improvement and peer review activities, and such other reasonable duties and responsibilities as assigned and consistent with his/her granted clinical privileges;

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

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

(f.) To inform the CAO and the Chief of Staff of any change in the practitioner's status or any change in the information provided on the individual's application form. This information will be provided with or without request, at the time the change occurs, and will include, but not be limited to, changes in licensure status or professional liability insurance coverage, the filing of a professional liability lawsuit against the practitioner, changes in the practitioner's status at any other hospital, exclusion or preclusion from participation in Medicare or any sanctions imposed, and any changes in the individual's ability to safely and competently exercise clinical privileges or perform the duties and responsibilities of appointment because of health status issues, including impairment due to addiction, and any charge of, or arrest for, driving under the influence ("DUI");

(g.) To immediately submit to a blood and/or urine test, any pertinent type of health evaluation, or to a complete physical and/or mental evaluation, as requested by an Officer of the Medical Staff, Chief Medical Officer, Clinical Affairs Medical Director, CAO, or Department Chief when it appears necessary to protect the well-being of patients and/or staff, when there is concern with the individual's

ability to safely and competently care for patients, or when requested by the MEC or Credentials Committee as part of an evaluation of the member of the Medical Staff or Advanced Practice Provider's ability to exercise privileges safely and competently, or as part of a post-treatment monitoring plan consistent with the Medical Staff and Hospital policies addressing practitioner health or impairment. The health care professional(s) to perform the testing and/or evaluations will be determined by the Medical Staff Leadership;

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

(i.) To use the Hospital sufficiently to allow continuing assessment of current competence;

(j.) To refrain from illegal fee splitting or other illegal inducements relating to patient referrals;

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

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

(m.) To seek consultation whenever necessary;

(n.) To complete in a timely manner all medical and other required records. Evidence of a medical history and physical examination completed and documented no more than thirty (30) days before or twenty (24) hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. The medical history and physical examination must be placed in the patient's medical record within 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. Details of requirements for completing a history and physical for inpatient and outpatient settings are found in the Rules and Regulations and Hospital policies;

(o.) To maintain confidentiality of peer review and protected health information in accordance with law, Hospital policies and the Hospital's Notice of Privacy Practices with respect to health care delivered in the Hospital;

(p.) To provide services to meet individual needs of patients seeking services in the Hospital regardless of their ability to pay, in accordance with Hospital and Medical Staff policies;

(q.) To perform all services and conduct himself/herself at all times in a cooperative and professional manner;

(r.) To promptly pay any applicable assessments and/or fines;

(s.) To satisfy continuing medical education requirements; and

(t.) That any misstatement in, or omission from the application, is grounds for the Hospital to stop processing the application. If appointment has been granted prior to the discovery of a misstatement or omission, appointment and privileges may be deemed to be automatically relinquished. In either situation, there will be no entitlement to a hearing or appeal. The individual will be informed in writing of the nature of the misstatement or omission and permitted to provide a written response. The Credentials Committee will review the individual's response and provide a recommendation to the Medical Executive Committee. The Medical Executive Committee will recommend to the Board whether the application should be processed further.

(u.) To authorize representatives of the Medical Staff and the Hospital to solicit, provide and act upon information bearing on his/her professional ability and other qualifications.

(v.) To be bound by the provisions of this Article and to waive all legal claims against any Hospital or Health System representative who acts in accordance with the provisions of this Article.

(w.) To acknowledge the provisions of this Article are express conditions to the application for, or acceptance of, Medical Staff or Advanced Practice Provider membership, or his/her exercise of clinical privileges at the Hospital.

(x.) Each Medical Staff member or Advanced Practice Provider must participate in any type of competency evaluation when determined necessary by the MEC and/or Board in order to properly delineate the member's clinical privileges.

(y.) Prior to admittance as a Medical Staff member or Advanced Practice Provider, and regularly thereafter as required, each Medical Staff or Advanced Practice Provider Leader shall promptly disclose to the Hospital Compliance Department any conflicts of interest with the Medical Staff, Advanced Practice Provider, the Hospital, and Health System.

2.B.2. Burden of Providing Information:

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

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

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

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

2.B.3. Provisional Period

(a.) All initial appointments to the Medical Staff or as an Advanced Practice Provider, regardless of staff category, and changes to staff category or granting of additional privileges shall be provisional and subject to focused professional practice evaluation. Each provisional appointee shall be assigned to a department where his/her performance shall be observed on an ongoing basis by the Department Chief and/or by a physician(s) designated by the Credentials Committee to determine the applicant's eligibility for the regular Medical Staff category to which he/she was provisionally appointed and for exercising the clinical privileges provisionally granted. While on provisional status an appointee shall not be eligible to vote or hold office. This shall be a twelve (12) month period, or as recommended by the Credentials Committee. The number and types of cases to be reviewed shall be determined by the Credentials Committee. A provisional period may be waived at the discretion of the Credentials Committee if the appointee has

already successfully completed a provisional period for the privileges requested at another system Hospital. A Focused Professional Practice Evaluation ("FPPE") may still be performed on the privileges requested.

(b.) In the event of a change in contract provider for any Hospital based department and the Department Chief is hereby initially appointed to the Medical Staff, such Department Chief shall have the right to vote.

(c.) During the provisional period the appointee will meet all the Rules and Regulations of the Medical Staff prior to his/her elevation to full status.

(d.) During the period of provisional status, an evaluation of the performance of each provisional Medical Staff Member or Advanced Practice Provider will be carried out by or under the direction of the Chief of the Department in which the individual has clinical privileges and/or by a physician designated by the Credentials Committee in accordance with established department criteria and/or policy.

(1.) Each provisional Medical Staff member or Advanced Practice Provider shall participate in an appropriate number of cases as determined by the Department Chief, cooperate in monitoring, and review conditions, and otherwise fulfill all requirements of appointment including but not limited to the timely completion of medical records and/or emergency service call responsibilities if applicable. Any provisional Medical Staff member or Advanced Practice Provider whose membership is terminated or who otherwise does not advance due to failure to meet such conditions shall be ineligible to reapply for initial appointment or privileges for a period of three (3) years.

(2.) If a Medical Staff member or Advanced Practice Provider who has been granted additional clinical privileges fails, during the provisional period, to participate in an appropriate number of cases or cooperate with the monitoring and review conditions, the additional clinical privileges shall be automatically relinquished at the end of the provisional period, unless an extension is granted. The individual may not reapply for the privileges in question for three (3) years.

(e.) At the end of this time, if the appointee fails within such period to fulfill the requirements for advancement from provisional status, his/her membership, or

particular clinical privileges, as applicable, shall automatically terminate, unless extended. If the practitioner is deemed to have insufficient experience to advance to full status, the period of provisional status may be extended if recommended by the Department Chief, and/or designated preceptor and ultimately accepted and approved by the Credentials Committee. The appointee whose provisional status is automatically terminated shall be given notice of such termination and shall be entitled to the procedural rights afforded in Article 12 of the Bylaws. When, based on the evaluation performed during the provisional period, clinical privileges are terminated, revoked, or restricted for reasons related to clinical competence or professional conduct, the individual shall be entitled to the procedural rights afforded in Article 12 of the Bylaws.

2.C. APPLICATION

2.C.1. Information:

(a.) Applications for appointment and reappointment will contain a request for specific clinical privileges and will require detailed information concerning the individual's professional qualifications.

(b.) In addition to other information, the applications will seek the following:

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

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

(3.) information concerning the applicant's professional liability litigation experience, including past and pending claims, final judgments, or settlements; the substance of the allegations as well as the findings and the ultimate disposition; and any additional information concerning such

proceedings or actions as the Credentials Committee, the Hospital Medical Executive Committee, or the Hospital Board may request; and

(4.) current information regarding the applicant's ability to safely and competently exercise the clinical privileges requested; and

(5.) a copy of a government-issued photo identification.

(c.) The applicant will sign the application and certify that he or she is able to perform the privileges requested and the responsibilities of appointment.

2.C.2. Misstatements and Omissions:

(a.) Any misstatement in, or omission from, the application is grounds to stop processing the application. The applicant will be informed in writing of the nature of the misstatement or omission and permitted to provide a written response. The Chair of the Credentials Committee and Chief Medical Officer will review the response and determine whether the application should be processed further.

(b.) If appointment has been granted prior to the discovery of a misstatement or omission, appointment and privileges may be deemed automatically relinquished pursuant to Section 2.B.2, Burden of Providing Information, in this part of this policy.

(c.) In the event that credentialing information obtained from primary source varies substantially from that provided by a practitioner, the practitioner will have the opportunity to correct information in the application which is inconsistent with information received via primary sources during the credentialing and recredentialing process. The Credentials Verification Office will inform the practitioner in writing of the discrepancy and will supply a copy of the application submitted, outlining the inconsistency. The written notice to the practitioner will not include copies from the National Practitioner Data Bank or protected peer review information. The practitioner has the right to clarify erroneous information received from the verification sources directly with the verifying source. The practitioner shall respond in writing regarding any conflicting information on the application and return a formal response to the Credentials Verification Office within thirty (30) days. The Credentials Verification Office will re-verify and review the information until the discrepancy is resolved. If the discrepancy is not resolved within thirty

(30) days, the application may be deemed incomplete and be administratively withdrawn.

