EMORY
SAINT JOSEPH'S
HOSPITAL

The following documents are provided for your review:

- **Medical Staff Bylaws**
- **Medical Staff Credentials Manual**
- **Medical Staff Committee Manual**
- **Medical Staff Rules and Regulations**
- **Allied Health Professionals Manual**

Please contact the ESJH Medical Staff Office with any questions: 678-843-7998

MEDICAL STAFF BYLAWS, POLICIES, AND RULES AND REGULATIONS OF EMORY SAINT JOSEPH'S HOSPITAL

MEDICAL STAFF BYLAWS

December 16, 2020

Medical Staff Bylaws
December 16, 2020
Table of Contents

DEFINITIONS 1

ARTICLE I. CATEGORIES OF THE MEDICAL STAFF 3
Section 1. The Medical Staff…….3
Section 2. The Honorary Medical Staff…….3
Section 3. The Emeritus Medical Staff……..3
Section 4. The Active Medical Staff……..3
Section 5. The Courtesy Medical Staff…… 4
Section 6. The Affiliate Medical Staff…….…..4
Section 7. The Research Affiliate Staff…….6

ARTICLE II. MEDICAL STAFF OFFICERS 7
Section 1. Officers of the Medical Staff…….…...7
Section 2. Qualifications of Officers……..…7
Section 3. Duties of Officer……...8
Section 4. Nomination and Election of Officers……8
Section 5. Dismissal of an Officer……..…9

ARTICLE III. MEDICAL STAFF DEPARTMENTS AND SECTIONS 9
Section 1. Organization of Departments and Sections……..……9
Section 2. Assignment to Departments and Sections……..…….11
Section 3. Functions of Departments and Sections…….…….11

ARTICLE IV. MEDICAL EXECUTIVE COMMITTEE .....…13

ARTICLE V. MEETINGS 15
Section 1. General Staff Meetings…….....15
Section 2. Special Meetings…….15
Section 3. Departmental Meetings……...15
Section 4. Attendance at Meetings……...15
Section 5. Voting……..15

ARTICLE VI. MEDICAL HISTORIES AND PHYSICAL EXAMINATIONS. 16

ARTICLE VII. OTHER MEDICAL STAFF DOCUMENTS.....19
Section 1. Rules and Regulations.....19

Section 2. Credentials Manual 20
Section 3. Committee Manual.....20
Section 4. Policies and Procedures 20
Section 5. Allied Health Professionals Manual 21

ARTICLE VIII. CONFLICT MANAGEMENT PROCESS.....21

ARTICLE IX. BASIC STEPS AND DETAILS 22
Section 1. Qualifications for Appointment.....22
Section 2. Process for Privileging.....22
Section 3. Process for Credentialing (Appointment and Reappointment).22
Section 4. Indications and Process for Automatic Relinquishment of Appointment and/or Privileges 22
Section 5. Indications and Process for Precautionary Suspension.....22
Section 6. Indications and Process for Recommending Termination or Suspension of Appointment and Privileges or Reduction of Privileges.....23
Section 7. Hearing and Appeal Process, Including Process for Scheduling and Conducting Hearings and the Composition of the Hearing Panel.....23

ARTICLE X. GENERAL PROVISIONS 24
Section 1. Forms 24
Section 2. Construction of Terms and Headings 24
Section 3. Transmittal of Reports 24
Section 4. Exclusive Means 24

ARTICLE XI. ADOPTION OF A UNIFIED MEDICAL STAFF 25

ARTICLE XII. AMENDMENTS 25

ARTICLE XIII. ADOPTION 26

DEFINITIONS

1. ALLIED HEALTH PROFESSIONALS ("AHPs") means individuals other than Medical Staff members who are authorized by law and by the Hospital to provide patient care services.

2. APPLICANT means a Practitioner who has completed and submitted an application for Medical Staff Membership or for Clinical Privileges or both.

3. BOARD or BOARD OF DIRECTORS means the Board of Directors of the Hospital, which has the overall responsibility for the Hospital, or its designated committee.

4. BYLAWS or MEDICAL STAFF BYLAWS means the Medical Staff Bylaws of Saint Joseph's Hospital of Atlanta, Inc.

5. CLINICAL PRIVILEGES means the authorization granted by the Board to render specific patient care services.

6. DAYS means calendar days.

7. DENTIST means a doctor of dental surgery ("D.D.S.") or doctor of dental medicine (D.M.D.)

8. EX OFFICIO means service as a member of a body by virtue of an office or position held and, unless otherwise expressly provided, means with voting rights.

9. HOSPITAL means Saint Joseph's Hospital of Atlanta, Inc.

10. MEMBER means any physician, podiatrist and dentist who has been granted Medical Staff appointment and Clinical Privileges by the Board to practice at the Hospital.

11. MEDICAL STAFF means all physicians, podiatrists and dentists who have been appointed to the Medical Staff by the Board.

12. MEDICAL STAFF YEAR means January 1 through December 31.

13. NOTICE means written communication by regular U.S. mail, e-mail, facsimile, or Hospital mail, or hand delivery.

14. ORGANIZED HEALTHCARE ARRANGEMENT or OHCA means the term used by the HIPAA Privacy Rule to describe a clinically-integrated care setting in which patients typically receive health care from more than one provider (such as a hospital and its Medical Staff) and which benefits from regulatory provisions designed to facilitate compliance with the HIPAA Privacy Rule.

15. PATIENT CONTACTS or ATTEND or ATTENDANCE TO PATIENTS includes any admission, consultation, procedure, response to emergency call, evaluation, treatment or service performed in any facility operated by the Hospital or affiliate, including outpatient facilities.

16. PHYSICIAN includes both doctors of medicine ("M.D.s") and doctors of osteopathy ("D.O.s").

17. PODIATRIST means a physician and surgeon of the human foot and leg; doctor of podiatric medicine ("DPM").

18. PRACTITIONER means, unless otherwise expressly defined, a Physician, Podiatrist, Dentist or AHP who has Clinical Privileges in the Hospital.

19. PRESIDENT means the individual appointed by the Board to act on its behalf in the overall management of the Hospital.

20. RESEARCH AFFILIATE STAFF means any non-physician, podiatrist, or dentist who has an academic appointment in a college or university or a research and development scientist in medical industry who has been granted a Research Affiliate Staff appointment and approval by the Board to consult with the Medical Staff on clinical, research, and management matters.

21. SUSPENSION means temporary removal of privileges pending further action.

ARTICLE I. CATEGORIES OF THE MEDICAL STAFF

Section 1. The Medical Staff

The Medical Staff shall be divided into Honorary, Emeritus, Active, Courtesy, and Affiliate members.

Section 2. The Honorary Medical Staff

The Honorary Medical Staff shall be composed of Physicians, Podiatrists and Dentists on whom the Medical Staff wishes to confer a special honor. While these usually will be Staff Members of the Hospital who have retired from active practice at the Hospital, Physicians and Dentists of outstanding reputation, not necessarily holding Medical Staff membership or residing in this community, may also be so honored. Honorary Medical Staff Members shall not be eligible to admit patients, to vote, to hold office or to serve on Medical Staff committees.

Section 3. The Emeritus Medical Staff

The Emeritus Medical Staff shall consist of Physicians, Podiatrists and Dentists who have retired from practice at the Hospital. Emeritus Medical Staff Members shall not be eligible to admit patients, to vote, to hold office or to serve on Medical Staff committees.

Section 4. The Active Medical Staff

The Active Medical Staff shall consist of Physicians, Podiatrists and Dentists who regularly admit patients to the Hospital. Attendance to at least twelve patients per Medical Staff Year shall be required to become and to remain a member of the Active Medical Staff

Active Medical Staff members must: (1) assume responsibility within their area of professional competence for the daily care and supervision of their patients, (2) strive to assure the provision of quality patient care through the monitoring and evaluation of the quality and appropriateness of patient care and the identification of opportunities to improve patient care, (3) participate, as appropriate, in risk management activities related to the clinical aspects of patient care and safety, (4) perform, as requested, on-call coverage in the Emergency Room and outpatient departments, (5) participate in committee activities. Exceptions to the above responsibilities may be established by the Medical Executive Committee.

Members of the Active Medical Staff shall be appointed to a specific department, shall be eligible to vote, to hold office and to serve on Medical Staff Committees.

Members in this category shall be subject to the additional requirements as stipulated by the Member's department and section, if appropriate, as found in the Medical Staff Rules and Regulations.

Section 5. The Courtesy Medical Staff

The Courtesy Medical Staff shall consist of Physicians, Podiatrists and Dentists qualified for staff membership but who only occasionally admit patients to the Hospital or who act primarily as consultants. Courtesy Medical Staff Members may not attend more than twelve patients to the Hospital during any calendar year. A Courtesy Medical Staff Member who has attended a yearly average of twelve patients to the Hospital during the two year reappointment period must either: a) receive approval of his appointment to the Active Medical Staff or b) receive specific approval of the waiver of such requirement from the Board of Directors upon the recommendations of his section chief and/or department chair.

A Courtesy Medical Staff Member must hold active staff membership at another JCAHO accredited hospital in the community where his hospital practice is reviewed, evaluated and monitored similarly to those peer review activities required of active staff members of this hospital.

In the event a Courtesy Medical Staff Member does not meet the qualifications for reappointment to the Courtesy Medical Staff, his appointment to the Staff shall automatically terminate; provided, however, the Medical Executive Committee and Board of Directors may, upon their joint approval, allow the practitioner to retain his appointment to the Courtesy Medical Staff.

A Courtesy Medical Staff Member shall be allowed to exercise such Clinical Privileges as are granted to him pursuant to the Medical Staff Credentials Manual. Courtesy Medical Staff Members shall not be eligible to vote or hold office nor shall they be required to attend Medical Staff meetings; however, they may be asked to serve on Medical Staff committees. Members in this category shall be subject to the additional requirements of the Member's department and section, if appropriate, as set forth in the Medical Staff Rules and Regulations.

Section 6. The Affiliate Medical Staff

The Affiliate Medical Staff shall consist of Physicians, Podiatrists and Dentists who do not desire to become practicing members of the Medical Staff but who wish to participate in a limited manner in the activities at the Hospital. They need not meet the qualifications for membership outlined in Article 2. (Qualifications), Section 2.A.1. (Eligibility Criteria) of the Medical Staff Credentials Manual, nor shall they be entitled to the rights afforded to members by these Bylaws.

Persons appointed to the Affiliate Medical Staff may attend the professional programs of the Medical Staff. They may not be granted Clinical Privileges but may confer with the attending

physician on patients referred for care by the Affiliate Medical Staff. Affiliate Medical Staff shall not be eligible to vote or hold office nor shall they be required to attend Medical Staff meetings. Affiliate Medical Staff may not serve on Medical Staff Committees.

This category of membership shall be available to Physicians and Podiatrists who do not intend to admit or manage patients in the Hospital, but who:

A. Practice in or around the Hospital service area and utilize the Hospital specialists. Practicing members of the Affiliate Category must meet one of the following requirements:

1. Physician or Podiatrist must have previously held membership on the Medical Staff of the Hospital; or

2. Physician or Podiatrist must have outstanding reputation in the Hospital service area; or

B. Serve in medico-administrative capacity for industry, insurance companies, etc.

Credentialing of Applicants to the Affiliate Medical Staff consists of, but is not limited to, the following:

A. Practicing Physicians or Podiatrists:

1. Submit a request for Affiliate membership by completing an application for appointment as described in Article 2, Section C. of the Medical Staff Credentials Manual.
2. Provide documentation to satisfy Article 2, Section 2.B.3.of the Medical Staff Credentials Manual.
3. Provide a letter of recommendation from the CEO or President of their primary hospital affiliation where an Active membership is held, if applicable.
4. Provide a letter of recommendation from the Chief of Staff of their primary hospital affiliation, if applicable; or

B. Medico-administrative Physicians or Podiatrists:

1. Submit a request for Affiliate membership by completing an application for appointment as described in Article 2, Section C. of the Medical Staff Credentials Manual.
2. Provide documentation to satisfy Article 2, Section 2.B.3 of the Medical Staff Credentials Manual.
3. Provide a letter of recommendation from the CEO or President of their firm; and Recommendation of the Medical Staff Credentials

Committee; and Recommendation of the Medical Staff Executive Committee; and Approval of the Board of Directors.

There is no implied ability to move from Affiliate Medical Staff to any other category of the Medical Staff. Such a move would require a separate completed application.

Section 7. The Research Affiliate Staff

The Research Affiliate Staff shall consist of faculty in academic institutions or research and development scientists in medically related industry who desire to participate in a limited manner in the management, clinical, and research activities at the Hospital. Research Affiliate Staff must meet the qualifications for membership outlined in Article 2.A.2. of the Medical Staff Credentials Manual (Eligibility Criteria for Academic Staff). Research Affiliate Staff need not meet items 2.B.1. (a), (c), (d), (g), (h), (I) (k), and (l) of the Medical Staff Credentials Manual (Basic Responsibilities and Requirements), nor shall they be entitled to the rights afforded to members by these Bylaws.

Persons appointed to the Research Affiliate Staff may attend professional programs of the Medical Staff. They may not be granted Clinical Privileges, but may confer with the attending physicians on patient care, collection and analyses of clinical and laboratory data, quality improvement processes and outcomes, and preclinical and clinical research. Research Affiliate Staff shall not be eligible to vote or hold office nor shall they be required to attend Medical Staff meetings. Research Affiliate Staff may not serve on Medical Staff Committees but may attend meetings as invited guests.

This category of membership shall be available to persons who are not eligible to admit or manage patients in the Hospital, but who:

A. Have expertise in, but not limited to, science, engineering, management, liberal arts, computing, and research, or intellectual property development which enhances the ability of the Medical Staff to provide quality patient care, participate in translational research, and engage in professional development.

B. Members of the Research Affiliate Staff category must meet the following requirements:
    1. Hold an academic or administrative appointment in a College or University or hold a position involving medical research or investigation in industry.
    2. Have an outstanding reputation in their area of expertise.
    3. Be a participant in an ongoing scientific or research project involving Saint Joseph's Health System.

Credentialing of Applicants to the Research Affiliate Staff consists of, but is not limited to, the following:

A. Submit a request for Research Affiliate Staff membership by completing an application for appointment as described in Article 2.C. of the Medical Staff Credentials Manual (Application).

B. Provide documentation to satisfy Article 2.B.2. of the Medical Staff Credentials Manual (Burden of Providing Information).

C. Provide a letter of recommendation from the President or Dean of the institution where the Applicant's primary academic appointment is held or provide a letter confirming current employment in the area of medical research

D. Provide a letter of recommendation from a member of the Medical Staff of the Hospital supporting the appointment.

E. Provide a letter of recommendation from the President of Saint Joseph's Translational Research Institute, an affiliate of the Hospital.

There is no implied ability to move from Research Affiliate Staff to any other category of the Medical Staff. Such a move would require a separate completed application.

ARTICLE II. OFFICERS

Purpose: The purpose of this Article is to specify the organization needed to provide effective self governance for the Medical Staff. The duties, qualifications and methods of selection of each officer is defined.

Section 1. Officers of the Medical Staff

The officers of the Medical Staff shall be:

A. Chief of Staff
B. Vice Chief of Staff

Section 2. Qualifications of Officers

Officers must have been Members of the Active Medical Staff for at least two (2) years prior to the time of nomination and election and must remain Members of the Active Medical Staff during their respective terms of office. Failure to maintain Active staff membership shall immediately create a vacancy in the office involved. Vacated offices may be filled as provided for in these Bylaws at any general Medical Staff Meeting.

Section 3. **Duties of Officers**

Chief of Staff: The Chief of Staff shall serve as the chief administrative officer of the Medical Staff to:

A. act in coordination and cooperation with the President in all matters of mutual concern within the Hospital; and
B. call, preside over all general meetings of the Medical Staff; and
C. serve as chairperson of the Medical Executive Committee; and
D. serve as ex-officio member of all other Medical Staff Committees; and
E. be responsible for the enforcement of Medical Staff Bylaws, Rules and Regulations, for implementation of sanctions where these are indicated; and
F. represent the Medical Staff to the Board of Directors and its committees and to the President; and
G. receive, and interpret the policies of the Board of Directors to the Medical Staff and report to the Board of Directors on the performance and maintenance of quality with respect to the Medical Staff's delegated responsibility to provide medical care.

Vice Chief of Staff: In the absence of the Chief of Staff, he shall assume all the duties and have the authority of the Chief of Staff.

Section 4. Nomination and Election of Officers

A slate of nominees for officers of the Medical Staff shall be presented by a subcommittee appointed by the Chief of Staff composed of three (3) Members of the Medical Executive Committee, other than the current officers, and the Chairpersons of the Departments of Surgery and Medicine. Said nominees must meet qualifications outlined in Article II (Officers), Section 2. (Qualifications of Officers), of these Bylaws. A motion may be made for voting by secret ballot.

In addition to the candidate(s) nominated by the Nominating Committee, other candidates may be placed on the election ballot if a petition signed by ten percent (10%) or more Active medical staff members is presented to the Medical Staff Office at least ten (10) days prior to the meeting of the Nominating Committee.

Prior to the General Staff Meeting at which the election will be held, all members of the Active Medical Staff shall be notified of the Nominating Committee's selections and the names of any other candidates which will be on the ballot.

Officers shall be elected by the Medical Staff at any general meeting and approved by the Board of Directors. Voting will be by mail ballot if more than one (1) candidate is on the election ballot. Otherwise, mail or secret ballot is not necessary.

Officers shall hold office for a two (2) year term, unless otherwise removed, and may be re-elected.

Section 5. Dismissal of an Officer

The matter of dismissal of an officer of the Medical Staff, after being charged by a majority of the Medical Executive Committee with failure to discharge satisfactorily the function of his office, will then be put before the next general meeting of the Medical Staff.

The dismissal of an officer of the Medical Staff shall be based on conduct determined to be detrimental to the interests of the hospital or if the officer is suffering from a physical or mental infirmity that renders the individual incapable of fulfilling the duties of that office. Criteria to be considered shall include, but not be limited to, the following:

A. Displays of consistently poor judgment in medico-administrative matters.
B. Acts inappropriately when representing the Medical Staff as its elected officer.
C. Attends inconsistently when the Medical Executive Committee meets for business.
D. Displays disruptive or unprofessional behavior.
E. Disregards Medical Staff or Hospital policies openly.
F. Ignores Medical Staff adopted Bylaws, Rules and Regulations when conducting Medical Staff business.
G. Fails to maintain Active category status.
H. Is physically or mentally incapable of fulfilling the role.

If in the judgment of a two-thirds majority of the voting members of the Medical Staff present sufficient cause for dismissal exists, the matter will be presented at the next regular meeting of the Board of Directors. A majority of the voting members of the Board of Directors shall be required to recommend dismissal of an officer to the Board of Directors. Final authority for dismissal of an officer rests with the Board of Directors.

ARTICLE III. MEDICAL STAFF DEPARTMENTS AND SECTIONS

Purpose: The purpose of this Article is to designate the required Medical Staff departments and sections and to define their relationships, their organization and their functions.

Section 1. Organization of Medical Staff Departments and Sections

There shall be seven (7) departments of the Medical Staff: Department of Medicine; Department of Surgery; Department of Pathology; Department of Radiology; Department of Anesthesiology; Department of Emergency Services; and Department of Hospital Medicine. Each department - shall be organized as a separate part of the Medical Staff and shall have a chairperson who shall be responsible for the supervision of his department. The chairperson must be certified by an appropriate specialty board, or affirmatively establish, through the privilege delineation process,

that he possesses comparable competence. The Chairpersons of the Departments of Medicine and Surgery must have been a member of the Active Medical Staff for two (2) years. Each chairperson shall be nominated by the section chiefs of his department, elected by his department, and approved by the Medical Executive Committee and the Board of Directors. He shall be elected to serve for a period of two (2) years. He may succeed himself. The Chairpersons of the Departments of Pathology, Radiology, Anesthesiology, Emergency Services and Hospital Medicine shall be the physician who is authorized by the Board of Directors to direct that Hospital service.

There shall be sections within the Departments of Medicine and Surgery. The decision to create a section shall be based on the existence of multiple Members of the Active Medical Staff practicing in the same specialty or sub-specialty area with a volume of patients sufficient to indicate the need for efficient and effective management. A recommendation to create, eliminate, subdivide, or delete a section shall be made by the Medical Executive Committee and shall be approved by the Board of Directors.

There shall be a chief of each section of the Departments of Medicine and Surgery elected by the members of the respective sections. The elected chief must have been a member of the Active Medical Staff for the prior eighteen (18) months, consecutively. In the event a section does not have Active members, the Medical Executive Committee may appoint a Courtesy staff member to serve as section chief for a defined period of time. The Section Chief must be certified by an appropriate specialty board, or affirmatively establish, through the credentialing process, that he possesses comparable competence. He shall be elected to serve for two (2) years and may be re elected.

The Chairperson of the Department of Surgery and each section chief from within the department shall form the Executive Committee of the Department of Surgery. This committee shall meet as often as necessary, to consider any issue affecting the department. Recommendations made by the committee shall be forwarded to the Medical Executive Committee for consideration.

Responsibilities of Medical Staff Department Chairpersons and Section Chiefs.

A. Department Chairs and Section Chiefs are responsible for the following:

1. All clinically related activities of the department;
2. All administratively related activities of the department, unless otherwise provided for by the hospital;
3. Continuing surveillance of the professional performance of all individuals who have delineated Clinical Privileges in the department;
4. Recommending to the Medical Staff the criteria for Clinical Privileges that are relevant to the care provided in the department;
5. Recommending Clinical Privileges for each member of the department;
6. Integrating the department into the organization's primary functions;

7. Coordinating and integrating interdepartmental and intradepartmental services;
8. Developing and implementing policies and procedures that guide and support the provision of care, treatment and services;
9. Recommending a sufficient number of qualified and competent persons to provide care, treatment and services;
10. Determining the qualifications and competence of department personnel who provide patient care, treatment and services and who are not licensed independent practitioners;
11. Continuously assessing and improving the performance of care, treatment and services provided;
12. Maintaining quality control programs, as appropriate;
13. Orienting and providing in-service training , and continuing education of persons in the department;
14. Recommending space and other resources needed by the department;
15. Assessing and recommending to the Board of Directors off-site sources for needed patient care, treatment and services not provided by the department or organization; and
16. Issuance of reports as required.

Section 2. Assignment to Medical Staff Departments and Sections

The Medical Executive Committee shall, after consideration of the recommendation of the Credentials Committee, recommend initial departmental and sectional assignments for all Medical Staff Members and for Allied Health Professionals within any department. The exercise of Clinical Privileges shall be subject to the Rules and Regulations pertaining to that department/section and the authority of the department chairperson or section chief. Each member of the Department of Medicine and Surgery shall be assigned membership in only one section, but may be granted Clinical Privileges in more than one section.

Section 3. Functions of Medical Staff Departments and Sections

Each department/section shall establish its own criteria, consistent with the policies of the Medical Staff and of the Board of Directors for the granting of Clinical Privileges.

All departments and sections shall meet as necessary to assure the provision of quality patient care through the monitoring and evaluation of the quality and effectiveness of patient care. The departments and sections may elect to meet individually or jointly.

The duties involving patient care evaluation and monitoring programs are:

A. adopt, subject to the approval of the Medical Executive Committee and the Board, a system designed to routinely collect information about important aspects of patient care provided by practitioners and about the clinical performance of

practitioners. Objective criteria, which have been agreed upon by each department and that reflect current knowledge and clinical experience, shall be used in the monitoring and evaluation system. At the discretion of the department or section, expert review may be sought to aid in the patient care evaluation and monitoring program. The duties include the periodic assessment of the information collected to identify opportunities to improve patient care and to identify important problems in patient care.

B. take actions and evaluate the effectiveness of such actions, when important problems in patient care and clinical performance or opportunities to improve care are identified.

C. document, as appropriate, but at least annually, the findings and results of department, section and committee quality monitoring and evaluation indicators and other staff activities designed to monitor patient care practice. Actions taken to correct identified problems or opportunities to improve patient care will be documented at least quarterly.

D. submit reports at least annually to the Medical Staff Peer Review Committee and Medical Executive Committee on the overall quality and efficiency of medical care provided in the Hospital and on department, section and committee patient care evaluation and monitoring activities.

E. participate in developing mechanism for assuring the accountability of the medical staff of the hospital for the care provided and for assuring the provision of the same level of quality of patient care by all practitioners, which mechanisms shall be described in the hospital's Quality Assessment/Risk Management Plan.

F. in addition, the quality assessment/improvement activities may be performed by various committees of the staff, including but not limited to the committees performing functions listed in Section 1. Paragraphs A, B, D, F, G, and H of the Medical Staff Committee Manual. In performing quality assessment/improvement functions (including but not limited to peer review, credentials, utilization review and functions designed to improve, promote or review quality of patient care) the minutes, proceedings, records, reports, memoranda, statements, recommendations, letters, data and other communications of the committees and staff members shall be confidential, privileged, and protected from discovery or admission into evidence to the fullest extent provided or permitted by state law.

G. participate, as appropriate in risk management activities of the Hospital related to the clinical aspects of patient care and safety by identifying general areas of potential risk, developing criteria for identifying specific cases with potential risk,

correct clinical problems and design programs to reduce risk in the clinical aspects of patient care and safety.

ARTICLE IV. MEDICAL EXECUTIVE COMMITTEE

The Medical Executive Committee shall consist of twenty-six (26) members:
(1) Chief of Staff;
(2) Vice Chief of Staff;
(3) the Chairperson of the Credentials Committee;
(4) the Chairperson of the Physicians' Quality Assessment-Improvement Committee;
(5-11) the Chairpersons of the Departments of Medicine, Surgery, Hospital Medicine, Anesthesiology, Emergency Medicine, Pathology and Radiology;
(12-19) eight (8) section chiefs from the Department of Medicine to include the section chief of cardiology, the section chief of general medicine, the section chief of gastroenterology, the section chief of infectious disease, the section chief of nephrology, the section chief of neurology, the section chief of oncology and the section chief of pulmonary/critical care;
(20-25) six (6) section chiefs from the Department of Surgery to include the section chief of cardiothoracic surgery, the section chief of vascular surgery, the section chief of orthopedic surgery, the section chief of general surgery, the section chief of urology, and the section chief of gynecology; and
(26) the medical director of the intensivist service. In the event a Medical Staff member holds two seats on the Medical Executive Committee, the Chief of Staff shall appoint a replacement for one seat.

The President or his designee attends each meeting as an ex-officio without a vote.

Any voting member of the committee may appoint a member of the Active Medical Staff with power to vote in his absence.

Medical Executive Committee meetings shall be open to any Member. Executive Session may be called at the discretion of the chairperson or presiding Member when matters requiring confidentiality are to be discussed. The Medical Executive Committee empowers the Executive Session with the full powers of the Medical Executive Committee.

The Chief of Staff serves as chairperson of this committee.

The duties of the Medical Executive Committee shall be:

A. to represent and to act on behalf of the Medical Staff, subject to such limitations as may be imposed by these Bylaws;

B. to coordinate the activities and general policies of the various departments;

C. to receive and act upon committee reports;

D. to implement policies of the Medical Staff not otherwise the responsibility of the departments;

E. to recommend action to the President on matters of a medico-administrative nature;

F. to make recommendations on Hospital management matters which affect the Medical Staff to the Board of Directors;

G. to fulfill the Medical Staff's accountability to the Board of Directors for quality of the overall medical care rendered to patients in the Hospital;

H. to ensure that the Medical Staff is kept abreast of quality assessment/improvement and standards compliance status of the Hospital;

I. to review the credentials of all Applicants and to make recommendations for staff membership, assignment to departments and delineations of Clinical Privileges;

J. to review periodically all information available regarding the performance and clinical competence of Staff Members and other Practitioners with Clinical Privileges and, as a result of such reviews, to make recommendations for reappointments and renewal or changes in Clinical Privileges as provided in Articles I and II of the Medical Staff Credentials Manual;

K. to take all reasonable steps to ensure professionally ethical conduct and competent clinical performance on the part of all Practitioners, including the initiation of and/or participation in corrective or review measures when warranted;

L. to report at each general staff meeting.

M. makes recommendations to the Board of Directors on the organization of the quality assessment/improvement activities of the medical staff, as well as the mechanism used to conduct, evaluate and revise such activities.

N. report at least quarterly to the Board of Directors on the findings of Medical Staff quality assessment/improvement monitoring and evaluation activities.

O. approves sources of patient care provided outside the Hospital.

ARTICLE V. MEETINGS

Section 1. General Staff Meetings

There shall be three general meetings of the Medical Staff. These will be held in the winter, summer and fall.

The winter meeting will be designated the annual meeting at which time officers, department Chairpersons, section chiefs and committee Chairpersons shall make their annual reports.

Section 2. Special Meetings

Special meetings of the Medical Staff may be called at any time by the Board of Directors, the Chief of Staff, the President or any twenty-five (25) Members of the Active Staff. No business shall be transacted at any special meeting except that stated in the notice calling the meeting. Sufficient notice shall be given each Member of the staff and the President by notification at least forty-eight (48) hours in advance.

Section 3. Departmental Meetings

Departments and sections shall hold meetings in accordance with Article VII. Section 3B of these Bylaws.

Section 4. Attendance at Meetings

All Members of the Medical Staff are strongly encouraged to attend the departmental/section, regular, special, and annual staff meetings but attendance is not mandatory. Attendance at these meetings will be recorded.

Any Member, regardless of Staff classification, who has attended a case that is to be presented for discussion at a departmental meeting shall be notified and shall be present for the discussion.

Section 5. Voting

Only Active Staff Members shall be eligible to vote at departmental/section, regular, annual and special staff meetings.

For any regular or special meeting of the medical staff, a department, section or committee, those voting members present shall constitute a quorum. However, for Medical Executive Committee and Credentials Committee meetings, the presence of at least one-half of the total membership eligible to vote is necessary for a quorum. Once a quorum is established, the business of the meeting may continue and all actions taken shall be binding.

Any Member eligible to vote at regular, annual or special staff meetings may request a question to be decided by a written ballot.

ARTICLE VI. MEDICAL HISTORIES AND PHYSICAL EXAMINATIONS

A. The attending physician shall perform and record an admission history and physical (H&P) examination within 24 hours after the patient's admission but prior to an invasive, interventional, surgical or diagnostic procedure, except in emergency situations.

