CREDENTIALING AND PRIVILEGING MANUAL
OF THE MEDICAL STAFF
OF
FORT WASHINGTON MEDICAL CENTER

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CREDENTIALING MANUAL
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OF
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SECTION 1. DEFINITIONS

All capitalized terms appearing herein shall be accorded the meaning ascribed to such terms in the "Definitions" section of the Bylaws of the Medical Staff of Fort Washington Medical Center, unless otherwise defined in this Credentialing Manual.

Medical Staff Membership: FWMC Medical Staff Membership includes, but not limited to doctors of medicine (MD) or osteopathy (DO), In accordance with state law, medical staff membership is also composed of other advanced degree professionals and allied health practitioners such as dentists, podiatrists, chiropractors, advanced practice registered nurses (nurse practitioners (NP) and nurse midwives), certified registered nurse anesthetists (CRNA), physician assistants (PA), psychologists, optometrists.

Patient Encounters: "Patient Encounters" are defined as admissions, consultations, diagnostic procedures, surgical procedures and emergency department visits in both the inpatient and outpatient settings. Referrals for testing, procedures and diagnostics are not considered "Encounters."

SECTION 2. MEDICAL STAFF MEMBERSHIP

2.1. Nature of Medical Staff Membership

Medical Staff Composition (CMS MLN 2004)

The Medical Staff must be composed of doctors of medicine (MD) or osteopathy (DO) and, in accordance with state law, may also be composed of other practitioners appointed by the Governing Body. These other practitioners may include, but are not limited to dentists, podiatrists, chiropractors, advanced practice registered nurses (nurse practitioners (NP) and nurse midwives), certified registered nurse anesthetists (CRNA), physician assistants (PA), psychologists, optometrists, etc.

The Medical Staff, as a group is responsible for the quality of care provided to patients by the hospital, for establishing the bylaws, rules, regulations, policies, etc. for the medical staff and for overseeing the quality of care provided by all the individual practitioners who provide a medical level of care or who conduct invasive, non-invasive and surgical procedures at the hospital.

Membership on the Medical Staff of Fort Washington Medical Center is a privilege that shall be extended to professionally competent doctors of medicine (MD) or osteopathy (DO). In accordance with state law, medical staff membership is also composed of other advanced degree professionals and allied health practitioners such as dentists, podiatrists, chiropractors, advanced practice registered nurses (nurse practitioners (NP) and nurse midwives), certified registered nurse anesthetists (CRNA), physician assistants (PA), psychologists, optometrists, etc.

Appointment to and membership on the Medical Staff shall confer upon the appointee or member only such Clinical Privileges and prerogatives as have been granted by the Board, or a committee thereof, in accordance with this Credentialing Manual.

2.2. Qualifications for Medical Staff Membership

2.2.1. To be eligible for Medical Staff membership, an Applicant must satisfy all of the following qualifications:

2.2.1.1. Be a qualified graduate of an approved medical school, dental school, podiatry school, or school of osteopathy;

2.2.1.2. Be a qualified graduate of an approved accredited Advanced Practitioner Degree or Allied Health Program.

2.2.1.3. Possess a current, valid license to practice within the scope of practice for medicine, dentistry, podiatry and advanced practice professionals and allied health practitioners in the State of Maryland;

2.2.1.4. Provide evidence of experience, background, training, current competence, and physical and mental health consistent with the provision of quality patient care;

2.2.1.5. Be certified by an appropriate specialty board or affirmatively establish comparable competency for privileges requested through the credentialing process;

2.2.1.6. Demonstrate, on the basis of documented references, adherence to the ethics of his respective profession, the ability to work cooperatively with others, and a willingness to participate in the discharge of Medical Staff responsibilities;

2.2.1.7. Provide evidence of continuous and adequate professional liability insurance from an insurance carrier authorized to conduct business in Maryland in the amounts of one million ($1,000,000) per claim and three million ($3,000,000) annual aggregate, or in such other amounts as may be established by the Board of Directors from time to time, and containing coverage for claims arising from treatment rendered at the Hospital but not asserted until after the cessation of the Medical Staff Member's Privileges ("tail coverage"), and such other terms as may be established by the Board from time to time; and

2.2.1.8. Possess current, valid Drug Enforcement Administration (DEA) and Maryland Controlled Dangerous Substance (MCDS) numbers if applicable.