(d.) No action taken pursuant to this section will entitle an applicant or any member of the Medical Staff or Advanced Practice Provider to a hearing or appeal.

2.C.3. Grant of Immunity and Authorization to Obtain/Release Information:

By requesting an application and/or applying for appointment, reappointment, or clinical privileges, the individual expressly accepts the following conditions:

(a.) whether or not appointment or clinical privileges are granted;

(b.) throughout the term of any appointment or reappointment period and thereafter;

(c.) should appointment, reappointment, or clinical privileges be revoked, reduced, restricted, suspended, and/or otherwise affected as part of the Hospital's professional review activities; and

(d.) as applicable to any third-party inquiries received after the individual leaves about his/her tenure at the Hospital.

(1.) Immunity:

To the fullest extent permitted by law, the individual releases from any and all liability, extends absolute immunity to, and agrees not to sue the Hospital, any member of the Medical Staff or Advanced Practice Provider, their authorized representatives, and third parties who provide information for any matter relating to appointment, reappointment, clinical privileges, or the individual's qualifications for the same. This immunity covers any actions, recommendations, reports, statements, communications, and/or disclosures involving the individual, that are made, taken, or received by the Hospital, its authorized agents, or third parties, in the course of credentialing and peer review activities.

(2.) Authorization to Obtain Information from Third Parties:

The individual specifically authorizes the Hospital, Medical Staff Leaders, and their authorized representatives (1) to consult with any third party who may have information bearing on the individual's professional qualifications, credentials, clinical competence, character, ability to perform safely and competently, ethics, behavior, or any other matter reasonably

having a bearing on his or her qualifications for initial and continued appointment to the Medical Staff or as an Advanced Practice Provider, and (2) to obtain any and all communications, reports, records, statements, documents, recommendations, or disclosures of third parties that may be relevant to such questions. The individual also specifically authorizes third parties to release this information to the Hospital and its authorized representatives upon request. The individual also agrees to sign any necessary authorizations to permit a consumer reporting agency to conduct a criminal background check on the individual and report the results to the Hospital.

(3.) Authorization to Release Information to Third Parties:

The individual also authorizes Hospital representatives to release information to other hospitals, health care facilities, managed care organizations, government regulatory and licensure boards or agencies, and their agents when information is requested in order to evaluate his or her professional qualifications for appointment, privileges, and/or participation at the requesting organization/facility, and any licensure or regulatory matter.

(4.) Hearing and Appeal Procedures:

The individual agrees that the hearing and appeal procedures set forth in the Medical Staff Bylaws will be the sole and exclusive remedy with respect to any professional review action taken by the Hospital.

(5.) Legal Actions:

If, notwithstanding the provisions in this Section, an individual institutes legal action challenging any credentialing, privileging, peer review, or other professional review action or any activity affecting appointment or privileges or ability to utilize the Hospital's facilities to provide patient care services, and does not prevail, he or she will reimburse the Hospital and any member of the Medical Staff, Advanced Practice Provider, or Board named

in the action for all costs incurred in defending such legal action, including reasonable attorney's fees and lost revenues.

ARTICLE 3
PROCEDURE FOR INITIAL APPOINTMENT

3.A. PROCEDURE FOR INITIAL APPOINTMENT

3.A.1. Application:

(a.) Applications for appointment will be in writing and will be on forms approved by the Hospital Board, upon recommendation by the Hospital Medical Executive Committee and Credentials Committee.

(b.) An individual seeking initial appointment will be sent a letter that outlines the threshold eligibility criteria for appointment and the applicable criteria for clinical privileges, and the application form.

(c.) Applications may be provided to residents who are in the final year of their training. Final action will not be taken until all applicable threshold eligibility criteria are satisfied.

3.A.2. Steps to be Followed for All Initial Applicants:

(a.) Evidence of the applicant's character, professional competence, qualifications, behavior, and ethical standing will be examined. This information may be contained in the application, and obtained from references and other available sources, including the applicant's past or current Department Chiefs at other health care entities, residency training director, and others who may have knowledge about the applicant's education, training, experience, and ability to work with others.

(b.) An interview with the applicant may be conducted. The purpose of the interview is to discuss and review any aspect of the applicant's application, qualifications, and requested clinical privileges. This interview may be conducted by any one or a combination of the following: the Department Chief, the Credentials Committee, a Credentials Committee representative, the Hospital Medical Executive Committee, the Chief of Staff. An interview is not required for Locums Tenens or Telemedicine providers.

3.A.3. Credentials Verification Office (CVO) Process:

(a.) The application and other documents will be reviewed by the Credentials Verification Office to ensure that all requested information has been provided and all requested documents have been furnished. A letter will be sent, within twenty (21) days of submission by the provider, requesting that any missing information be supplied by the applicant. In the event, the applicant fails to provide the missing information within thirty (30) days of the request from the Credentials Verification Service Department, the application will be considered incomplete, and the application will be deemed to be withdrawn.

(b.) An applicant may request the status of his or her application at any time, which is stated in the cover letter provided with the application.

(c.) After receipt of a completed application, the Credentials Verification Office will verify all submitted information provided by the applicant. This includes, but is not limited to, primary source verification of education, training, licensure, certification, work history, ten years of malpractice claims history, prior and current hospital affiliations, no less than three professional references within the same discipline, and the National Practitioner Data Bank.

(d.) Any malpractice cases (open or closed) will be reviewed by legal counsel and transmitted to the appropriate Department Chief, or designee, Chair of the Credentials Committee, or other System leadership, if appropriate.

(e.) During the verification process and ongoing per regulatory requirements, all applicants are screened to verify that they are not listed on the Health and Human Services/Office of Inspector General List of Excluded Individuals and Entities and the Centers for Medicare and Medicaid Services Opt-Out file. An appropriate response will be prepared if there is a match.

(f.) The Credentials Verification Office will undertake to contact members of the Medical Staff and any Advanced Practice Provider of other hospitals at which the applicant has been associated, as well as other persons, who may have information relative to the applicant's competence to exercise the clinical privileges requested and the applicant's moral and ethical qualifications.

(g.) An application will be considered complete when all requested information has been provided by the applicant

(h.) This System does not use any offshore resources to complete credentialing or recredentialing activities.

(i.) This System does not typically delegate credentialing and re-credentialing activities to an outside agency. If the System enters into a contractual service in which credentialing and re-credentialing activities are outsourced to an outside agency, the outside agency will:

(1.) At time of initial entry into contract, supply a roster of all providers, including but not limited to provider name, West Virginia license number, DEA number, and delineation of privileges.

(2.) Supply an annual roster and undergo an annual audit to ensure that these policies and procedures are followed.

(3.) Supply monthly updates regarding providers initial appointment, reappointment, change in privileges, resignation, and other elements deemed appropriate by the Credentials Committee.

(4.) Provide access to the providers full credentials file upon request.

3.A.4. Department Chief Procedure:

(a) The Credentials Verification Office will transmit the complete application and all supporting materials to the Department Chief of each department in which the applicant seeks clinical privileges. Each chief will provide written approval regarding whether the applicant has satisfied all of the qualifications for appointment and the clinical privileges requested.

(b) The Department Chief will be available to the Credentials Committee, Hospital Medical Executive Committee, and the Hospital Board to answer any questions that may be raised with respect to that Chief's report and findings.

3.A.5. Credentials Committee Process:

(a.) The Credentials Committee will include Medical Staff members and Advanced Practice Providers from each Hospital and include representation from a majority of sections/departments.

(b.) The application and attestation may not be greater than one hundred eighty (180) days old at the time the Credentials Committee makes its recommendation.

(c.) The Credentials Committee will consider the report prepared by the Department Chief or Section Chief, when applicable, and will make a recommendation.

(d.) The Credentials Committee may use the expertise of the Department Chief(s) or designee(s), or any Medical Staff or Advanced Practice Provider of the department, or an outside consultant, if additional information is required regarding the applicant's qualifications.

(e.) The Credentials Committee may, at its discretion, invite the candidate to meet with the Credentials Committee for a personal interview.

(f.) Any applicant who is requested to appear for an interview and who fails to appear at the agreed time and place will be deemed to have withdrawn his or her application. No further action will be taken on the application unless the applicant so requests, within ten (10) days of the missed interview, in which event another interview date will be established. Failure to attend the rescheduled interview will be regarded as final withdrawal of the application, and the application will not be processed.

(g.) The Credentials Committee may recommend the imposition of specific conditions related to behavior, health, or clinical issues. The Credentials Committee may also recommend that appointment and/or privileges be granted for a period of less than three (3) years in order to permit closer monitoring of the applicant's compliance with any conditions.