1) The admission H&P may also be performed and recorded by the physician's physician assistant or nurse practitioner to be reviewed, approved and co-signed by the physician. The physician's registered nurse may dictate the H&P to be reviewed, amended as necessary, approved and co-signed by the physician. (The H&P must be performed by the physician and not the RN.)

2) Patients admitted for dental surgery must have recorded on their chart an admission history and physical examination performed by a physician on staff of this hospital who shall be responsible for the medical aspects of care throughout the patient's hospital stay. A history and pertinent physical findings shall also be recorded by the oral surgeon.

3) The admission H&P for patients admitted for podiatric surgery with ASA Class I designation may be performed and recorded by a podiatrist who has been granted such privileges. Otherwise, these patients must have recorded on their chart an admission history and physical examination performed by a physician member of Saint Joseph's Medical Staff who shall be responsible for the medical aspects of care throughout the patient's hospital stay. A history and pertinent physical findings shall also be recorded by the podiatric surgeon.

B. If a patient's H&P is completed before admission:

1) The H&P must have been performed and recorded, within 30 days prior to hospital admission, by a member of the Saint Joseph's Medical Staff or by a referring physician not on the Saint Joseph's Medical Staff.

2) An update note is required as follows:

a. The attending physician, or other designee qualified to perform the H&P, must perform an updated physical assessment of the patient to update any components of the patient's current medical status that may have changed since the prior H&P, including confirming that the necessity for the procedure or care is still present and the H&P is still current.

b. The update note must be documented within 24 hours after the patient's admission but before an invasive, interventional, surgical or diagnostic procedure (except in emergency situations).
c. The History and Physical Update Note form must be used, including documenting the location of the original History and Physical Exam and what changes have occurred since the time of the original History and Physical Exam.

C. When the history and physical examination has not been recorded prior to the time of an invasive, interventional or diagnostic procedure, the procedure shall be cancelled, unless the attending surgeon states in writing that such delay would constitute hazard to the patient. In cases where histories and physical examinations have been dictated but not yet typed and placed in the patient's record, a written statement to this effect in the admission note along with any pertinent information necessary for the safe administration of anesthesia and conduct of the operative procedure will be acceptable.

D. At a minimum, the history and physical report shall include histories, systems reviews, and physical findings pertinent to the current illness or procedure and shall also include the following:

- A statement of the reason for admission to the hospital stated as a chief complaint.
- In the case of surgery or other procedure, a statement as to the necessity for the procedure.
- A history of any drug allergies.
- A statement of the working diagnosis, conclusions or impressions drawn from the history and physical examination.
- A plan of diagnostic and or therapeutic action.

E. The following table is prepared as a guideline to physicians to describe the H&P requirements based on patient status (inpatient or outpatient) or level of sedation administered for the procedure.

Patient status or Anesthesia Type	H&P Requirement	Transfer Records
Inpatient Admission	Comprehensive H&P Chief complaint History of present illness Past History Medications Family History Social History Review of systems Physical examination	H&P from transferring facility & physician acceptable if: • completed within 7 days of admission to SJHA • exam meets SJHA criteria above • Staff MD reviews, confirms and/or updates H&P and authenticates confirmation in record

	Vital signs General Skin HEENT Neck Heart Lungs Abdomen Extremities Neurological When appropriate to the medical condition or care provider: Breast Pelvic Rectal Assessment Plan of treatment	or on H&P
Outpatient Procedures with Deep Sedation (Includes: General Anesthesia, Blocks, MAC)	Comprehensive H&P or Short Stay Form	Same as above
Patient status or Anesthesia Type	H&P Requirement	Transfer Records
Outpatient Procedures with Moderate Sedation (Includes Conscious Sedation)	1. Minimum H&P (as noted above); or 2. Completed Conscious Sedation Form; or 3. Focused physicians' office note or 4. Short Stay Form	Same as above
Outpatient Procedures with Minimum Sedation	Minimum H&P	Same as above
Outpatient Observation	Short Stay H&P; or Minimum H&P; or Progress Note detailing reasons for observation status	
Outpatient Emergency Department encounter	Comprehensive H&P; or Minimum H&P pertinent to illness	
Outpatient Procedures with	No H&P required	

Local anesthetic only		

ARTICLE VII. OTHER MEDICAL STAFF DOCUMENTS

In addition to the Medical Staff Bylaws, there shall be policies and procedures and other applicable documents of the Medical Staff. These Medical Staff documents include, but are not limited to, the Medical Staff Credentials Manual, the Medical Staff Committee Manual, the Allied Health Professionals Manual and the Medical Staff Rules and Regulations. Adoption of and changes to these documents will become effective only when approved by the Board of Directors.

Section 1. Rules and Regulations

The Medical Staff shall adopt such Rules and Regulations as may be necessary to implement more specifically the general principles found within these Bylaws, subject to the approval of the Board of Directors. These shall relate to the proper conduct of Medical Staff organizational activities as well as embody the level of practice that is to be required of each Practitioner in the Hospital.

An amendment to the Medical Staff Rules and Regulations may be made by a majority vote of the members of the Medical Executive Committee. Notice of all proposed amendments to the Rules and Regulations shall be provided to each voting member of the Medical Staff at least fourteen (14) days prior to the vote by the Medical Executive Committee. Any voting member of the Medical Staff may submit written comments on the amendments to the Medical Executive Committee.

The Medical Executive Committee and the Board shall have the power to provisionally adopt urgent amendments to the Medical Staff Rules and Regulations that are needed in order to comply with any law or regulation, without providing prior notice of the proposed amendments to the Medical Staff. Notice of all provisionally adopted amendments shall be provided to each member of the Medical Staff as soon as possible. The Medical Staff shall have fourteen (14) days to review and provide comments on the provisional amendments to the Medical Executive Committee. If there is no conflict between the Medical Staff and the Medical Executive Committee, the provisional amendments to the Medical Staff Rules and Regulations shall stand. If there is conflict over the provisional amendments, then the process for resolving conflicts shall be implemented.

Amendments to the Medical Staff Rules and Regulations may also be proposed by a petition signed by twenty five percent (25%) of the voting members of the Medical Staff. Any such proposed amendments will be reviewed by the Medical Executive Committee.

Adoption of and changes to the Medical Staff Rules and Regulations will become effective only when approved by the Board and communicated to the Medical Staff.

Section 2. Credentials Manual

The Medical Staff shall follow such procedures for appointment and reappointment to the Medical Staff as are more specifically described in the Medical Staff Credentials Manual.

The Credentials Manual shall fully describe the application for appointment to the Medical Staff, the process utilized in reviewing and acting upon each application for appointment, reappointment, requests for modification of appointment and the granting of Clinical Privileges.

An amendment to the Credentials Manual may be made by a majority vote of the members of the Medical Executive Committee, provided that the written recommendations of the Credentials Committee concerning the proposed amendments shall have first been received and reviewed by the Medical Executive Committee. Notice of all proposed amendments to the Credentials Manual shall be provided to each voting member of the Medical Staff at least fourteen (14) days prior to the vote by the Medical Executive Committee. Any voting member of the Medical Staff may submit written comments on the amendments to the Medical Executive Committee.

Adoption of and changes to the Credentials Manual will become effective only when approved by the Board and communicated to the Medical Staff.

Section 3. Committee Manual

The Medical Staff shall designate in the Medical Staff Committee Manual the committees necessary to carry out the functions of the Medical Staff organization. The Committee Manual will define the composition, duties and accountability of each committee as well as establish the nature and frequency of meetings of said committees.

An amendment to the Medical Staff Committee Manual may be made by a majority vote of the members of the Medical Executive Committee. Notice of all proposed amendments to the Committee Manual shall be provided to each voting member of the Medical Staff at least fourteen (14) days prior to the vote by the Medical Executive Committee. Any voting member of the Medical Staff may submit written comments on the amendments to the Medical Executive Committee.

Adoption of and changes to the Medical Staff Committee Manual will become effective only when approved by the Board and communicated to the Medical Staff.

Section 4. Policies and Procedures

The Medical Staff has the responsibility to develop policies and procedures to guide and direct its implementation of the general principles found within these Bylaws.

Such policies and procedures shall be a part of these Bylaws, except that they may be adopted and amended by a majority vote of the Medical Executive Committee. Adoption of and changes to Medical Staff policies and procedures will become effective when approved by the Board of Directors and communicated to the Medical Staff.
Amendments to Medical Staff policies and procedures may also be proposed by a petition signed by twenty five percent (25%) of the voting members of the Medical Staff. Any such proposed amendments will be reviewed by the Medical Executive Committee.

Section 5. Allied Health Professionals Manual

The Allied Health Professionals Manual sets forth the credentialing process and the general practice parameters for Allied Health Professionals not on the Medical Staff who are permitted to provide services at the Hospital.

> An amendment to the Allied Health Professionals Manual may be made by a majority vote of the members of the Medical Executive Committee, provided that the written recommendations of the Credentials Committee concerning the proposed amendments shall have first been received and reviewed by the Medical Executive Committee. Notice of all proposed amendments to these documents shall be provided to each voting member of the Medical Staff at least fourteen (14) days prior to the vote by the Medical Executive Committee. Any voting member of the Medical Staff may submit written comments on the amendments to the Medical Executive Committee.

Adoption of and changes to the Allied Health Professionals Manual will become effective only when approved by the Board and communicated to the Medical Staff.

ARTICLE VIII. CONFLICT MANAGEMENT PROCESS

In the event there is a conflict between the Medical Staff and the Medical Executive Committee with regard to: (a) proposed amendments to the Medical Staff Rules and Regulations, (b) a new policy and procedure proposed by the Medical Executive Committee, or (c) proposed amendments to an existing policy and procedure that is under the authority of the Medical Executive Committee, a special meeting of the Medical Staff will be called in accordance with the process for calling special meetings. The agenda for that meeting will be limited to the amendment(s) or policy and procedure at issue. The purpose of the meeting is to strive to resolve differences that exist with respect to Medical Staff Rules and Regulations or policies and procedures.

If the differences cannot be resolved, the Medical Executive Committee shall forward its recommendations, along with the proposed recommendations pertaining to the Medical Staff Rules and Regulations or policies and procedures offered by the voting members of the Medical Staff, to the Board of Directors for final action.

ARTICLE IX. BASIC STEPS AND DETAILS

The details associated with the following Basic Steps are contained in the Credentials Manual and the Allied Health Professionals Manual.

Section 1. Qualifications for Appointment

To be eligible to apply for initial appointment or reappointment to the Medical Staff or for the grant of Clinical Privileges, an Applicant must demonstrate appropriate education, training, experience, current clinical competence, professional conduct and ability to safely and competently perform the Clinical Privileges requested as set forth in the Credentials Manual.

Section 2. Process for Privileging

Complete applications are transmitted to the applicable department chairperson and section chief, who prepare written reports to the Credentials Committee, Medical Executive Committee and Board.

Section 3. Process for Credentialing (Appointment and Reappointment)

Complete applications are transmitted to the applicable department chairperson and section chief, who prepare written reports to the Credentials Committee, Medical Executive Committee and Board.

Section 4. Indications and Process for Automatic Relinquishment of Appointment and/or Privileges

A. Appointment and Clinical Privileges will be automatically relinquished if an individual:

1. fails to do any of the following:
   - timely complete medical records;
   - satisfy threshold eligibility criteria;
   - provide requested information;
   - attend a special conference;

2. is involved or alleged to be involved in defined criminal activity; or

3. makes a misstatement or omission on an application form.

B. Automatic relinquishment shall take effect immediately and shall continue until the matter is resolved in the specified manner.

Section 5. Indications and Process for Precautionary Suspension

A. Whenever failure to take action may result in imminent danger to the health and/or safety of any individual or may interfere with the orderly operation of the Hospital, the Chief of Staff, the chairperson of a clinical department, the President of the Hospital, or the Board chairperson is authorized to suspend or restrict all or any portion of an individual's Clinical Privileges pending an investigation.

B. A precautionary suspension is effective immediately and will remain in effect unless it is modified by the President of the Hospital or Medical Executive Committee.

C. The individual shall be provided a brief written description of the reason(s) for the precautionary suspension.

D. The Medical Executive Committee will review the reasons for the suspension within a reasonable time.

E. Prior to, or as part of, this review, the individual will be given an opportunity to meet with the Medical Executive Committee.

Section 6. Indications and Process for Recommending Termination or Suspension of Appointment and Privileges or Reduction of Privileges

Following an investigation, the Medical Executive Committee may recommend suspension or revocation of appointment or Clinical Privileges based on concerns about (a) clinical competence or practice; (b) violation of ethical standards or the bylaws, policies, Rules and Regulations of the Hospital or the Medical Staff; or (c) conduct that is considered lower than the standards of the Hospital or disruptive to the orderly operation of the Hospital or its Medical Staff.

Section 7. Hearing and Appeal Process, Including Process for Scheduling and Conducting Hearings and the Composition of the Hearing Panel.

A. The hearing will begin no sooner than (thirty) 30 days after the notice of the hearing, unless an earlier date is agreed upon by the parties.

B. The Hearing Panel will consist of at least three (3) members or there will be a Hearing Officer.

C. The hearing process will be conducted in an informal manner; formal rules of evidence or procedure will not apply.

D. A stenographic reporter will be present to make a record of the hearing.

E. Both sides will have the following rights, subject to reasonable limits determined by the Presiding Officer: (a) to call and examine witnesses, to the extent they are available and

willing to testify; (b) to introduce exhibits; (c) to cross-examine any witness on any matter relevant to the issues; (d) to have representation by counsel who may call, examine, and cross-examine witnesses and present the case; and (e) to submit a written statement at the close of the hearing.

F. The personal presence of the affected individual is mandatory. If the individual who requested the hearing does not testify, he or she may be called and questioned.
G. The Hearing Panel may question witnesses, request the presence of additional witnesses, and/or request documentary evidence.

H. The affected individual and the Medical Executive Committee may request an appeal of the recommendations of the Hearing Panel to the Board.

ARTICLE X. GENERAL PROVISIONS

Section 1. Forms

Application forms and any other forms required by these Bylaws for use in connection with staff appointments, reappointments, delineations of Clinical Privileges, corrective action, notices, recommendations, reports and other matters shall be adopted by the Medical Executive Committee.

Section 2. Construction of Terms and Headings

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

Section 3. Transmittal of Reports

Reports and other information which these Bylaws require the medical staff to transmit to the Board shall be deemed so transmitted when delivered to the President.

Section 4. Exclusive Means

These Bylaws provide the sole and exclusive means for the delivery of patient services by practitioners at the hospital. No practitioner shall deliver any such services at the hospital unless such practitioner has been granted privileges hereunder to deliver such services at the hospital.

ARTICLE XI. ADOPTION OF A UNIFIED MEDICAL STAFF

If the Board adopts a single unified Medical Staff structure that includes the Hospital, the voting members of the Medical Staff may approve or opt out of the unified Medical Staff structure by conducting a vote in accordance with the process outlined in Section 8.A for amending these Medical Staff Bylaws.

Upon approval of a unified Medical Staff structure, the unified Medical Staff will adopt Medical Staff bylaws, policies, and rules and regulations that:

(a) take into account the unique circumstances of each participating hospital, including any significant differences in the patient populations that are served and the clinical services that are offered; and

(b) address the localized needs and concerns of Medical Staff members at each of the participating hospitals.

If a unified Medical Staff structure is approved, the voting members of the unified Medical Staff may later vote to opt out of the unified Medical Staff. Any such vote will be conducted in accordance with the process outlined in the Medical Staff Bylaws in force at the time of the vote.

ARTICLE XII. AMENDMENTS

Amendments to the Medical Staff Bylaws may be proposed by a petition signed by at least ten percent (10%) of the voting members of the Medical Staff or by the Medical Executive Committee.

All proposed amendments must be reviewed by the Medical Executive Committee prior to a vote by the Medical Staff. The Medical Executive Committee shall provide notice of all proposed amendments, including amendments proposed by a petition of the voting members of the Medical Staff as set forth above, to the voting members of the Medical Staff. The Medical Executive Committee may also report on any proposed amendments, either favorably or unfavorably, at the next regular meeting of the Medical Staff, or at a special meeting called for such purpose.

The proposed amendments may be voted upon at any meeting of the Medical Staff if notice has been provided at least fourteen (14) days prior to the meeting. To be adopted, the amendment must receive a majority of the votes cast by the voting members of the Medical Staff at the meeting.

The Medical Executive Committee may also present any proposed amendments to the voting members of the Medical Staff by written or electronic ballot, returned to the Medical Staff Office by the date indicated by the Medical Executive Committee. Along with the proposed amendments, the Medical Executive Committee may, in its discretion, provide a written report on them either favorably or unfavorably. To be adopted, an amendment must receive a majority of the votes cast by the respondents.

The Medical Executive Committee shall have the power to adopt such amendments to these Bylaws which are needed because of reorganization, renumbering, or punctuation, spelling or other errors of grammar or expression.

All amendments shall be effective only after approval by the Board.

If the Board has determined not to accept a recommendation submitted to it by the Medical Executive Committee or the Medical Staff, the Medical Executive Committee may request a conference between the officers of the Board and the officers of the Medical Staff. Such conference shall be for the purpose of further communicating the Board's rationale for its contemplated action and permitting the officers of the Medical Staff to discuss the rationale for the recommendation. Such a conference will be scheduled by the President of the Hospital within two weeks after receipt of a request.

Medical Staff Bylaws, Rules and Regulations, Credentials Manual, Committee Manual, Allied Health Professional Manual and Medical Staff policies shall be reviewed at least every three (3) years by the Medical Staff.

ARTICLE XIII. ADOPTION

These Bylaws and any amendments thereto, shall be adopted and become effective when approved by the Board of Directors. Such adoption automatically repeals any previous bylaws of the Medical Staff.

APPROVED BY THE MEDICAL EXECUTIVE COMMITTEE ON NOVEMBER 17, 2020.

APPROVED BY THE BOARD OF DIRECTORS ON DECEMBER 16, 2020.

MEDICAL STAFF BYLAWS, POLICIES, AND RULES AND REGULATIONS
OF
EMORY SAINT JOSEPH'S HOSPITAL

MEDICAL STAFF

CREDENTIALS MANUAL

November 23, 2020

TABLE OF CONTENTS

PAGE

1. GENERAL 1

1.A. DEFINITIONS 1

1.B. TIME LIMITS 3

1.C. DELEGATION OF FUNCTIONS 3

2. QUALIFICATIONS, CONDITIONS AND RESPONSIBILITIES 4

2.A. QUALIFICATIONS 4

2.A.1. Eligibility Criteria 4
2.A.2. Eligibility Criteria for Research Affiliate Staff 6
2.A.2. Waiver of Criteria 7
2.A.3. Factors for Evaluation 7
2.A.4. No Entitlement to Appointment 8
2.A.5. Nondiscrimination 8
2.A.6. Ethical and Religious Directives 8

2.B. GENERAL CONDITIONS OF APPOINTMENT AND REAPPOINTMENT 8

2.B.1. Basic Responsibilities and Requirements 8
2.B.2. Basic Responsibilities and Requirements for Research Affiliate Staff. 10
2.B.3. Burden of Providing Information 11

2.C. APPLICATION 12

2.C.1. Information 12
2.C.2. Grant of Immunity and Authorization to Obtain/Release Information 13

3. PROCEDURE FOR INITIAL APPOINTMENT 15

3.A. PROCEDURE FOR INITIAL APPOINTMENT 15

3.A.1. Request for Application 15

PAGE

3.A.2. Initial Review of Application 15
3.A.3. Steps to Be Followed for All Initial Applicants 15
3.A.4. Department Chairperson and Section Chief Procedure 15
3.A.5. Credentials Committee Procedure 15
3.A.6. Staff Executive Committee Recommendation 17
3.A.7. Board Action 17
3.A.8. Time Periods for Processing 18

4. CLINICAL PRIVILEGES 19

4.A. CLINICAL PRIVILEGES 19

4.A.1. General 19
4.A.2. Voluntary Relinquishment of Privileges 20
4.A.3. Clinical Privileges for New Procedures 21
4.A.4. Clinical Privileges That Cross Specialty Lines 22
4.A.5. Clinical Privileges for Dentists and Oral and Maxillofacial Surgeons 22
4.A.6. Clinical Privileges for Podiatrists 23
4.A.7. Physicians in Training 23
4.A.8. Telemedicine Privileges 24

4.B. TEMPORARY CLINICAL PRIVILEGES 25

4.B.1. Eligibility to Request Temporary Clinical Privileges 25
4.B.2. Supervision Requirements 25
4.B.3. Termination of Temporary Clinical Privileges 26

4.C. EMERGENCY SITUATIONS 27

4.D. DISASTER PRIVILEGES 27

4.E. CONTRACTS FOR SERVICES 28

5. PROCEDURE FOR REAPPOINTMENT 30

5.A. PROCEDURE FOR REAPPOINTMENT 30

5.A.1. Eligibility for Reappointment 30
5.A.2. Factors for Evaluation 30
5.A.3. Reappointment Application 32

PAGE

5.A.4. Processing Applications for Reappointment 33
5.A.5. Time Periods for Processing 33

6. PEER REVIEW PROCEDURES FOR MATTERS INVOLVING PROFESSIONAL PERFORMANCE OF MEDICAL STAFF MEMBERS 34

6.A. COLLEGIAL INTERVENTION 34

6.B. INVESTIGATIONS 34

6.B.1. Initial Review 34
6.B.2. Initiation of Investigation 35
6.B.3. Investigative Procedure 36
6.B.4. Recommendation 37

6.C. PRECAUTIONARY SUSPENSION OR RESTRICTION OF CLINICAL PRIVILEGES 39

6.C.1. Grounds for Precautionary Suspension or Restriction 39
6.C.2. Staff Executive Committee Procedure 39
6.C.3. Care of Patients 40

6.D. AUTOMATIC RELINQUISHMENT 40

6.D.1. Failure to Complete Medical Records 40
6.D.2. Action by Government Agency or Insurer 40
6.D.3. Failure to Satisfy Threshold Eligibility Criteria 41
6.D.4. Failure to Provide Requested Information 41
6.D.5. Failure to Attend Special Conference 42

6.E. LEAVES OF ABSENCE 42

7. HEARING AND APPEAL PROCEDURES 44

7.A. INITIATION OF HEARING 44

7.A.1. Grounds for Hearing 44
7.A.2. Actions Not Grounds for Hearing 45
7.A.3. Notice of Recommendation 45
7.A.4. Request for Hearing 46
7.A.5. Notice of Hearing and Statement of Reasons 46

PAGE

7.A.6. Witness List 46
7.A.7. Hearing Panel, Presiding Officer, and Hearing Officer 47
7.A.8. Counsel....49

7.B. PRE-HEARING PROCEDURES....49

7.B.1. General Procedures 49
7.B.2. Provision of Relevant Information....49
7.B.3. Pre-Hearing Conference....50
7.B.4. Stipulations....50
7.B.5. Provision of Information to the Panel 50

7.C. THE HEARING....50

7.C.1. Failure to Appear....50
7.C.2. Record of Hearing....51
7.C.3. Rights of Both Sides and the Hearing Panel at the Hearing 51
7.C.4. Admissibility of Evidence....51
7.C.5. Post-Hearing Statement....51
7.C.6. Persons to be Present....52
7.C.7. Postponements and Extensions 52
7.C.8. Presence of Hearing Panel Members 52

7.D. HEARING CONCLUSION, DELIBERATIONS, AND RECOMMENDATIONS 52

7.D.1. Order of Presentation 52
7.D.2. Basis of Hearing Panel Recommendation....52
7.D.3. Deliberations and Recommendation of the Hearing Panel 52
7.D.4. Disposition of Hearing Panel Report 53

7.E. APPEAL PROCEDURE 53

7.E.1. Time for Appeal 53
7.E.2. Grounds for Appeal....53
7.E.3. Time, Place and Notice 53
7.E.4. Nature of Appellate Review....53
7.E.5. Final Decision of the Board 54
7.E.6. Further Review....54
7.E.7. Right to One Hearing and One Appeal Only 54

PAGE

8. CONFIDENTIALITY AND PEER REVIEW PROTECTION.....55

8.A. CONFIDENTIALITY.....55
8.B. PEER REVIEW PROTECTION.....55

9. AMENDMENTS.....57

10. ADOPTION.....58

ARTICLE 1

GENERAL

1.A. DEFINITIONS

The following definitions apply to terms used in this Manual:

(1) "ALLIED HEALTH PROFESSIONALS" ("AHPs") means individuals other than Medical Staff members who are authorized by law and by the Hospital to provide patient care services.

(2) "BOARD" means the Board of Directors of the Hospital, which has the overall responsibility for the Hospital, or its designated committee.

(3) "BOARD CERTIFICATION" is the designation conferred by one of the affiliated specialties of the American Board of Medical Specialties ("ABMS") upon a practitioner who has successfully completed an approved educational training program and an evaluation process, including passing an examination, in the applicant's area of clinical practice.

(4) “BYLAWS” means the Medical Staff Bylaws of Saint Joseph’s Hospital of Atlanta, Inc.

(5) "CLINICAL PRIVILEGES" means the authorization granted by the Board to render specific patient care services.

(6) "DAYS" means calendar days.

(7) "DENTIST" means a doctor of dental surgery ("D.D.S.") or doctor of dental medicine ("D.M.D.").

(8) “Focused Professional Practice Evaluation” means a time-limited period of evaluating and determining a practitioner’s, privilege-specific competence, if the practitioner a) does not have documented evidence of competency performing the required privilege at the hospital; or b) a question has arisen regarding the practitioner’s ability to provide safe, high quality patient care. This type of Focused Evaluation is implemented for all initially requested privileges and it can include chart review, monitoring, simulation, proctoring, external peer review and discussion with individuals involved in patient care.

(9) "HOSPITAL" means Saint Joseph's Hospital of Atlanta, Inc.

(10) "MEDICAL STAFF" means all physicians, podiatrists and dentists who have been appointed to the Medical Staff by the Board.

(11) "MEDICAL STAFF LEADER" means any Medical Staff officer, medical director, department chairperson, section chief, and committee chair.

(12) "MEMBER" means any physician, podiatrist and dentist who has been granted Medical Staff appointment and clinical privileges by the Board to practice at the Hospital.

(13) "NOTICE" means written communication by regular U.S. mail, e-mail, facsimile, or Hospital mail, or hand delivery.

(14) “Ongoing Professional Practice Evaluation” means ongoing review and identification of professional practice trends. This type of Ongoing Evaluation can include chart review, direct observation, monitoring, and discussions. This information is used to determine a) whether to continue, limit, or revoke existing privileges; and b) whether a period of Focused Evaluation for a particular practitioner should occur.

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

(16) "PATIENT CONTACTS" includes any admission, consultation, procedure, response to emergency call, evaluation, treatment, or service performed in any facility operated by the Hospital or affiliate, including outpatient facilities.

(17) "PHYSICIAN" includes both doctors of medicine ("M.D.s") and doctors of osteopathy ("D.O.s").

(18) “PODIATRIST” means a physician and surgeon of the human foot and leg; doctor of podiatric medicine (“DPM”)

(19) “PRACTITIONER” means, unless otherwise expressly defined, a Physician, Podiatrist, Dentist or AHP who has Clinical Privileges in the Hospital.

(20) "PRESIDENT" means the individual appointed by the Board to act on its behalf in the overall management of the Hospital.

(21) “RESEARCH AFFILIATE STAFF” means any non-physician, podiatrist, or dentist who has an academic appointment in a college or university or a

research and development scientist in medical industry who has been granted a Research Affiliate Staff appointment and approval by the Board to consult with the Medical Staff on clinical, research, and management matters.

(22) "SPECIAL NOTICE" means hand delivery, certified mail (return receipt requested), or overnight delivery service providing receipt.

(23) "STAFF EXECUTIVE COMMITTEE" means the Executive Committee of the Medical Staff.

1.B. TIME LIMITS

Time limits referred to in this Manual are advisory only and are not mandatory, unless it is expressly stated that a particular right is waived by failing to take action within a specified period.

1.C. DELEGATION OF FUNCTIONS

When a function is to be carried out by a person or committee, the person, or the committee through its chairperson, may delegate performance of the function to one or more qualified designees.

ARTICLE 2

QUALIFICATIONS, CONDITIONS AND RESPONSIBILITIES

2.A. QUALIFICATIONS

2.A.1. Eligibility Criteria:

To be eligible to apply for initial appointment or reappointment to the Medical Staff, physicians, podiatrists and dentists must:

(a) have a current, unrestricted license to practice in Georgia and have never had a license to practice revoked or suspended by any state licensing agency;

(b) where applicable to their practice, have a current, unrestricted DEA registration;

(c) satisfy the following residence and response time requirements so that patients will receive timely and continuous care at the Hospital:

(1) maintain a residence and an office within forty-five (45) minutes of the Hospital;

(2) be able to respond to the Hospital, in person, within forty-five (45) minutes of being requested to do so in order to attend to a patient; and

(3) if the Hospital has any concern with an individual's ability to satisfy (1) and (2), the individual must provide the Hospital with a written agreement from another member of the Medical Staff, with appropriate clinical privileges, who satisfies (1) and (2) and who agrees to be available to care for the individual's patients in the event of an untimely response or unavailability;

(d) have current, valid professional liability insurance coverage in a form and in amounts satisfactory to the Hospital;

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

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

(g) have never had Medical Staff appointment or clinical privileges denied, revoked, resigned, relinquished, or terminated by any health care facility or health plan for reasons related to clinical competence or professional conduct;

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

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

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

(k) have successfully completed a residency training program approved by the Accreditation Council for Graduate Medical Education 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 residency at a program approved by the Council on Podiatric Medical Education. (This requirement is applicable only to those individuals who apply for initial staff appointment on or after the date of adoption of this Manual.);

(l) be certified in the specialty in which they practice by the appropriate specialty board of the ABMS, the American Board of Oral and Maxillofacial Surgery, or the American Board of Podiatric Surgery, as applicable. In the event a physician qualifies for multiple boards, the department chair and section chief shall make recommendations regarding required board certification(s) to the Staff Executive Committee at the time of the physician's initial appointment or reappointment. Those applicants who are not board certified at the time of application must obtain certification within the eligibility time period defined by the appropriate specialty board(s) or, if such board(s) has not defined an eligibility time period, then within four (4) years following completion of the applicant's residency training . (This requirement is applicable only to those individuals who apply for initial staff appointment after the date of adoption of this Manual. All individuals appointed previously shall be governed by the board certification requirements in effect at the time of their appointments); and

(m) all individuals appointed after April 1, 1983 must maintain certification in the specialty in which they practice and, to the extent required by the applicable specialty/subspecialty board, satisfy recertification requirements. In the event a physician qualifies for multiple boards, the department chair and section chief shall make recommendations regarding required board certification(s) to the Staff Executive Committee at the time of the physician's initial

appointment or reappointment. Recertification will be assessed at the time of reappointment according to the following:

(1) A Medical Staff member who fails to pass a recertification examination shall be permitted to retain his/her Medical Staff membership and clinical privileges until such time as he/she is no longer eligible to take the recertification examination; provided, however, that such individual must provide documentation at the time of each reappointment that he/she is actively seeking recertification. Documentation such as CME, review courses, and evidence of the scheduled examinations will be taken into consideration when assessing the individual's satisfaction of this requirement.