2.2.2. Appointment or Reappointment to the Medical Staff, or delineation of particular Clinical Privileges, shall not be made on the basis of an Applicant's gender, race, creed, national origin, or any other criterion not related to the delivery of quality patient care at the Hospital, professional ability and judgment, or community and Hospital need.

2.2.3. No Physician, dentist, podiatrist, Advanced Practice Professional or Allied Health Practitioner (AHP) as defined above shall be automatically entitled to Medical Staff membership or to the exercise of particular Clinical Privileges solely because he is

licensed to practice in this or any other state; or because he is a member of any professional organization; or because he is certified by any clinical board; or because he had, or presently has, staff membership or clinical privileges at another health care facility or in another practice setting.

2.2.4. Individuals in administrative positions who desire Medical Staff membership or Clinical Privileges must possess the same minimum qualifications and are subject to the same procedures as other Applicants.

2.2.5. Practitioners who provide specific professional and/or administrative services pursuant to a contract with the Hospital must meet the same membership qualifications, must be processed for Appointment, Reappointment, and Clinical Privileges in the same manner, and must fulfill all of the same obligations of his membership category as any other Applicant or Staff Member.

2.2.6. The Medical Staff membership and Clinical Privileges of a Practitioner providing specific professional and/or administrative services pursuant to a contract with the Hospital may be contingent on the continuance of the contract. Such membership and Privileges shall automatically terminate upon termination of the Practitioner's contract or other affiliation with the Hospital or group under contract with the Hospital, or upon termination of the contract with the Hospital, in accordance with the terms of the contract. **In such cases, the affected Practitioner(s) shall not be entitled to the procedural rights set forth in the Fair Hearing Manual.**

2.2.7. Due process rights shall not be available to any Applicant or Member who is denied an Appointment, Reappointment, or Clinical Privileges because he has not satisfied the qualifications for Medical Staff membership set forth in this subsection 2.2. of the Credentialing Manual.

2.3. Ethical Principles

The professional conduct of Members of the Medical Staff shall conform to:

2.3.1. The principles of professional ethics as adopted or amended by the American Medical Association, the American College of Osteopathy, the American Dental Association, the American Podiatric Medical Association, and such other associations as may be appropriate and as designated by the Board of Directors;

2.3.2. The requirements for hospital accreditation as specified by the Joint Commission or other accrediting and certification bodies the hospital participates in;

2.3.3. Applicable federal, State, and local statutes, rules, and regulations; and

2.3.4. The medical staff and hospital wide policy on **"**Disruptive Behavior and Physician Expectation Document"

2.4. General Responsibilities

Each Applicant and Medical Staff Member agrees to accept and duly execute the following responsibilities, as applicable:

2.4.1. To abide by the Bylaws, rules and regulations, and policies and procedures of the Medical Staff and the Hospital;

2.4.2. To adhere to the ethical standards of his profession;

2.4.3. To provide for the continuous and timely care of assigned patients;

2.4.4. To work cooperatively with others;

2.4.5. To provide professional care in accordance with recognized standards of quality and efficiency;

2.4.6. To practice at the Hospital exclusively within the scope of his delineated Clinical Privileges;

2.4.7. To participate in performance improvement and peer review activities;

2.4.8. To provide all reasonably requested evidence and to otherwise cooperate with activities designed to assess his clinical competence, conduct, and capabilities;

2.4.9. To engage in appropriate continuing education activities;

2.4.10. To participate in the discharge of Medical Staff responsibilities as assigned;

2.4.11. To immediately notify the President of the Hospital and the MEC upon:

2.4.11.1. Any State licensing authority action taken against the Applicant's or Member's license, including without limitation revocation, suspension or imposition of probation subject to terms and conditions;

2.4.11.2. Disciplinary action against the Applicant or Member taken by another health care facility, medical society, or official body;

2.4.11.3. The filing and disposition of any medical malpractice claim against the Applicant or Member; or

2.4.11.4. The Applicant or Member's notification of exclusion from participation in Medicare, Medicaid, or any other federal or State health care program.