(h.) If the recommendation of the Credentials Committee is delayed longer than sixty (60) days, the Chair of the Credentials Committee will send a letter to the applicant, with a copy to the Hospital–specific Chief Administrative Officer, explaining the reasons for the delay.

(i.) After determining that an applicant is otherwise qualified for appointment and/or privileges, the Credentials Committee may review information pertaining to the applicant's health status to determine if there is any question about the applicant's ability to perform the privileges requested and the responsibilities of appointment. If so, the Credentials Committee may require a physical or mental examination by a physician(s) satisfactory to the Credentials Committee. The results of this examination will be made available to the Credentials Committee. Failure to undergo an examination within a reasonable time after a written request from the

Credentials Committee will be considered a voluntary withdrawal of the application.

(j.) If the recommendation of the Medical Executive Committee is to appoint, the recommendation will be forwarded to the Board through the CAO.

(k.) If the recommendation of the Medical Executive Committee would entitle the applicant to request a hearing, the Medical Executive Committee will forward its recommendation to the CAO, who will promptly send special notice to the applicant. The CAO will then hold the application until after the applicant has completed or waived a hearing and appeal.

3.A.6. Medical Executive Committee Recommendation:

(a.) At its next regular meeting after receipt of the written findings and recommendation of the Credentials Committee, the Medical Executive Committee will: adopt the findings and recommendation of the Credentials Committee, as its own; or

(b.) Credentials Committee will be considered a voluntary withdrawal of the application.

(l.) If the recommendation of the Medical Executive Committee is to appoint, the recommendation will be forwarded to the Board through the CAO.

(m.) If the recommendation of the Medical Executive Committee would entitle the applicant to request a hearing, the Medical Executive Committee will forward its recommendation to the CAO, who will promptly send special notice to the applicant. The CAO will then hold the application until after the applicant has completed or waived a hearing and appeal.

3.A.7. Board Action:

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

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

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

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

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

(k.) Upon receipt of a recommendation of the Medical Executive Committee or a decision of the Board Committee, the Board may:

(1.) appoint the applicant and grant clinical privileges or ratify the appointment and clinical privileges granted by the Board Committee, as appropriate; or

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

(3.) reject or modify the recommendation.

(e.) If the Board disagrees with a favorable recommendation of the Medical Executive Committee, before rejecting or modifying that recommendation, it should first discuss the matter with the Chair of the Credentials Committee and the Chair of the Medical Executive Committee. If the Board's determination remains unfavorable to the applicant, the CAO will promptly send special notice to the applicant that the applicant is entitled to request a hearing.

(f.) Any final decision by the Board to grant, deny, revise or revoke appointment and/or clinical privileges is disseminated to appropriate individuals and as required, reported to appropriate entities.

3.A.8. Time Periods for Processing:

Once an application is deemed complete, it is expected to be processed within one hundred twenty (120) days, unless it becomes incomplete. This time period is intended to be a guideline

only and will not create any right for the applicant to have the application processed within this precise time period.

ARTICLE 4

CLINICAL PRIVILEGES

4.A. CLINICAL PRIVILEGES

4.A.1. General:

(a.) Appointment or reappointment will not confer any clinical privileges or right to practice at the Hospital.

(b.) Each individual who has been appointed to the Medical Staff or as an Advanced Practice Provider is entitled to exercise only those clinical privileges specifically granted by the Board.

(c.) The granting of clinical privileges may include responsibility for emergency service call established to fulfill the Hospital's responsibilities under the Emergency Medical Treatment and Active Labor Act and/or other applicable requirements or standards.

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

(e.) Requests for clinical privileges that are subject to a preferential contract will not be processed except as consistent with applicable contracts.

(f.) The clinical privileges recommended to the Board will be based upon consideration of the following:

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

(2.) appropriateness of utilization patterns; and

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

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

(5.) availability of qualified Medical Staff or Advanced Practice Providers to provide coverage in case of the applicant's illness, or unavailability; and

(6.) adequate professional liability insurance coverage for the clinical privileges requested; and

(7.) the Hospital's available resources and personnel;

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

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

(10.) practitioner-specific data as compared to aggregate data, when available; and

(11.) morbidity and mortality data, when available; and

(12.) professional liability actions, especially any such actions that reflect an unusual pattern or excessive number of actions.

(g.) The applicant has the burden of establishing qualifications and current competence for all clinical privileges requested.

(h.) The applicant must provide proof of compliance with health testing requirements (e.g., tuberculosis testing) or submit to testing from Employee Health.

(i.) The report of the Department Chief in which privileges are sought will be forwarded to the Chair of the Credentials Committee and processed as a part of the initial application for staff appointment.

(j.) During the term of appointment, a Medical Staff member or Advanced Practice Provider may request increased privileges by applying in writing. The request will state the specific additional clinical privileges requested and information sufficient to establish eligibility, as specified in applicable criteria. If the individual is eligible and the application is complete, it will be processed in the same manner as an application for initial clinical privileges.

(k.) Requests for clinical privileges that are subject to an exclusive contract will not be processed except as consistent with the applicable contract.

4.A.2. Activation of Privileges at Additional Mon Health Facility

(a.) If a Medical Staff member or Advanced Practice Provider would like to exercise clinical privileges at a facility where he or she has not previously practiced, the Medical Staff member or Advanced Practice Provider must request an application from the Medical Staff Office. The application will be processed following the process previously described in this policy, excluding peer reference requirements.

(b.) Medical Staff or Advanced Practice Providers requiring a waiver of threshold eligibility criteria for their initial appointment as subject to the Section 2.A.5.(g.) of this policy which states a provider with an approved waiver at one Hospital must request an additional waiver of threshold eligibility criteria for the new hospital.

(c.) Applications for activation of privileges at an additional Hospital must be approved in writing by the new hospital's Department Chief, Chief of Staff and the Chairperson of the Credentials Committee.

(d.) The Credentials Committee must be notified for informational purposes of this activation of privileges.

4.A.3 Clinical Privileges for New Procedures:

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

(b.) The Credentials Committee will make a preliminary recommendation as to whether the new procedure should be offered to the community. Factors to be considered by the Credentials Committee include, but are not limited to, whether there is empirical evidence of improved patient outcomes and/or other clinical benefits to patients, whether the new procedure is being

performed at other similar hospitals and the experiences of those institutions, and whether the Hospital has the resources, including space, equipment, personnel, and other support services, to perform the new procedure safely and effectively.

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

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

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

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

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

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

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

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

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

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

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

4.A.5. Clinical Privileges at Age 75:

(a.) Individuals who desire to exercise clinical privileges at the age of 75 or older must apply for reappointment on a yearly basis.

(b.) As part of the annual reappointment process, these Medical Staff or Advanced Practice Providers will be required to have a physical and mental health assessment performed by a physician who is acceptable to the Credentials Committee. The examining physician shall provide a written report, addressing whether the individual has any physical or mental condition that may affect his/her ability to safely and competently exercise the clinical privileges requested, discharge the responsibilities of Medical Staff or Advanced Practice Provider duties and responsibilities, or work cooperatively in a Hospital setting. The examining physician shall provide this report directly to the Committee and shall be available to discuss any questions or concerns that the Committee may have.

(c.) If the Credentials Committee determines that there are issues in any of these areas and/or other concern areas, the Credentials Committee will determine what next steps are to be taken to address the concerns raised. The Credentials Committee may meet with the individual to discuss these concerns and to try to determine what collegial and voluntary steps, such as a voluntary restructuring of privileges, further monitoring, or focused review (as examples only), can be taken.

4.A.6. Clinical Privileges for Dentists and Oral and Maxillofacial Surgeons:

(a.) The scope and extent of surgical procedures that a dentist or an oral and maxillofacial surgeon may perform in the Hospital will be delineated and recommended in the same manner as other clinical privileges.

(b.) Surgical procedures performed by dentists or oral and maxillofacial surgeons will be under the overall supervision of the Chief of Surgery. A medical history and physical examination of the patient will be made and recorded by a physician who is a Medical Staff member of the Medical Staff before dental surgery will be performed (with the exception of (c) below), and a designated physician will be responsible for the medical care of the patient throughout the period of hospitalization.

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

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

4.A.7. Clinical Privileges for Podiatrists:

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

(b.) Surgical procedures performed by podiatrists will be under the overall supervision of the Chief of Surgery. A medical history and physical examination of each patient will be made and recorded by a physician who

is a member of the Medical Staff before podiatric surgery will be performed, and a designated physician will be responsible for the medical care of the patient throughout the period of hospitalization.

(c.) The podiatrist will be responsible for the podiatric care of the patient, including the podiatric history and the podiatric physical examination, as well as all appropriate elements of the patient's record. Podiatrists may write orders which are within the scope of their license and consistent with the Medical Staff Rules and Regulations and in compliance with the Hospital and Medical Staff Bylaws, including this Credentials Policy.