(2) Any Medical Staff member who ceases to be eligible to take a recertification examination or who ceases to actively seek recertification shall be ineligible for reappointment until he/she again becomes board certified in the specialty in which he/she practices.

2.A.2. Eligibility Criteria for Research Affiliate Staff

To be eligible to apply for initial appointment or reappointment to the Research Affiliate Staff, the individual must:

(a) Hold a current academic appointment at a college or university or be currently employed as a research and development scientist in medical industry and have no active or pending issues of ethical or professional misconduct;

(b) Have never been convicted of federal or state governmental fraud, program abuse, or have been required to pay civil penalties for the same;

(c) Have never been and are not currently excluded or precluded from participation in federal or state governmental research funding programs;

(d) Have never had an academic appointment terminated, revoked, resigned, relinquished, by an academic institution for reasons related to ethical or professional misconduct; and

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

2.A.3. Waiver of Criteria:

(a) Any individual who does not satisfy a criterion may request that it be waived. The individual requesting the waiver bears the burden of demonstrating that his or her qualifications are equivalent to, or exceed, the criterion in question.

(b) The Board may grant waivers in exceptional cases after considering the findings of the Credentials Committee, Staff Executive Committee, or other committee designated by the Board, the specific qualifications of the individual in question, and the best interests of the Hospital and the community it serves. The granting of a waiver in a particular case is not intended to set a precedent for any other individual or group of individuals.

(c) No individual is entitled to a waiver or to a hearing if the Board determines not to grant a waiver.

(d) A determination that an individual is not entitled to a waiver is not a "denial" of appointment or clinical privileges.

2.A.4. Factors for Evaluation:

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

(a) relevant training, experience, demonstrated current competence, and judgment;

(b) adherence to the ethics of their profession;

(c) good reputation and character;

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

(e) ability to work harmoniously with others sufficiently to convince the Hospital that all patients treated by them will receive quality care and that the Hospital and its Medical Staff will be able to operate in an orderly manner.

(f) demonstration of general competence in patient care, medical/clinical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice.

2.A.5. No Entitlement to Appointment:

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

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

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

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

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

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

Additionally, prior to the granting, reviewing or revising of a privilege, the hospital assesses whether sufficient space, equipment, staffing and financial resources are in place or available in a specified timeframe to support each required privilege.

2.A.6. Nondiscrimination:

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

2.A.7. Ethical and Religious Directives:

All members shall abide by the terms of the Ethical and Religious Directives for Catholic Health Care Services promulgated by the National Conference of Catholic Bishops with respect to their practice at the Hospital. No activity prohibited by said directives shall be engaged in at the Hospital by any Member.

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 specifically agrees to the following:

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

(b) to abide by all Bylaws, policies, Corporate Responsibility Program and Rules and Regulations of the Hospital, Health System and Medical Staff in force during the time the individual is appointed and reappointed;

(c) to accept committee assignments, emergency service call obligations, care for unassigned patients, charity care obligations, and such other reasonable duties and responsibilities as assigned;

(d) to provide immediately within twenty-one (21) days, with or without request, new or updated information to the President as it occurs, pertinent to any question on the application form. Information to be provided includes: final actions by another hospital or health care facility where such member holds Medical Staff membership or has the right to exercise clinical privileges, or from a government agency, resulting in action being taken by such other hospital or health care facility or government agency with respect to such member. The term "action" shall include action seeking to institute probation or require consultation or supervision; reduce, suspend or revoke privileges; reduce staff status or limit any prerogatives directly related to patient care; suspend or revoke staff membership; or suspend or revoke such member's license or right to prescribe any medication. The affected member shall provide the Hospital with complete information as to the reasons for the action and the progress of the proceedings.

Moreover, any member who is summarily suspended from any hospital where he or she holds Medical Staff membership or has the right to exercise clinical privileges or any member who is excluded or debarred from participation in any government health care program must notify the Hospital within twenty-four (24) hours of such summary suspension, exclusion or debarment.

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

(f) to appear for personal interviews in regard to an application for initial appointment or reappointment;

(g) to use the Hospital sufficiently to allow continuing assessment of current competence;

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

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

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

(k) to seek consultation whenever necessary;

(l) to participate in assigned monitoring and evaluation activities;

(m) to complete in a timely manner all medical and other required records, containing all information required by the Hospital;

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

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

(p) to promptly pay any applicable dues, assessments, and/or fines;

(q) to satisfy continuing medical education requirements as may be established by the Staff Executive Committee and the Board; and

(r) that, if there is any misstatement in, or omission from, the application, the Hospital may stop processing the application (or, if appointment has been granted prior to the discovery of a misstatement or omission, appointment and privileges may be deemed to be automatically relinquished). There shall be no entitlement to a hearing or appeal for such issues.

2.B.2. Basic Responsibilities and Requirements for Research Affiliate Staff:

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

(a) to provide consultation with the Medical Staff on areas of mutual interest to the benefit of quality patient care, enhancement of preclinical and clinical research, and improved operations of Saint Joseph's Hospital in Atlanta.

(b) to abide by all Bylaws, policies, Corporate Responsibility Program and Roles and Regulations of the Hospital, Health System, and Medical Staff in force during the time the individual is appointed and reappointed.

(c) to provide immediately within twenty-one (21) days, with or without request, new or updated information to the President as it occurs, pertinent to any question on the application form.

(d) to immediately submit to a blood and/or urine test, or to complete physical and/or mental evaluation, if at least two Medical Staff leaders (or one Medical Staff leader and one member of the Administrative team) are concerned with the individual's ability to safely and competently provide consultation with Medical Staff and/or supervise students. The health care professional(s) to perform the testing and/or evaluations shall be determined by the Medical Staff leadership.

(e) to complete in a timely manner all required documents containing all information required by the Hospital.

(f) to perform all activities in a cooperative and professional manner.

(g) that, if there is any misstatement in, or omission fro, the application, the Hospital may stop processing the application (or, if appointment has been granted prior to the discovery of a misstatement or omission, appointment may be deemed to be automatically relinquished). There shall be no entitlement to a hearing or appeal for such issues.

2.B.3. 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.

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

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

2.C. APPLICATION

2.C.1. Information:

(a) Applications for appointment and reappointment shall contain a request for specific clinical privileges and shall require detailed information concerning the individual's professional qualifications. The applications for initial appointment and reappointment existing now and as may be revised are incorporated by reference and made a part of this Manual.

(b) In addition to other information, the applications shall require the following:

(1) information as to whether the applicant's medical staff 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;

(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;

(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 Staff Executive Committee, or the Board may request; and

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

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

2.C.2. 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, whether or not appointment or clinical privileges are granted, and throughout the term of any appointment or reappointment.

(a) 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, their authorized representatives, and appropriate third parties for any matter relating to appointment, reappointment, clinical privileges, or the individual's qualifications for the same. This includes any actions, recommendations, reports, statements, communications, or disclosures involving the individual which are made, taken, or received by the Hospital, its authorized agents, or appropriate third parties.

(b) 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, 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.

(c) 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, 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.

(d) Hearing and Appeal Procedures:

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

(e) Legal Actions:

If, notwithstanding the provisions in this Section, an individual institutes legal action and does not prevail, he or she shall reimburse the Hospital and any member of the Medical Staff named in the action for all costs incurred in defending such legal action, including reasonable attorney's fees.

ARTICLE 3

PROCEDURE FOR INITIAL APPOINTMENT

3.A. PROCEDURE FOR INITIAL APPOINTMENT

3.A.1. Request for Application:

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

(b) An individual seeking initial appointment shall be sent a letter that outlines the 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 six months of their training. Final action will not be taken until all applicable eligibility criteria are satisfied.

3.A.2. Initial Review of Application:

(a) A completed application form with copies of all required documents must be returned to the Medical Staff Office within 60 days after receipt. The application must be accompanied by the application fee.

(b) As a preliminary step, the application will be reviewed by the Medical Staff Office to determine that all questions have been answered and that the individual satisfies all threshold criteria. Incomplete applications will not be processed. Individuals who fail to return completed applications or fail to meet the threshold criteria will be notified that their application will not be processed.

(c) The Medical Staff Office shall oversee the process of gathering and verifying relevant information, and confirming that all references and other information or materials deemed pertinent have been received.

(d) The names of applicants shall be posted so that members of the Medical Staff may submit information bearing on the applicant's qualifications for appointment or clinical privileges.

3.A.3. Steps to Be Followed for All Initial Applicants:

(a) Evidence of the applicant's character, professional competence, qualifications, behavior, and ethical standing shall be examined. This information may be contained in the application, and may be 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 of the following: the section chief, the department chairperson, the Credentials Committee, a Credentials Committee representative or designee, the Staff Executive Committee, a Staff Executive Committee representative, and/or the Chief of Staff.

3.A.4. Department Chairperson and Section Chief Procedure:

(a) The Medical Staff Office shall refer the complete application and all supporting materials to the chairperson of each department and section chief of each section in which the applicant seeks clinical privileges. Each chairperson shall prepare a written report regarding whether the applicant has satisfied all of the qualifications for appointment, the clinical privileges requested, and the type/scope of the Focused Professional Practice Evaluation which will occur if privileges are granted.

(b) The department chairperson and section chief shall be available to the Credentials Committee, Staff Executive Committee, and the Board to answer any questions that may be raised with respect to that chairperson's report and findings.

3.A.5. Credentials Committee Procedure:

(a) The Credentials Committee shall review and consider the report prepared by the relevant department chairperson and section chief and shall make a recommendation.

(b) The Credentials Committee may use the expertise of the department chairperson, section chief, or any member of the department and section, or an outside consultant, if additional information is required regarding the applicant's qualifications.

(c) The Credentials Committee may recommend the imposition of specific conditions. These conditions may relate to behavior (e.g., code of conduct) or to clinical issues (e.g., general consultation requirements, proctoring). The Credentials Committee may also recommend that appointment be granted for a period of less than two years in order to permit closer monitoring of an individual's compliance with any conditions.

(d) If the recommendation of the Credentials Committee is delayed longer than 60 days, the Chairperson of the Credentials Committee shall notify the applicant, in writing, with a copy to the President, explaining the reasons for the delay.

3.A.6. Staff Executive Committee Recommendation:

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

(1) adopt the findings and recommendation of the Credentials Committee as its own; or

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

(3) state its reasons in its report and recommendation, along with supporting information, for its disagreement with the Credentials Committee's recommendation.

(b) If the recommendation of the Staff Executive Committee is to appoint, the recommendation shall be forwarded to the Board through the President.

(c) If the recommendation of the Staff Executive Committee would entitle the applicant to request a hearing, the Staff Executive Committee shall forward its recommendation to the President, who shall promptly send special notice to the applicant. The President shall then defer action on the application until after the applicant has completed or waived a hearing and appeal.

3.A.7. Board Action:

(a) The Board may delegate to a committee, consisting of at least two Board members, action on appointment, reappointment, and clinical privileges if there has been a favorable recommendation from the Credentials Committee, and the Staff 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 shall be effective immediately and shall be forwarded to the Board for ratification at its next meeting.

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

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

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

(3) reject or modify the recommendation.

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

3.A.8. Time Periods for Processing:

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

ARTICLE 4

CLINICAL PRIVILEGES

4.A. CLINICAL PRIVILEGES

4.A.1. General:

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

(b) Each individual who has been appointed to the Medical Staff is entitled to exercise only those clinical privileges specifically granted by the Board, and must cooperate with Ongoing and Focused Evaluation activities.

(c) The granting of clinical privileges includes 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 all applicable eligibility criteria.

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

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

(1) the applicant's education, training, experience, demonstrated current competence and judgment, references, utilization patterns, and ability to perform the privileges requested competently and safely;

(2) availability of qualified staff members to provide coverage in case of the applicant's illness or unavailability;

(3) adequate professional liability insurance coverage for the clinical privileges requested;

(4) the Hospital's available resources and personnel;

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

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

(7) practitioner-specific data are compared to aggregate data, when available; and

(8) morbidity and mortality data, when available.

(9) the results of any Focused or Ongoing Professional Practice Evaluation activities;

(10) current demonstration of competence in patient care, medical/clinical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism and system-based practice.

(11) unusual pattern or excessive number of suits resulting in verdicts against the applicant; and

(12) documentation of the applicant's health status.

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

(h) The report of the chairperson of the clinical department and the chief of the section in which privileges are sought shall be forwarded to the Chairperson of the Credentials Committee and processed as a part of the initial application for staff appointment.

(i) During the term of appointment, a member may request additional privileges by written application. The request shall 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 shall be processed in the same manner as an application for initial clinical privileges.

4.A.2. Voluntary Relinquishment of Privileges:

(a) A Medical Staff member may request voluntary relinquishment of clinical privileges by submitting a written request to the department chairperson and section chief specifying the clinical privilege(s) to be relinquished and the reasons for the request. The department chairperson and section chief shall make a recommendation to the Staff Executive Committee.

(b) The Staff Executive Committee shall evaluate whether the relinquishment of the privilege(s) would create an unreasonable burden on the Hospital's services and the on-call rotation. The Staff Executive Committee may request a meeting with the member involved. The Staff Executive Committee shall make a recommendation to the Board.

(c) The Board shall 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 shall be reported in writing by the President to the member, the Staff Executive Committee, and the applicable department chairperson and section chief. If the Board approves the relinquishment of privileges, it shall specify the effective date of the relinquishment.

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

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

4.A.3. Clinical Privileges for New Procedures:

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

(b) The Credentials Committee and the Staff Executive Committee shall make a preliminary recommendation as to whether the new procedure should be offered, considering whether the Hospital has the capabilities, including sufficient space, equipment, staffing and financial resources to support the requested privilege.

(c) If it is recommended that the new procedure be offered, the Credentials Committee shall conduct research and consult with experts, including those on the Medical Staff and those outside the Hospital, and develop recommendations regarding (1) the minimum education, training, and experience necessary to perform the new procedure, and (2) the extent of monitoring and supervision involved in the Focused Evaluation which will

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 shall forward its recommendations to the Staff Executive Committee, which shall 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 shall conduct research and consult with experts, including those on the Medical Staff (e.g., department chairperson, section chief, 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 shall develop recommendations regarding (1) the minimum education, training, and experience necessary to perform the clinical privileges in question, and (2) the extent of monitoring and supervision that should occur. These recommendations may or may not permit individuals from different specialties to request the privileges at issue. The Credentials Committee shall forward its recommendations to the Staff Executive Committee, which shall review the matter and forward its recommendations to the Board for final action.

4.A.5. 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 shall be delineated and recommended in the same manner as other clinical privileges.

(b) Surgical procedures performed by dentists or oral and maxillofacial surgeons shall be under the overall supervision of the Chairperson of Surgery. A medical history and physical examination of the patient shall be made and recorded by a physician who is a member of the Medical Staff before dental surgery shall be performed (with the exception of (c) below), and a designated physician shall 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 Staff Executive Committee.

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

4.A.6. Clinical Privileges for Podiatrists:

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

(b) Surgical procedures performed by podiatrists shall be under the overall supervision of the Chairperson of Surgery. A medical history and physical examination of the patient shall be made and recorded by a physician (MD or DO) who is a member of the Medical Staff before podiatric surgery shall be performed, and a designated physician shall be responsible for the medical care of the patient throughout the period of hospitalization.

(c) The podiatrist shall be responsible for the podiatric care of the patient, including the portion of the history and physical examination related to any podiatric problem, as well as all appropriate elements of the patient's record. Podiatrists may write orders within the scope of their licensure and consistent with the Medical Staff Rules and Regulations and in compliance with the Hospital and Medical Staff Bylaws and this Manual.

4.A.7. Physicians in Training:

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

4.A.8. Telemedicine Privileges:

(a) Telemedicine is the exchange of medical information from one site to another via electronic communications for the purpose of improving patient care, treatment, and services. The Board shall determine the clinical services that may be provided through telemedicine after considering the recommendations of the appropriate Department Chairperson, Section Chief, the Credentials Committee, and the Staff Executive Committee.

(b) Individuals providing telemedicine services shall be credentialed in accordance with this section, but need not be appointed to the Medical Staff. In addition, the contractual arrangement that authorizes them to provide services at the Hospital shall address quality review and assessment mechanisms that are designed to promote the provision of safe and competent services.

(c) In processing a request for telemedicine privileges, the Hospital may utilize any of the following mechanisms:

(1) credential and grant privileges to the practitioner in accordance with the provisions of this Manual in the same manner as any other applicant; or

(2) credential and grant privileges to the practitioner in accordance with the provisions of this Manual, but utilize the credentialing information from the practitioner's primary hospital, provided that hospital is accredited by the Joint Commission on Accreditation of Healthcare Organizations; or

(3) credential and grant privileges to the practitioner based on the credentialing information and privileging decision from the practitioner's primary hospital, if the following conditions are met:

(i) the primary hospital is accredited by the Joint Commission on Accreditation of Healthcare Organizations;

(ii) the practitioner has clinical privileges at the primary hospital to perform the same service or procedure being requested at the Hospital; and

(iii) the Hospital reviews the practitioner's performance of the privileges being requested and provides information resulting from that review to the primary hospital.

4.B. TEMPORARY CLINICAL PRIVILEGES

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

(a) Temporary privileges may be granted by the President, upon recommendation of the Chief of Staff, when there is an important patient care, treatment, or service need. Specifically, temporary privileges may be granted for: (i) the care of a specific patient; (ii) an individual serving as a locum tenens for a member of the Medical Staff; or (iii) the purpose of proctoring or teaching. Prior to the granting of temporary privileges in these situations, current licensure and current competence shall be verified.

(b) Temporary privileges may also be granted by the President, upon the favorable report and recommendation of the applicable department chairperson, the section chief, the Credentials Committee, and the Chief of Staff, when an applicant for initial appointment has submitted a completed application and the application is pending review by the Staff Executive Committee and Board. 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; compliance with privileges criteria; and consideration of information from the Data Bank. In order to be eligible for temporary privileges, an individual must demonstrate that there are no current or previously successful challenges to his or her licensure or registration and 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.

(c) Prior to 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.

(d) Temporary privileges shall be granted for a specific period of time, as warranted by the situation. In no situation should the initial grant of temporary privileges be for a period exceeding 120 days.

(e) Temporary privileges shall expire at the end of the time period for which they are granted.

4.B.2. Supervision Requirements:

In exercising temporary privileges, the individual shall act under the supervision of the department chairperson and section chief. Special requirements of supervision and reporting may be imposed on any individual granted temporary clinical privileges.

4.B.3. Termination of Temporary Clinical Privileges:

(a) The President may, at any time after consulting with the Chief of Staff, the Chairperson of the Credentials Committee, the department chairperson, or the section chief, terminate temporary admitting privileges. Clinical privileges shall 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 President, the department chairperson, or the Chief of Staff may immediately terminate all temporary privileges. The department chairperson or the Chief of Staff shall assign to another member of the Medical Staff responsibility for the care of such individual's patients until they are discharged. Whenever possible, consideration shall 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 shall entitle the individual to a hearing or appeal.

4.C. EMERGENCY SITUATIONS

(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.

(2) In an emergency situation, a member of the Medical Staff may administer treatment to the extent permitted by his or her license, regardless of department status or specific grant of clinical privileges. Similarly, in an emergency situation, any practitioner who is not currently appointed to the Medical Staff may administer treatment to the extent permitted by his or her license.

(3) When the emergency situation no longer exists, the patient shall be assigned by the department chairperson or the Chief of Staff to a member with appropriate clinical privileges, considering the wishes of the patient.

(4) The President or his/her designee will complete the verification process of the credentials and privileges of individuals granted emergency temporary privileges as soon as the immediate situation is under control. This verification process will be identical to the process described in Section 4.B.1.

(5) Emergency privileges are intended for the duration of an emergency and shall expire when the Hospital determines that the emergency has ended.

4.D. DISASTER PRIVILEGES

In the event of a mass disaster, when the Emergency Operations Plan has been activated, Medical Staff members and employees may not be able to provide all the care required by individuals seeking treatment at this Hospital's facilities. Under such circumstances, the President or the Chief of Staff, or their designated representative, is authorized to grant disaster privileges or permission to treat patients to volunteer licensed independent practitioners and volunteer practitioners who are not licensed independent practitioners upon receipt of satisfactory evidence that such individuals are currently licensed in some state or otherwise capable of providing services to patients.

Before a volunteer practitioner is allowed to function, the Hospital will obtain his or her valid government-issued identification (for example, a driver's license or passport) and at least one of the following:

- current photo identification from another health care organization that clearly identifies professional designation
- current license to practice
- primary source verification of licensure
- identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT), the Medical Reserve Corps (MRC), the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP), or other recognized state or federal response hospital or group
- identification indicating that the individual has been granted authority by a government entity to provide patient care, treatment or services in disaster circumstances
- confirmation by a licensed independent practitioner currently privileged by the Hospital or a staff member with personal knowledge of the volunteer practitioner's ability to act as a volunteer practitioner during a disaster.

Furthermore, notwithstanding any existing delineation of privileges or scope of authority, during a mass disaster current Medical Staff members, employees and volunteers are authorized to take whatever steps they reasonably believe are necessary to save or preserve the life or health of patients or to protect the public health.

All individuals granted disaster privileges will be issued appropriate identification that will clearly distinguish volunteer practitioners from Medical Staff members or Hospital employees. All volunteer practitioners and will be managed under the direct supervision of a Medical Staff member or Hospital employee. Upon initial approval, volunteer licensed independent practitioners (LIPs) will be assigned to a Medical Staff member who will collaborate in the care of disaster victims and oversee the

professional practice of the volunteer LIP. Oversight of the volunteer LIP's performance will be conducted through direct observation, mentoring, medical record review, or other appropriate mechanisms developed by the Medical Staff and Hospital. Based on its oversight of each volunteer LIP , the hospital will determine within 72 hours of the practitioner's arrival if the individual's status as a volunteer practitioner should continue.

The President or his/her designee will obtain primary source verification of licensure for all volunteer LIPs as soon as the immediate situation is under control or within 72 hours from the time the volunteer presented him or herself to the hospital, whichever comes first. If primary source verification of a volunteer LIP's licensure cannot be completed within 72 hours of the practitioner's arrival due to extraordinary circumstances, the hospital will document all of the following:

- Reason(s) it could not be performed within 72 hours of the practitioner's arrival
- Evidence of the licensed independent practitioner's demonstrated ability to continue to provide adequate care, treatment and services
- Evidence of the hospital's attempt to perform primary source verification as soon as possible

If, due to extraordinary circumstances, primary source verification of a volunteer LIP's licensure cannot be completed within 72 hours of the practitioner's arrival, it is performed as soon as possible.

Note: Primary source verification of licensure is not required if the volunteer licensed practitioner has not provided care, treatment or services under the disaster privileges.

Disaster privileges are intended for the duration of the disaster and shall expire when the Hospital determines that the disaster has ended.

4.E. CONTRACTS FOR SERVICES

(1) From time to time, the Hospital may enter into contracts with physicians and/or groups of physicians for the performance of clinical and/or administrative services at the Hospital. All individuals functioning pursuant to such contracts shall obtain and maintain Medical Staff appointment and/or clinical privileges at the Hospital, in accordance with the terms of this Manual.

(2) To the extent that any such contract confers the exclusive 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.

(3) If any such exclusive contract would have the effect of preventing an existing Medical Staff member from exercising clinical privileges that had previously been granted, the affected member shall be given notice of the exclusive contract and have the right to meet with the Board or a committee designated by the Board to discuss the matter prior to the effective date of the contract in question. At the meeting, the affected member shall be entitled to present any information relevant to the decision to enter into the exclusive contract. That individual shall 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 this Manual. The inability of a physician to exercise clinical privileges due to an exclusive contract is not a matter that requires a report to the state licensure board or to the National Practitioner Data Bank.

(4) In the event of any conflict between this Manual or the Medical Staff Bylaws and the terms of any contract, the terms of the contract shall control.

ARTICLE 5

PROCEDURE FOR REAPPOINTMENT

5.A. PROCEDURE FOR REAPPOINTMENT

All terms, conditions, requirements, and procedures relating to initial appointment shall 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 as may be established by the Staff Executive Committee and the Board;

(c) satisfied all Medical Staff responsibilities, including payment of dues, 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; and

(f) paid the reappointment processing fee.

5.A.2. Factors for Evaluation:

The following factors will be evaluated as part of the reappointment process:

(a) results of any Ongoing and/or Focused Professional Practice Evaluation activities;

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

(c) participation in Medical Staff duties, including committee assignments and emergency call;

(d) behavior at the Hospital, including cooperation with Medical Staff and Hospital personnel as it relates to patient care, the orderly operation of the Hospital, and ability to work with others;

(e) use of the Hospital's facilities for patients, taking into consideration practitioner-specific information compared to aggregate information concerning other individuals in the same or similar specialty (provided that, other practitioners shall not be identified);

(f) whether the applicant's Medical Staff appointment or clinical privileges have been voluntarily or involuntarily relinquished, withdrawn, denied, revoked, suspended, subjected to probationary or other conditions, or otherwise limited at any other hospital or health care facility, or are currently being investigated or challenged;

(g) whether the applicant's license to practice in any state, DEA registration, or any state controlled substances registration has been voluntarily or involuntarily suspended, modified, terminated, restricted, or relinquished, or is currently being investigated or challenged;

(h) whether the applicant's professional liability coverage and/or professional liability litigation experience has changed, including specifically information concerning 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 Staff Executive Committee, or the Board may request;

(i) current ability to safely and competently exercise the clinical privileges requested and perform the responsibilities of staff appointment;

(j) capacity to satisfactorily treat patients as indicated by the results of the Hospital's performance improvement and professional and peer review activities;

(k) appropriate resolution of any verified complaints received from patients and/or staff;

(l) demonstration of current competence in patient care, medical/clinical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism and system-based practice;

(m) unusual pattern or excessive number of suits resulting in verdicts against the applicant;

(n) documentation of the applicant's health status.

(o) other reasonable indicators of continuing qualifications.

5.A.3. Reappointment Application:

(a) An application for reappointment shall be furnished to members at least five months prior to the expiration of their current appointment term. A completed reappointment application must be returned to the Medical Staff Office within 30 days.

(b) Failure to return a completed application within this time frame will result in the assessment of a reappointment processing fee. At the discretion of the President, a physician whose application has not been completed may, within 60 days of the expiration of his last appointment, be allowed to proceed with the reappointment process by providing all outstanding information.

(c) Reappointment shall be for a period of not more than two 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 shall 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 those situations where the Board has not acted on a pending application for reappointment and there is an important patient care need that mandates an immediate authorization to practice, including but not limited to an inability to meet on-call coverage requirements, or denying the community access to needed medical services, the President shall have the authority to grant the individual temporary clinical privileges until such time as the Board can act on the application. Prior to granting temporary privileges, the President shall consult with the Chief of Staff, or the Chief's designee. The temporary clinical privileges shall be only for a period not to exceed 120 days.

(f) 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 two years may be granted pending the completion of that process.

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

(h) The Medical Staff Office shall oversee the process of gathering and verifying relevant information. The Medical Staff Office shall also be responsible for confirming that all relevant information has been received.

5.A.4. Processing Applications for Reappointment:

(a) The Medical Staff Office shall forward the application to the relevant department chairperson and section chief and the application for reappointment shall be processed in a manner consistent with applications for initial appointment. Applications for reappointment and renewal of clinical privileges shall instead be processed through the full Credentials Committee and the Staff Executive Committee.

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

5.A.5. Time Periods for Processing:

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

ARTICLE 6

PEER REVIEW PROCEDURES FOR MATTERS INVOLVING PROFESSIONAL PERFORMANCE OF MEDICAL STAFF MEMBERS

6.A. COLLEGIAL INTERVENTION

(1) This Manual encourages the use of progressive steps by Medical Staff leaders and Hospital management, beginning with collegial and educational efforts, to address matters involving the professional performance of Medical Staff members. The goal of these efforts is to arrive at voluntary, responsive actions by the individual to resolve matters that have been raised.

(2) Collegial efforts may include, but are not limited to, counseling, sharing of comparative data, monitoring, additional training or education and Focused Professional Practice Evaluation.

(3) All collegial intervention efforts by Medical Staff leaders and Hospital management are part of the Hospital's performance improvement and professional and peer review activities.

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

(5) Collegial intervention efforts are encouraged, but are not mandatory, and shall be within the discretion of the appropriate Medical Staff leaders.

(6) The Chief of Staff, in conjunction with the President, shall determine whether to direct that a matter be handled in accordance with another Policy, such as the Policy on Practitioner Health or other applicable policy, or to direct it to the Staff Executive Committee for further determination.

6.B. INVESTIGATIONS

6.B.1. Initial Review:

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

(1) the clinical competence or clinical practice of any member of the Medical Staff, including the care, treatment or management of a patient or patients;

(2) the known or suspected violation by any member of the Medical Staff of applicable ethical standards or the Bylaws, policies, Rules and Regulations of the Hospital or the Medical Staff; and/or

(3) conduct by any member of the Medical Staff that is considered lower than the standards of the Hospital and the Medical Staff, or disruptive to the orderly operation of the Hospital or its Medical Staff, including the inability of the member to work harmoniously and professionally with others,

the matter may be referred to the Chief of Staff, the chairperson of the department, the chairperson of a standing committee, the President, or the Chairperson of the Board.

(b) The person to whom the matter is referred shall make sufficient inquiry to satisfy himself or herself that the question raised is credible and, if so, shall forward it in writing to the Staff Executive Committee.

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

6.B.2. Initiation of Investigation:

(a) When a question involving clinical competence or professional conduct is referred to, or raised by, the Staff Executive Committee, the Staff Executive Committee shall review the matter and determine whether to conduct an investigation, to direct the matter to be handled pursuant to another policy (such as the Policy on Practitioner Health or other applicable policy), or to proceed in another manner. In making this determination, the Staff Executive Committee may discuss the matter with the individual. An investigation shall begin only after a formal determination by the Staff Executive Committee to do so.