2.5. Terms of Appointment and Reappointment

2.5.1. Initial Appointment

Initial Appointment to the Medical Staff shall be for a term of 24 months with an initial FPPE period of at least 3 months and an extension of the FPPE period for up to 12 consecutive months. Refer to the Fort Washington Medical Center FPPE and OPPE Policy Manual, which are entered as an addendum to this Credentialing and Privileging Manual).

2.5.2. Reappointment

Reappointment to the Medical Staff shall be for a period of not more than two (2) Medical Staff years.

SECTION 3. LEAVES OF ABSENCE

3.1. Leave Status

A Member of the Medical Staff must request a voluntary leave of absence from the Medical Staff if he will be absent from active practice for a period exceeding three (3) months. Leaves of absence may be granted for unforeseen reasons such as medical illness or family emergency, or for planned activities such as prolonged vacations, sabbaticals or other educational activities. Leaves of absence are granted at the discretion of the MEC and the Board of Directors. During the period of leave, the Member may not exercise Clinical Privileges at the Hospital, and Membership responsibilities and prerogatives shall be inactive, except that the obligation to pay dues, if any, shall continue unless waived by the MEC.

3.2. Termination of Leave

Reinstatement of Clinical Privileges and Medical Staff responsibilities and prerogatives following a leave of absence is not automatic. The Member must submit a written request for termination of leave in accordance with subsection 3.3. of this Credentialing Manual, and shall be generally subject to the procedures for Reappointment and Clinical Privileges delineation set forth in Sections 6 and 7 of this Credentialing Manual.

3.3. Requests for Leave and Requests for Termination of Leave

Requests for leave of absence and for termination of leave of absence must be directed to the respective Department Chair, who shall make a recommendation to the MEC and the Board of Directors. Written requests for planned leaves of absence must be submitted to the Department Chair at least thirty (30) days in advance of the first day of the planned leave, and must state the period of leave requested and the reason for such request. Written requests for termination of leave must be submitted at least thirty (30) days prior to the anticipated termination of leave.

3.4. Failure to Request Leave or Termination of Leave

Absent good cause, failure to request a leave of absence or termination of a leave of absence in accordance with subsection 3.3., shall be deemed a voluntary resignation from the Medical Staff and shall result in automatic termination of Medical Staff membership, Privileges, and prerogatives. A Member whose membership is automatically terminated pursuant to this subsection shall be entitled to the procedural rights set forth in the Fair Hearing Manual of the Medical Staff for the sole purpose of determining whether the failure to request a leave of absence or termination of a leave of absence was excusable for good cause. A request for Medical Staff membership that is subsequently received from a Member so terminated, absent excuse for good cause shown, shall be submitted and processed in the manner specified for applications for initial Appointment.

SECTION 4. CATEGORIES OF THE MEDICAL STAFF

4.1. Assignment to a Category

4.1.1. The medical staff membership categories of the Medical Staff shall include the following:

1. Active Staff
2. Associate Staff
3. Affiliate Staff
4. Advanced Practice and Allied Health Practitioner (AHPs) Staff
5. Emeritus Staff

6. Administrative Staff

4.1.2. At the time of each Member's Appointment or Reappointment, the Member shall be assigned to one such category in accordance with the criteria set forth in this Credentialing Manual, and shall be subject to the responsibilities and prerogatives of that category as set forth herein. The prerogatives set forth under each category are general in nature and may be subject to limitations or special conditions for individual Members imposed in accordance with the provisions of this Credentialing Manual

4.2 New members of the medical staff will be required to complete an individualized Focused Practitioner Practice Evaluation period for **at least 3 months**. This FPPE review period may be extended as outlined in the Medical Staff approved OPPE and FPPE Policy Manual. Reappointment of privileges will consist of an Ongoing Practitioner Performance Evaluation (OPPE) during the reappointment process and every 8 months during the 2 year reappointment period at which time an evaluation is conducted by the Medical Staff Department Chairs, Division Chairs, MEC and Board regarding continuation or possible revision of current medical staff privileges based on quality outcomes and trended quality data.