4.A.8. Telemedicine Privileges:

(a.) Telemedicine is the provision of clinical services to patients by practitioners from a distance via electronic communications.

(b.) A qualified individual may be granted telemedicine privileges but need not be appointed to the Medical Staff or as an Advanced Practice Provider.

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

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

(2.) If the individual requesting telemedicine privileges is practicing at a distant hospital that participates in Medicare or a telemedicine entity (as that term is defined by Medicare), and the hospital or telemedicine entity is accredited by The Joint Commission or DNV-GL, a request for telemedicine privileges may be processed using an alternative process that relies on the credentialing and privileging decisions made by the distant hospital or telemedicine entity. In such cases, the Hospital must ensure, through a written agreement

that the distant hospital or telemedicine entity complies with all applicable Medicare regulations and accreditation standards. The distant hospital or telemedicine entity must provide:

i. Confirmation that the practitioner is licensed in West Virginia;
ii. A current list of the privileges granted to the practitioner
iii. Information indicating that the applicant has actively exercised the relevant privileges during the previous twelve (12) months and has done so in a competent manner;
iv. A signed attestation that the applicant satisfies all of the distant hospital or telemedicine entity's qualifications for the clinical privileges granted;
v. A signed attestation that all information provided by the distant hospital or telemedicine entity is complete, accurate, and up to date; and
vi. Any other attestations or information required by the agreement or requested by the Hospital.

(3.) This information received about the individual requesting telemedicine privileges will be provided to the Credentials Committee for review and recommendation and the Hospital–specific Medical Executive Committees for review and recommendation and to the Board for final action.

(d.) Notwithstanding the process set forth in this subsection, the Hospital may determine that an applicant for telemedicine privileges is ineligible for appointment or clinical privileges if the applicant fails to satisfy the threshold eligibility criteria set forth in this Policy.

(e.) Telemedicine privileges, if granted, will be for a period of not more than three (3) years.

(f.) Individuals granted telemedicine privileges will be subject to the Hospital's peer review activities. The results of the peer review activities, including any adverse events and complaints filed about the practitioner providing telemedicine services from patients, other practitioners or staff, will be shared with the hospital or entity providing telemedicine services.

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

4.A.9. Physicians in Training:

Physicians in training will not hold appointments to the Medical Staff and will not be granted specific privileges. The program director, clinical faculty, and/or attending Medical Staff member will be responsible for the direction and supervision of the on-site and/or day-to-day patient care activities of each trainee, who will be permitted to perform only those clinical functions set out in curriculum requirements, affiliation agreements, and/or training protocols. The applicable program director will be responsible for verifying and evaluating the qualifications of each physician in training.

4.A.10. Voluntary Relinquishment of Privileges:

(a.) A Medical Staff member or Advanced Practice Provider may request voluntary relinquishment of clinical privileges by submitting a written request to the Department Chief specifying the clinical privilege(s) to be relinquished and the reasons for the request. The Department Chief will make a recommendation to the Medical Executive Committee.

(b.) The Medical Executive Committee will evaluate whether the relinquishment of the privilege(s) would create an unreasonable burden on the on-call rotation. The Medical Executive Committee may request a meeting with the Medical Staff or Advanced Practice Provider involved. The Medical Executive Committee will make a recommendation to the Board.

(c.) The Board will make a final decision on the request, based upon, among other factors, how the request will affect the Hospital's ability to comply with applicable regulatory requirements, including the Emergency Medical Treatment and Active Labor Act. The Board's decision will be reported in writing by the CAO to the Medical Staff member or Advanced Practice Provider, the Medical Executive Committee, and the applicable Department Chief. If the Board permits the relinquishment of privileges, it will specify the effective date of the relinquishment.

(d.) Failure of a Medical Staff member to request relinquishment of clinical privileges as set forth above will result in the Medical Staff member being maintained on the call schedule without any change to his or her call responsibilities.

(e.) Medical Staff members must maintain competency for the core privileges in their specialty. Medical Staff members who have voluntarily limited their practice to include less than core privileges typically associated with their specialty may be required either to arrange for appropriate coverage or to participate in a general on-call schedule and to maintain sufficient competence to fulfill this responsibility.

4.B. Core Privileges

4.B.1. Application Process Requirements:

Individuals requesting clinical privileges at the Hospital are required to apply for core privileges in their specialties as may be defined by each clinical department. The scope of core privileges for each clinical department shall be recommended by the Department Chief and must be approved by the Credentials Committee, hospital-specific Medical Executive Committee, and Board. Core privileges (and the eligibility criteria related to them) may be revised if recommended by the Department Chief and approved by the Credentials Committee, Medical Executive Committee, and Board.

4.B.2. Rules Governing Exercise of Core Privileges:

Individuals who have been granted core privileges shall be required to do the following:

(a.) provide emergency call coverage for patients requiring emergency care within the scope of their core privileges (Medical Staff only); and

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

4.B.3. Exemption from Core Privileges:

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

(b) After considering the recommendations from the relevant Department Chief and the Credentials Committee, the Medical Executive Committee shall make a recommendation in support of or against such exemption. The following factors may be considered by the Medical Staff Leadership in their review of the request:

(1) the Hospital's mission and its obligation to serve the health care needs of the community by providing timely, quality health care on a local basis; and

(2) fairness to the individual requesting the exemption, including past service and the other demands placed upon the individual;

(3) fairness to the other Medical Staff members who serve on the call roster in that specialty, including the effect that the removal would have upon them; and

(4) any gaps in call coverage that might/would result from a Medical Staff member's removal from the call roster for the specific privilege and the feasibility and safety of transferring patients to other facilities in that situation; and

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

(6) the perceived inequities in exemptions being available to some; and

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

(c) If the Medical Executive Committee recommends against granting an exemption, the individual shall be entitled to appear before the Medical Executive Committee

before the Medical Executive Committee makes a final recommendation to the Board.

(d) If the Medical Executive Committee recommends in favor of granting the exemption, the recommendation shall be forwarded to the Board for its review and action.

(e) The Board shall make a final decision on the exemption request based upon consideration of the factors set forth in (a) above. The Board's decision shall be reported in writing by the Chief of Staff to the Medical Staff member, the Medical Executive Committee, and the applicable department Chief, and shall specify the effective date of the exemption.

(f) No individual is entitled to an exemption or to a hearing if the Board determines not to grant an exemption. A denial of a request for exemption does not entitle an individual to the procedural rights contained in Article 7 of this Credentials Policy.

4.B.4. Special Privileges Beyond the Core:

Individuals who have requested and been granted special privileges in addition to the core privileges for their specialty shall be required to provide such services on an emergency and consultative basis, as may be requested.

4.C. TEMPORARY CLINICAL PRIVILEGES

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

(a.) Applicants. Temporary privileges may be granted by the CAO or his designee, upon recommendation of the Chief of Staff, when an applicant for initial appointment has submitted a completed application and the application is pending review by the Medical Executive Committee and Board, following a favorable recommendation of the Credentials Committee. Prior to temporary privileges being granted in this situation, the credentialing process must be complete, including verification of current licensure, relevant training or experience, current competence, ability to exercise the privileges requested and

current professional liability coverage; compliance with privileges criteria; and consideration of information from the National Practitioner Data Bank and from a criminal background check. In order to be eligible for temporary privileges, an individual must demonstrate that

(i) there are no current or previously successful challenges to his or her licensure or registration, and

(ii) he/she has not been subject to involuntary termination of Medical Staff or as an Advanced Practice Provider, or involuntary limitation, reduction, denial, or loss of clinical privileges, at another health care facility. In addition, the applicant must not be under investigation or suspension at another facility.

(iii) he/she must meet other criteria as required by the Medical Staff Bylaws, this Credentials Policy and related Medical Staff Rules and Regulations. Temporary privileges in this situation will be granted for a period not to exceed one hundred twenty (120) days.

(b.) Compliance with Bylaws and Policies. Prior to any temporary privileges being granted, the individual must agree in writing to be bound by the Bylaws, Rules and Regulations, policies, procedures and protocols of the Medical Staff and the Hospital.

4.C.2. Privileges for Locum Tenens:

(a.) Short-Term Need. The CAO may grant privileges (both admitting and treatment) to a locum tenens physician who is filling in for a Medical Staff member who is on vacation, attending an educational seminar, ill, and/or otherwise needs coverage assistance for a limited period of time, under the following conditions:

(i.) the applicant has submitted an appropriate application, along with the application fee;

(ii.) the verification process is complete, including verification of current licensure, relevant training or experience, current competence (verification of good standing in all hospitals where the individual practiced for at least the previous ten years), a minimum of two

professional references, ability to exercise the privileges requested, current professional liability coverage, compliance with privileges criteria, and consideration of information from the National Practitioner Data Bank, from a criminal background check, and from OIG queries;

a. the applicant demonstrates that
    i. there are no current or previously successful challenges to his or her licensure or registration, and
    ii. he or she has not been subject to involuntary termination of Medical Staff membership or involuntary limitation, reduction, denial, or loss of clinical privileges, at another health care facility;
b. the applicant has received a favorable recommendation from the Chief of Staff, after considering the evaluation of the Department Chief and the VPMA or CAMD;
c. the applicant will not be appointed to the Medical Staff, but will be subject to any focused professional practice requirements established by the Hospital; and
d. the individual may exercise privileges as a locum tenens physician for a maximum of one hundred twenty (120) days, consecutive or not, anytime during the 24-month period following the date they are granted, subject to the following conditions:
    i. the individual must notify Medical Staff Services at least fifteen (15) days prior to each time that he or she will be exercising these privileges (exceptions for shorter notice periods may be considered in situations involving health issues); and
    ii. along with this notification, the individual must inform the Medical Staff Office of any change that has occurred to any of the information provided on the initial application for privileges.