(b) The Staff Executive Committee shall inform the individual that an investigation has begun. Notification may be delayed if, in the Staff Executive Committee's judgment, informing the individual immediately would compromise the investigation or disrupt the operation of the Hospital or Medical Staff.

(c) The Board may also determine to commence an investigation and may delegate the investigation to the Staff Executive Committee, a subcommittee of the Board, or an ad hoc committee.

(d) The Chief of Staff shall keep the President fully informed of all action taken in connection with an investigation.

6.B.3. Investigative Procedure:

(a) Once a determination has been made to begin an investigation, the Staff Executive Committee shall either investigate the matter itself, request that the Credentials Committee conduct the investigation, or appoint an ad hoc committee to conduct the investigation. Any ad hoc committee shall not include partners, associates, or relatives of the individual being investigated, but may include individuals not on the Medical Staff. Whenever the matters raised concern the clinical competence of the individual under review, the ad hoc committee shall include a peer of the individual (e.g., physician or dentist).

(b) The committee conducting the investigation ("investigating committee") shall have the authority to review relevant documents and interview individuals. It shall also have available to it the full resources of the Medical Staff and the Hospital, as well as the authority to use outside consultants, if needed. An outside consultant or agency may be used whenever a determination is made by the Hospital and investigating committee that:

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

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

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

(c) The investigating committee may require a physical and/or mental examination of the individual by health care professional(s) acceptable to it. The individual being investigated shall execute a release allowing (i) the investigating committee (or its representative) to discuss with the health care professional(s) conducting the examination the reasons for the examination; and (ii) the health care professional(s) conducting the examination to discuss and provide documentation of the results of such examination directly to the investigating committee.

(d) The individual shall have an opportunity to meet with the investigating committee before it makes its report. Prior to this meeting, the individual shall be informed of the general matters being investigated. At the meeting, the

individual shall be invited to discuss, explain, or refute the matters that gave rise to the investigation. A summary of the interview shall be made by the investigating committee and included with its report. This meeting is not a hearing, and none of the procedural rules for hearings shall apply. The individual being investigated shall not have the right to be represented by legal counsel at this meeting.

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

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

(g) In making its recommendations, the investigating committee shall strive to achieve a consensus as to what is in the best interests of patient care and the smooth operation of the Hospital, while balancing fairness to the individual, recognizing that fairness does not require that the individual agree with the recommendation. Specifically, the committee may consider:

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

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

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

6.B.4. Recommendation:

(a) The Staff Executive Committee may accept, modify, or reject any recommendation it receives from an investigating committee. Specifically, the Staff Executive Committee may:

(1) determine that no action is justified;

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

(3) impose conditions for continued appointment;

(4) impose a requirement for monitoring or consultation;

(5) recommend additional training or education;

(6) recommend a period of Focused Professional Practice Evaluation;

(7) recommend reduction of clinical privileges;

(8) recommend suspension of clinical privileges for a specified term;

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

(10) make any other recommendation that it deems necessary or appropriate.

(b) A recommendation by the Staff Executive Committee that would entitle the individual to request a hearing shall be forwarded to the President, who shall promptly inform the individual by special notice. The President shall hold the recommendation until after the individual has completed or waived a hearing and appeal.

(c) If the Staff Executive Committee makes a recommendation that does not entitle the individual to request a hearing, it shall take effect immediately and shall remain in effect unless modified by the Board.

(d) In the event the Board considers a modification to the recommendation of the Staff Executive Committee that would entitle the individual to request a hearing, the President shall inform the individual by special notice. No final action shall occur until the individual has completed or waived a hearing and appeal.

(e) When applicable, any recommendations or actions that are the result of an investigation or hearing and appeal shall be monitored by Medical Staff leaders on an ongoing basis through the Hospital's performance improvement activities or pursuant to the applicable policies regarding conduct, as appropriate.

6.C. PRECAUTIONARY SUSPENSION OR RESTRICTION OF CLINICAL PRIVILEGES

6.C.1. Grounds for Precautionary Suspension or Restriction:

(a) The Chief of Staff, the chairperson of a clinical department, the President, or the Board Chairperson shall each have the authority to suspend or restrict all or any portion of an individual's clinical privileges whenever, in their sole discretion, failure to take such action may result in imminent danger to the health and/or safety of any individual or may interfere with the orderly operation of the Hospital. The individual may be given an opportunity to refrain voluntarily from exercising privileges pending an investigation.

(b) Precautionary suspension or restriction is an interim step in the professional review activity, but it is not a complete professional review action in and of itself. It shall not imply any final finding of responsibility for the situation that caused the suspension or restriction.

(c) A precautionary suspension or restriction shall become effective immediately upon imposition, shall immediately be reported in writing to the President and the Chief of Staff, and shall remain in effect unless it is modified by the President or Staff Executive Committee.

(d) The individual shall be provided a brief written description of the reason(s) for the precautionary suspension.

6.C.2. Staff Executive Committee Procedure:

(a) The Staff Executive Committee shall review the matter resulting in a precautionary suspension or restriction within a reasonable time under the circumstances, not to exceed 14 days. Prior to, or as part of, this review, the individual shall be given an opportunity to meet with the Staff Executive Committee. The individual may propose alternatives other than precautionary suspension or restriction to protect patients, employees and/or the smooth operation of the Hospital, depending on the circumstances.

(b) After considering the matters resulting in the suspension or restriction and the individual's response, if any, the Staff Executive Committee shall determine whether there is sufficient information to warrant a final recommendation, or whether it is necessary to commence an investigation. The Staff Executive Committee shall also determine whether the precautionary suspension or restriction should be continued, modified, or terminated pending the completion of the investigation (and hearing, if applicable).

(c) There is no right to a hearing based on the imposition or continuation of a precautionary suspension or restriction.

6.C.3. Care of Patients:

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

(b) All members of the Medical Staff have a duty to cooperate with the Chief of Staff, the department chairperson, the Staff Executive Committee, and the President in enforcing precautionary suspensions or restrictions.

6.D. AUTOMATIC RELINQUISHMENT

6.D.1. Failure to Complete Medical Records:

Failure to complete medical records shall result in automatic relinquishment of all clinical privileges, after notification by the medical records department of delinquency. Relinquishment shall continue until all delinquent records are completed and reinstatement accomplished in accordance with applicable Rules and Regulations. Failure to complete the medical records that caused relinquishment within the time required by applicable Rules and Regulations shall be deemed an automatic resignation from the Medical Staff.

6.D.2. Action by Government Agency or Insurer:

(a) Any action taken by any licensing board, professional liability insurance company, court or government agency regarding any of the matters set forth below must be promptly reported to the President.

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

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

(2) DEA Registration: Revocation, expiration, suspension or the placement of conditions or restrictions on an individual's DEA registration (provided, however, that medical staff appointment shall not be relinquished, but only such privileges as are affected by the DEA action).

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

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

(5) Criminal Activity: Conviction, or a plea of guilty or no contest, pertaining to any felony; or to any misdemeanor involving (i) controlled substances; (ii) illegal drugs; (iii) Medicare, Medicaid, or insurance or health care fraud or abuse; or (iv) violence against another. (Any formal indictment or charge filed against a Medical Staff member with respect to any of these matters shall be reported promptly to the Staff Executive Committee, which shall determine what actions are necessary under the circumstances.)

(c) Automatic relinquishment shall take effect immediately and continue until the matter is resolved, if applicable. Requests for reinstatement shall be reviewed by the relevant department chairperson and section chief, the Chairperson of the Credentials Committee, the Chief of Staff, and the President. If all these individuals make a favorable recommendation on reinstatement, the Medical Staff member may immediately resume clinical practice at the Hospital. This determination shall then be forwarded to the Credentials Committee, Staff Executive Committee, and the Board for ratification. If, however, any of the individuals reviewing the request have any questions or concerns, those questions shall be noted and the reinstatement request shall be forwarded to the full Credentials Committee, Staff Executive Committee, and Board for review and recommendation.

6.D.3. Failure to Satisfy Threshold Eligibility Criteria:

Failure to satisfy eligibility criteria defined in Article 2., Section 2.A.1., for the duration of appointment shall result in automatic relinquishment of all clinical privileges until criteria is met or a waiver is granted.

6.D.4. Failure to Provide Requested Information:

Failure to provide full and correct information pertaining to an individual's qualifications for appointment or clinical privileges, in response to a written request from the Credentials Committee, the Staff Executive Committee, the President, or any other committee authorized to request such information, shall result in automatic relinquishment of all clinical privileges until the information is provided.

6.D.5. Failure to Attend Special Conference:

(a) Whenever there is an apparent or suspected deviation from standard clinical practice involving any individual, the department chairperson or the Chief of Staff may require the individual to attend a special conference with Medical Staff leaders and/or with a standing or ad hoc committee of the Medical Staff.

(b) The notice to the individual regarding this conference shall be given by special notice at least three days prior to the conference and shall inform the individual that attendance at the conference is mandatory.

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

6.E. LEAVES OF ABSENCE

(1) An individual appointed to the Medical Staff may request a leave of absence by submitting a written request to the President. The request must state the beginning and ending dates of the leave, which shall not exceed one year, and the reasons for the leave. Any absence from Medical Staff and/or from patient care responsibilities for longer than 60 days shall require an individual to request a leave of absence.

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

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

(4) Individuals requesting reinstatement shall 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 shall then be reviewed by the relevant department chairperson and section chief, the Chairperson of the Credentials Committee, the Chief of Staff, and the President. If all these individuals make a favorable recommendation on reinstatement, the Medical Staff member may immediately resume clinical practice at the Hospital. This

determination shall then be forwarded to the Credentials Committee, the Staff Executive Committee, and the Board for ratification. If, however, any of the individuals reviewing the request have any questions or concerns, those questions shall be noted and the reinstatement request shall be forwarded to the full Credentials Committee, Staff Executive Committee, and Board for review and recommendation.

(5) 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) Absence for longer than one year shall result in automatic relinquishment of Medical Staff appointment and clinical privileges unless an extension is granted by the President. Extensions will be considered only in extraordinary cases where the extension of a leave is in the best interest of the Hospital.

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

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

ARTICLE 7

HEARING AND APPEAL PROCEDURES

7.A. INITIATION OF HEARING

7.A.1. Grounds for Hearing:

(a) An individual is entitled to request a hearing whenever the Staff Executive Committee makes one of the following recommendations:

(1) denial of initial appointment to the Medical Staff;

(2) denial of reappointment to the Medical Staff;

(3) revocation of appointment to the Medical Staff;

(4) denial of requested clinical privileges;

(5) revocation of clinical privileges;

(6) suspension of clinical privileges for more than 30 days;

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

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

(b) No other recommendations shall entitle the individual to a hearing.

(c) If the Board proposes to take any such adverse action without an adverse recommendation by the Staff Executive Committee, an individual would also be entitled to request a hearing. For ease of use, this Article refers to adverse recommendations of the Staff Executive Committee. When a hearing is triggered by an adverse recommendation of the Board, any reference in this Article to "the Staff Executive Committee" shall be interpreted as a reference to "the Board."

7.A.2. Actions Not Grounds for Hearing:

None of the following actions shall constitute grounds for a hearing, and they shall take effect without hearing or appeal, provided that the individual shall be entitled to submit a written explanation to be placed into his or her file:

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

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

(c) recommendation or imposition of a Focused Professional Practice Evaluation;

(d) termination of temporary privileges;

(e) automatic relinquishment of appointment or privileges;

(f) imposition of a requirement for additional training or continuing education;

(g) precautionary suspension;

(h) denial of a request for leave of absence, or for an extension of a leave;

(i) determination that an application is incomplete;

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

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

7.A.3. Notice of Recommendation:

The President shall promptly give special notice of a recommendation which entitles an individual to request a hearing. This notice shall contain:

(a) a statement of the recommendation and the general reasons for it;

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

(c) a copy of this Manual.

7.A.4. Request for Hearing:

An individual has 30 days following receipt of the notice to request a hearing. The request shall be in writing to the President and shall include the name, address, and telephone number of the individual's counsel, if any. Failure to request a hearing shall constitute waiver of the right to a hearing, and the recommendation shall be transmitted to the Board for final action.

7.A.5. Notice of Hearing and Statement of Reasons:

(a) The President shall schedule the hearing and provide, by special notice, the following:

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

(2) a proposed list of witnesses who will give testimony at the hearing and a brief summary of the anticipated testimony;

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

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

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

7.A.6. Witness List:

(a) At least 15 days before the pre-hearing conference, the individual requesting the hearing shall provide a written list of the names of witnesses expected to offer testimony on his or her behalf.

(b) The witness list shall include a brief summary of the anticipated testimony.

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

7.A.7. Hearing Panel, Presiding Officer, and Hearing Officer:

(a) Hearing Panel:

(1) The President, after consulting with the Chief of Staff, shall appoint a Hearing Panel composed of not less than three members, one of whom shall be designated as chairperson. The Hearing Panel shall be composed of members of the Medical Staff who did not actively participate in the matter at any previous level, physicians, podiatrists, dentists or laypersons not connected with the Hospital, or a combination thereof. Knowledge of the matter involved shall not preclude any individual from serving as a member of the Hearing Panel. Employment by, or a contract with, the Hospital or an affiliate shall not preclude any individual from serving on the Hearing Panel.

(2) The Hearing Panel shall not include anyone who is in direct economic competition with, professionally associated with or related to, or involved in a significant referral relationship with, the individual requesting the hearing.

(3) Members of the Hearing Panel, the Presiding Officer, or the Hearing Officer may be compensated for their service. The individual requesting the hearing may participate in that compensation. Compensation will not constitute grounds for challenging the impartiality of the Hearing Panel members.

(b) Presiding Officer:

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

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

(3) The Presiding Officer shall:

(i) allow the participants in the hearing to have a reasonable opportunity to be heard and to present evidence, subject to reasonable limits on the number of witnesses and duration of direct and cross-examination;

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

(iii) maintain decorum throughout the hearing;

(iv) determine the order of procedure;

(v) rule on all matters of procedure and the admissibility of evidence;

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

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

(5) The Presiding Officer may participate in the private deliberations of the Hearing Panel and be a legal advisor to it, but shall not be entitled to vote on its recommendations.

(c) Hearing Officer:

(1) As an alternative to a Hearing Panel, the President, after consulting with the Chief of Staff, may appoint a Hearing Officer, preferably an attorney, to perform the functions of a Hearing Panel. The Hearing Officer may not be, or represent clients, in direct economic competition with the individual requesting the hearing.

(2) If a Hearing Officer is appointed instead of a Hearing Panel, all references in this Article to the "Hearing Panel" or "Presiding Officer" shall be deemed to refer to the Hearing Officer.

(d) Objections:

Any objection to any member of the Hearing Panel, or the Hearing Officer or Presiding Officer, shall be made in writing, within 10 days of receipt of notice, to the President. A copy of such written objections must be provided to the Chief of Staff and must include the basis for the objection, and may include proposed questions to be asked of the Panel member(s) regarding any potential bias. The Presiding Officer shall give the Chief of Staff a reasonable opportunity to comment. The Presiding Officer may pose some or all of the questions to the Panel member(s). The Presiding Officer shall then make a recommendation to the President regarding the objections, and the President shall determine whether to replace any Panel member(s).

7.A.8. Counsel:

The Presiding Officer, Hearing Officer, and counsel for either party may be an attorney at law who is licensed to practice, in good standing, in any state.

7.B. PRE-HEARING PROCEDURES

7.B.1. General Procedures:

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

7.B.2. Provision of Relevant Information:

(a) The individual requesting the hearing is entitled to the following, subject to the condition that all documents and information be maintained as confidential and not disclosed or used for any purpose outside of the hearing:

(1) copies of, or reasonable access to, all patient medical records referred to in the statement of reasons, at the individual's expense;

(2) reports of experts relied upon by the Staff Executive Committee;

(3) copies of relevant minutes (with portions regarding other practitioners and unrelated matters deleted); and

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

The provision of this information is not intended to waive any privilege under the Georgia peer review protection statutes.

(b) The individual shall have no right to discovery beyond the above information. No information shall be provided regarding other practitioners.

(c) Prior to the pre-hearing conference, on dates set by the Presiding Officer or agreed upon by both sides, each party shall provide the other party with its proposed exhibits. All objections to documents or witnesses, to the extent then reasonably known, shall be submitted in writing in advance of the pre-hearing conference. The Presiding Officer shall not entertain subsequent objections unless the party offering the objection demonstrates good cause.

(d) Evidence unrelated to the reasons for the recommendation or to the individual's qualifications for appointment or the relevant clinical privileges shall be excluded.

(e) Neither the individual, nor his or her attorney, nor any other person acting on behalf of the individual shall contact Hospital employees appearing on the Staff Executive Committee's witness list concerning the subject matter of the hearing, unless specifically agreed upon by counsel.

7.B.3. Pre-Hearing Conference:

The Presiding Officer shall require a representative (who may be counsel) for the individual and for the Staff Executive Committee to participate in a pre-hearing conference. At the pre-hearing conference, the Presiding Officer shall resolve all procedural questions, including any objections to exhibits or witnesses, and the time to be allotted to each witness's testimony and cross-examination. It is expected that the hearing will last no more than 10 hours, with each side being afforded approximately five hours to present its case, in terms of both direct and cross-examination of witnesses. Both parties are required to prepare their case so that a hearing shall be concluded after a maximum of 10 hours, on consecutive days. The Presiding Officer may, after considering any objections, grant limited extensions upon a demonstration of good cause and to the extent compelled by fundamental fairness.

7.B.4. Stipulations:

The parties and counsel, if applicable, shall use their best efforts to develop and agree upon stipulations, so as to provide for a more orderly and efficient hearing by narrowing the issues on which live testimony is reasonably required.

7.B.5. Provision of Information to the Panel:

The Presiding Officer shall transmit to the Hearing Panel the following documents, at least one week in advance of the hearing: Statement of Reasons, any pre-hearing statement that the individual requesting the hearing may choose to submit, and an exhibit book agreed upon by the parties, without the need for authentication.

7.C. THE HEARING

7.C.1. Failure to Appear:

Failure, without good cause, to appear and proceed at the hearing shall constitute a waiver of the right to a hearing and the matter shall be transmitted to the Board for final action.

7.C.2. Record of Hearing:

A stenographic reporter shall be present to make a record of the hearing. The cost of the reporter shall be borne by the Hospital. Copies of the transcript shall be available at the individual's expense. Oral evidence shall be taken only on oath or affirmation administered by any person entitled to notarize documents in this state.

7.C.3. Rights of Both Sides and the Hearing Panel at the Hearing:

(a) At a hearing, both sides shall have the following rights, subject to reasonable limits determined by the Presiding Officer:

(1) to call and examine witnesses, to the extent they are available and willing to testify;

(2) to introduce exhibits;

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

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

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

(b) The personal presence of the affected individual is mandatory. If the individual who requested the hearing does not testify, he or she may be called and questioned.

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

7.C.4. Admissibility of Evidence:

The hearing shall not be conducted according to rules of evidence. Evidence shall not be excluded merely because it is hearsay. Any relevant evidence shall be admitted if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law. The guiding principle shall be that the record contain information sufficient to allow the Board to decide whether the individual is qualified for appointment and clinical privileges.

7.C.5. Post-Hearing Statement:

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

7.C.6. Persons to be Present:

The hearing shall be restricted to those individuals involved in the proceeding. Administrative personnel may be present as requested by the President or the Chief of Staff.

7.C.7. Postponements and Extensions:

Postponements and extensions of time may be requested by anyone, but shall be permitted only by the Presiding Officer or the President on a showing of good cause.

7.C.8. Presence of Hearing Panel Members:

A majority of the Hearing Panel shall be present throughout the hearing. In unusual circumstances when a Hearing Panel member must be absent from any part of the hearing, he or she shall read the entire transcript of the portion of the hearing from which he or she was absent.

7.D. HEARING CONCLUSION, DELIBERATIONS, AND RECOMMENDATIONS

7.D.1. Order of Presentation:

The Staff Executive Committee shall first present evidence in support of its recommendation. Thereafter, the burden shall shift to the individual who requested the hearing to present evidence.

7.D.2. Basis of Hearing Panel Recommendation:

Consistent with the burden on the individual to demonstrate that he or she satisfies, on a continuing basis, all criteria for initial appointment, reappointment and clinical privileges, the Hearing Panel shall recommend in favor of the Staff Executive Committee unless it finds that the individual who requested the hearing has proved, by a preponderance of the evidence, that the recommendation that prompted the hearing was arbitrary, capricious, or not supported by credible evidence.

7.D.3. Deliberations and Recommendation of the Hearing Panel:

Within 20 days after final adjournment of the hearing (which may be designated as the time the Hearing Panel receives the hearing transcript or any post-hearing statements, whichever is later), the Hearing Panel shall conduct its deliberations outside the presence of any other person except the Presiding Officer. The Hearing Panel shall render a recommendation, accompanied by a report, which shall contain a concise statement of the basis for its recommendation.

7.D.4. Disposition of Hearing Panel Report:

The Hearing Panel shall deliver its report to the President. The President shall send by special notice a copy of the report to the individual who requested the hearing. The President shall also provide a copy of the report to the Staff Executive Committee.

7.E. APPEAL PROCEDURE

7.E.1. Time for Appeal:

Within 10 days after notice of the Hearing Panel's recommendation, either party may request an appeal. The request shall be in writing, delivered to the President either in person or by certified mail, return receipt requested, and shall include a statement of the reasons for appeal and the specific facts or circumstances which justify further review. If an appeal is not requested within 10 days, an appeal is deemed to be waived and the Hearing Panel's report and recommendation shall be forwarded to the Board for final action.

7.E.2. Grounds for Appeal:

The grounds for appeal shall be limited to the following:

(a) there was substantial failure to comply with this Manual and/or the Bylaws of the Hospital or Medical Staff during or prior to the hearing, so as to deny a fair hearing; and/or

(b) the recommendations of the Hearing Panel were made arbitrarily or capriciously and/or were not supported by credible evidence.

7.E.3. Time, Place and Notice:

Whenever an appeal is requested as set forth in the preceding Sections, the Chairperson of the Board shall schedule and arrange for an appeal. The individual shall be given special notice of the time, place, and date of the appeal. The appeal shall be held as soon as arrangements can reasonably be made, taking into account the schedules of all the individuals involved.

7.E.4. Nature of Appellate Review:

(a) The Chairperson of the Board shall appoint a Review Panel composed of not less than three persons, either members of the Board or others, including but not limited to reputable persons outside the Hospital, to consider the record

upon which the recommendation before it was made, or the Board may consider the appeal as a whole body.

(b) Each party shall have the right to present a written statement in support of its position on appeal. The party requesting the appeal shall submit a statement first and the other party shall then have ten days to respond. In its sole discretion, the Review Panel (or Board) may allow each party or its representative to appear personally and make oral argument not to exceed 30 minutes.

(c) The Review Panel (or Board) may, in its discretion, accept additional oral or written evidence subject to the same rights of cross-examination or confrontation provided at the Hearing Panel proceedings. Such additional evidence shall be accepted only if the party seeking to admit it can demonstrate that it is new, relevant evidence or that any opportunity to admit it at the hearing was improperly denied, and then only at the discretion of the Review Panel (or Board).

(d) The Review Panel shall recommend final action to the Board.

7.E.5. Final Decision of the Board:

Within 30 days after receipt of the Review Panel's recommendation, the Board shall render a final decision in writing, including specific reasons, and shall send special notice thereof to the individual. The Board may affirm, modify, or reverse the recommendation of the Review Panel or, in its discretion, refer the matter for further review and recommendation, or make its own decision based upon the Board's ultimate legal responsibility to grant appointment and clinical privileges. A copy shall also be provided to the Staff Executive Committee for its information.

7.E.6. Further Review:

Except where the matter is referred for further action and recommendation, the final decision of the Board following the appeal shall be effective immediately and shall not be subject to further review. If the matter is referred for further action and recommendation, such recommendation shall be promptly made to the Board in accordance with the instructions given by the Board.

7.E.7. Right to One Hearing and One Appeal Only:

No member of the Medical Staff shall be entitled to more than one hearing and one appellate review on any matter. If the Board denies initial appointment to the Medical Staff or reappointment or revokes the appointment and/or clinical privileges of a current member of the Medical Staff, that individual may not apply for staff appointment or for those clinical privileges for a period of five years unless the Board provides otherwise.

ARTICLE 8

CONFIDENTIALITY AND PEER REVIEW PROTECTION

8.A. CONFIDENTIALITY

Actions taken and recommendations made pursuant to this Manual shall be strictly confidential. Individuals participating in credentialing and peer review activities shall make no disclosures of any such information (discussions or documentation) outside of peer review committee meetings, except:

(1) when the disclosures are to another authorized member of the Medical Staff or authorized Hospital employee and are for the purpose of conducting legitimate credentialing and peer review activities; or

(2) when the disclosures are authorized, in writing, by the President or by legal counsel to the Hospital.

Any breach of confidentiality may result in a professional review action and/or appropriate legal action.

8.B. PEER REVIEW PROTECTION

(1) All credentialing and peer review activities pursuant to this Manual and related Medical Staff documents shall be performed by "Peer Review Committees," "Review Organizations," and "Medical Review Committees" (referred to collectively as "peer review committees"), in accordance with Georgia law. Peer review committees include, but are not limited to:

(a) all standing and ad hoc Medical Staff and Hospital committees;

(b) hearing panels;

(c) the Board and its committees;

(d) any individual acting for or on behalf of any such entity, including but not limited to department chairpersons, section chairpersons, committee chairpersons and members, officers of the Medical Staff, and experts or consultants retained to assist in peer review activities;

(e) all departments and sections; and

(f) medical education conferences organized to engage in activities such as, but not limited to, the following: practice analysis, utilization

review, compliance audits, and case presentations and recommendations for improved care. These activities are undertaken for the purposes of evaluating and improving the quality of health care rendered by professional health care providers at Saint Joseph's Hospital of Atlanta and for determining whether health care services were professionally indicated, appropriate, reasonable, and/or safe. Such activities are protected from disclosure by O.C.G.A.§ 31-7-130 and § 31-7-140

All reports, recommendations, actions, and minutes made or taken by peer review committees are confidential and covered by the provisions of O.C.G.A. §31-7-15, O.C.G.A.§ 31-7-131 *et seq.*, O.C.G.A.§ 31-4-140 *et seq.*, and/or the corresponding provisions of any subsequent federal or state statute providing protection to peer review or related activities.

(2) All peer review committees shall also be deemed to be "professional review bodies" as that term is defined in the Health Care Quality Improvement Act of 1986, 42 U.S.C. § 11101 *et seq.*

ARTICLE 9

AMENDMENTS

(a) This Manual may be amended by a majority vote of the members of the Staff Executive Committee present and voting at any meeting of that committee where a quorum exists, provided that the written recommendations of the Credentials Committee concerning the proposed amendments shall have first been received and reviewed by the Staff Executive Committee. Notice of all proposed amendments shall be posted on the Medical Staff bulletin board at least 14 days prior to the Staff Executive Committee meeting and any member of the Medical Staff may submit written comments to the Staff Executive Committee.

(b) Alternatively, the Staff Executive Committee may present proposed amendments to the voting staff by mail ballot, returned to the Medical Staff Office by the date indicated by the Staff Executive Committee. Along with the proposed amendments, the Staff Executive Committee may, in its discretion, provide a written report on them either favorably or unfavorably. To be adopted, an amendment must receive a majority of the votes cast, so long as the amendment is voted on by at least 25% of the staff eligible to vote.

(c) No amendment shall be effective unless and until it has been approved by the Board.

ARTICLE 10

ADOPTION

This Manual is adopted and made effective upon approval of the Board, superseding and replacing any and all other Bylaws, Rules and Regulations of the Medical Staff or Hospital policies pertaining to the subject matter thereof.

Adopted by the Medical Executive Committee: October 20, 2020

Approved by the Board: November 23, 2020

MEDICAL STAFF BYLAWS, POLICIES, AND RULES AND REGULATIONS OF EMORY SAINT JOSEPH'S HOSPITAL

MEDICAL STAFF

COMMITTEE MANUAL

November 23, 2020

MEDICAL STAFF COMMITTEE MANUAL

November 23, 2020

Table of Contents

Section 1. Medical Staff Committees 3

A. Blood Usage Review Committee 3
B. Credentials Committee 4
C. Critical Care Committee 5
D. Graduate Medical Education Committee 6
E. Medical Education Committee 7
F. Peer Review Committee 8
G. Pharmacy and Therapeutics Committee 9
H. Professional Conduct Committee 11
I. Utilization Review Committee 11

Section 2. Infection Prevention Committee 13

Section 3. Oncology Committee 14

Section 4. Patient Safety Quality Management Committee 15

Purpose: The purpose of this Medical Staff Committee Manual is to designate the committees necessary to carry out the functions of the Medical Staff organization, to define the composition, duties and accountability of each committee and to establish the nature and frequency of meetings of said committees. The Medical Staff Committees, the Infection Prevention Committee, the Oncology Committee and the Hearing Committee are formed to (a) evaluate and improve the quality of health care rendered by the providers of health services; (b) determine that the health services rendered were professionally indicated.

All Medical Staff committees are considered peer review committees. The Hospital and Board committees of Infection Prevention, Oncology and Patient Safety Quality Management are also considered peer review committees. These committees, including Medical Staff Committees, can participate in Ongoing and Focused Professional Practice Evaluation and can refer issues or concerns to other peer review committees or directly to the Chief of Staff.

Appointment of Committee Chairs and Members

The members and chairs of Medical Staff committees shall be selected by the Chief of Staff, with input from the Chief Medical Officer and shall be approved by the Medical Executive Committee. They shall serve an initial term of two years and may be reappointed.

Committee assignment shall be available to Active and Courtesy, Medical Staff members, and Allied Health Professionals.

Hospital personnel may be appointed by the CEO to Medical Staff Committees as non-voting members.

Medical Staff committees shall meet monthly, or as needed, maintain permanent records, and report to the Medical Executive Committee regarding their activities and recommendations.

A. Blood Usage Review Committee

(1) The Blood Usage Review Committee shall consist of at least seven (7) members of the Active Medical Staff. Other members shall include representatives from Nursing Service, Patient Care Management, the Blood Bank Supervisor, and a representative from Hospital Management.