4.3. Active Staff

4.3.1. Qualifications for Active Staff

The Active Staff shall consist of Members who:

4.3.1.1. Satisfy all of the general Medical Staff membership qualifications set forth in subsection 2.2. of this Credentialing Manual;

4.3.1.2. Have satisfactorily completed the FPPE Period;

4.3.1.3. Reside and have offices, if any, located within a reasonable proximity to the Hospital in order to provide continuous patient care and assure availability within a reasonable time period when a patient's condition requires prompt attention; and

4.3.1.4. Render patient care at Fort Washington Medical Center on a regular basis and demonstrate a continuing commitment to the Hospital.

4.3.2. Prerogatives of Active Staff

A Member of the Active Staff shall be entitled to:

4.3.2.1. Admit patients in accordance with his delineated Clinical Privileges;

4.3.2.2. Exercise such other Clinical Privileges as are granted to him in accordance with this Credentialing Manual;

4.3.2.3. Serve on committees of the Medical Staff upon appointment by the President of the Medical Staff;

4.3.2.4. Vote upon all matters presented at general and special meetings of the Medical Staff, Departments, and committees of which he is a member;

4.3.2.5. Nominate candidates to serve as officers of the Medical Staff;

4.3.2.6. Hold an office at any level of organization of the Medical Staff;

4.3.2.7. Chair a committee of the Medical Staff; and to

4.3.2.8 The following are issues not pertaining to individual peer review, formal investigations of professional performance or conduct, denial of requests for appointment or clinical privileges, or any other matter relating to individual membership or privileges.

1) To meet with the MEC on matters relevant to the responsibilities of the MEC; In the event the practitioner is unable to resolve a matter of concern after working with his or her department or division chair or other appropriate medical staff leader(s), that practitioner may, on written notice to the Chief Medical Officer or President of the Medical Staff two weeks in advance of a regular meeting, meet with the MEC to discuss the issue;

2) To initiate a recall election of a medical staff officer by following the procedure outlined in Section 5.4.7 of the Medical Staff Bylaws, regarding removal and resignation from office;

3) To call a general staff meeting of the medical staff to discuss a matter relevant to the medical staff; on presentation of a petition signed by 51% of the members of the active category, the MEC shall schedule a general staff meeting for the specific purposes addressed by the petitioners. No business other than that detailed in the petition may be transacted;

4) To challenge any rule or policy established by the MEC; In the event that a rule, regulation, or policy is thought to be inappropriate, any active staff member may submit a petition signed by 51% of the members of the active category. On presentation of such a petition, the adoption procedure outlined in Article 11 of the Medical Staff Bylaws will be followed; and

5) To call for a department meeting by presenting a petition signed by 51% of the members of the department. On presentation of such a petition, the department chair will schedule a department meeting.

4.3.3. Responsibilities of Active Staff

A Member of the Active Staff shall be obligated to:

4.3.3.1. Execute all applicable general responsibilities of Medical Staff membership as set forth in subsection 2.4. of this Credentialing Manual;
4.3.3.2. Have a minimum of 12 patient encounters per 12 month period
4.3.3.5. Satisfy special appearance requirements as set forth in Article 7 of the Bylaws;
4.3.3.6. Provide emergency department on-call coverage in accordance with the

on-call coverage schedule of his respective Department;

4.3.3.7. Provide consultation to other Staff Members consistent with his delineation of Privileges;

4.3.3.8. Assist with FPPE performance assessment as requested by the President of the Medical Staff, CMO or Department Chair;

4.3.3.9. Pay all Staff dues and assessments promptly; and

4.3.3.10. Fulfill such other Medical Staff functions as may be reasonably required of Members of the Active Medical Staff.

4.4. **Associate Staff:** Associate Medical Staff are those Physicians who do not regularly admit, perform procedures, and/or provide care to patients at the Hospital, but who wish to have the right to admit and treat a limited number of patients at the Hospital or ambulatory care setting. Refer patients to other physicians on staff at the Hospital or those who order diagnostic or therapeutic services at the Hospital. Associate Staff must fulfill the focused and/or ongoing professional performance evaluation requirements specified in the Bylaws/ Procedures, Medical Staff Quality Plan, and any specific requirements outlined in the pertinent Departmental Rules and Regulations.