(iii.) The CAO may grant privileges only after to the Chief of Staff and VPMA or CAMD have provided written approval. Privileges will be effective on the date of CAO approval.

(iv.) Locum Tenens will be presented to the Credentials Committee for informational purposes only.

(b) Long-Term Need. In those cases where a long-term need for a locum tenens physician has been identified (e.g., the individual is filling a vacancy until a permanent health care professional is hired or is assisting with seasonal coverage needs), the request for privileges will be processed through the same process for Medical Staff applications, as set forth in this Policy. In such cases, the individual will be required to complete a full initial application for the appropriate staff category. They must satisfy all qualifications and requirements set forth in this Policy, except those relating to geographic location. The individual will face no limitations on the number of days he or she may practice.

4.C.3. Supervision Requirements:

In exercising temporary privileges, the individual will act under the supervision of the Department Chief or physician designated by the Credentials Committee. Special requirements of supervision and reporting may be imposed on any individual granted temporary clinical privileges.

4.C.4. Termination of Temporary Clinical Privileges:

(a.) The CAO may, at any time after consulting with the Chief of Staff, the Chair of the Credentials Committee, or the Department Chief, terminate temporary admitting privileges. Clinical privileges will be terminated when the individual's inpatients are discharged.

(b.) If the care or safety of patients might be endangered by continued treatment by the individual granted temporary privileges, the CAO, the Department Chief, or the Chief of Staff may immediately terminate all temporary privileges. The Department Chief or the Chief of Staff will assign to another member of the Medical Staff responsibility for the care of such individual's patients until they are discharged. Whenever possible, consideration will be given to the wishes of the patient in the selection of a substitute physician.

(c.) The granting of temporary privileges is a courtesy and may be terminated for any reason.

(d.) Neither the denial nor termination of temporary privileges will entitle the individual to a hearing or appeal.

4.D. EMERGENCY SITUATIONS

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

4.D.2. In an emergency situation, a member of the Medical Staff or an Advanced Practice Provider may administer treatment to the extent permitted by his or her license, regardless of department status or specific granting of clinical privileges.

4.D.3. When the emergency situation no longer exists, the patient will be assigned by the Department Chief or the Chief of Staff to a Medical Staff member with appropriate clinical privileges, considering the wishes of the patient.

4.D.4. When a decision has been made by the Hospital CAO and the Chief Medical Officer or Hospital Chief of Staff, that emergency privileges are required to treat a patient at a facility where the applicant is not currently appointed; privileges may be granted after verification of identity, licensure and training or certification.

(a.) The provider’s identity may be verified through a valid government-issued photo identification (i.e., driver’s license or passport)

(b.) The provider’s medical license may be verified through the primary source verification of the medical license.

(c.) The provider’s training may be verified through a copy of the diploma or primary source verification.

(d.) The provider’s certification may be verified through primary source verification.

4.E. DISASTER PRIVILEGES

4.E.1. When the emergency operations plan has been implemented and the immediate needs of patients in the facility cannot be met, the Hospital–specific Chief Administrative Officer, the Chief Medical Officer, the Hospital–specific Chief of

Staff, or the Hospital–specific Vice President of Medical Affairs or Clinical Affairs Medical Director may use a modified credentialing process to grant disaster privileges to eligible volunteer licensed independent practitioners ("volunteers"). Safeguards must be in place to verify that volunteers are competent to provide safe and adequate care.

4.E.2. Disaster privileges are granted on a case-by-case basis after verification of identity and licensure.

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

(b.) A volunteer's medical license may be verified in any of the following ways:

(1.) Current hospital picture ID card that clearly indicates the individual's professional designation;

(2.) Current license to practice;

(3.) Primary source verification of the license;

(4.) Identification indicating the individual has been granted authority to render patient care in disaster circumstances or is a member of a Disaster Medical Assistance Team, the Medical Reserve Corps, the Emergency System for Advance Registration of Volunteer Health Professionals, or other recognized state of federal organizations or groups; or

(5.) Identification by a current Hospital employee, Medical Staff or Advance Practice Provider who possesses personal knowledge regarding the individual's ability to act as a volunteer during a disaster.

(c.) Primary source verification of a volunteer's license will begin as soon as the immediate situation is under control and must be completed within 72 hours from the time the volunteer begins to provide service at the Hospital.

(d.) In extraordinary circumstances when primary source verifications cannot be completed within 72 hours, it should be completed as soon as possible. In these situations, there must be documentation of the following:

(1.) The reason primary source verification could not be performed in the required time frame;

(2.) Evidence of the volunteer's demonstrated ability to continue to provide adequate care; and

(3.) An attempt to obtain primary source verification as soon as possible. If a volunteer has not provided care, then primary source verification is not required.

(e.) The Medical Staff will oversee the care provided by volunteer licensed independent practitioners and Advanced Practice Providers. This oversight will be conducted through direct observation, mentoring, clinical record review, or other appropriate mechanisms developed by the Medical Staff and Hospital.

4.F. CONTRACTS FOR SERVICES

4.F.1. From time to time, the Hospital may enter into contracts with providers and/or groups of providers for the performance of clinical and/or administrative services at the Hospital. All individuals functioning pursuant to such contracts will obtain and maintain Medical Staff or Advanced Practice Provider appointment and/or clinical privileges at the Hospital, in accordance with the terms of the Medical Staff Bylaws.

(a.) To the extent that any such contract confers the preferential right to perform specified services at the Hospital on the other party to the contract, no other person may exercise clinical privileges to perform the specified services while the contract is in effect unless the patient specifically requests the services of that person.

(b.) If any such preferential contract would have the effect of preventing an existing Medical Staff or Advanced Practice Provider from exercising clinical privileges that had previously been granted (except by specific patient request), the affected Medical Staff or Advanced Practice Provider will be given notice of the preferential contract and have the right to meet with the Board or a committee designated by the Board to discuss the matter prior to the contract in question being executed. At the meeting, the affected Medical Staff or Advanced Practice Provider will be entitled to present any information relevant to the decision to enter into the

preferential contract. That individual will not be entitled to any other procedural rights with respect to the decision or the effect of the contract on his/her clinical privileges, notwithstanding any other provision of the Medical Staff Bylaws. The inability of a provider to exercise clinical privileges because of a preferential contract is not a matter that requires a report to the state licensure board or to the National Practitioner Data Bank.

(c.) In the event of any conflict between the Medical Staff Bylaws and the terms of any contract, the terms of the contract will control.

Appointments and privileges based on contracted services shall terminate with the expiration of the underlying contract or termination of the relationship between the Medical Staff or Advanced Practice Provider and the entity with which the contract was entered into.

ARTICLE 5

PROCEDURE FOR REAPPOINTMENT

5.A. PROCEDURE FOR REAPPOINTMENT

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

5.A.1. Eligibility for Reappointment:

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

(a.) completed all medical records;

(b.) completed all continuing medical education requirements;

(c.) satisfied all Medical Staff or Advanced Practice Provider responsibilities, including payment of fines, and assessments;

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

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

(f.) a reappointment assessment fee of $100.00 for any applicant who has not had any contact with the Hospital during the previous three-year term of privileges. Contact would be defined as, any activity within the hospital, referral of patients for admission, or use of outpatient services at the Hospital.

5.A.2. Factors for Evaluation:

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

(a.) compliance with the Bylaws, Rules and Regulations, and policies of the Medical Staff and the Hospital;

(b.) participation in Medical Staff or Advanced Practice Provider duties, including committee assignments and emergency call;

(c.) the results of the Hospital's performance improvement, ongoing professional practice evaluations, and other peer review activities, taking into consideration practitioner-specific information compared to aggregate information concerning other individuals in the same or similar specialty (provided that, other practitioners will not be identified);

(d.) any focused professional practice evaluations;

(e.) verified complaints received from patients and/or staff; and

(f.) other reasonable indicators of continuing qualifications.

(g.) for Advanced Practice Providers, an assessment prepared by the Supervising Physician(s) will be considered.

5.A.3. Reappointment Application:

(a.) An application for reappointment will be furnished to Medical Staff or the Advanced Practice Provider at least six (6) months prior to the expiration of their current appointment term. A completed reappointment application must be returned to the Credentials Verification Office within thirty (30) days.