(2) The duties of the Blood Usage Review Committee shall be:

(a) to perform blood usage review at least quarterly to continuously improve the appropriateness and effectiveness with which blood and blood components are used;

(b) to evaluate all confirmed transfusion reactions;

(c) to approve policies and procedures relating to the distribution, handling, use and administrations of blood and blood components using clinically valid criteria

(d) to review the adequacy of transfusion services to meet the needs of patients;

(e) to review ordering practices for blood and blood products.

(3) Reports of findings, conclusions, recommendations, actions taken and follow-up shall be made to the sections, departments, Patient Safety Quality Management Committee and Medical Executive Committee at least annually.

B. Credentials Committee

(1) The Credentials Committee shall consist of at least seven (7) Members of the Active Medical Staff. Three (3) Members shall be from the Department of Medicine. Three (3) Members shall be from the Department of Surgery. One (1) Member shall be among the Hospital based physicians. The Chairmen of the Departments of Medicine and Surgery will be members of the Credentials Committee without vote. The President and Chief of Staff shall be an ex-officio member without vote.

(2) The duties of the Credentials Committee shall be:

(a) to review the credentials of all Applicants and to make recommendations for membership and delineations of Clinical - Privileges in compliance with Articles I and II of the Medical Staff Credentials Manual;

(b) to make a report to the Medical Executive Committee on each applicant applying for Medical Staff membership or requesting a change in staff status or clinical privileges;

(c) to review periodically all information available regarding the competence of Staff Members and, as a result of such reviews, including Ongoing Professional Practice Evaluation, to make recommendations for the granting of privileges, reappointments, and the assignment of practitioners to the various departments or services as provided in Articles I and II of the Medical Staff Credentials Manual;

(d) consider the type and scope of Focused Professional Practice Evaluation for (1) all initial applicants; and (2) existing practitioners seeking new or additional privileges.

(e) to investigate any breach of ethics if so directed by the Chief of Staff;

(f) to review matters that are referred by the Medical Executive Committee or the Chief of Staff; and

(g) to review the credentials and define the scope of activities authorized for SPP's and make recommendations to the Board of Directors through the Medical Executive Committee for final approval of their applications.

C. Critical Care Committee

(1) The Critical Care Committee shall consist of at least six (6) Physician Members, including the four (4) Medical Directors of the Critical Care Units, and representatives from Anesthesiology, Emergency Services and eICU. Nursing Services shall be represented by the Critical Care Clinical Specialists and the Nursing Directors, or designees, from each of the Critical Care Units. Representatives from Hospital Administration and Respiratory Services and case managers shall also be members.

(2) The duties of the Critical Care Committee shall be:

(a) to evaluate the quality and effectiveness of patient care and to monitor and evaluate on an ongoing, planned, systematic basis to identify problems in patient care. When important problems are identified, appropriate actions are taken, the effectiveness of those

actions is evaluated, and findings and conclusions of monitoring activities shall be reported in accordance with the Medical Staff's Performance Improvement]/Risk Management Plan.

(b) to evaluate the proper utilization of the units;

(c) to evaluate training programs for effective use of diagnostic and therapeutic equipment and other specialized techniques of critical care management;

(d) to make recommendations regarding the operation of the units with regard to policies, equipment and procedures;

(e) to assess the safety of the critical care units with regard to the patients and personnel.

D. Graduate Medical Education Committee

(1) The Graduate Medical Education (GME) Committee shall consist of a minimum of five members of the Active Staff, including all GME program site directors for ESJH and additional hospital representation as recommended by the Board or hospital administration. The Chief of Staff, the Chief Quality Officer and the Chief Medical Officer shall be ex-officio members without vote. The GME Committee shall be established or dissolved, at the determination of the MEC and Board, for the acceptance of medical residents and/or fellows.

(2) The duties of the Graduate Medical Education Committee shall be:

(a) to be responsible for the safety and quality of patient care provided by, and the related education and supervisory needs of, the participants in the professional educational programs;

(b) to meet at least four times a year and submit a report of its findings and recommendations to the MEC on the education needs and performance of the participants in the program; and

(c) to develop and periodically update Hospital and Medical Staff GME Policies and Procedures.

E. Medical Education Committee

(1) This committee shall consist of at least six (6) Members of the Active Medical Staff and representatives from other disciplines are required.

(2) The duties of the Medical Education Committee shall be:

(3) To serve as an advisory committee regarding the provision of the Medical Library holdings and services to meet the needs of the Medical Staff and Hospital employees.

(4) To review and approve policies and procedures for the development and implementation of continuing medical education programs sponsored or jointly sponsored by Saint Joseph's Hospital to insure that these programs achieve the Hospital's CME mission and institutional mission and values including the following:

(5) to enhance the delivery of high quality, cost effective medical care provided by the Medical Staff;

(a) to identify the educational needs of the Medical Staff by evaluating input from multiple sources;

(b) to address appropriate quality improvement issues identified by the Patient Care Management Department;

(c) to inform the Medical Staff of pertinent new medical developments in medical knowledge and technology;

(d) to provide CME forums for the Medical Staff that address important issues in medicine in a comprehensive and objective manner to enhance physician's ability to make informed and effective medicine decisions;

(e) to provide CME programs in Hospital's areas of clinical excellence for physicians in metro Atlanta, the state of Georgia and/or states contiguous to Georgia;

(f) to support Medical Staff involvement in Hospital sponsored medical education programs;

(g) to provide CME programs to meet the educational needs and interests of primary care physicians in the Hospital's outreach service areas;

(h) to provide practice management education programs to assist physicians and their practice managers in successfully managing their practices;

(i) to evaluate the effectiveness of all hospital sponsored medical education activities;

(j) to collaborate with the Joint Medical Education Committee for Northside and Saint Joseph's Hospitals;

(k) to develop and implement CME programs in compliance with the accreditation essentials of the Accreditation Council for Continuing Medical Education of the American Medical Association.

F. Peer Review Committee

(1) This committee shall consist of at least five (5) Members of the Active Medical Staff and representatives from other disciplines required. The Nominating Committee approves membership as described in the Medical Staff Bylaws. The Peer Review Committee is a standing Medical Staff committee and shall meet on a monthly basis.

(2) The committee shall provide for physician peer review according to the Peer Review Process Policy (Policy number 10154-08). The committee purpose shall be to evaluate the quality of care provided, monitor for quality of care issues and trends and facilitate performance improvement accordingly. The discussions, data and records collected pursuant to the Peer Review Committee constitute records of a review organization which shall be held in confidence and shall not be subject to discovery or introduction into evidence in any litigation related to matters which are the subject of such data pursuant to the Peer Review Statutes of the Official code of Georgia (including, but not limited to OCGA Sections 31-7-130;31-7-131;31-7-132;31-7-133;31-7-140;31-7-143); the Health Care Quality Improvement Act of 1986 (42 U.S.C. Sections 11101-11152) and any other applicable laws or regulations.

(3) The duties of the Peer Review Committee, in addition to the duties listed in the Peer Review Policy, shall be to:

a. Provide physician peer review and facilitate quality improvement.

b. Review and evaluate the care of patients at Saint Joseph's Hospital
c. Identify quality of care issues and trends via the Physician Peer Review Process
d. Address appropriate quality issues
e. Make recommendations for improvement and/or action.
f. Report physician quality findings to the Medical Executive Committee on a quarterly basis
g. Report to the Chief of Staff when immediate action is indicated
h. Report peer review finding to the Credentials Committee upon appointment or reappointment
i. Report clinical process improvement issues to the Patient Safety Quality Management Committee on a quarterly basis or as deemed by the committee chair.
j. Support Medical Staff involvement in Hospital Performance Improvement

G. Pharmacy and Therapeutics Committee

(1) Composition:

The Pharmacy and Therapeutics Committee shall consist of at least six members of the voting staff (active medical staff), one of whom shall be designated as chair. The Chief Medical Officer and the Chief Quality Officer shall serve on the committee without vote. Members of Nursing Services and Pharmacy shall be appointed as needed. A quorum is defined as at least 4 voting members.

(2) Duties:

The Pharmacy and Therapeutics Committee shall meet at least quarterly and shall:

(a) oversee the improvement efforts in medication use and intravenous nutrition care, including the responsibility for preventing, monitoring, reporting and addressing medication errors;

(b) review applicable policies and procedures periodically;

(c) perform review of all PowerPlans containing medications prior to initiation of use and when any major medication changes are made to existing PowerPlans;

(d) oversee additions and deletions of medications to the Hospital formulary;

(e) evaluate clinical, safety and financial data concerning new drugs or preparations requested for use in the Hospital;

(f) oversee the hospital Antimicrobial Stewardship Program;

(g) monitor and evaluate selected drugs that the committee and/or other committees within the hospital have deemed necessary due to potential safety, financial or other concerns;

(h) maintain a record of actions, recommendations and follow up to be reported at least quarterly to the sections and Medical Executive Committee;

(i) and comply with the requirement of signing yearly "Conflict of Interest Disclosure Statement" as needed. Statements will be disseminated to all voting members at the beginning of each calendar year and to new members as they are appointed.

(3) Conflict resolution:
Disagreements regarding restricted/non-formulary medications where a request for a restricted/non-formulary medication is not approved, the provider should be encouraged to discuss concerns with the chair of the Pharmacy and Therapeutics Committee or with the individual's specialty representative that sits on P&T. The committee will attempt to work collaboratively with the relevant prescriber or medical team to come to a mutually agreeable therapeutic decision. If no agreement can be reached, the provider responsible for the patient may appeal to the Chief Medical Officer at the Emory Saint Joseph's Hospital.

H. Professional Conduct Committee

(1) This committee shall be composed of the Chief of Staff, Vice Chief of Staff, the Past Chief of Staff and the Chairmen of the departments of medicine and surgery.

(2) The duties of this committee shall include:

a. Review of all reports alleging inappropriate conduct by a Medical Staff Member or Allied Health Professional.

b. Communication as appropriate with representatives of the HR department and others to investigate reports of inappropriate conduct.

c. Seek resolutions utilizing, as appropriate, collegial and educational steps.

d. When warranted, refer of matters to the Medical Executive Committee for review and action.

e. Compliance with all aspects of the Medical Staff Code of Conduct Policy

(3) This committee shall meet on an as-needed basis.

I. Utilization Review Committee

(1) The Utilization Review Committee consists of at least five (5) and not more than nine (9) members of the Active [?] Medical Staff.

(2) The duties of the Utilization Review Committee shall be:

(a) To provide physician oversight of the utilization review function by monitoring on a systematic basis, admission to the Hospital, duration of stay and professional services furnished to evaluate the medical necessity of the services and for the purpose of promoting the most efficient use of available health facilities and services.

(b) To develop and revise, as may be required, a Utilization Review Plan and Policies appropriate to the Hospital in accordance with applicable federal law and regulations and state requirements which provides for (i) review of admissions and continued Hospital stay; (ii) review of professional services rendered in extraordinarily high cost cases reasonably assumed by Hospital to be outliers; (iii) discharge planning; (iv) data collecting and reporting; (v) identifying utilization related problems; and (vi) the procedures for conducting concurrent review and specifies the time period within in which the review should be initiated following admission.

(c) To address concerns regarding the medical necessity for admission, continued stay or level of care in response to questions raised by Care Management, Hospital staff or member(s) of the Medical Staff in a timely manner pursuant to the Utilization Review Plan and applicable Policy.

(d) To require that the Utilization Review Plan is in effect, known to members of the Medical Staff, and functioning at all times;

(e) To conduct such studies, take such actions and make such recommendations as are required by the Utilization Review Plan.

(3) The Utilization Review Committee shall submit reports as required by the Utilization Review Plan.

Section 2. Infection Prevention Committee

This committee shall be a Hospital committee, however, the responsibilities of the committee shall remain a function of the Medical Staff. All recommendations of the Infection Prevention Committee must be approved by the Medical Executive Committee.

(1) The Members and chairman of the Infection Prevention Committee shall be selected and shall serve according to the guidelines for standing committees set in Section 1 of this Medical Staff Committee Manual. Membership shall include the Infection Prevention Specialist or Manager and representatives from the Microbiology Section, Central Supply, Operating Room, Hospital Management, Nursing Service and Environmental Services, in addition to at least six (6) Physician Members, including representatives from Surgery and, Medicine.

(2) The duties of the Infection Prevention Committee shall include the determination of the type of surveillance and reporting programs to be used for the surveillance of Hospital infection potentials, the review and analysis of actual infections, the promotion of a preventative and corrective program designed to minimize infection hazards, and the supervision of infection Prevention in all phases of the Hospital's activities, including:

(a) operating rooms, recovery rooms, special care units;

(b) sterilization procedures by heat, chemicals or otherwise;

(c) isolation procedures;

(aa) prevention of cross-infection by anesthesia apparatus or inhalation therapy equipment;

(bb) testing of Hospital Personnel for carrier status;

(cc) disposal of infectious material;

(dd) institution of control measures, through the chairman of the committee, when patients or employees are in danger;

(ee) other situations as requested by the Medical Executive Committee.

(3) The Committee recommends corrective action based on records and reports of infections and infection potential among patients and hospital personnel.

Actions are reported to sections, departments, Patient Safety Quality Management Committee, Medical Executive Committee and others as appropriate.

Section 3. Oncology Committee

This committee shall be a Hospital committee, however, the responsibilities of the committee shall remain a function of the Medical Staff. All recommendations of the Oncology Committee must be approved by the Medical Executive Committee.

(1) The Members and Chairman of the Oncology Committee shall be selected and shall serve according to the guidelines for standing committees set in Section 1 of this Medical Staff Committee Manual. The membership of the Oncology Committee shall consist of a Physician chairman, and one board certified physician representative from surgery, medical oncology, radiation oncology, diagnostic radiology, pathology, palliative care and the cancer liaison physician. In addition there shall be a representative from Nursing Service, Social Services of the Patient Care Management Department, the Cancer Registry, Case Management of the Patient Care Management and Hospital Administration.

(2) The duties of the Oncology Committee shall be:

a. develops and evaluates the annual goals and objectives for the clinical, educational and programmatic activities related to cancer;

b. promotes a coordinated, multidisciplinary approach to patient management;

c. ensures that educational and consultative cancer conferences cover all major sites and related issues

d. ensures that an active supportive care system is in place for patients, families and staff;

e. monitors quality management and improvement through completion of quality management studies that focus on quality, access to care and outcomes;

f. promotes clinical research;

g. supervises the cancer registry and ensures accurate and timely abstracting, staging and follow-up reporting;

h. performs quality control of registry data;

i. encourages data usage and regular reporting;

j. uphold ethical standards;

k. ensures that the medical record contains documentation of cancer staging by the managing physician or other designated physician.

(3) The Oncology Committee shall meet at least quarterly. The meeting schedule shall meet overall program needs and may require the committee to meet more frequently.

Section 4. Patient Safety Quality Management Committee

The Patient Safety Quality Management Committee ("PSQMC") is a peer review committee, which meets at least quarterly. The discussions, data and records collected pursuant to PSQMC constitute records of a review organization which shall be held in confidence and shall not be subject to discovery or introduction into evidence in any litigation related to matters which are the subject of such data pursuant to the Peer Review Statutes of the Official code of Georgia (including, but not limited to OCGA Sections 31-7-130;31-7-131;31-7-132;31-7-133;31-7-140;31-7-143); the Health Care Quality Improvement Act of 1986 (42 U.S.C. Sections 11101-11152) and any other applicable laws or regulations.

PSQMC is a committee of the Board. It is chaired by a designated member of the Medical Staffand the Executive Vice President of Saint Joseph's Hospital of Atlanta ("SJHA") and has, as its members, administrative, medical and support staff representatives. PSQMC is responsible for:

a. The establishment of strategic quality goals for the organization;

b. Setting priorities for Performance Improvement (PI) initiatives;

c. Full support of PI projects through review of team progress, allocation of resources and recognition of progress toward goals;

d. Elimination of redundancy in foci;

e. Reviewing patient satisfaction scores, recommending action and following up on action items, oversight of the Customer Service Committee;

f. Oversight of the Specialty Teams (interdisciplinary, usually product line teams)) and performance metrics;

g. Evaluation of quality goals on an annual basis or as indicated

h. Assuring, through the appropriate leader, that the ongoing, day to day monitoring and measurement occur

i. Monitoring emerging risk management trends/issues through the oversight of the Hospital Unusual Occurrence Committee, Sentinel Events and other occurrences related to clinical performance.

j. Assuring that mechanisms are in place to identify Sentinel Events and to assure completion of necessary Root Cause Analyses

k. Selection of Key Outcome indicators and monitoring, reporting and action planning in response to identified trends

l. Oversight of hospital performance on National Quality Measures and other national quality initiatives and registries

ADOPTED by the Medical Executive Committee on October 20, 2020.

APPROVED by the Board of Directors on November 23, 2020.

MEDICAL STAFF BYLAWS, POLICIES, AND RULES AND REGULATIONS OF EMORY SAINT JOSEPH'S HOSPITAL

MEDICAL STAFF

Rules & Regulations

November 23, 2020

MEDICAL STAFF RULES AND REGULATIONS

November 23, 2020

General ……..Page 1

The Department of Surgery…….……...Page 4

Cardiothoracic Surgery Section…… Page 4
General & Colon-Rectal Surgery Section.....……. Page 7
Neurosurgery Section…….....Page 8
Ophthalmology Section……..…… Page 8
Oral & Maxillofacial Surgery and General Dentistry…..... Page 9
Orthopedic Surgery Section.....…… Page 10
Otolaryngology Section…….....…… Page 11
Podiatry…….... Page 11
Urology Section .....…... Page 12
Vascular Section...…… Page 13

The Department of Anesthesiology..... Page 15

The Department of Medicine……..……... Page 16

Cardiology Section.....…… Page 17
Gastroenterology Section.....…… Page 19
Infectious Disease Section..... Page 21
Neurology Section……..Page 21
Oncology/Hematology Section…….. Page 21
Pulmonary Disease Section.....…… Page 22

The Department of Pathology.....…….. Page 24

The Department of Radiology.....…..Page 25

APPENDIX I, Physician's Orders.....….Page 26

APPENDIX II, Medical Records.....… Page 28

APPENDIX III, Critical Care Areas.....…. Page 36

APPENDIX IV, Emergency Services.....… Page 38

APPENDIX V, Guidelines for Proctoring.....…… Page 39

General

1. Patients may be admitted to the hospital only by physicians and dentists who have been duly appointed to membership and granted clinical privileges on the staff. Temporary privileges may be granted according to Article II, Section 2, of the Medical Staff Credentials Manual.

2. A member of the Medical Staff shall be responsible for the medical care and treatment of each patient in the hospital, for providing a working diagnosis, for the prompt completeness and accuracy of the medical record, for necessary special instructions, and for transmitting reports of the condition of the patient to relatives of the patient. Whenever these responsibilities are transferred to another member, an order covering the transfer of the responsibility shall be made on the order sheet and a transfer note made on the progress sheet. It is the responsibility of the transferring physician to obtain the other physician's agreement to accept the transfer.

3. Admission to the hospital is a "complex medical judgment" that can only be made by physician after considering several factors, such as:
   — Patient medical needs and history
   — Severity of signs and symptoms
   — Likelihood of adverse event

   Status determination includes the admitting/admission status and any following status conversions reflecting changes the patient's clinical condition, new information in the record, and contractuals with managed care payors. Physicians have the responsibility to ensure their EM billing matches hospital status.

   The attending physician is required to document the need for continued hospitalization during the patient's stay.

4. The determination that an admission or continued stay is not medically necessary may be made by one member of the UR committee if the practitioner(s) responsible for the care of the patient concur with the determination or fail to present their views when afforded the opportunity. The determination must be made by at least two members of the UR committee in all other cases.

5. Patients shall be discharged only on order of the attending physician. Should a patient leave the hospital against the medical advice of his attending physician, or without proper discharge, a notation of the incident shall be made in the patient's medical record, and the appropriate release form shall be signed by the patient.

6. Physicians should plan the patients hospital stay in order that hospitalization be time and cost effective. Consideration should be given by the physician to pre-admission testing and scheduling of in-hospital procedures. Discharge plans should be timely and comply with dismissal time of 11:00 A.M.

7. Discharge Planning will be initiated by Social Services upon admission of the patient without the need for a physician's order.

8. Members of the medical staff should secure written consent of the legally responsible relative or representative for autopsies. All autopsies shall be performed by the hospital Pathologist or by a physician to whom he delegates this duty.

    a. Consistent with hospital policy, deaths will be reported to the Medical Examiner for autopsy and disposition.

    b. The family may request an autopsy and the Pathologist may elect to perform this autopsy after consultation with the family and involved physicians.

    c. An autopsy justification is required by the clinician requesting examination to include a death summary and a specific statement to indicate what problems the clinician expects to solve by the performance of an autopsy.

    d. Suggested criteria for physicians to follow when considering which patients should be autopsied are: unanticipated death; death where the disease process is not sufficiently understood; death where autopsy documentation may benefit family members as in genetic counseling.

9. Drugs ordered for patients shall meet the standards of the United States Pharmacopoeia, National Formulary, New and Nonofficial Drugs. Drugs for bona fide clinical investigations shall be approved by the Pharmacy and Therapeutics Committee, and Institutional Review Committee.

10. Physicians are responsible for ordering isolation procedures in accordance with infection control policies.

11. Consultations

    a. For all cases in which the diagnosis is obscure or there is doubt as to the best therapeutic measures to be utilized (other than in emergency situations), the physician is expected to seek consultation with another physician who is well qualified in the field in which additional expertise is being sought.

    b. Professional courtesy and optimal patient care warrants communication between requesting and consulting practitioners at all times. All consults must be communicated directly between requesting and consulting practitioners.

    c. All consultation request orders must specify a specific physician or specific specialty group name, reason for consultation and expected response time.

12. All physicians shall perform assignments issued in accordance with the Medical Disaster Plan.

13. Physician's orders shall be followed by the Division of Nursing in accordance with the guidelines outlined in Appendix I.

14. The attending physician is responsible for a complete medical record on each patient, as outlined in Appendix II.

15. Patients are admitted to the Critical Care Areas in accordance with the Rules and Regulations outlined in Appendix III.

16. Emergency Services are provided as outlined in Appendix IV.

17. Sanctions: Failure to adhere to these Rules and Regulations will result in corrective action outlined in the Medical Staff Credentials Manual.

18. The following documents must be completed and signed prior to the start of any invasive, interventional or diagnostic procedure:

    a. Informed consent
    b. Current history and physical (Dictated H&P does not need to be signed immediately by physician).
    c. Immediate pre-sedation assessment performed – signed, dated and timed.
    d. Time-Out performed.

19. Exception to Section Call Requirements

    Applicant/Medical Staff may request exception to a section's call requirements for ED unassigned patients, either as an individual or group of individuals. This requires:

    - A written request delivered to the section Chief, and,
    - Approval of > ½ (one-half) of the remaining section members who take call and who vote, and,
    - Approval of the Chief of Staff, and,
    - Advanced written notification of this approval signed by the section Chief, and provided to the Medical Staff Office 30 days prior to date of effect.
    - A majority vote of the MEC can rescind this exception with sixty (60) days notice.

The Department of Surgery

1. A surgical operation shall be performed only on consent of the patient or his legal representative except in emergency situations.

2. If a surgical procedure is cancelled the surgeon must document in the medical record the reason for cancellation.

3. Specimens removed at operation shall be sent to the hospital Pathologist in accordance with the Medical Staff policy. All specimens shall remain the property of the hospital.

4. Reports of surgical and other invasive procedures shall be dictated or written in the medical record immediately after their performance.

5. Patients admitted for dental surgery must have recorded on their chart an admission history and physical examination performed by a physician on staff of this hospital who shall be responsible for the medical aspects of care throughout the patient's hospital stay. A history and pertinent physical findings shall also be recorded by the oral surgeon.

6. Operations for the primary purpose of abortion or sterilization are not permitted in this hospital.

7. A Physician First Assistant must have privileges as a primary surgeon in the Operating Room.

Department of Surgery - Section of Cardiothoracic Surgery

A. Provisional Staff Members

   1. Being proctored is a responsibility of Provisional staff members.

   2. The following cases must be performed in the presence of a proctor:

      a. For cardiothoracic surgery privileges - The first five (5) open heart cases performed at Saint Joseph's Hospital of Atlanta.
      b. For thoracic surgery privileges - Five (5) major thoracic cases. Two of these cases must be performed at SJHA -- the other three may be performed at other JCAHO accredited hospitals in the metropolitan area.

   3. The proctor must be an Active staff member of the SJHA Cardiothoracic Section with privileges to perform the surgery being proctored.

   4. A Proctor Report shall be completed and forwarded to the Medical Staff Office for each of the proctored cases.

5. The Section Chief, after reviewing the proctor reports, shall determine if performance of cases is satisfactory enough to conclude proctoring or if additional cases will be required -- and so notify the Provisional staff member, Medical Staff Office and Operating Room. If the Section Chief recommends that additional proctored cases be required, concurrence of the Department Chairman must be obtained.

6. Provisional staff members will not be placed on the Emergency Room Call Schedule until all proctoring requirements have been fulfilled.

7. Provisional staff members are required to attend 50% of the section meetings held during the Provisional year.

8. To be considered for advancement to Active or Courtesy, Provisional section members must provide documentation of the following SJHA patient activity to the Credentials Committee:

   a. For <u>cardiothoracic surgery privileges</u>

      - Performance of 15 open heart cases during Provisional year(s)
        AND
      - 15 patient admissions and/or consults during Provisional year(s)

   b. For <u>thoracic surgery privileges</u>

      - Performance of 5 major thoracic cases during Provisional year
        AND
      - 5 patient admissions and/or consults during Provisional year

B. Active Staff Members

1. Active staff members will make every effort to assist Provisional members in completing their proctoring requirements.

2. Active staff members will serve on the Emergency Room Call Schedule unless excused by the Section Chief.

3. Active staff members are required to attend 50% of the section meetings held during the one year reappointment period.

4. To maintain Active status, section members must provide documentation of the following SJHA patient activity to the Credentials Committee:

a. For cardiothoracic surgery privileges

- Performance of 30 open heart cases during the two year reappointment period

AND

- 24 patient admissions and/or consults during the two year reappointment period

b. For thoracic surgery privileges

- Performance of 10 major thoracic cases during the two year reappointment period

AND

- 24 patient admissions and/or consults during the two year reappointment period.

Courtesy Staff Members

1. Courtesy staff members will not be placed on the Emergency Room Call Schedule.

2. To maintain Courtesy status, section members must provide documentation of the following SJHA patient activity to the Credentials Committee:

a. For cardiothoracic surgery privileges

- Performance of 20 open heart cases during the two year reappointment period

AND

- 20 patient admissions and/or consults during the two year reappointment period

b. For thoracic surgery privileges

- Performance of 10 major thoracic cases during the two year reappointment period. (These cases may be performed at SJHA or other JCAHO accredited hospitals in the metropolitan area.)

Department of Surgery - General & Colon-Rectal Surgery Section

A. Provisional Staff Members

1. Provisional staff members will placed on the General Surgery ER Call Roster. Until the proctoring requirements have been fulfilled, an Active staff member will be placed on the ER call as back-up to the Provisional physician. The Active member will be called in as proctor if circumstances require the Provisional physician to treat the patient in the ER or take the patient to surgery.

2. For a member of the Provisional General & Colon-Rectal Surgery Staff to be considered for promotion to Active medical staff, the following must be documented to the Credentials Committee:

    a. Attendance record of 50% or section meetings and 50% of general staff meetings during the Provisional period (no less than one year - no more than two).

    b. Proctoring of the first fifteen (15) cases to include major cases representing the scope of surgery for the general-colon-rectal surgeon or within the scope of the applicant's practice in the case of a narrowly defined surgeon's sub-specialty practice.

        i. Being proctored is a responsibility of Provisional staff members.

        ii. Proctors shall be obtained by the Provisional staff member and arranged for mutual convenience, Active staff member's convenience having priority.

        iii. The section requires Provisional staff members to utilize at least five (5) Active staff members to proctor his/her cases.

        iv. Less than 50% of the proctored cases may be performed at another JCAHO accredited institution in the metro Atlanta area provided that the proctor is a fully credentialed Active staff member of the General Surgery Section of Saint Joseph's Hospital of Atlanta.

        v. A surgical observation report shall be completed and forwarded to the Section Chief for each of the proctored cases and a copy to the Medical Staff Office for member's file.

        vi. The Section Chief, after reviewing the proctor reports, shall determine if performance of cases is satisfactory enough to conclude

proctoring and, if so, notify the Provisional staff member, Medical Staff Office and Operating Room.

3. Provisional staff members shall participate in section and Committee activities without votes and may not hold office.

B. Active Staff Members

1. Active staff members must attend 50% of the Section Meetings and 50% of the General Staff Meetings.

2. Active General Surgery staff members will take rotation on the ER Call Roster until age 55; unless excused by the General Surgery Section.

3. Participation on the ER Call Roster as back up for Provisional members will fulfill an Active staff members ER call responsibility for that rotation period.

4. Active staff members will make every effort to assist Provisional members in completing their proctoring requirements.

Department of Surgery - Neurosurgery Section

A. Emergency Room On-Call Requirements

1. Active members will take rotation on the ER Call Roster until age 50. After the age of 50, participation will be on a voluntary basis.

2. Courtesy members will not be required to take rotation on the ER Call Roster.

3. Section members with clinical privileges for gamma knife only will be exempt from the ER Call Roster, regardless of staff category.

Department of Surgery – Section of Ophthalmology

A. Active and Courtesy members will take rotation on the ER Call Roster until age 55; unless otherwise excused by vote of the Ophthalmology Section.

Department of Surgery - Oral & Maxillofacial Surgery and General Dentistry Section

A. General Guidelines

All applicants must have successfully completed a hospital based oral and maxillofacial surgery residency program or its equivalent approved by the American Dental Association. All applicants who are not specifically trained in such a hospital based oral and maxillofacial surgery residency program must show evidence of successful completion of hospital based residency training or its equivalent approved by the American Dental Association. The training program must consist of a minimum of twelve months of hospital based training either in a dental specialty recognized by the American Dental Association or in a general practice residency. Clinical privileges will be granted according to the specific residency completed.

B. Oral and Maxillofacial Surgeons - Advancement from Provisional Staff

Criteria for approval of to advance from the Provisional Staff category are as follows:

1. At least the first three (3) minor or dentoalveolar oral surgery procedures, and at least the first three maxillofacial surgery procedures, must be monitored and approved by a member of the Active staff who is a member of the Oral and Maxillofacial Surgery subsection. The monitor may not be a partner or office associate of the Provisional staff member. No more than fifty percent of the cases may be monitored by the same person.