4.4.1. Qualifications of Associate Staff shall consist of Members who:

4.4.1.1. Satisfy all of the general Medical Staff membership qualifications set forth in subsection 2.2. of this Credentialing Manual;

4.4.1.2. Have satisfactorily completed the FPPE Period;

4.4.1.3. Are members in good standing of the Medical Staff of another hospital that requires peer review and performance improvement activities of a substance and character similar to those at Fort Washington Medical Center as evidenced by accreditation;

4.4.2. Prerogatives of Associate Medical Staff member

4.4.2.1. A Member of the Associate Staff shall be entitled to:

4.4.2.1.1. Admit, attend, treat, and **perform consultations** and procedures for, inpatients and outpatients of the Hospital. Must have at least one patient encounter as defined in the “definitions section” of this manual

4.4.2.1.2 May have access to data on their patients within the Hospital and its medical records and information systems.

4.4.1.3. May attend, with voice and vote, all meetings of the Medical Staff.

4.4.1.4 Are eligible for appointment to all Medical Staff Committees but may not serve as Chair of any such Committees.

4.4.1.5 Are <u>not eligible</u> to serve as a Medical Staff Officer or Clinical Department Chair.

4.4.1.6 May attend Hospital-sponsored and Medical Staff-sponsored continuing professional education activities, receive Medical Staff publications and communications, and attend Medical Staff social functions.

4.4.3. Responsibilities and Obligations of an Associate Staff member

A Member of the Associate Medical Staff shall be obligated to:

4.4.3.1. Execute all applicable general responsibilities of Medical Staff membership as

set forth in subsection 2.4. of this Credentialing Manual;

4.4.3.2. Satisfy special appearance requirements as set forth in Article 7 of the Bylaws;

4.4.3.3. Provide consultation to other Staff Members consistent with his delineation of Privileges;

4.4.3.4. Pay all Staff dues and assessments promptly; and

4.4.3.5. Fulfill such other Medical Staff functions as may be reasonably required of Members of the Associate Staff.

4.4.3.6 Attend at least one quarterly Medical Staff meeting per year.

4.4.3.7 Participate in Clinical Department, Medical Staff, and Hospital quality improvement and performance improvement activities, as requested, and cooperate with all such activities.

4.4.3.8 Serve on Medical Staff Committees, as reasonably requested and subject to availability considering private practice and other hospital responsibilities.

4.5. Affiliate Staff

4.5.1. ***Qualifications for Affiliate Staff:*** Affiliate Staff membership is a **"refer and review"** category and shall consist of physicians, dentists, Allied Health Practitioners, Advance Practice Professionals, podiatrists and other professionals defined in Section 2 of the Credentialing Manual and who:

4.5.1.1. Meet all qualifications for membership on the Medical Staff, but hold no privileges and are exempt from the routine hospital verification process including verification of:

4.5.1.2. Current malpractice coverage

4.5.1.3. Current Federal DEA certificate

4.5.1.4. CME credits

4.5.1.5. Refer patients to other physicians on staff at the Hospital or those who order diagnostic or therapeutic services at the Hospital.

This Affiliate Staff Category will require licensure verification when referring patients for admission, testing and procedures. Fort Washington Medical Center medical staff has adopted an Outpatient Referral Licensure Verification and OIG Sanction Check process for all providers referring patients for testing Refer to medical staff policy on licensure verification. This category does not require participation in the OPPE/FPPE process.

4.5.2. **Prerogatives*:*** Members of the Affiliate Medical Staff who routinely refer and review:

4.5.2.1. May visit their referred patients in the Hospital, review their patients' medical records and receive information concerning their patients' medical condition and treatment.

4.5.2.2. May write outpatient and referral orders for diagnostic testing, labs, and ancillary services and other treatment modalities

4.5.2.3. May attend departmental and General Medical Staff meetings.

Members of the Affiliate Medical Staff may **NOT:**

4.5.2.4 Vote or hold office.

4.5.2.5 Make any entries in the Medical record.

4.5.2.6 Admit, write orders for inpatient care, perform surgical or invasive procedures or otherwise treat patients in the Hospital.

4.5.2.7 Have delineated clinical privileges.
4.5.2.8 Participate in the hospital's OPPE/FPPE review process

4.5.3 **Responsibilities**: The responsibilities of an Affiliate member of the medical staff who routinely refers and reviews patients are to abide by the Bylaws and Procedures of the Medical Staff and the Hospital.