(b.) Failure to submit a complete application at least four (4) months prior to the expiration of the Medical Staff or the Advanced Practice Provider's current term will result in automatic expiration of appointment and clinical privileges at the end of the then current term of appointment.

(c.) Reappointment will be for a period of not more than three (3) years.

(d.) Except as provided below, if an application for reappointment is submitted timely, but the Board has not acted on it prior to the end of the current term, the individual's appointment and clinical privileges will expire at the end of the then

current term of appointment. Subsequent Board action may be to grant reappointment and renewal of clinical privileges.

(e.) In the event the application for reappointment is the subject of an investigation or hearing at the time reappointment is being considered, a conditional reappointment for a period of less than three (3) years may be granted pending the completion of that process.

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

(g.) The Credentials Verification Office will oversee the process of gathering and verifying relevant information. The Credentials Verification Office will also be responsible for confirming that all relevant information has been received.

5.A.4. Processing Applications for Reappointment:

(a.) The Credentials Verification Office will forward the application to the relevant Department Chief and the application for reappointment will be processed in a manner consistent with applications for initial appointment.

5.A.5. Conditional Reappointments:

(a.) Recommendations for reappointment and renewed privileges may be contingent upon an individual's compliance with certain specific conditions. These conditions may relate to behavior (e.g., code of conduct) or to clinical issues (e.g., general consultation requirements, proctoring, completion of CME requirements). Unless the conditions involve the matters set forth in Section 12.1 of the Bylaws, the imposition of such conditions does not entitle an individual to request the procedural rights set forth in Article 12 of the Bylaws.

(b.) In addition, reappointments may be recommended for periods of less than three (3) years in order to permit closer monitoring of an individual's compliance with any conditions that may be imposed. A recommendation for reappointment for a period of less than three (3) years does not, in and of itself, entitle an individual to the procedural rights set forth in Article 12 of the Bylaws.

5.A.6. Potential Adverse Recommendation and Conditional Reappointment

(a.) If the Credentials Committee or the Medical Executive Committee is considering a recommendation to deny reappointment or to reduce clinical privileges, the committee chairperson will notify the Medical Staff or the Advanced Practice Provider of the possible recommendation and will invite the member to meet with the committee.

(b.) Prior to this meeting, the Medical Staff or the Advanced Practice Provider will be notified of the general nature of the information supporting the proposed recommendation.

(c.) At the meeting, the Medical Staff or the Advanced Practice Provider will be invited to discuss, explain, or refute this information. A summary of the interview will be made and included with the committee's recommendation. This meeting is not a hearing, and none of the procedural rules for hearings will apply. The Medical Staff or the Advanced Practice Provider will not have the right to be represented by legal counsel at this meeting.

(d.) Recommendations for reappointment may be subject to an applicant's compliance with specific conditions. These conditions may relate to behavior (e.g., personal code of conduct) or to clinical issues (e.g., performance improvement plan). Reappointments may be recommended for periods of less than three (3) years in order to permit closer monitoring of a Medical Staff or the Advanced Practice Provider's compliance with any conditions that may be imposed.

(e.) A recommendation of a conditional reappointment or for reappointment for a period of less than three (3) years does not, in and of itself, entitle a Medical Staff or the Advanced Practice Provider to request a hearing or appeal.

(f.) In the event the applicant for reappointment is the subject of an investigation or a hearing at the time reappointment is being considered, a conditional reappointment for a period of less than three (3) years may be granted pending the completion of that process.

5.A.7. Time Periods for Processing:

Once an application is deemed complete, it is expected to be processed within one hundred twenty (120) days, unless it becomes incomplete. This time period is intended to

be a guideline only and will not create any right for the applicant to have the application processed within this precise time period.

ARTICLE 6

LEAVE OF ABSENCE

6.A REQUEST FOR LEAVE OF ABSENCE

An individual appointed to the Medical Staff may request a leave of absence by submitting a written request to the CAO, Chief Medical Officer, or Vice President of Medical Affairs or Clinical Affairs Medical Director. The request must state the beginning and ending dates of the leave, which will not exceed one year, and the reasons for the leave.

Medical Staff must report to the CAO any time they are away from medical staff and/or patient care responsibilities for longer than thirty (30) days and the reason for such absence is related to their physical or mental health or otherwise to their ability to care for patients safely and competently. Under such circumstances, the CAO, in consultation with the Chief of Staff, may trigger an automatic leave of absence.

6.B. GRANTING OF LEAVE OF ABSENCE

The CAO will determine whether a request for a leave of absence will be granted. In determining whether to grant a request, the CAO will consult with the Chief of Staff and the relevant Department Chief. The granting of a leave of absence, or reinstatement, as appropriate, may be conditioned upon the individual's completion of all medical records.

6.C LIMITATIONS

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

6.D. REINSTATEMENT

6.D.1. Request for Reinstatement

Individuals requesting reinstatement will submit a written summary of their professional activities during the leave, and any other information that may be requested by the Hospital. Requests for reinstatement will then be reviewed by the relevant Department Chief, the Chairperson of the Credentials Committee, the Chief of Staff, and the CAO.

6.D.2 Determination of Reinstatement

If all these individuals make a favorable recommendation on reinstatement, the Medical Staff member may immediately resume clinical practice at the Hospital. This determination will then be forwarded to the Credentials Committee, the Medical Executive Committee, and the Board for ratification. If, however, any of the individuals reviewing the request have any questions or concerns, those questions will be noted and the reinstatement request will be forwarded to the full Credentials Committee, Medical Executive Committee, and Board for review and recommendation. However, if a request for reinstatement is not granted, for reasons related to clinical competence or professional conduct, the individual will be entitled to request a hearing and appeal.

6.D.3. Leave of Absence for Health Reasons

If the leave of absence was for health reasons, the request for reinstatement must be accompanied by a report from the individual's physician indicating that the individual is physically and/or mentally capable of resuming a hospital practice and safely exercising the clinical privileges requested.

6.D.4 Absences Greater than One Year

Absence for longer than one year will result in automatic relinquishment of Medical Staff appointment and clinical privileges unless an extension is granted by the

CAO. Extensions will be considered only in extraordinary cases where the extension of a leave is in the best interest of the Hospital.

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

6.D.5 Request for Extension

Leaves of absence are matters of courtesy, not of right. In the event that it is determined that an individual has not demonstrated good cause for a leave, or where a request for extension is not granted, the determination will be final, with no recourse to a hearing and appeal.

ARTICLE 7

HOSPITAL EMPLOYEES

7.A Except as provided below, the employment of an individual by the Hospital will be governed by the Hospital's employment policies and manuals and the terms of the individual's employment relationship or written contract. To the extent that the Hospital's employment policies or manuals, or the terms of any applicable employment contract, conflict with this part of the policy, the employment policies, manuals and descriptions and terms of the individual's employment relationship or written contract will apply.

7.B A request for appointment, reappointment, or clinical privileges, submitted by an applicant or member of the Medical Staff or Advanced Practice Provider who is employed by the Hospital, will be processed in accordance with the terms of this policy. A report regarding each practitioner's qualifications will be made to Administration or Human Resources (as appropriate) to assist the Hospital in making employment decisions.

ARTICLE 8

AMENDMENTS

8.A.1. This policy may be amended as set forth in the Article 13.3 of the Medical Staff Bylaws.

APPENDIX A

ADVANCED PRACTICE PROVIDER POLICY

A.1 SCOPE OF POLICY

(a.) This Policy addresses those Advanced Practice Providers who are permitted to provide patient care services in the Hospital and are listed in the Appendices to this Policy.

(b.) This Policy sets forth the credentialing process and the general practice parameters for these individuals, as well as guidelines for determining the need for additional categories of Advanced Practice Providers at the Hospital.

A.2 CATEGORIES OF ADVANCED PRACTICE PROVIDERS

(a.) Only those specific categories of Advanced Practice Providers that have been approved by the Board of Directors will be permitted to practice at the Hospital. All Advanced Practice Providers who are addressed in this Policy may be classified as either "Licensed Independent Practitioners" or "Advanced Dependent Practitioners."

(b.) Current listings of the specific categories of Advanced Practice Providers functioning in the Hospital as Licensed Independent Practitioners or Advanced Dependent Practitioners included in Section A.3 of this policy.

A.3 DEFINITIONS

(a.) Those Advanced Practice Providers currently practicing as Licensed Independent Practitioners at are as follows:

(1.) Licensed Independent Clinical Social Worker (clinic-based privileges)

(2.) Psychologists (clinic-based privileges)

(b.) Those Advanced Practice Providers currently practicing as Advanced Dependent Practitioners are as follows:

(1.) Physician Assistants

(2.) Nurse Practitioners

(3.) Certified Registered Nurse Anesthetists

(4.) Certified Nurse Midwives

(5.) Psychologists (hospital-based privileges)

(6.) Licensed Independent Clinic Social Workers (hospital-based privileges)

(7.) Certified Registered Nurse First Assistant

A.3 CONDITIONS OF PRACTICE APPLICABLE TO ADVANCED DEPENDENT PRACTITIONERS

(a.) Oversight by Supervising Physician

(1.) Advanced Dependent Practitioners may function in the Hospital only so long as they have a Supervising Physician. Supervision may include general oversight availability in the treatment area, availability on the premises, availability by telephone, or direct presence. The written agreement between the supervising practitioner and Advanced Practice Provider must outline the level of supervision that will be provided by the supervising practitioner, in accordance with Hospital policy.