2. Additional monitoring may be required to determine the member's competence, ethics, good reputation, and ability to work with others with sufficient accuracy to assure that the member will provide a high quality of care.

3. It shall be the responsibility of the Provisional staff member to arrange for the monitoring of each case prior to the patient's hospital admission, at the convenience of the monitor, except in cases of emergency surgery. In the event that emergency surgery is required in a case otherwise subject to monitoring under these rules, the Provisional staff member shall so notify an Active staff member who is a member of the Oral and Maxillofacial Surgery subsection.

C. Other Specialists - Advancement from Provisional

Criteria for approval of members seeking clinical privileges other than in oral and maxillofacial surgery to advance from the Provisional staff category are as follows:

1. At a minimum, six cases in which the member is involved in patient care at Saint Joseph's Hospital during one year must be monitored and approved by a member of the Active staff who is a member of the Oral and Maxillofacial Surgery subsection.

In cases in which the member is involved in consultation with respect to patient care, rather than in the performance of a specific procedure that may be observed by the monitor, the patient's chart will be reviewed by the monitor. The monitor may not be a partner or office associate of the Provisional staff member. No more than fifty percent of the cases may be monitored by the same person.

2. Additional monitoring may be required to determine the member's competence, ethics, good reputation and ability to work with others with sufficient accuracy to assure that the member will provide a high quality of care.

3. It shall be the responsibility of the Provisional staff member to arrange for the monitoring of each case prior to the patient's hospital admission, at the convenience of the monitor, except in cases of emergency.

D. Emergency Room Call Rotation

Active and Provisional Staff members having privileges in oral and maxillofacial surgery must serve on the Emergency Room call. Any member of the subsection required to serve on the Emergency Room call rotation who fails to fulfill this responsibility is subject to the sanctions provided in the Medical/Dental Staff Bylaws.

Department of Surgery - Orthopedic Section

A. Proctoring requirements

Proctoring of the first five (5) cases representing the general scope of orthopedics for the general orthopedist or within the scope of applicant's practice in the case of a narrowly defined orthopedist's sub-specialty practice. Three (3) cases will be performed at SJHA and two (2) cases will be accepted from another JCAHO accredited hospital.

i. Only Active staff members of the Orthopedic Surgery Section may serve as proctors.

ii. Proctors shall be obtained by the proctoree and arranged for mutual convenience, Active staff member's convenience having priority.

iii. No more than three (3) of the required twenty (20) cases may be proctored by physicians from the proctoree’s partnership or group.

iv. The section requires proctorees utilize at least three (3) Active staff members to proctor his/her cases.

v. A surgical observation report shall be completed and forwarded to the Medical Staff Office for each of the proctored cases.

vi. The Section Chief, after reviewing observation reports, shall determine if performance of cases is satisfactory enough to conclude proctoring and, if so, notify the proctoree, Medical Staff Office and Operating Room. If the Section Chief recommends that additional proctored cases be required, concurrence of the Department Chairman must be obtained.

All proctoring requirements must be completed during the first two (2) years of staff appointment in order to be eligible for reappointment.

B. Active Staff Members

1. Active Orthopedic staff members will take rotation on the ER Call Roster until age 50; unless excused by vote of the Orthopedic Section.

2. Active staff members will make every effort to assist other section members in completing their proctoring requirements.

C. Courtesy Staff Members

1. Courtesy Orthopedic staff members are not required to take rotation on the ER Call Roster but may do so voluntarily.

Department of Surgery – Section of Otolaryngology

B. Active and Courtesy members will take rotation on the ER Call Roster until age 55; unless otherwise excused by vote of the Otolaryngology Section.

Department of Surgery – Section of Podiatry

A. Admission History and Physical Examination Requirements

1. The admission H&P for patients admitted for podiatric surgery with ASA Class I designation may be performed and recorded by a podiatrist who has been granted such privileges. Otherwise, these patients must have recorded on their chart an admission history and physical examination performed by a physician member of Saint Joseph's Medical Staff who shall be responsible for the medical aspects of care throughout the patient's hospital stay. A history and pertinent physical findings shall also be recorded by the podiatric surgeon.

B. On-Call Requirements

1. All members of the Podiatry Section will be required to participate on a call schedule for inpatient consultations.

Department of Surgery - Section of Urology

A. Provisional Staff Members

1. Proctoring Requirements

a. Being proctored is a responsibility of Provisional staff members.

b. The first major case must be performed in the presence of a proctor. If the first case is not a major case, proctoring will continue until a major case is proctored.

c. The proctor must be an Active staff member of the Urology Section. Proctors shall be obtained by the Provisional staff member and arranged for mutual convenience, Active staff member's convenience having priority. Proctors shall not be from the Provisional member's partnership or group.

d. A Proctor Report shall be completed and forwarded to the Medical Staff Office for each of the proctored cases.

e. The Section Chief, after reviewing the proctor report(s), shall determine if performance of case(s) is satisfactory enough to conclude proctoring and, if so, notify the Provisional staff member, Medical Staff Office and Operating Room. If the Section Chief recommends that additional proctored cases be required, concurrence of the Department Chairman must be obtained.

f. There shall be a retrospective review of cases 6 months after the initial appointment by the Section Chief or an Active member of the individual's section that is not in the same practice.

2. Emergency Room Call

a. Provisional staff members will not be placed on the Urology ER Call Schedule until all proctoring requirements have been fulfilled.

B. Active Staff Members

1. Active staff members will make every effort to assist Provisional members in completing their proctoring requirements.

Department of Surgery – Section of Vascular Surgery

In accord with the Saint Joseph's Hospital of Atlanta (SJHA) Medical Staff Bylaws, all applicants must have certification or be eligible for certification by each of the specialty and subspecialty boards in the clinical department in which he is applying. For purposes of vascular surgery applicants, this shall be defined as certification by The American Board of Surgery with additional certification in Vascular Surgery.

Membership of the vascular surgery section shall be comprised of medical staff members whose majority of surgical cases performed at SJHA is vascular cases.

A. Provisional Staff Members

1. Emergency Room On-Call Requirements: Provisional staff members will be placed on the Vascular Surgery emergency room on-call schedule. Until the provisional member's proctoring requirements have been fulfilled, an Active staff member will be placed on the ER on-call schedule as back up to the Provisional physician. The Active member will be called in as proctor if circumstances require the Provisional physician to take the patient to surgery.

2. For a member of the Provisional Vascular Surgery staff to be considered for promotion to Active Vascular Surgery staff, the following must be documented to the Credentials Committee:

    a. Proctoring Requirements: Proctoring of the first five (5) cases to include major cases representing the scope of surgery for the vascular surgeon or within the scope of the applicant's practice in the case of a narrowly defined surgeon's subspecialty practice.

        i. Being proctored is a responsibility of Provisional staff members.

        ii. Proctors shall be obtained by the Provisional staff member and arranged for mutual convenience, Active staff member's convenience having priority.

        iii. The section requires Provisional staff members to utilize at least two (2) Active staff members to proctor his/her cases.

        v. Less than 50% of the proctored cases may be performed at another JCAHO accredited institution in the metro Atlanta area provided that the proctor is a fully credentialed Active staff member of the Vascular Surgery Section of Saint Joseph's Hospital of Atlanta.

v. A surgical observation report shall be completed and forwarded to the Section Chief for each of the proctored cases and a copy to the Medical Staff Office for member's file.

vi. The Section Chief, after reviewing the proctor reports, shall determine if performance of cases is satisfactory enough to conclude proctoring and, if so, notify the Provisional staff member, Medical Staff Office and Operating Room.

3. Provisional staff members shall participate in section and Committee activities without votes and may not hold office.

B. Active Staff Members

1. Emergency Room On Call Requirements: Active staff members will take rotation on the emergency room on-call schedule until age 55 unless excused by the vascular surgery section chief.

   Participation on the emergency room on-call schedule as back up for Provisional staff will fulfill an Active staff member's ER on-call responsibility for that rotation period.

2. Proctoring: Active staff members will make every effort to assist Provisional staff members in completing their proctoring requirements.

The Department of Anesthesiology

1. The Department of Anesthesiology is responsible for the administration of all general and conductive anesthesia for surgical and diagnostic procedures in the hospital. This shall include: (a) pre-operative evaluation and medication of patients, (b) post-operative follow-up of patients. With respect to inpatients, a post anesthesia evaluation must be completed and documented by an individual qualified to administer anesthesia within 48 hours after surgery. Notations shall be made on the anesthesia record.

2. The members of the Department of Anesthesiology shall act in cooperation with the Operating Room Supervisor in the scheduling of cases.

3. The members of the Department of Anesthesiology shall act in cooperation with the Recovery Room Supervisor and personnel in the proper operation of the Recovery Room and assist in the management of patient care.

4. Members of the Department of Anesthesiology, when available, shall participate immediately on notification in the emergency resuscitation of patients in the various areas of the hospital where such emergency situations may arise.

5. Members of the Department of Anesthesiology shall engage in teaching of nurses and other personnel as the need for instruction arises and the schedule permits. This service shall be rendered without compensation or remuneration.

6. Members of the Department of Anesthesiology shall supervise the purchasing, utilization, maintenance and cleaning of all anesthetic and anesthesia related equipment in the Operating Room, Emergency Room and Cardiac Catheterization Laboratory.

7. Members of the Department of Anesthesiology shall assist in the management of patients requiring respiratory therapy in the hospital when their services are requested and they are available.

8. Each member of the Department of Anesthesiology shall prepare a report of his cases monthly, tabulating methods and complications. These records shall be used to make the annual report that is required by the Administration.

The Department of Medicine

Emergency Room On-Call Requirements

1. The following specialties within the Department of Medicine must have on-call schedules:

   Cardiology
   Gastroenterology
   Infectious Diseases
   Nephrology
   Neurology
   Oncology/Hematology
   Pulmonary Disease
   Rheumatology

2. All Active section members will be required to serve on the on-call schedule unless otherwise excluded in accordance with section rules and regulations.

3. Courtesy section members may be required to serve on the on-call schedules in accordance with section rules and regulations.

Department of Medicine - Section of Cardiology

A. Emergency Room On-Call Requirements

1. All Cardiologists who meet the eligibility requirements, listed in section B below, for Cardiology ER Call must participate in Cardiology ER Call;
2. All Cardiologists with Interventional Privileges who meet the are eligibility requirements for Cardiology ER Call must participate in Interventional Cardiology ER Call;
3. After age 60, Cardiology ER Call and Interventional Call are optional.

B. Emergency Room On-Call eligibility Criteria

1. Section members must be Active staff physicians to participate in ED Call; and
2. Section members must provide documentation of a minimum of twenty-five (25) discharges, Cardiac Catheterizations, PCIs, Ablations, Device Procedures or Outpatient procedures (i.e. TEE, Tilt Table Test) per annual year at ESJH. Physicians new to staff will be provided one calendar year to meet the minimum volume requirements and will be eligible to take call during that initial year.
3. Based upon clinical need, the Section Chair of Cardiology may waive the volume requirements in one year increments.

C. Proctoring Guidelines

1. Assuring that a proctor is present when required is the responsibility of the physician who is to be proctored.

2. Active staff members will make every effort to assist other section members in completing their proctoring requirements.

3. The proctor must be a fully credentialed Active staff member of the Cardiology Section of Saint Joseph's Hospital of Atlanta.

4. Proctors shall be obtained by the physician who is to be proctored and arranged for mutual convenience.

5. At least two different physicians must act as proctors. Greater than 50% of procedures shall be proctored by section members outside the proctored physician's group.

6. The proctoring physician must be present in the cath lab area during the entire procedure in order for the procedure to be considered a proctored procedure.

7. Emergency cases may not be performed until all proctoring requirements are fulfilled.

8. During the proctoring period, the physician being proctored is primarily responsible for the patient management and procedure. The role of the proctor is that of observer and evaluator except in the instance of a life threatening emergency.

9. A proctor report shall be completed and forwarded to the Medical Staff Office for each of the proctored cases. It is the responsibility of the physician being proctored to see that this is done.

10. To conclude the proctoring period, the Section Chief of Cardiology and the Medical Director of the Cardiac Catheterization Lab will review the completed proctor reports to determine acceptable case performance. The Section Chief and Medical Director of the Cardiac Catheterization Lab are expected to notify the physician and the Medical Staff Office of the results of review of the proctor reports. If the Section Chief or Medical Director recommends that additional proctoring be required, concurrence of the Department Chair must be obtained.

D. Minimum Activity Requirements

1. Cardiac Catheterization Privileges - Section members must provide documentation of their performance of at least twelve (12) of these procedures per year at Saint Joseph's Hospital of Atlanta.

2. Percutaneous Transluminal Coronary Angioplasty (PTCA) Privileges - Section members must provide documentation of their performance of at least twelve (12) of these procedures per year at Saint Joseph's Hospital of Atlanta. When minimum activity requirement for PTCA is met, activity requirement for cardiac caths is waived.

4. Pacemakers – Section members must provide documentation of their performance of at least five (5) procedures per year at Saint Joseph's Hospital of Atlanta.

4. Diagnostic Electrophysiologic Studies - Section members must provide documentation of their performance of at least twelve (12) procedures per year performed at Saint Joseph's Hospital of Atlanta.

5. Insertion of ICD Privileges - Section members must provide documentation of their performance of at least six (6) procedures per year performed at Saint Joseph's Hospital of Atlanta.

6. Catheter Ablation Privileges - Section members must provide documentation of their performance of at least twelve (12) procedures per year performed at Saint Joseph's Hospital of Atlanta. When minimum activity requirement for ablation is met, activity requirement for Electrophysiologic Studies is waived.

7. Transesophageal Echocardiography Privileges - Section members must provide documentation of their performance of at least five (5) procedures per year performed at Saint Joseph's Hospital of Atlanta.

8. The case outcomes of physicians who do not meet the minimum activity requirements will be reviewed by the Specialty Director of Cardiac Services, the Section Chief of Cardiology and the Medical Director of the Cardiac Catheterization Lab. Their recommendations will be forwarded to the Credentials Committee for review.

Department of Medicine - Section of Gastroenterology

A. Proctoring

1. Standard proctoring for members of the Gastroenterology Section will be as follows:

   a. Colonoscopy – Three (3)
   b. Upper Endoscopy (EGD) - Three (3)
   c. Endoscopic retrograde cholangiopancreatography (ERCP) - Three (3)
   d. Endoscopic Ultrasound (EUS) – Five (5)

2. All section members will make every effort to assist other section members in completing their proctoring requirements.

3. It is the responsibility of the physician who is to be proctored to arrange with another physician to serve as proctor. The proctor must have privileges for the procedure that is to be proctored. The GIDU staff will not be asked to contact proctors.

4. The GIDU staff will make appropriate proctoring forms available as needed. The completion of forms and submission of such to the Medical Staff Office is the responsibility of the physician who is being proctored.

5. The proctor must be a fully credentialed staff member of the Gastroenterology Section of Emory Saint Joseph's Hospital. At least two different physicians must act as proctors. Greater than 50% of procedures shall be proctored by a member outside the provisional physician's group.

6. Less than 50% of the proctored cases may be performed at another JCAHO accredited institution in the metro Atlanta area provided that the proctor is a fully credentialed Active staff member of the Gastroenterology Section of Emory Saint Joseph's Hospital. The proctored cases performed

off campus must meet the same criteria as the proctored cases performed at ESJH with substantially the same type of documentation.

7. The proctoring physician must be present during the entire procedure in order for the procedure to be considered a proctored procedure. If the proctor is not present and the physician performs the procedure, an incident report will be filed by GIDU staff.

8. During the proctoring period, the physician being proctored is primarily responsible for the patient management and procedure. The role of the proctor is that of observer and evaluator.

9. If the physician being proctored requires assistance, the proctor must be in attendance and manage the case. If this occurs, the intervention must be reported to the section chief within twenty-four hours.

10. The Section Chief, after reviewing the completed proctor reports, shall determine if performance of cases is satisfactory enough to conclude proctoring and, if so, notify the Medical Staff Office. If the Section Chief recommends that additional proctoring be required, concurrence of the Department Chairman must be obtained.

11. Emergency Procedures: Physicians with outstanding proctoring requirements are responsible for having a previously arranged plan in place should the need for emergency proctoring arise.

12. Proctoring for Extension of Privileges: Proctoring in connection with an extension of privileges will fall under the same guidelines as initial privileges to a section member. If it is a new procedure being introduced to ESJH and the medical staff lacks a qualified physician to act as proctor, then the section chief has the option of inviting an expert from another institution to evaluate the physician.

B. Emergency Room On-Call Requirements

Active members may request to be removed from the ER Call Roster at age 55.

Department of Medicine - Section of Infectious Disease

1. Active, Provisional members will take rotation on the ER Call Roster until age 55 at which time they may request to be removed.

Department of Medicine - Section of Neurology

A. On-Call Requirements

1. Active and Courtesy members will take rotation on the ER Call Roster until age 55; unless excused by vote of the Neurology Section.
2. Neuro-opthalmologists will not be required to take rotation on the ER Call Roster.

C. Meeting Attendance Requirements

1. Each member of the Active Staff shall be required to attend 50% of all regularly scheduled section meetings.
2. Excused absences are not granted unless approved by the Section Chief, and only in exceptional cases such as prolonged illness or absence from a member's practice.
3. Failure to meet annual meeting attendance requirements imposed by the Section shall result in that physician being removed from the on-call schedule for the next twelve month period.

Department of Medicine - Section of Oncology/Hematology

A. Emergency Room On-Call Requirements

1. Active members will take rotation on the ER Call Roster until age 55. After the age of 55, participation will be on a voluntary basis.
2. Courtesy staff members will not be required to take rotation on the ER Call Roster.

Department of Medicine - Section of Pulmonary Disease

A. Provisional Staff Members

1. For a Provisional staff member of the Pulmonary Disease Section to be considered for promotion to the Active medical staff, the following must be documented to the Credentials Committee:

a. Proctoring of six (6) bronchoscopies which will include two (2) transbronchial biopsies and observance of one (1) chest tube placement.

i. Being proctored is a responsibility of Provisional staff members.

ii. The proctor must be an Active staff member of the Pulmonary Disease Section. Proctors shall be obtained by the Provisional staff member and arranged for mutual convenience. At least one procedure shall be proctored by a member outside the Provisional staff member's group.

iii. A proctor report shall be completed and forwarded to the Medical Staff Office for each of the proctored cases.

iv. The Section Chief, after reviewing the proctor reports, shall determine if performance of cases is satisfactory enough to conclude proctoring and, if so, notify the Provisional staff member and Medical Staff Office. If the Section Chief recommends that additional proctored cases be required, concurrence of the Department Chairman must be obtained.

b. Satisfactory review by the Section Chief of ten (10) consultation reports, one (1) chest tube placement, one (1) intubation, three (3) ventilator management cases and five (5) patient records. The purpose of this review being to determine adequacy of documentation including indications for procedures, choices of therapy, outcome and morbidity and mortality.

B. Active Staff Members

1. Active staff members will make every effort to assist Provisional members in completing their proctoring requirements.

C. Emergency Room On-Call Requirements

1. Active members will take rotation on the ER Call Roster until age 60. After the age of 60, participation will be on a voluntary basis.

The Department of Pathology

1. Division of Responsibility - The Director of the Laboratory is responsible for establishing a philosophy and a direction of the Laboratory in keeping with the hospital mission, role, and its annually updated goals and objectives. The Director of the Laboratory is, according to the hospital bylaws, the Chairman of the Department of Pathology, and it is that physician who is authorized by the Board of Trustees to direct that hospital's service. The basic philosophy should evolve around the idea of being accurate in assessment of patient data, helpful and supportive to physicians and their intermediaries in ordering and interpreting laboratory services, and continually trying to upgrade the quality of our services through an ongoing Quality Assurance Program.

2. Professional Standards - Each Pathologist within the Department must be Board eligible or Board certified in Anatomic and/or Clinical Pathology. The Pathologist is expected to participate in the Quality Assurance Program of the Department, and is expected to continue his own educational process through his own self-study program.

The Department of Radiology

1. Division of Responsibility - The Medical Director of the Department of Radiology is responsible for establishing a philosophy and a direction for the Radiology Department in keeping with the hospital mission, role and it's annually updated goals and objectives. The Director of the Department of Radiology is, according to the hospital bylaws, the Chairman of the Department of Radiology and it is that physician who is authorized by the Board of Trustees to direct that hospital's service. The basic philosophy of the department is to perform radiological examinations of high quality, on a timely basis, give accurate and meaningful interpretations on a timely basis, consult with the referring physicians in regard to the patient's radiological needs so that only those examinations pertinent to their medical or surgical problems be performed and to continually upgrade the quality of our services through an ongoing Quality Assurance Program and add new services as they are developed.

2. Professional Standards - Each radiologist within the Department of Radiology must be board eligible or board certified in Diagnostic Radiology. The radiologist will participate in Quality Assurance programs within the department and participate in teaching programs and professional conferences within the hospital. He is expected to continue his own educational process by self-study programs and attend a minimum of two weeks of post graduate study at meetings and conventions per year.

APPENDIX I

PHYSICIAN'S ORDERS

1. Admission Status Orders must be signed or co-signed prior to discharge.

2. Telephone or verbal orders may be taken by appropriate medical care providers. Verbal orders (face to face communication of orders) may only be used infrequently and must not be a common practice. The use of verbal orders should be limited to those situations in which it is impossible or impractical for the prescriber to write the order or enter it into a computer. Verbal orders are not to be used for the convenience of the ordering practitioner (physician, PA, NP or RN).

   a. The individual receiving the order shall immediately write the order and then read back the order and the name of the ordering physician. The prescribing physician or other authorized practitioner shall verify that the repeated order is correct. The individual receiving the order shall document, in the patient's medical record, that the order was "read back and verified" (RAV). (Example: T.O. RAV/John Smith, M.D./Mary Smith, RN)

   b. Telephone and verbal orders transcribed and verified by the repeated and verified procedure (RAV), with the exception of the admission status order, shall be authenticated by the prescribing physician or by another physician who is responsible for the care of the patient within thirty (30) days after the patient's discharge. If the patient stay was less than forty-eight hours then the orders, with the exception of the admission status order, must be authenticated within thirty days of discharge, whether or not a "repeat and verify" protocol was used.Physicians responsible for the care of the patient may authenticate verbal orders for partners in practice, for covering physicians who are not partners in practice and for any other physicians involved in the patient's care. Authentication of telephone and verbal orders must be dated and timed.

   c. Orders may be written for a physician by his assigned P.A. Physician-employed registered nurses may write orders after discussion with the physician. In this instance, the physician-employed nurse will document the order as follows: *"Symptoms and findings discussed with Dr. Smith, who then gave the following orders:"* Orders may be written for a physician by his nurse practitioner in accordance with written protocols. In the absence of a written protocol, the nurse practitioner may write orders in the same manner as a physician-employed registered nurse.

   d. Telephone or verbal orders may be taken from a P.A., R.N. or N.P. and indicated as follows: *V.O. John Smith, MD, M.D./Mary Smith, P.A./Jane Doe, RN.* Note: As with written orders, a physician's nurse (RN) may not give telephone or verbal orders without first communicating with his/her employing physician. The physician's nurse

practitioner must also communicate with his/her employing physician prior to giving an order unless the nurse practitioner is acting in accordance with a written protocol.

In critical situations the nurse may refuse to accept an order from a P.A., R.N. or N.P. unless immediately confirmed by the attending physician to whom the P.A., R.N. or N.P. is responsible.

2. Orders shall only be given by Medical Staff members or by PAs and NPs who have been credentialed by the Medical Staff.

3. When a medication order is unclear for any reason, the clinician will contact the prescriber for clarification prior to medication administration.

4. All clinical entries in the patient's medical record shall be legible, complete, accurately timed and dated and authenticated by signature or electronic format. Effective January 1, 2012, the practitioner's ID number should be noted on all signatures.

1. All entries in the medical record by an Allied Health Professional must include the name of his/her physician employer/sponsor. Example: Steven Jones, PA/John Smith, MD

APPENDIX II
MEDICAL RECORDS

1. The attending physician shall be responsible for the preparation of a complete and legible medical record for each individual who is evaluated or treated as an in-patient, out-patient, or emergency patient. This record shall include identification data; complaint; personal history; family history; history of present illness; physical examination; special reports such as consultations, clinical laboratory and radiology services; provisional diagnosis; diagnostic and therapeutic orders; evidence of informed consent; medical or surgical treatment; operative report; pathological findings; progress notes; final diagnosis; clinical resume, and autopsy report when performed.

2. History and Physical Examination

   A. The attending physican shall perform and record an admission history and physical (H&P) examination within 24 hours after the patient's admission but prior to an invasive, interventional, surgical or diagnostic procedure, except in emergency situations.

      1) The admission H&P may also be performed and recorded by the physician's physician assistant or nurse practitioner to be reviewed, approved and co-signed by the physician. The physician's registered nurse may dictate the H&P to be reviewed, amended as necessary, approved and co-signed by the physician. (The H&P must be performed by the physician and not the RN.)

      2) Patients admitted for dental surgery must have recorded on their chart an admission history and physical examination performed by a physician on staff of this hospital who shall be responsible for the medical aspects of care throughout the patient's hospital stay. A history and pertinent physical findings shall also be recorded by the oral surgeon.

      3) The admission H&P for patients admitted for podiatric surgery with ASA Class I designation may be performed and recorded by a podiatrist who has been granted such privileges. Otherwise, these patients must have recorded on their chart an admission history and physical examination performed by a physician member of Saint Joseph's Medical Staff who shall be responsible for the medical aspects of care throughout the patient's hospital stay. A history and pertinent physical findings shall also be recorded by the podiatric surgeon.

   B. If a patient's H&P is completed before admission:

      1) The H&P must have been performed and recorded, within 30 days prior to hospital admission, by a member of the Saint Joseph's Medical Staff or by a referring physician not on the Saint Joseph's Medical Staff.

2) An update note is required as follows:

a. The attending physician, or other designee qualified to perform the H&P, must perform an updated physical assessment of the patient to update any components of the patient's current medical status that may have changed since the prior H&P, including confirming that the necessity for the procedure or care is still present and the H&P is still current.

b. The update note must be documented within 24 hours after the patient's admission but before an invasive, interventional, surgical or diagnostic procedure (except in emergency situations).

c. The History and Physical Update Note form must be used, including documenting the location of the original History and Physical Exam and what changes have occurred since the time of the original History and Physical Exam.

C. When the history and physical examination has not been recorded prior to the time of an invasive, interventional or diagnostic procedure, the procedure shall be cancelled, unless the attending surgeon states in writing that such delay would constitute hazard to the patient. In cases where histories and physical examinations have been dictated but not yet typed and placed in the patient's record, a written statement to this effect in the admission note along with any pertinent information necessary for the safe administration of anesthesia and conduct of the operative procedure will be acceptable.

D. At a minimum, the history and physical report shall include histories, systems reviews, and physical findings pertinent to the current illness or procedure and shall also include the following:

- A statement of the reason for admission to the hospital stated as a chief complaint.
- In the case of surgery or other procedure, a statement as to the necessity for the procedure.
- A history of any drug allergies.
- A statement of the working diagnosis, conclusions or impressions drawn from the history and physical examination.
- A plan of diagnostic and or therapeutic action.

E. The following table is prepared as a guideline to physicians to describe the H&P requirements based on patient status (inpatient or outpatient) or level of sedation administered for the procedure.

Patient status or Anesthesia Type	H&P Requirement	Transfer Records
Inpatient Admission	Comprehensive H&P Chief complaint History of present illness Past History Medications Family History Social History Review of systems Physical examination Vital signs General Skin HEENT Neck Heart Lungs Abdomen Extremities Neurological When appropriate to the medical condition or care provider: Breast Pelvic Rectal Assessment Plan of treatment	H&P from transferring facility & physician acceptable if: • completed within 7 days of admission to SJHA • exam meets SJHA criteria above • Staff MD reviews, confirms and/or updates H&P and authenticates confirmation in record or on H&P
Outpatient Procedures with Deep Sedation (Includes: General Anesthesia, Blocks, MAC)	Comprehensive H&P or Short Stay Form	Same as above
Patient status or Anesthesia Type	H&P Requirement	Transfer Records
Outpatient Procedures with Moderate Sedation (Includes Conscious Sedation)	1. Minimum H&P (as noted above); or 2. Completed Conscious Sedation Form; or 3. Focused physicians'	Same as above

	office note or 4. Short Stay Form	
Outpatient Procedures with Minimum Sedation	Minimum H&P	Same as above
Outpatient Observation	Short Stay H&P; or Minimum H&P; or Progress Note detailing reasons for observation status	
Outpatient Emergency Department encounter	Comprehensive H&P; or Minimum H&P pertinent to illness	
Outpatient Procedures with Local anesthetic only	No H&P required	

3. Pertinent progress notes shall be recorded at the time of observation, sufficient to permit continuity of care and transferability. Wherever possible each of the patient's clinical problems should be clearly identified in the progress notes and correlated with specific orders as well as results of tests and treatment. It is the responsibility of the attending physician to ensure that progress notes shall be written at least daily on all patients. When there is an unusual occurrence this should immediately be entered into the progress notes.

4. Operative, other invasive, and noninvasive procedures that place the patient at risk, require a dictated or written report immediately after the procedure. The report shall record the name of the primary physician and assistants, findings, procedures performed and description of the procedure, estimated blood loss, as indicated, specimens removed, and postoperative diagnosis. The completed report shall be authenticated by the physician and made available in the medical record as soon as possible after the procedure.

   The physician must complete and sign an immediate post-operative note into the medical record before the patient moves to the next level of care.

5. All clinical entries in the patient’s medical record shall be accurately dated and timed and authenticated by signature of the person making the entry. Handwritten or electronic signatures, or facsimiles or original written or electronic signatures are acceptable.

   Stamped signatures are not acceptable on any entry in the patient’s medical record.

6. All entries in the medical record by an Allied Health Professional must include the name of his/her physician employer/sponsor. Example: Steven Jones, PA/John Smith, MD

7. Symbols and abbreviations may be used in the medical record only when they have been approved by the Medical Staff. The EHC Abbreviations List and a List of Do Not Use Abbreviations are housed electronically on the ESJH intranet under General Resources.

Unapproved abbreviations may not be used in any communication, whether verbal, written or computer entry, regarding patient care.