A Member of the Affiliate Staff shall be obligated to:

4.5.3.1. Execute all applicable general responsibilities of Medical Staff membership as set forth in subsection 2.4. of this Credentialing Manual;
4.5.3.2. Except as otherwise noted above under Section 4.5 satisfy special appearance requirements as set forth in Article 7 of the Bylaws;

4.6. Advanced Practice Professionals and Allied Health Practitioners

***Definition*:** "Advanced Practice Professionals" ("APPs") and Allied Health Practitioners (AHPs) means Clinical Psychologists, Certified Nurse Midwives, Certified Nurse Practitioners, Certified Physician Assistants, Certified Register Nurse Anesthetists, Chiropractors, and any other health care practitioners defined above in Section 2 (Medical Staff Membership) with expert knowledge and experience in fields of medicine who the Hospital declares eligible for Membership on the Medical Staff and to receive clinical privileges in accordance with the Bylaws and Credentials manual/policies.

4.6.1 Prerogatives and Responsibilities. Advanced Practice Professionals and Allied Health Practitioner medical staff members:

4.6.1.1 May attend the Full Medical Staff Committee (without vote)
4.6.1.2 May attend educational activities sponsored by the Medical Staff and the Hospital;
4.6.1.3 May exercise such clinical privileges as are granted to them;
4.6.1.4 May serve on medical staff and hospital committees (with vote);
4.6.1.5 May actively participate in and shall cooperate in the professional practice evaluation and performance improvement processes;
4.6.1.6 May not hold office or serve as department or committee chairs
4.6.1.7 Must pay applicable fees, dues and assessments;
4.6.1.8 Are excused from providing coverage for the Emergency Department and providing care for unassigned patients unless the MEC declares a need for such coverage or services; and
4.6.1.9 May admit patients or perform consultations under the supervision of the sponsoring physician and in accordance with the Medical Staff Bylaws and governance documents.

4.7 **Administrative Staff Membership**: These are physicians (i.e. Chief Medical Officer) who by virtue of contract with the hospital have some administrative duties in addition to their clinical duties. They shall be members of the Medical Staff and shall meet the requirements for continuing membership. Contractual services shall be governed by the terms of the contract with hospital and corporation and **shall not** be subject to appeal as provided by these bylaws. Termination of the employment contract or relationship shall result in the automatic termination of Medical Staff membership as specified in the contract.

4.7.1 Members of this Medical Staff Category are charged with assisting the Medical Staff in carrying out medical-administrative functions, including, but not limited to quality assessment and

improvement and utilization review functions. Administrative Staff includes members who qualify through one of the following categories:

4.7.1.1 Serves in a medical-administrative leadership position of the hospital

4.7.1.2 Functions in a Hospital leadership position requiring medical staff membership as requested by Hospital and Administration; and/or

4.7.1.3 Serves as the oversight medical director of any Residency Program or affiliate School of Medicine program and is required to maintain Medical Staff membership;

4.7.2 Prerogatives of Administrative Medical Staff Status:

4.7.2.1 May attend meetings of the Medical Staff and the Clinical Department of which he/she is a member;

4.7.2.2 May hold office in the Medical Staff organization;

4.7.2.3 May serve as a voting member of Medical Staff Committees;

4.7.2.4 May access the electronic health record;

4.7.2.5 **May not** admit, treat or otherwise consult on patients; and

4.7.3.6 **May not** exercise Clinical Privileges.

4.8 Emeritus Membership: Medical Staff are those Physicians who have retired from the practice of medicine, have at least ten (10) years of continuous service as members of the Medical Staff, and whom the Medical Executive Committee and Board wishes to recognize and honor for their distinguished service to the Hospital and its patients. The MEC will recommend to the Board recommendations for Emeritus Status.

4.8.1 Prorogatives for Emeritus Medical Staff Members:

4.8.1.1 May attend, with voice but no vote, all meetings of the Medical Staff.

4.8.1.2 Are eligible for appointment to all Medical Staff Committees except the Medical Executive Committee but may not serve as Chair of any such Committees; provided, however, that one member of the Emeritus Medical Staff may be appointed by the President of the Medical Staff to serve on the Medical Executive Committee as provided for in the Bylaws.