(2.) The level of supervision required for each category of Advanced Practice Provider is as follows:

(i.) Physician Assistant

- An approved supervising physician shall be available in person or by electronic communication at all times when the PA is caring for patients. A physician may not supervise more than five (5) PAs simultaneously.
- A supervising physician shall delegate to a PA only those tasks and procedures consistent with the supervising physician's privileges or usual and customary practice and with the patient's health and condition.
- A supervising physician shall observe or review evidence of the PA's performance of all tasks and procedures to be delegated to the PA until assured of competency.
- The supervising physician has continuing responsibility to follow the progress of the patient and to make sure that the PA does not function autonomously. The supervising physician shall be

responsible for all medical services provided by a PA under his or her supervision.

(ii.) Nurse Practitioner

- A Nurse Practitioner must meet the State regulations regarding independent practice (practicing for at least three years under the supervision of a physician).
- Once initial competency is established, and the Nurse Practitioner's standardized procedures have been defined and approved, the Nurse Practitioner is authorized to perform approved standardized procedures without the direct observation, supervision, or approval of a physician. Physician consultation must be available at all times either on-site or by immediate electronic communication, when needed for any reason, as defined by the individual standardized procedure. With respect to the ordering or furnishing of drugs or devices by the Nurse Practitioner, the supervising physician must be available by telephone at the time of patient examination by the Nurse Practitioner.

(iii.) Certified Nurse Midwife

Supervision by a practicing, licensed physician qualified in maternity care.

(iv.) CRNA

A staff anesthesiologist must sponsor and supervise the CRNA. A surgeon may sponsor and supervise the CRNA if the Hospital where the CRNA practices does not employ or contract with anesthesiologists.

(v.) Psychologist

A psychiatrist must sponsor a Hospital-based psychologist.

(vi.) Licensed Clinical Social Worker

A practicing licensed physician or psychiatrist must sponsor an LCSW.

(vii.) CRNFA

The CRNFA provides services under the direct supervision of the surgeon.

(3.) It will be the responsibility of the Supervising Physician to countersign all medical record entries made by his or her Advanced Dependent Practitioner in accordance with applicable policies and rules and regulations.

(4.) If the Medical Staff appointment or clinical privileges of a Supervising Physician are resigned, revoked, or terminated, the Advanced Dependent Practitioner's scope of practice or clinical privileges will automatically terminate, unless an alternative physician is identified. The System Credentials Committee may, however, recommend that Advanced Dependent Practitioner be permitted to arrange for another Supervising Physician.

(5.) As a condition of a scope of practice or clinical privileges, an Advanced Dependent Practitioner and the Supervising Physician must provide the Hospital with notice of any revisions or modifications that are made to the supervision agreement. This notice must be provided to the CAO within three (3) days of any such change.

A.4. QUESTIONS REGARDING THE AUTHORITY OF ADVANCED DEPENDENT PRACTITIONERS

(a.) Should any member of the Medical Staff, or any employee of the Hospital who is licensed or certified by the state, have a reasonable question regarding the clinical competence or authority of an Advanced Dependent Practitioner to act or issue instructions outside the presence of the Supervising Physician, such individual will have the right to request that the Supervising Physician validate, either at the time or later, the instructions of the Advanced Dependent Practitioner. Any act or instruction of the Advanced Dependent Practitioner will

be delayed until such time as the individual with the question has ascertained that the act is clearly within the scope of practice granted to the individual.

(b.) Any question regarding the conduct of an Advanced Dependent Practitioner will be reported to the Chief of Staff, the Chair of the Credentials Committee, the relevant Department Chief, or the CAO for appropriate action. The individual to whom the concern has been reported shall also discuss the matter with the Supervising Physician.

A.5. RESPONSIBILITIES OF SUPERVISING PHYSICIAN

(a.) The Supervising Physician will remain responsible for all care provided by the Advanced Dependent Practitioner in the Hospital.

(b.) The number of Advanced Dependent Practitioners acting under the supervision of one Medical Staff member, as well as the care they may provide, will be consistent with applicable state statutes and regulations and any other policies adopted by the Hospital.

(c.) It may be the responsibility of the Supervising Physician to provide, or to arrange for, professional liability insurance coverage for the Advanced Dependent Practitioner in amounts required by the Board. The insurance must cover all activities of the Advanced Dependent Practitioner in the Hospital. The Supervising Physician will furnish evidence of such coverage to the Hospital. The Advanced Dependent Practitioner will act in the Hospital only while such coverage is in effect.

APPENDIX B

MEDICAL STAFF DEVELOPMENT PLAN

1. If a request for an application is received for clinical privileges or a clinical service in which the Hospital's Medical Staff Development Plan sets forth limitations with respect to the granting of appointment or clinical privileges, and the applicant does not meet those limitations, no application will be sent, and the prospective applicant will be advised by the CAO of the reason for declining to provide an application. Declining to send an application is not considered a denial of appointment or privileges and will not give rise to any right of hearing or review.
2. If a Medical Staff member or Advanced Practice Provider met the criteria set forth in the Hospital's Medical Staff Development Plan at the time of initial appointment and thereafter fails to meet such conditions, the Medical Staff member or Advanced Practice Provider will be notified that appointment and/or clinical privileges will be automatically relinquished as set forth in Article 11 of the Bylaws. Automatic relinquishment of appointment or clinical privileges under such circumstances will not give rise to any right of hearing or review.
3. If following the time of initial appointment, the Board contemplates closing or otherwise limiting clinical privileges or a clinical service, the Board will send notices to all affected Medical Staff member or Advanced Practice Provider . This notice will outline a procedure whereby such individuals may present information for consideration by the Professional Affairs Committee. Prior to making a recommendation to the Board, the Professional Affairs Committee will review all information presented to it. Upon recommendation made by the Professional Affairs Committee, the Board may grandfather those individuals who would not otherwise meet the revised limitations set forth in the Medical Staff Development Plan. In the event the Board determines not to grandfather individuals who otherwise would not meet the revised Medical Staff Development Plan limitations, such Medical Staff member or Advanced Practice Provider will be notified that their appointment and/or clinical privileges will automatically be relinquished. Such relinquishment will not give rise to any right of hearing or review.
4. If an applicant or Medical Staff member or Advanced Practice Provider believes that the determination not to provide an application or an automatic relinquishment of his/her Medical Staff membership or clinical privileges constitutes an incorrect interpretation of the Medical Staff Development Plan, the individual may make a written request for reconsideration to the Board through the Chief Administrative Officer. The written request

will be reviewed at the next regularly scheduled meeting of the Board and the individual will be notified of the decision. The decision of the Board is final and does not entitle the individual to hearing rights.

APPENDIX C

FOCUSED PROFESSIONAL PRACTICE EVALUATION PROCEDURE

1. The information used in the Focused Professional Practice Evaluation may be acquired through the following:
    a. Periodic chart review;
    b. Direct observation;
    c. Monitoring of diagnostic and treatment techniques;
    d. Feedback from other individuals involved in the care of the patient, including but not limited to consulting physicians, assistants at surgery, nursing and administrative personnel; and,
    e. Output from practitioner-specific data analysis software .
2. Criteria/indicators will include triggers and fall generally into the following six areas of general competence:
    a. Patient care;
    b. Medical/clinical knowledge;
    c. Practice-based learning and improvement;
    d. Interpersonal and communication skills;
    e. Professionalism; and
    f. System-based practice.
3. Triggers can be single incidents or evidence of a clinical practice trend.
4. Monitoring criteria should include measures that are specialty-specific and evidence-based.
5. The applicable Medical Staff Department and the Medical Executive Committee (MEC) will approve indicator criteria and trigger (threshold) parameters.
6. Criteria/indicators may be added or deleted at the recommendation of the Medical Executive Committee, Department Chairperson, Peer Review Committee, and/or Credentials Committee.
7. The list of criteria/indicators will be reviewed on an ongoing basis and in conjunction with this policy.

8. Reported concerns regarding privileged practitioner's professional performance will be uniformly investigated and addressed as defined by the organization and applicable law.
9. Any individual (including patient/family, Medical Staff, Advanced Practice Provider, or Hospital employee) may report any concerns regarding the professional performance of a practitioner.
10. Relevant information from the practitioner practice review process will be integrated into performance improvement initiatives and will be utilized to determine whether to continue, limit, or revoke existing privileges.
11. If there is uncertainty regarding the practitioner's professional performance, the course of action defined in the Medical Staff Bylaws for further evaluation will be followed. If the performance of the practitioner is sufficiently egregious, the Chief of Staff, VPMA or CAMD, or CAO shall determine, within his/her sole discretion, whether the provisions of this policy need not be followed, whereupon the provisions of the Bylaws, and not this policy, shall govern.
12. The activities of the focused professional practice evaluation are considered privileged, confidential, and peer review protected.