8. A discharge summary shall be written or dictated on all medical records of patients hospitalized over forty-eight hours. The discharge summary shall include (1) brief clinical history; (2) pertinent physical, lab, and X-ray findings, (3) treatment, complications; (4) condition on discharge, drugs, specific instructions given to the patient and/or family, follow-up care; and (5) final diagnosis. In all instances, the content of the medical record shall be sufficient to justify the diagnosis and warrant the treatment and end result. All discharge summaries shall be authenticated by the responsible physician.

   A final progress note may be substituted for the resume in the case of patients with problems of minor nature who require less than a forty-eight (48) hour period of hospitalization. The final progress note should include any instructions given to the patient and/or family.

9. Written consent of the patient or his legally qualified representative is required for release of medical information to persons, not otherwise authorized to receive this information, including physicians not directly participating in the patient's care.

10. Records may be removed from the hospital's jurisdiction and safekeeping only in accordance with a court order, subpoena or statute. All records are the property of the hospital. All incomplete records shall remain in the Medical Record Department until completed, except in instances when they are required for patient care or peer review. In case of readmission of a patient, all previous records shall be available for the use of the attending practitioner. This shall apply whether the patient be attended by the same practitioner or by another. Unauthorized removal of charts from the hospital is grounds for corrective action according to Article V of the Medical Staff Bylaws. (Approved 3/1/84)

11. Access to all medical records of all patients shall be afforded to members of the medical staff for bona fide study and research consistent with preserving the confidentiality of personal information concerning the individual patients. All such projects shall be approved by the Saint Joseph's Institutional Review Board before records can be studied.

    Subject to the discretion of the Chief Executive Officer, former members of the medical staff shall be permitted free access to information from the medical records of their patients covering all periods during which they attended such patients in the hospital. (Approved 3/1/84)

12. A medical record shall not be permanently filed until it is completed by the responsible physician or is ordered filed by the Chief Medical Officer. No medical staff member should be permitted to complete a medical record on a patient unfamiliar to him in order to retire a record that was the responsibility of another staff member.

Medical Records Completion and Suspension Procedure

A. Full procedure reports for operative and other invasive procedures, and non-invasive procedures that place the patient at risk, must be completed within 24 hours of the procedure. (Note: The immediate post-operative or procedure note does not replace the requirement for a full procedure report.) Records that are missing these items will be deemed delinquent.

B. It is expected that the patient's medical record should be complete at the time of discharge. If incomplete at discharge, the physician has 30 days to complete the record including history and physical examination report dictated or written and signed, operative and invasive procedure reports dictated and signed, verbal orders signed, progress notes, principal and secondary diagnoses, principal procedure(s) and complication(s), (dictated and signed) clinical resume and answered and signed coding and CDI clarifications If not complete within 30 days of discharge, the record will be deemed delinquent.

C. Every week, the Health Information Management Department will count all incomplete and delinquent records, as described in items A and B above. Physicians will be notified, by email or fax, of the specific incomplete and delinquent medical records. The physicians will be informed that such records must be completed within 10 days from the date of the notification.

C. If the physician fails to appropriately complete all delinquent medical records within 10 days from the date of notification, the physician will be automatically suspended. The physician will also be notified of the requirement to attend the next Medical Executive Committee meeting for possible disciplinary action, including the imposition of fines or revocation of full Medical Staff membership and clinical privileges.

D. When a physician is suspended due to delinquent medical records, the physician's clinical privileges, with the exception of privileges for ongoing care of patients currently admitted and privileges for care of patients during fulfillment of the physician's scheduled emergency room on-call responsibilities will be automatically suspended until all delinquent records are completed.

E. Vacation/Illness/Extended Leave

When a physician goes on vacation, or is otherwise absent from practice for an extended period of time, the Medical Records Department should be notified in order that he or she not be held accountable for his/her delinquent records. If the physician is absent due to illness, his/her representative or his/her office should notify the Health Information Department.

APPENDIX III

CLINICAL CARE OF CRITICALLY ILL OR INJURED PATIENTS

In the last 20 years a growing body of high-quality medical research has shown that comprehensive medical care of critically ill patients by ICU specialists ("intensivists") increases patient safety, improves efficiency of resource utilization, and reduces morbidity and mortality. ICU physician staffing by board-certified intensivists is highly recommended by many health-care entities as a health care practice that improves patient outcome and care quality.

At Emory Saint Joseph's Hospital, care for critically ill or injured patients is provided 24 hours per day, 7 days per week by the Critical Care Service, a team of highly trained professionals, which includes physicians and advanced practice professionals.

Critical Care Med/Surg/CCU (2E, 2S)

Admission and Care:

1. All patients admitted to these critical care units will have a consultation to the Critical Care Service.

2. Professional courtesy and optimal patient care warrants communication between requesting and consulting practitioners at all times. As such the admitting physician, or his/her designee, shall engage in a "hand-off"-type communication with the Critical Care Service regarding the clinical issues in a timely fashion. The patient's physician, or his/her designee, must also notify the family or representatives of the admission to these critical care units.

3. The admitting physician, at his/her discretion, may designate the extent to which the Critical Care Service will provide care, with the anticipation that regardless of extent, there will be continual communication between the patient's physician, or his/her designee, and the Critical Care Service throughout a stay in these critical care units.

4. The Critical Care Service will make formal Multidisciplinary Rounds, and implement state-of-the-art standardized care practices for all patients admitted to these critical care units. Any of these practices identified by the Critical Care Service to not reconcile with care needs of a particular patient will be discussed with the patient's physician, or his/her designee.

5. For all cases in which the diagnosis is obscure or there is doubt as to the best therapeutic measures to be utilized (other than in emergency situations), the Critical Care Service will seek consultation with another physician who is well qualified in the field in which additional expertise is being sought. In addition, all consultation request orders must

stipulate a specific physician or specific specialty group name, reason for consultation and expected response time.

Transfer:

1. Patients whose clinical conditions have improved such as to no longer require critical care will be transferred to a regular nursing unit, or to a rehabilitative or long-term care nursing facility. The Critical Care Service will engage in a hand-off type communication with the patient's physician, or his/her designee, prior to transfer.

2. The Critical Care Service will notify the family or representatives of the transfer from a critical care unit.

APPENDIX IV

EMERGENCY SERVICES

Emergency Services are provided in an out-patient facility staffed by full time physicians. This facility is fully equipped and is staffed with personnel who possess the necessary skills to manage problems ranging from relatively minor illnesses to life threatening catastrophic emergencies.

The assigned physicians are responsible for the care and disposition of each patient unless the patient has a private physician who is contacted and then assumes full responsibility for the care of his patient, which includes follow-up of any studies or interpretation of studies still pending at the time of admission. An "On Call" list of physicians for each clinical service, including specialties and subspecialties, is maintained for those patients who do not have a private doctor, are seriously ill and require hospitalization or consultation. The physicians "on-call" are required to respond within a reasonable time of notification. "On Call" physicians are also required to respond to consult requests for inpatients. EMTALA regulations require the emergency department physician to document "in the medical record the name and address of any on-call physician who has refused or failed to appear within a reasonable time to provide necessary stabilizing treatment". This should be reported to the Medical Staff Office and Risk Management as well.

In addition, the facility provides diagnostic and therapeutic services for duty related employee injuries and for injured or acutely ill hospital visitors. All patients are offered stabilizing treatment within the capacity of the hospital.

Procedures performed in the Emergency Room are usually of a minor diagnostic or therapeutic nature. Procedures which require general anesthesia are permitted only for short term minor cases and are scheduled only after mutual agreement among the charge nurse, staff physician, and anesthesiologist.

The initial medical screening examinations may be performed by an emergency department physician or their physician assistant or nurse practitioner when appropriate

APPENDIX V

GUIDELINES FOR PROCTORING

I. INTRODUCTION

The granting or extension of clinical privileges is the responsibility of the Saint Joseph's Hospital of Atlanta, Inc., ("Saint Joseph's") Board. At present, there are no regional or national regulatory agencies in the United States that mandate appropriate qualifications for performing a particular procedure. Each hospital has its own mechanism and criteria for determining the criteria for privileges, but usually adopts "national" standards developed by specialty boards or specialty societies.

The appointment process at Saint Joseph's begins with the applicant's submission of a completed application to the President. The President verifies the information and, if the application is deemed complete within a timely manner, it is transmitted to the Chairman of the Department and the Section Chief. Upon completion of review and recommendation, the Section Chief and Department Chair then submit the application to the Credentials Committee. The Credentials Committee reviews information about each candidate and then brings its recommendation to the Staff Executive Committee for discussion and decision by the medical staff leaders. The Staff Executive Committee then presents its recommendations to the Saint Joseph's Board for review. If the Saint Joseph's Board approves the privileges, it then becomes the responsibility of the individual Departments and Sections to assure, through the peer review process, that the community served will receive quality care from competent practitioners.

With the rapidly changing health care delivery systems and the new technology available to the physician today, more physicians will be requesting extension of privileges for additional procedures. The optimal means to evaluate initial privileges, or an extension of privileges, is through the proctoring of these practitioners. Therefore, the ultimate responsibility of credentialing and monitoring the peer review process falls on the shoulders of each Department and Section.

II. OBJECTIVES

These guidelines provide a framework upon which proctoring programs may be developed by each Department and Section. Also provided are both policy and practical guidelines for designing such programs which are designed to protect the rights of the patients, proctors and the provisional physicians or practitioners.

These guidelines address the introduction of new technology to the community served by Saint Joseph's.

The process of proctoring should not become burdensome to the proctor or the physician being proctored. This document intends to foster a spirit of collegiality and unselfish and unremunerated cooperation by the medical staff of Saint Joseph's in order to assure quality care to the community we serve.

III. DEFINITIONS

A. **"Certification"** and **"Credentials"** both refer to the documentation of successful completion of a period of education or training, such as, a medical school diploma, specialty board certificate, certificate of attendance at a postgraduate course or seminar, or statement by a preceptor certifying competence.

B. **"Competence"** is defined as a safe and acceptable level of skill and can refer either to a physician's general ability within a specialty to care for patients or the ability to perform a technical procedure, operation, or group of similar operations.

C. **"Clinical Privileges"** are those functions and procedures that a physician is permitted to perform in the course of caring for patients in a given hospital.

D. **"Proctoring"** is a period of monitoring and observation during which a physician's work, for which he or she has privileges, is evaluated.

E. **"Must"** or **"Shall"** indicates a mandatory or indispensable recommendation.

F. **"Should"** indicates a highly desirable recommendation.

G. **"May"** or **"Could"** indicates an optional recommendation, alternatives may be appropriate.

H. **"Emergency"** constitutes a sudden unforeseen occurrence to a patient that may be life threatening or threatening to limb or overall life style. This would require immediate intervention by the physician.

I. **"Provisional Physician"** or **"Proctoree"** indicates the physician being proctored.

IV. ROLES

A. Responsibility of the Section. It is the responsibility of the individual Sections to set up a proctoring program for provisional privileges and the extension of privileges consistent with these Guidelines and the Medical Staff Rule and Regulations.

B. Proctoring of a Partner. A physician may proctor another member of his or her group practice, but such practice is discouraged. The proctoring of a fellow group member is not the most effective way to gain objective feedback concerning a colleague's clinical abilities.

C. Responsibility of the Proctor. Except as stated below, the proctor shall only observe and monitor the physician. It is not, nor should it be, the responsibility of the proctor to teach the physician how to perform a procedure. If the proctor feels that the patient is in jeopardy, or that the proctoree is unable to complete the procedure, then the proctor must intervene and take over the procedure. This intervention must then be reported to the Section Chief within twenty four hours of the incident.

D. Responsibility of the Section Chiefs and the Department Chairs. The Section Chiefs and Department Chairs may waive the proctoring process if allowed by the Section proctoring policy and they feel the individual has established proficiency or there is a consensus among the proctoring physicians of the safety of the provisional physician.

Proctoring may be waived under the following conditions:

- Practitioners in active practice for the previous 2 years at a TJC (The Joint Commission) or similar, accredited institution(s) in the metro Atlanta area, and,
- Provider provides to ESJH documentation of procedural volume meeting or exceeding ESJH re-reappointment requirements. If a section does not publish reappointment requirements, the Section Chief may choose to use nationally published benchmarks as a surrogate, and,
- Validation of the above and good standing by the section Chief of that provider, and,
- Approved by the ESJH Section Chief.

The proctor shall extend the proctoring process if Quality Assessment issues are raised by the proctoring physicians, or if an intervention, as described above, has occurred. Information related to the proctoring process shall be forwarded to the Chief of Staff and the Chair of the Credentials Committee in writing and added to the provisional member's medical staff file.

V. GUIDELINES FOR COMPONENTS OF THE PROCTORING PROCEDURE

A. Rotate the Responsibility. The Section Chief may assign several members of the section to monitor the provisional physician during the proctoring period. This will prevent the proctoring responsibility from becoming too burdensome for one person. Rotating the proctoring responsibility allows the proctoree to benefit from more

than one proctor and decreases the potential for allegations of bias against the proctoree.

B. Place the Burden of the Process on the Provisional Physician. The names of the proctors should be provided to the Provisional Physician. The Provisional Physician is responsible for making arrangements for the proctoring of cases. The patient should be made aware of the presence of the proctor but the proctor must not interfere with the patient physician relationship. Also, an explanation of the Proctoring Process should be given to the Provisional Physician. The Provisional Physician should seek the consent of the patient to undergo a proctored procedure.

C. Proctoring by Several Sections May be Required. Increasing subspecialization and technologic changes have blurred the boundaries that once identified specific procedures as the sole province of one specialty. Accordingly, one procedure may be performed by more than one section. The total number of cases required for proctoring by the primary Section shall not be increased if additional sections are involved.

D. Responsibility of the Proctor. The proctor must be an active member of the Section with a proficiency in the procedure being proctored. The proctoring physician must complete the Proctor Form at the time of the procedure. The form should be delivered to the Medical Staff Office within twenty-four hours of the procedure. The Section Chief and Medial Staff Office should be notified immediately of any problem or intervention.

E. Concurrent Reviews. This type of review is the most useful, reliable method of assessing the proctoree's competence to perform the procedure. Concurrent review provides first hand knowledge based upon the Proctoring Physician's ability to watch and assess the proctoree's clinical judgment, skill, technique, and ability to work under pressure. Problems or interventions can be reported to the Section Chiefs immediately by the Proctoring Physician.

F. Retrospective Reviews. This type of review is appropriate for provisional physicians deemed competent by the Section Chief and the members of the section. It is at the discretion of the Section Chief and Section members to waive the proctoring process. Waiver of the proctoring process is discouraged for invasive procedures. With the retrospective review, it is the responsibility of the Section Chief to review the Quality Assessment Reports for the proctoree at one, two and three month intervals. If the Quality Assessment Reports indicate a problem, the Provisional physician should be subject to the formal proctoring program.

G. Retrospective Review for Internal Medicine or Family Practice Physician. This is the most highly desirable type of review for these Sections and also any other of the

medical sections that do not perform invasive procedures. The review would be assessing practice patterns.

H. Emergency Room Call and Performing of Emergency Procedures by Provisional Physicians. The Section Chief and the section's members may choose to allow a Provisional Physician to cover the emergency room or perform emergency procedures. However, if a Provisional Physician attains the privilege of covering the Emergency Room, then it is the responsibility of the proctor to either be present or clear the Provisional Physician to proceed with the procedure. It then becomes the responsibility of the proctor to retrospectively review the procedure and file a proctoring report within twenty-four hours. If the Provisional Physician requires assistance, the proctor must be in attendance and either assist or intervene in the procedure. If this occurs, then the intervention must be reported to the Section Chief within twenty-four hours.

I. Proctoring for an Extension of Privileges. Proctoring in connection with an extension of privileges will fall under the same guidelines as initial privileges to a Section member. If it is a new procedure being introduced to Saint Joseph's Hospital and the medical staff lacks a qualified physician to act as proctor, then the Section Chief has the option of inviting an expert from another institution to evaluate the physician.

J. Recertification and Recredentialing. This is an ongoing process and is covered in the Medical Staff Bylaws. However, it is at the discretion of each Section Chief and its members to set up minimum requirements for proficiency with a particular procedure. This is a quality assessment issue and must be followed. The number of cases required and the time interval is to be determined by the Section. However, the Section should follow the General Guidelines of this document for proctoring and recertification.

K. The Medical/Legal issues of Proctoring. Saint Joseph's provides insurance coverage for proctoring physicians, to the extent they perform within the proctoring role as defined by the Medical Staff Bylaws and the Medical Staff Rules and Regulations.

ADOPTED by the Staff Executive Committee on October 20, 2020.

APPROVED by the Board of Directors on November 23, 2020.

MEDICAL STAFF BYLAWS, POLICIES, AND RULES AND REGULATIONS
OF
EMORY SAINT JOSEPH'S HOSPITAL

ALLIED HEALTH

PROFESSIONALS MANUAL

October 25, 2017

TABLE OF CONTENTS

PAGE

1. DEFINITIONS 1

1.1 Definitions 1
1.2 Time Limits 1
1.3 Delegation of Functions 1

2. SCOPE AND OVERVIEW OF POLICY 2

2.1 Scope of Policy 2
2.2 Categories of Allied Health Professionals 2
2.3 Licensed Independent Practitioners 2
2.4 Licensed Dependent Practitioners 3
2.5 Dependent Practitioners 3
2.6 Additional Policies 3

3. GUIDELINES FOR DETERMINING THE NEED FOR NEW CATEGORIES OF ALLIED HEALTH PROFESSIONALS 4-5

3.1 Determination of Need 4
3.2 Development of Policy 5

4. QUALIFICATIONS, CONDITIONS, AND RESPONSIBILITIES 6

4.1 General Qualifications 6
4.2 Waiver of Criteria 7
4.3 No Entitlement to Medical Staff Appointment 8
4.4 Non-Discrimination Policy 8
4.5 Ethical and Religious Directives 8
4.6 Assumption of Duties and Responsibilities 8
4.7 Burden of Providing Information 10
4.8 Application Form 10
4.9 Grant of Immunity and Authorization to Obtain/Release Information 11

5. CREDENTIALING AND PEER REVIEW PROCEDURES 13

5.1 Request for Application 13
5.2 Initial Review of Application 13
5.3 Department Chairperson Procedure for Category I and Category II Practitioners 14

5.4 Credentials Committee Procedure for Category I and Category II Practitioners 14
5.5 Staff Executive Committee Procedure for Category I and Category II Practitioners 15
5.6 Board Action for Category I and Category II Practitioners 15
5.7 Procedure for Category III Practitioners 16
5.8 Time Periods for Processing 16
5.9 Request for Temporary Clinical Privileges 16
5.10 Termination of Temporary Clinical Privileges 17
5.11 Renewal of Permission to Practice (Category I and II) 17
5.12 Renewal of Permission to Practice (Category III) 18

6. CONDITIONS OF PRACTICE APPLICABLE TO CATEGORY II AND CATEGORY III PRACTITIONERS 19

6.1 Standards of Practice for Category I and Category II Practitioners 19
6.2 Oversight by Supervising Physician 20
6.3 Questions Regarding Authority of a Category II or Category III Practitioner 21
6.4 Responsibilities of Supervising Physician 21

7. PEER REVIEW PROCEDURES FOR QUESTIONS INVOLVING ALLIED HEALTH PROFESSIONALS 22

7.1 Collegial Intervention 22
7.2 Administrative Suspension 22
7.3 Automatic Relinquishment of Clinical Privileges or Scope of Practice 23
7.4 Leave of Absence 23

8. PROCEDURAL RIGHTS FOR ALLIED HEALTH PROFESSIONALS 25

8.1 General 25
8.2 Procedural Rights for Category III Practitioners 25
8.3 Procedural Rights for Category I and Category II Practitioners 26
8.4 Hearing Process for Category I and Category II Practitioners 26
8.5 Ad Hoc Committee or Hearing Officer Report 27
8.6 Appeals Process for Category I and Category II Practitioners 27

9. HOSPITAL EMPLOYEES 29

10. AMENDMENTS 30

11. ADOPTION 31

APPENDIX A

APPENDIX B

APPENDIX C

ARTICLE 1

DEFINITIONS

1.1 Definitions:

The definitions that apply to terms used in all the Medical Staff documents are set forth in the Medical Staff Credentials Policy document.

1.2 Time Limits:

Time limits referred to in this Policy are advisory only and are not mandatory, unless it is expressly stated that a particular right is waived by failing to take action within a specified period.

1.3 Delegation of Functions:

When a function is to be carried out by a member of Hospital management, by a Medical Staff member, or by a Medical Staff committee, the individual, or the committee through its chairperson, may delegate performance of the function to one or more qualified designees.

ARTICLE 2

SCOPE AND OVERVIEW OF POLICY

2.1 Scope of Policy:

(a) This Policy addresses those Allied Health Professionals not on the Medical Staff who are permitted to provide services at the Hospital. It also addresses those physicians who do not desire Medical Staff appointment, but who nevertheless seek to exercise certain limited privileges at the Hospital under the conditions set forth in this Policy. 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 Allied Health Professionals at the Hospital.

(b) This Policy shall not apply to Allied Health Professionals who are employed by the Hospital (except to the extent set forth in Article 9).

2.2 Categories of Allied Health Professionals:

Only those specific categories of Allied Health Professionals that have been approved by the Board shall be permitted to practice at the Hospital. All such categories shall be classified as either "Licensed Independent Practitioners," "Licensed Dependent Practitioners," or "Dependent Practitioners," each having a slightly different relationship to the Hospital.

2.3 Licensed Independent Practitioners:

(a) "Licensed Independent Practitioners" (hereinafter referred to as Category I practitioners) shall include all those Allied Health Professionals who are licensed or certified under state law, authorized to function independently in the Hospital, and granted clinical privileges. Category I practitioners shall also include that small class of physicians referenced above who seek to exercise certain limited clinical privileges at the Hospital under the conditions set forth in this Policy. These individuals require no formal or direct supervision by a physician.

(b) A current listing of the specific categories of Allied Health Professionals functioning in the Hospital as Category I practitioners is attached to this Policy as Appendix A. This Appendix may be modified or supplemented by action of the Board after receiving the recommendations of the Medical Executive Committee, without the necessity of further amendment of this Policy.

2.4 Advanced Dependent Practitioners:

(a) "Advanced Dependent Practitioners" (hereinafter referred to as Category II practitioners) shall include all those Allied Health Professionals who provide a medical level of care or perform surgical tasks consistent with granted clinicl privileges, but who are required by law and/or the Hospital to exercise some or all of those clinical privileges under the direction of, or in collaboration with, a Supervising Physician pursuant to a written supervision or collaborative agreement. The supervising physician(s) is responsible for the actions of the Category II practitioner in the Hospital.

(b) A current listing of the specific categories of Allied Health Professionals functioning in the Hospital as Category II practitioners is attached to this Policy as Appendix B. This Appendix may be modified or supplemented by action of the Board after receiving the recommendations of the Medical Executive Committee, without the necessity of further amendment of this Policy.

2.5 Dependent Practitioners:

(a) "Dependent Practitioners" (hereinafter referred to as Category III practitioners) shall include all those Allied Health Professionals who are permitted to practice in the Hospital only under the direct supervision of a physician(s) appointed to the Medical Staff and who function pursuant to a scope of practice. The supervising physician(s) is responsible for the actions of the Category III practitioner in the Hospital.

(b) A current listing of the specific categories of Allied Health Professionals functioning in the Hospital as Category III practitioners is attached to this Policy as Appendix C. This Appendix may be modified or supplemented by action of the Board, after receiving the recommendations of the Medical Executive Committee, without the necessity of further amendment of this Policy.

2.6 Additional Policies:

The Board shall adopt a separate policy for each category of Allied Health Professionals that it approves to practice in the Hospital. These separate policies shall supplement this Policy and shall address the specific matters set forth in Section 3.2 of this Policy.

ARTICLE 3

GUIDELINES FOR DETERMINING THE NEED FOR
NEW CATEGORIES OF ALLIED HEALTH PROFESSIONALS

3.1 Determination of Need:

Whenever Allied Health Professionals in a category that has not been approved by the Board requests permission to practice at the Hospital, the President shall appoint an ad hoc committee to evaluate the need for that particular category of Allied Health Professionals and to make a recommendation to the Board. As part of the process, the individual shall be invited to submit information about the nature of the proposed practice, why Hospital access is sought, and the potential benefits to the community by having such services available at the Hospital. The ad hoc committee may consider the following factors when making a recommendation to the Board as to the need for the services of this category of Allied Health Professionals:

(a) the nature of the services that could be offered;

(b) any state license or regulation which outlines the scope of practice for the Allied Health Professional;

(c) any state "non-discrimination" or "any willing provider" laws that would apply to the Allied Health Professional;

(d) the patient care objectives of the Hospital, including patient convenience;

(e) how well the community's needs are currently being met and whether they could be better met if the services offered by the Allied Health Professional were provided by the Hospital or as part of its facilities;

(f) the type of training that is necessary to perform the services that could be offered and whether there are individuals with more training currently providing those services;

(g) the availability of supplies, equipment, and other necessary Hospital resources;

(h) the need for and availability of trained staff to support the services that would be offered; and

(i) the ability to appropriately supervise performance.

3.2 Development of Policy:

(a) If the ad hoc committee recommends that there is a need for the particular category of Allied Health Professionals at the Hospital, the committee shall recommend:

(1) any specific qualifications and/or training that they must possess beyond that set forth in this Policy;

(2) a detailed description of their authorized clinical privileges or scope of practice;

(3) any specific conditions that apply to their functioning within the Hospital; and

(4) any supervision requirements, if applicable.

(b) In developing such recommendations, the ad hoc committee shall consult the appropriate department chairperson(s) and applicable state law and may contact applicable professional societies or associations. The ad hoc committee may also recommend to the Board the number of Allied Health Professionals that are needed in a particular category.

ARTICLE 4

QUALIFICATIONS, CONDITIONS, AND RESPONSIBILITIES

4.1 General Qualifications:

To be eligible to apply for initial and continued permission to practice at the Hospital, an Allied Health Professional must:

(a) have a current, unrestricted license or certification to practice in Georgia and have never had a license or certification revoked or suspended by any state licensing agency;

(b) where applicable to his or her practice, have a current, unrestricted DEA registration;

(c) satisfy the following residence and response time requirements so that patients will receive timely and continuous care at the Hospital:

(1) maintain a residence and an office within forty-five (45) minutes of the Hospital; and

(2) be able to respond to the Hospital, in person, within forty-five (45) minutes of being requested to do so in order to attend to a patient;

(d) have current, valid professional liability insurance coverage in a form and in amounts satisfactory to the Hospital;

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

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

(g) have never had clinical privileges, scope of practice, or employment denied, revoked, resigned, relinquished, or terminated by any health care facility or health plan for reasons related to clinical competence or professional conduct;

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

(i) satisfy all additional eligibility qualifications relating to his or her specific area of practice that may be established by the Hospital;

(j) if seeking to practice as a Category II or III practitioner, have a supervision agreement with a physician who is appointed to the Medical Staff; and

(k) be able to document his or her:

(1) relevant training, experience, demonstrated current clinical competence, and judgment;

(2) adherence to the ethics of his or her profession;

(3) good reputation and character;

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

(5) ability to utilize medical resources efficiently; and

(6) ability to work harmoniously with others sufficiently to convince the Hospital that all patients treated by him or her will receive quality care and that the Hospital and its Medical Staff will be able to operate in an orderly manner.

4.2 Waiver of Criteria:

(a) Any individual who does not satisfy a criterion may request in writing that it be waived. The individual requesting the waiver bears the burden of demonstrating that his or her qualifications are equivalent to, or exceed, the criterion in question.

(b) The Board may grant waivers in exceptional cases after considering the findings of the Medical Executive Committee or other committee designated by the Board, the specific qualifications of the individual in question, and the best interests of the Hospital and the community it serves. The granting of a waiver in a particular case is not intended to set a precedent for any other individual or group of individuals.

(c) No individual is entitled to a waiver or to a hearing if the Board determines not to grant a waiver.

4.3 No Entitlement to Medical Staff Appointment:

Allied Health Professionals shall not be appointed to the Medical Staff or entitled to the rights, privileges, and/or prerogatives of Medical Staff appointment.

4.4 Non-Discrimination Policy:

No individual shall be denied permission to practice at the Hospital on the basis of gender, race, creed, or national origin.

4.5 Ethical and Religious Directives:

All Allied Health Professionals shall abide by the terms of the Ethical and Religious Directives for Catholic Health Care Services promulgated by the National Conference of Catholic Bishops with respect to their practice at the Hospital. No activity prohibited by said directives shall be engaged in at the Hospital by any individual.

4.6 Assumption of Duties and Responsibilities:

As a condition of permission to practice at the Hospital, all Allied Health Professionals shall specifically agree to the following:

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

(b) to abide by all applicable bylaws, policies, Corporate Responsibility Program and Rules and Regulations of the Hospital, Health System and Medical Staff;

(c) to accept committee assignments and such other reasonable duties and responsibilities as may be assigned;

(d) to provide immediately within twenty-one (21) days, with or without request, new or updated information to the President as it occurs, pertinent to any question on the Allied Health Professionals application form. Information to be provided includes: final actions by another hospital or health care facility where such individual has the right to exercise clinical privileges or a scope of practice, or from a government agency, resulting in action being taken by such other hospital or health care facility or government agency with respect to such individual. The term "action" shall include action seeking to: institute probation or require consultation or supervision; reduce, suspend or revoke privileges or a scope of practice; suspend or revoke an individual's allied health professional staff membership; limit any prerogatives directly related to patient care; or suspend or revoke such member's license, certification or right to

prescribe any medication (if applicable). The affected individual shall provide the Hospital with complete information as to the reasons for the action and the progress of the proceedings.

Moreover, any Allied Health Professional who is summarily suspended from any hospital where he or she has the right to exercise clinical privileges or scope of practice or any individual who is excluded or debarred from participation in any government health care program must notify the Hospital within twenty-four (24) hours of such summary suspension, exclusion or debarment;

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

(f) to acknowledge that the individual has had an opportunity to read a copy of this Policy and any other applicable bylaws, policies, rules and regulations and agrees to be bound by them;

(g) to appear for personal interviews in regard to an application for permission to practice as may be requested;

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

(i) to refrain from assuming responsibility for diagnosis or care of hospitalized patients for which he or she is not qualified or without adequate supervision;

(j) to refrain from deceiving patients as to the individual's status as an Allied Health Professional;

(k) to seek consultation when appropriate;

(l) to participate in the monitoring and evaluation activities;

(m) to complete, in a timely manner, all medical and other required records, containing all information required by the Hospital;

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

(o) to satisfy applicable continuing education requirements;

(p) to promptly pay any applicable dues and assessments; and

(q) that, if there is any misstatement in, or omission from, the application, the Hospital may stop processing the application (or, if permission to practice has been granted prior to the discovery of a misstatement or omission, the permission may be deemed to be automatically relinquished). In either situation, there shall be no entitlement to the procedural rights provided in this Policy.