Please refer to the Focused Professional Practice Evaluation Policy for additional information.

APPENDIX D

ONGOING PROFESSIONAL PRACTICE EVALUATION AND QUALITY DATA INDICATORS PROCEDURES

1. Each Department Chief is responsible for determining which quality indicators will be utilized for the department for the ongoing professional practice evaluation (OPPE) process.
2. Each Department Chief will establish department specific criteria for utilizing the quality data for measuring performance which will be applied consistently within a single department. The criteria indicators will include triggers and fall generally into the following six areas of clinical competence:
    a. patient care;
    b. medical/clinical knowledge;
    c. practice-based learning and improvement;
    d. interpersonal and communication skills;
    e. professionalism; and f. system-based practice.
3. The Department Chief and the Medical Executive Committee will approve indicator criteria and trigger parameters.
4. A core data set based on the established department specific indicators for each Medical Staff member or Advanced Practice Provider will be collected and reviewed by the respective Department Chief in connection with the OPPE, reappointments and/or renewals of clinical privileges. Such data may include peer review triggers, suspensions for delinquent records, malpractice activity, periodic chart review, direct observation (based on the privilege, e.g., surgical), monitoring of diagnostic and treatment activities, feedback from other individuals involved in the care of the patient, including consulting physicians, assistants at surgery, nursing and administrative personnel, and patients, and other like data. In addition, data on hospital acquired conditions will be provided to the respective Department Chiefs at established time intervals for inclusion in the data packet that is provided to Medical Staff member or Advanced Practice Provider . The Department Chief will also review the outcomes of the peer review process as outlined in the Medical Staff Peer Review Policy.
5. If Hospital data is not available, the Medical Staff member or Advanced Practice Provider will be required to furnish appropriate data from his/her primary hospital or practice as determined by the System Credentials Committee.

6. Department Chiefs, in conjunction with Section Chiefs where applicable, will conduct the OPPE at regular intervals - no less frequently than six (6) to nine (9) months and provide documentation of such reviews. The documentation of OPPE will be maintained in the Medical Staff member or Advanced Practice Provider 's quality file in the respective Department.
7. If the quality data meets department criteria, a communication from the Department Chief or Section Chief may be provided to the Medical Staff member or Advanced Practice Provider indicating that no further action is required but at a minimum each Medical Staff member or Advanced Practice Provider will receive performance feedback during the reappointment period.
8. If quality data falls below established department criteria, an accompanying letter from the Department Chief will be sent to the Medical Staff member or Advanced Practice Provider requesting additional data. It is the responsibility of each Medical Staff member or Advanced Practice Provider to provide the additional information or data within the required time frame set forth, by the Department Chief or Section chief.
9. If the Department Chief or Section Chief determines that a quality issue exists, the Department Chief or Section Chief will meet with the Medical Staff member or Advanced Practice Provider to establish an improvement plan. The Department Chief or Section Chief will monitor the performance over the remaining year period.
10. If there is improvement at the time of reappointment, a one- or two-year reappointment may be recommended. If there is no improvement, the Department Chief may recommend that the Medical Staff member or Advanced Practice Provider not be reappointed or recommend a conditional reappointment subject to a continued improvement plan.

Please refer to the Ongoing Professional Practice Evaluation Policy for additional information.

APPENDIX E

DEA REGISTRATION OR COVERING PROVIDER POLICY

1. This policy applies to providers who are in the process of obtaining a DEA that meets regulatory standards.
2. All credentialed providers, as outlined in Section 2.A.2.(e.) of this policy, are required to maintain DEA registration in compliance with federal or state regulations.
3. If a provider does not have a DEA registration with a West Virginia address they are required to maintain a current DEA Covering Provider Agreement with the Credentials Verification Office (CVO).
4. The covering provider retains the right to obtain a second opinion or refuse to manufacture, distribute, import, export, prescribe or dispense prescriptions due to clinical concerns.
5. Requesting provider eligibility and responsibility:
    a. Supply current DEA and/or CDS registration in another state
    b. Supply a completed DEA Covering Provider Agreement form to the Credentials Verification Office including obtaining the signature of the covering provider.
    c. Allow the covering provider sufficient time to complete the prescription request.
    d. Not request any other Medical Staff member or Advanced Practice Provider to manufacture, distribute, import, export, prescribe or dispense prescription(s) in the covering provider's absence.
    e. Obtain an independent DEA or new DEA Covering Provider Agreement in the event that the current covering provider relinquishes their clinical privileges.
6. Covering provider eligibility and responsibility:
    a. Currently maintain clinical privileges, in good standing, at the facility(ies) the coverage will occur.
    b. Have a current unrestricted DEA that meets the Credentials policy, federal regulations and state regulations on file with the Credentials Verification Office.
    c. Be in the same general specialty as the requesting provider.
    d. Notify the requesting provider if:
        i. The covering provider will not be available to manufacture, distribute, import, export, prescribe or dispense prescriptions for any extended length of time that may impact continuity of patient care. (i.e. vacation)
        ii. Clinical privileges will be relinquished from one or more facilities that the current agreement covers.

e. Notify the Credentials Verification Office if:

i. Any clinical concerns arise regarding the kind or amount of prescriptions requested by the requesting provider.

ii. The volume of prescription requests becomes cumbersome and wishes to void the current agreement. Until such notification is received and process the current agreement must be upheld.

7. Time period:

a. Must obtain DEA withing thirty (30) days of initial appointment and provide documentation to the CVO (Exhibit A).

EXHIBIT A

DEA COVERING PROVIDER AGREEMENT

I, _____, NPI # _____ **do not** hold a DEA/CDS license; therefore, I will not prescribe any Schedule II – V medications while practicing in this State.

Please describe your process for handling instances when a patient requires a controlled substance.

Select one of the options below and complete any applicable fields:

- ☐ I do not prescribe controlled substances for my patients. If I determine that a patient may require a controlled substance, I refer the patient to their PCP or to another practitioner for evaluation and management

- ☐ I am eligible for a DEA or CDS, but do not have a current certificate. Therefore, I have an arrangement in place with the following provider and/or office, who currently holds an active DEA/CDS license:

  _____

Provider Signature: _____ Date: _____

APPENDIX F

ADMITTING COVERING PROVIDER POLICY

1. All credentialed providers with admitting privileges are required to maintain a current Admitting Covering Provider Agreement (Exhibit B) with the Credentials Verification Office.
2. The Covering Provider of the agreement is defined as the individual who will manage hospital admissions or Hospital care in the provider's absence.
3. If covering arrangements are made with a group verse one individual only one member of the group must sign the agreement. The agreement may not be signed as a group name.
4. Requesting provider responsibility:
    a. Supply a completed Admitting Covering Provider Agreement to the Credentials Verification Office including obtaining the signature of the covering provider.
    b. Obtain a new Admitting Covering Provider Agreement in the event that the current covering provider relinquishes their clinical privileges.
5. Covering provider eligibility and responsibility:
    a. Currently maintain admitting privileges, in good standing, at the facility(ies) the coverage will occur.
    b. Be in the same general specialty as the requesting provider.

Notify the requesting provider if clinical privileges will be relinquished from one or more facilities that the current agreement covers.

EXHIBIT B: Hospital Admitting & Coverage Arrangement

Instructions: Complete Section 1 or Section 2 to verify admitting/coverage arrangements.

I'm attesting, I do not have active admitting privileges at a participating network hospital and my practice will be confined to outpatient care. I hereby agree and attest, that if non-emergency hospitalization is necessary, I will refer member care to a participating physician or hospitalist who has active admitting privileges at a participating network hospital.

Section 1: Practitioners without Admitting Arrangements *(please print)*

I will facilitate hospital admissions for my patients as follows:

☐ **Option A:** Through the participating practitioner indicated below, of the same specialty who has active admitting privileges at _____ Hospital.

Provider Name	Specialty
Admitting Provider Name	Admitting Provider NPI

Admitting Physician Signature	Date
Practitioner Signature	Date

Section 2: Practitioners with Transfer Agreements or Hospitalist Program

I will facilitate hospital admissions for my patients as follows:

☐ **Option B:** I have an arrangement with a Hospitalist Program that has agreed to perform admissions for my patients. (Enclose such agreement).

Hospital name	Address

City	State	Zip Code	Phone Number
Practitioner Signature			Date

PLEASE NOTE - This requirement does not apply to providers practicing the following specialties: Chiropractor, Dermatology, Pathology, Radiology, Occupational Therapy, Physical Therapy, Nutritionists/Dietitians, Acupuncturists