4.7 Burden of Providing Information:

(a) Allied Health Professionals seeking permission to practice shall 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 about such qualifications.

(b) Allied Health Professionals seeking appointment have the burden of providing evidence that all the statements made and information given on the application are accurate.

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

(d) It is the responsibility of the individual seeking permission to practice to provide a complete application, including adequate responses from references. An incomplete application will not be processed.

4.8 Application Form:

(a) The application forms for both initial and renewed permission to practice as an Allied Health Professional shall require detailed information concerning the applicant's professional qualifications. The Allied Health Professional applications existing now and as may be revised are incorporated by reference and made a part of this Policy. In addition to other information, the applications shall seek the following:

(1) information as to whether the applicant's clinical privileges, scope of practice, permission to practice, and/or affiliation has ever been voluntarily or involuntarily relinquished, withdrawn, denied, revoked, suspended, reduced, subjected to probationary or other conditions, limited, terminated, or not renewed at any hospital or health care facility, or is currently being investigated or challenged;

(2) information as to whether the applicant's license or certification to practice any profession in any state or Drug Enforcement Administration registration or state controlled substance license is, or has ever been voluntarily or involuntarily relinquished, suspended, modified, terminated, restricted, or is currently being investigated or challenged;

(3) information concerning the applicant's professional liability litigation experience and/or any professional misconduct proceedings involving the applicant, in this state or any other state, whether such proceedings are closed or still pending, including the substance of the allegations of such proceedings or actions, the substance of the findings of such proceedings or actions, the ultimate disposition of any such proceedings or actions that have been closed, and any additional information concerning such proceedings or actions as the Medical Executive Committee or Board may deem appropriate; and

(4) current information regarding the applicant's ability to perform, safely and competently, the clinical privileges requested and the duties of Allied Health Professionals.

(b) The applicant shall sign the application and certify that he or she is able to perform the clinical privileges requested and the responsibilities of Allied Health Professionals.

4.9 Grant of Immunity and Authorization to Obtain/Release Information:

By applying for permission to practice at the Hospital, Allied Health Professionals expressly accept the following conditions during the processing and consideration of the application, whether or not permission to practice is granted, and as a condition of continued permission to practice, if granted:

(a) Immunity:

To the fullest extent permitted by law, the Allied Health Professional releases from any and all liability, extends absolute immunity to, and agrees not to sue the Hospital,

the Medical Staff, their authorized representatives, and appropriate third parties for any matter relating to permission to practice, clinical privileges at the Hospital, or the individual's qualifications for the same. This includes any actions, recommendations, reports, statements, communications, or disclosures involving the individual which are made, taken, or received by the Hospital, its authorized agents, or appropriate third parties.

(b) Authorization to Obtain Information from Third Parties:

The Allied Health Professional 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 Allied Health Professional'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 permission to practice at the Hospital, 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 Allied Health Professional also specifically authorizes third parties to release this information to the Hospital and its authorized representatives upon request.

(c) Authorization to Release Information to Third Parties:

The Allied Health Professional also authorizes Hospital representatives to release information to other hospitals, health care facilities, managed care organizations, and their agents when information is requested in order to evaluate his or her professional qualifications for appointment, privileges, permission to practice, and/or participation status at the requesting organization/facility.

(d) Procedural Rights:

The Allied Health Professional agrees that the procedural rights set forth in this Policy shall be the sole and exclusive remedy with respect to any professional review action taken by the Hospital.

(e) Legal Actions:

If, notwithstanding the provisions in this Section, an Allied Health Professional institutes legal action and does not prevail, he or she shall reimburse the Hospital and any of its authorized representatives named in the action for all costs incurred in defending such legal action, including reasonable attorney's fees.

ARTICLE 5

CREDENTIALING AND PEER REVIEW PROCEDURES

5.1 Requests for Application:

(a) Applications for permission to practice at the Hospital shall be in writing and shall be on forms approved by the Board upon recommendation by the Medical Executive Committee.

(b) Any individual requesting an application for permission to practice at the Hospital shall be sent a letter that outlines the eligibility criteria for permission to practice, as well as any eligibility requirements that relate to the Allied Health Professional's specific area of practice, and the application form.

(c) Allied Health Professionals who are in a category of practitioners that has not been approved by the Board for access to the Hospital shall be ineligible to receive an application. A determination of ineligibility does not entitle an Allied Health Professional to the procedural rights outlined in Article 8 of this Policy.

5.2 Initial Review of Application:

(a) A completed application, with copies of all required documents, must be submitted to the Medical Staff Office within 60 days after receipt of the application if the Allied Health Professional desires further consideration. The application must be accompanied by the application processing fee.

(b) As a preliminary step, the Medical Staff Office shall review all applications to determine that all questions have been answered and that the individual satisfies all threshold criteria. Individuals who fail to return completed applications or fail to meet the eligibility criteria set forth in Section 4.1 (a-j) of this Policy will be notified that they are not eligible for permission to practice at the Hospital and that their application will not be processed. A determination of ineligibility does not entitle an Allied Health Professional to the procedural rights outlined in Article 8 of this Policy.

(c) The Medical Staff Office shall review the application to determine if all questions have been answered, all references and other information or materials have been received, and pertinent information provided on the application has been verified with primary sources. Thereafter, the completed application and all supporting materials shall be transmitted to the applicable department chairperson.

5.3 Department Chairperson Procedure for Category I and Category II Practitioners:

(a) The department chairperson shall prepare a written report regarding whether the Category I or Category II applicant has satisfied all of the qualifications for permission to practice and the clinical privileges requested. As part of the process of making this report, the department chairperson has the right to meet with the applicant and the supervising physician (if applicable) to discuss any aspect of the application, qualifications, and requested clinical privileges. The department chairperson may also confer with experts within the department and outside of the department in preparing the report (e.g., other physicians, relevant Hospital department heads, nurse managers). In the event that the department chairperson is unavailable or unwilling to prepare a written report, the Chief of Staff shall appoint an individual to prepare the report.

(b) The department chairperson shall be available to the Credentials Committee, Medical Executive Committee, or the Board to answer any questions that may be raised with respect to that chair's report and findings.

5.4 Credentials Committee Procedure for Category I and Category II Practitioners:

(a) The Credentials Committee shall review the report from the appropriate department chairperson and the information contained in references given by the applicant and from other available sources. The Credentials Committee shall examine evidence of the applicant's character, professional competence, qualifications, prior behavior, and ethical standing and shall determine whether the applicant has established and satisfied all of the necessary qualifications for the clinical privileges requested.

(b) The Credentials Committee may use the expertise of any individual on the Medical Staff or in the Hospital, or an outside consultant, if additional information is required regarding the applicant's qualifications. The Credentials Committee may also meet with the applicant and, when applicable, the Supervising Physician. The appropriate department chairperson may participate in this interview.

(c) The Credentials Committee may recommend the imposition of specific conditions. These conditions may relate to behavior (e.g., code of conduct) or to clinical issues (e.g., general consultation requirements, proctoring). The Credentials Committee may also recommend that appointment be granted for a period of less than two years in order to permit closer monitoring of an individual's compliance with any conditions.

5.5 Medical Executive Committee Procedure for Category I and Category II Practitioners:

(a) At its next meeting after receipt of the written findings and recommendation of the Credentials Committee, the Medical Executive Committee shall:

(1) adopt the findings and recommendations of the Credentials Committee as its own; or

(2) refer the matter back to the Credentials Committee for further consideration and responses to specific questions raised by the Medical Executive Committee; or

(3) set forth in its report and recommendation specific reasons, along with supporting information, for its disagreement with the Credentials Committee's recommendation.

(b) If the Medical Executive Committee's recommendation is favorable to the applicant, the Committee shall forward its recommendation to the Board, through the Chief of Staff, including the findings and recommendation of the department chairperson and the Credentials Committee. The Medical Executive Committee's recommendation must specifically address the clinical privileges requested by the applicant, which may be qualified by any probationary or other conditions or restrictions relating to such clinical privileges.

(c) If the Medical Executive Committee's recommendation would entitle the applicant to the procedural rights set forth in this Policy, the Medical Executive Committee shall forward its recommendation to the President, who shall notify the applicant of the recommendation and his or her procedural rights. The President shall then hold the Medical Executive Committee's recommendation until after the individual has completed or waived the procedural rights outlined in Article 9 of this Policy.

5.6 Board Action for Category I and Category II Practitioners:

(a) Upon receipt of a recommendation from the Medical Executive Committee, the Board may:

(1) grant the applicant permission to practice and clinical privileges as recommended; or

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

(3) reject or modify the recommendation.

(b) If the Board determines to reject a favorable recommendation, it will first discuss the matter with the Chief of Staff. If the Board's determination remains unfavorable, the President shall notify the applicant of its determination and the applicant's procedural rights as outlined in this Policy.

5.7 Procedure for Category III Practitioners:

The Medical Staff Office will determine whether a Category III applicant has satisfied all of the qualifications for permission to practice and the scope of practice requested. Thereafter, the Chief Executive Officer may grant the Category III applicant permission to practice and a scope of practice. The Chief Executive Officer may impose specific conditions relating to behavior (e.g., code of conduct) or to clinical issues.

5.8 Time Periods for Processing:

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

5.9 Request for Temporary Clinical Privileges for Category I and II Practitioners:

(a) Temporary clinical privileges may be granted by the President, upon recommendation of the Chief of Staff, when a Category I or II practitioner 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.

(b) Prior to temporary privileges being granted , the credentialing process must be complete, including, where applicable, verification of current licensure, relevant training or experience, current competence, ability to exercise the privileges requested, and compliance with criteria, and consideration of information from the Data Bank. In order to be eligible for temporary privileges, an individual must demonstrate that there are no current or previously successful challenges to his or her licensure or registration and that he or she has not been subject to involuntary termination of membership, or involuntary limitation, reduction, denial, or loss of clinical privileges, at another health care facility.

(c) The individual must also agree in writing to be bound by all applicable bylaws, rules and regulations, policies, procedures and protocols prior to temporary privileges being granted.

(d) Temporary privileges shall be granted for a specific period of time, not to exceed 120 days, and shall expire at the end of the time period for which they are granted.

5.10 Termination of Temporary Clinical Privileges for Category I and II Practitioners:

(a) The President may terminate temporary privileges for any reason and at any time, after consulting with the Chief of Staff, the Credentials Committee Chairperson or the department chairperson.

(b) The granting of temporary clinical privileges is a courtesy. Neither the denial nor termination of temporary privileges~~,~~ shall entitle the individual to the procedural rights set forth in Article 8.

5.11 Renewal of Permission to Practice for Category I and II Practitioners:

(a) Renewal of an Allied Health Professional's clinical privileges or scope of practice shall be considered only upon submission of a completed application for renewed permission to practice. Five months prior to the date of expiration of the Allied Health Professional's clinical privileges or scope of practice, the Medical Staff Office shall give the individual special notice of the date of expiration and an application form for renewed clinical privileges or scope of practice.

(b) Failure to return a completed application to the Medical Staff Office within 30 days will result in the assessment of a reappointment processing fee. In addition, failure to submit an application at least two months prior to the expiration of the individual's current term shall result in automatic expiration of permission to practice and clinical privileges or scope of practice at the end of the then current term, and the individual may not practice until an application is processed.

(c) Renewed permission to practice, if granted, shall be for a period of not more than two years.

(d) Once an application for renewed permission to practice has been completed and submitted to the Medical Staff Office, it shall be evaluated in the same manner and follow the same procedures outlined in this Policy for initial applicants.

(e) As part of the process for renewal of clinical privileges for Category I and Category II practitioners, the following factors shall be considered, as appropriate:

(1) the competency of the practitioner as assessed by the appropriate department chairperson and documented on a biennial evaluation form;

(2) a recommendation from a peer;

(3) use of the Hospital's facilities taking into consideration practitioner-specific information concerning other individuals in the same or similar specialty;

(4) assessment by the Supervising Physician(s).

5.12 Renewal of Permission to Practice for Category III Practitioners:

Renewal of permission to practice for Category III practitioners will be evaluated on an annual basis. The competency of Category III practitioners will be assessed by the Supervising Physician(s). Additional requirements may be imposed as part of the renewal process for Category III practitioners depending on their area of practice.

ARTICLE 6

CONDITIONS OF PRACTICE APPLICABLE TO
CATEGORY II AND CATEGORY III PRACTITIONERS

6.1 Standards of Practice for Category II and Category III Practitioners:

(a) Category II and Category III practitioners are not permitted to function independently in the inpatient Hospital setting. As a condition of being granted permission to practice at the Hospital, all Category II and Category III practitioners specifically agree to abide by the standards of practice set forth in this Section. In addition, as a condition of being permitted to utilize the services of Category II and Category III practitioners in the Hospital, all Medical Staff members who serve as Supervising Physicians to such individuals also specifically agree to abide by the standards set forth in this Section.

(b) The following standards of practice are applicable to Category II and Category III practitioners in the Hospital:

(1) Admitting Privileges. Category II and Category III practitioners are not granted admitting privileges and therefore may not admit patients independent of their Supervising Physician.

(2) Consultations. Category II practitioners may independently perform requested consultations as directed by their Supervising Physician and document such in the medical record for co-signature by the Supervising Physician. Category III practitioners may not perform consultations but may, as directed by their Supervising Physician, visit the patient to gather data to facilitate the physician's performance of the requested consultation.

(3) Emergency On-Call Coverage. Category II and Category III practitioners may not independently participate in the emergency on-call roster in lieu of their Supervising Physician. The Supervising Physician may direct a Category II or Category III practitioner to see the patient, gather data, and order tests for further review by the Supervising Physician. The Supervising Physician must personally see the patient when requested by the Emergency Department physician.

(4) Calls Regarding Hospitalized Inpatients. Category II and Category III practitioners may, in collaboration with the Supervising Physician, respond

to calls from the floor or special care units regarding hospitalized patients. It is within the discretion of the individual requesting assistance whether to contact a Category II or Category III practitioner prior to the Supervising Physician. However, if the individual requesting assistance determines that it is in the best interest of patient care to speak directly to the Supervising Physician, the Supervising Physician must personally respond.

(5) Daily Inpatient Rounds. Category II and Category III practitioners may perform daily inpatient rounds in collaboration with the Supervising Physician.

(6) Invasive Procedures. When performing invasive procedures, Category II and Category III practitioners must function under the supervision of their Supervising Physician and in accordance with their written collaboration and/or supervision agreements and in accordance with the privileges or scope of practice granted.

6.2 Oversight by Supervising Physician:

(a) Any activities permitted by the Board to be done at the Hospital by a Category II or Category III practitioner shall be done only under the supervision of the physician supervising that individual.

(b) Category II or Category III practitioners may function in the Hospital only so long as (i) they are supervised by a physician currently appointed to the Medical Staff ("Supervising Physician"), and (ii) they have a current, written supervision agreement with that physician. In addition, should the Medical Staff appointment or clinical privileges of the Supervising Physician be revoked or terminated, the individual's permission to practice at the Hospital and clinical privileges or scope of practice shall be automatically relinquished (unless the individual will be supervised by another physician on the Medical Staff).

(c) As a condition for permission to practice at the Hospital, each Category II or Category III practitioner and his/her Supervising Physician must submit a copy of their written supervision or collaboration agreement to the Hospital. This agreement must meet the requirements of all applicable Georgia statutes and regulations, as well as any additional requirements of the Hospital. It is also the responsibility of the Category II or Category III practitioner and his/her Supervising Physician to provide the Hospital, in a timely manner, with any revisions or modifications that are made to the agreement.

6.3 Questions Regarding Authority of a Category II or Category III Practitioner:

(a) Should any Medical Staff member or Hospital employee who is licensed or certified by the state have any question regarding the clinical competence or authority of a Category II or Category III practitioner either to act or to issue instructions outside the physical presence of the Supervising Physician in a particular instance, the Medical Staff member or Hospital employee shall have the right to require that the Category II or Category III practitioner's supervisor validate, either at the time or later, the instructions of the Category II or Category III practitioner. Any act or instruction of the Category II or Category III practitioner shall be delayed until such time as the staff member or Hospital employee can be certain that the act is clearly within the scope of the Category II or Category III practitioner's activities as permitted by the Board.

(b) Any question regarding the clinical practice or professional conduct of a Category II or Category III practitioner shall be immediately reported to the Chief of Staff, the relevant department chairperson, or the President, who shall undertake such action as may be appropriate under the circumstances.

6.4 Responsibilities of Supervising Physician:

(a) The Supervising Physician shall be responsible for the actions of the Category II or Category III practitioner in the Hospital.

(b) The number of Category II or Category III practitioners acting under the supervision of one physician, as well as the acts they may undertake, shall be consistent with applicable state statutes and regulations and any other policies adopted by the Hospital. The Supervising Physician shall make all appropriate filings with the State Board of Medicine regarding the supervision and responsibilities of the Category II or Category III practitioner, to the extent that such filings are required.

(c) It shall be the responsibility of the Supervising Physician to provide, or to arrange for, professional liability insurance coverage for the Category II or Category III practitioner in amounts required by the Board that covers any activities of the Category II or Category III practitioner at the Hospital, and to furnish evidence of such coverage to the Hospital. The Category II or Category III practitioner shall act at the Hospital only while such coverage is in effect.

ARTICLE 7

PEER REVIEW PROCEDURES FOR QUESTIONS
INVOLVING ALLIED HEALTH PROFESSIONALS

7.1 Collegial Intervention:

(a) As part of the Hospital's performance improvement and professional and peer review activities, this Policy encourages the use of collegial intervention and progressive steps by Medical Staff leaders and Hospital administration to arrive at voluntary, responsive actions by the individual to resolve questions that have been raised. Collegial intervention efforts are not mandatory, and shall be within the discretion of the appropriate Medical Staff leaders.

(b) Collegial efforts may include, but are not limited to, counseling, sharing of comparative data, monitoring, and additional training or education.

7.2 Administrative Suspension:

(a) The Chief of Staff, the relevant department chairperson, and the President shall each have the authority to impose an administrative suspension of all or any portion of the clinical privileges or scope of practice of any Allied Health Professional whenever a concern has been raised about such individual's clinical practice or conduct.

(b) An administrative suspension shall become effective immediately upon imposition, shall immediately be reported in writing to the President and the Chief of Staff, and shall remain in effect unless or until modified by the President or the Medical Executive Committee.

(c) Upon receipt of notice of the imposition of an administrative suspension, the President and the Chief of Staff shall forward the matter to the full Medical Executive Committee, which shall review and consider the question(s) raised and thereafter make an appropriate recommendation to the Board. If the Medical Executive Committee's recommendation is to restrict or terminate the Allied Health Professional's clinical privileges or scope of practice, the individual and, when applicable, the Supervising Physician shall be entitled to the procedural rights outlined in Article 8 of this Policy before the Medical Executive Committee's recommendation is considered by the Board.

7.3 Automatic Relinquishment of Clinical Privileges or Scope of Practice:

The clinical privileges or scope of practice of an Allied Health Professional shall be automatically relinquished, without entitlement to the procedural rights outlined in this Policy, in the following circumstances:

(a) the Allied Health Professional no longer satisfies all of the threshold eligibility criteria set forth in Section 4.1 (a-j) or any additional threshold credentialing qualifications set forth in the specific Hospital policy relating to his or her discipline;

(b) the Medical Staff appointment or clinical privileges of the staff physician supervising a Category II or Category III practitioner is revoked or terminates for any reason (unless the Category II or Category III practitioner will be supervised by another physician on the Medical Staff);

(c) a Category II or Category III practitioner ceases to be directly supervised by a physician currently appointed to the Medical Staff for any reason (unless the Category II or Category III practitioner will be supervised by another physician on the Medical Staff);

(d) the revocation, limitation, suspension, or lapse of an Allied Health Professional's license, certification, DEA registration, and/or insurance coverage;

(e) an Allied Health Professional's termination, exclusion, or preclusion from participation in the Medicare or Medicaid program by action of the government;

(f) an Allied Health Professional's indictment, conviction, or plea of guilty or no contest to any felony; or to any misdemeanor involving violations of law pertaining to controlled substances, illegal drugs, insurance fraud or abuse, or violence; or

(g) a determination is made that there is no longer a need for the services that are being provided by the Allied Health Professional.

7.4 Leave of Absence:

(a) Allied Health Professionals may request a leave of absence, for a period not to exceed a year, by submitting a written request to the President. The President will determine whether a request for a leave of absence shall be granted. Requests for reinstatement must be made at least 30 days prior to the conclusion of the leave of absence.

(b) 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.

(c) The request for reinstatement shall be referred to the Medical Executive Committee for review and recommendation and then to the Board for final action.

ARTICLE 8

PROCEDURAL RIGHTS FOR ALLIED HEALTH PROFESSIONALS

8.1 General:

Allied Health Professionals shall not be entitled to the hearing and appeals procedures set forth in the Credentials Manual. Any and all procedural rights to which these individuals are entitled are set forth in this Article.

8.2 Procedural Rights for Category III Practitioners:

(a) In the event that a recommendation is made by the Medical Executive Committee that a Category III practitioner not be granted the scope of practice requested, or that the scope of practice previously granted be restricted, terminated, or not renewed, the individual shall be notified of the recommendation. The notice shall include a general statement of the reasons for the recommendation and shall advise the individual that he or she may request a meeting with the Medical Executive Committee before its recommendation is forwarded to the Board.

(b) If a meeting is requested, the meeting shall be scheduled to take place within a reasonable time frame. The meeting shall be informal and shall not be considered a hearing. The Supervising Physician and the Category III practitioner shall both be permitted to attend this meeting. However, no counsel for either the Category III practitioner or the Medical Executive Committee shall be present.

(c) Following this meeting, the Medical Executive Committee shall make its final recommendation to the Board.

8.3 Procedural Rights for Category I and Category II Practitioners:

(a) In the event that a recommendation is made by the Medical Executive Committee that a Category I or Category II practitioner not be granted the clinical privileges requested, or that the clinical privileges previously granted be restricted, terminated, or not renewed, the practitioner shall be notified of the recommendation. The notice shall include the specific reasons for the recommendation and shall advise the individual that he or she may request a hearing before the adverse recommendation is transmitted to the Board for final action.

(b) If the Category I or Category II practitioner desires to request a hearing, he or she must make such request in writing and direct it to the President within 30 days after receipt of the written notice of the adverse recommendation.

(c) If a request for a hearing is made in a timely manner, the President, in conjunction with the Chief of Staff, shall appoint an Ad Hoc Committee composed of up to three individuals (including, but not limited to, individuals appointed to the Medical Staff, Allied Health Professionals, Hospital management, individuals not connected to the Hospital, or any combination of these individuals) and a Presiding Officer, who may be legal counsel to the Hospital. The Ad Hoc Committee shall not include anyone who previously participated in the recommendation, any relatives or practice partners of the Category I or Category II practitioner, or any competitors of the affected individual.

(d) As an alternative to the Ad Hoc Committee described in paragraph (c) of this Section, the President, in conjunction with the Chief of Staff, may instead appoint a Hearing Officer to perform the functions that would otherwise be carried out by the Ad Hoc Committee. The Hearing Officer shall preferably be an attorney at law. The Hearing Officer may not be in direct economic competition with the individual requesting the hearing and shall not act as a prosecuting officer or as an advocate to either side at the hearing. If the Hearing Officer is an attorney, he or she shall not represent clients who are in direct economic competition with the affected individual. In the event a Hearing Officer is appointed instead of an Ad Hoc Committee, all references in this Article to the Ad Hoc Committee shall be deemed to refer instead to the Hearing Officer, unless the context would clearly otherwise require.

(e) The hearing shall be convened as soon as is practical, but no sooner than 30 days after the notice of the hearing, unless an earlier hearing date has been specifically agreed to by the parties.

8.4 Hearing Process for Category I and Category II Practitioners:

(a) At the hearing, a representative of the Medical Executive Committee shall first present the reasons for the recommendation. The Category I or Category II practitioner shall be invited to present information, both orally and in writing, to refute the reasons for the recommendation, subject to a determination by the Presiding Officer (or the Hearing Officer) that the information is relevant. The Presiding Officer (or the Hearing Officer) shall have the discretion to determine the amount of time allotted to the presentation by the representative of the Medical Executive Committee and the Category I or Category II practitioner.

(b) Both parties shall have the right to present witnesses. The Presiding Officer (or Hearing Officer) shall permit reasonable questioning of such witnesses.

(c) The Category I or Category II practitioner and the Medical Executive Committee may be represented at the hearing by legal counsel, provided, however, that while counsel may be present at the hearing, counsel shall not call, examine, and cross-examine witnesses nor present the case.

(d) The affected practitioner shall have the burden of demonstrating that the recommendation of the Medical Executive Committee was arbitrary, capricious, or not supported by substantial evidence. The quality of care provided to patients and the smooth operation of the Hospital shall be the paramount considerations.

(e) Minutes of this proceeding shall be kept and shall be attached to the report and recommendation of the Ad Hoc Committee.

8.5 Ad Hoc Committee or Hearing Officer Report:

(a) The Ad Hoc Committee (or the Hearing Officer) shall prepare a written report and recommendation within 30 days after the conclusion of the proceeding, and shall forward it along with all supporting information to the President. The President shall send a copy of the written report and recommendation, via certified mail, return receipt requested, to the Category I or Category II practitioner. A copy shall also be provided to the Medical Executive Committee.

(b) Within ten days after receiving notice of the recommendation, either the Category I or Category II practitioner or the Medical Executive Committee may make a request for an appeal. The request must be in writing and must include a statement of the reasons for appeal, including the specific facts, which justify further review. The request shall be delivered to the President either in person or by certified mail.

(c) If a written request for appeal is not submitted within the ten day time frame specified above, the recommendation and supporting information shall be forwarded by the President to the Board for final action. If a timely request for appeal is submitted, the President shall forward the report and recommendation, the supporting information, and the request for appeal to the Chairperson of the Board.

8.6 Appeals Process for Category I and Category II Practitioners:

(a) The grounds for appeal shall be limited to the following assertions: (1) there was substantial failure to comply with this Policy and/or other applicable bylaws or

policies of the Hospital or the Medical Staff and/or (2) the recommendation was arbitrary, capricious, or not supported by evidence.

(b) The Chairperson of the Board, or a committee of the Board appointed by the Chairperson, will consider the record upon which the adverse recommendation was made. New or additional written information that is relevant and could not have been made available to the Ad Hoc Committee (or Hearing Officer) may be considered at the discretion of the Chairperson or the appellate review committee. This review shall be conducted within 30 days after receiving the request for appeal.

(c) The Category I or Category II practitioner and the Medical Executive Committee shall each have the right to present a written statement in support of its position on appeal.

(d) At the sole discretion of the Chairperson of the Board or the committee appointed by the Chairperson, the Category I or Category II practitioner and a representative of the Medical Executive Committee may also appear personally to discuss their position. In that event, however, neither party shall be represented by counsel at the appeal.

(e) Upon completion of the review, the Chairperson of the Board or the committee appointed by the Chairperson shall provide a report and recommendation to the full Board for action. The Chairperson (or the committee) may also refer the matter to any committee or individual deemed appropriate for further review and recommendation to the full Board. The Board shall then make its final decision based upon the Board's ultimate legal responsibility to grant privileges and to authorize the performance of clinical activities at the Hospital.

(f) The Category I or Category II practitioner shall receive special notice of the Board's action. A copy of the Board's final action will also be sent to the Medical Executive Committee for information.

ARTICLE 9

HOSPITAL EMPLOYEES

(a) The employment of Allied Health Professionals by the Hospital will be governed by the Hospital's employment policies and manuals and the terms of the individual's employment relationship and/or written contract.

(b) A request for clinical privileges or scope of practice, on an initial basis or for renewal, submitted by Allied Health Professionals seeking employment or who are employed by the Hospital, will be processed in accordance with the terms of Article 5 of this Policy, except that the Board will not need to act on the request. Instead, a report regarding each Allied Health Professional's qualifications resulting from that process will be provided to Hospital management personnel or Human Resources (as appropriate) to assist the Hospital in making employment decisions.

(c) If an Allied Health Professional's employment is terminated for any reason, the individual's permission to practice in the Hospital will automatically expire without any procedural rights set forth in this Policy.

(d) Except as otherwise provided above, to the extent that the Hospital's employment policies or manuals, or the terms of any applicable employment contract, conflict with this Policy, the employment policies, manuals, and descriptions and terms of the individual's employment relationship and/or written contract will apply.

ARTICLE 10

AMENDMENTS

(a) This Policy may be amended by a majority vote of the members of the Medical Executive Committee present and voting at any meeting of that committee where a quorum exists, provided that the written recommendations of the Credentials Committee concerning the proposed amendments shall have first been received and reviewed by the Medical Executive Committee. Notice of all proposed amendments shall be posted on the Medical Staff bulletin board at least 14 days prior to the Medical Executive Committee meeting and any member of the Medical Staff may submit written comments to the Medical Executive Committee.

(b) Alternatively, the Medical Executive Committee may present proposed amendments to the voting staff by mail ballot, returned to the Medical Staff Office by the date indicated by the Medical Executive Committee. Along with the proposed amendments, the Medical Executive Committee may, in its discretion, provide a written report on them either favorably or unfavorably. To be adopted, an amendment must receive a majority of the votes cast, so long as the amendment is voted on by at least 25% of the staff eligible to vote.

(c) No amendment shall be effective unless and until it has been approved by the Board.

ARTICLE 11

ADOPTION

This Policy is adopted and made effective upon approval of the Board, superseding and replacing any and all other Medical Staff bylaws, rules and regulations, or Hospital policies pertaining to the subject matter thereof.

Adopted by the Medical Executive Committee: September 19, 2017

Approved by the Board: October 25, 2017

APPENDIX A

Those individuals currently practicing as Category I practitioners at the Hospital are as follows:

Clinical Psychologists

APPENDIX B

Those individuals currently practicing as Category II practitioners at the Hospital are as follows:

Nurse Practitioners

Physician Assistants

Surgical Assistants and Surgical Technicians

Pathologists' Assistants

APPENDIX C

Those individuals currently practicing as Category III practitioners at the Hospital are as follows:

Registered Nurses