4.8.1.3 May attend Hospital-sponsored and Medical Staff sponsored continuing professional education activities, receive Medical Staff publications and communications, and attend Medical Staff social functions.

4.8.1.4 Members may attend Medical Staff, Department, and educational meetings. They may not admit patients nor exercise clinical privileges and they shall not be eligible to vote or to hold office.

4.8.1.5 Emeritus Medical Staff members shall be exempt from any liability coverage requirements deemed necessary by the Board of Directors.

4.8.2 Obligations of Emeritus Medical Staff Members: may participate in the activities described above at their sole discretion, but shall have no other obligations as a member of the Emeritus Medical Staff. Members of the Emeritus Staff shall not have clinical privileges and shall not be subject to the regular reappointment processes.

4.9. Change in Medical Staff Category, Department Assignment during Term of Reappointment

The MEC may, upon its own initiative, upon recommendation of the Department Chair, or upon request of a Member, recommend to the Board that the Member's Medical Staff Category or Department assignment be changed prior to the conclusion of the Member's term of

Reappointment, provided that the Member satisfies all qualifications for the Medical Staff Status Category and meet the requirements for the Department to which reassignment is recommended or requested. A request for change in Medical Staff category or Department assignment is processed in the same manner as an application for Reappointment as set forth in Section 6 of this Credentialing Manual, but does not substitute for an upcoming Reappointment.

SECTION 5. APPOINTMENT TO THE MEDICAL STAFF

5.1. Application for Appointment

5.1.1. Application for initial Appointment to the Medical Staff shall be presented by the Applicant in writing on a form approved by the Board of Directors.

5.1.2. Concurrently with the application form, a prospective Applicant shall be provided a copy of the current Medical Staff Bylaws and related documents; Rules and Regulations; all forms for requesting delineated Clinical Privileges in the applicable Department(s); all credentialing criteria of the applicable Department(s); and other pertinent Hospital and Medical Staff documents.

5.2. Content of the Application

The application for initial Appointment shall include, but shall not be limited to, the following:

5.2.1. Appointment Requested

The Applicant shall designate the Department(s) to which an Appointment is requested.

5.2.2. Privileges Requested

Where Clinical Privileges are requested, the Applicant shall indicate the specific Clinical Privileges requested in each Department to which the Applicant seeks Appointment on a form approved by the Board of Directors.

5.2.3. Qualifications

The Applicant shall provide complete information bearing on the Applicant's professional qualifications and competence for the particular Medical Staff Appointment and Privileges requested, including but not limited to information concerning education; licensure; board certification and admissibility for certification; relevant training and experience; federal Drug Enforcement Administration ("DEA") and Maryland Division of Drug Control ("MDDC") registrations, if applicable; background checks (state and national levels); and the Applicant's physical, mental, or emotional status to the extent that such status may have bearing upon the Applicant's ability to competently execute the Clinical Privileges for which he has applied, or to competently execute other responsibilities of Medical Staff membership.

5.2.4. Other Affiliations

The Applicant shall provide complete information concerning any other hospital or health care institution or practice where the Applicant currently has or in the past been employed,

appointed, and/or granted clinical privileges.

5.2.5. References

The Applicant shall provide the names and current addresses of at least three (3) Peers who:

5.2.5.1. Are not currently partners of the Applicant, in professional practice with the Applicant, or related to the Applicant;

5.2.5.2. Have personal knowledge of the Applicant's professional performance, judgment, and clinical skills within the last five (5) years, acquired through recent observation of the Applicant's clinical performance over a reasonable period of time;

5.2.5.3. Have personal knowledge of the Applicant's ethical character, ability to work with others, and health status as it may relate to the Applicant's ability to competently execute the Clinical Privileges for which he has applied and to competently perform other responsibilities of Medical Staff membership, acquired through recent observation of the Applicant's professional performance over a reasonable period of time; and

5.2.5.4. Is willing to provide specific written comments on these matters upon request from Hospital or Medical Staff authorities. At a minimum, peer recommendations should include information regarding the practitioner's current:

- Medical/clinical knowledge
- Technical and clinical skills
- Clinical judgment
- Interpersonal Skills
- Communication Skills
- Professionalism
- Applicant's health status as related to ability to perform privileges requested

5.2.6. Professional liability insurance

The Applicant shall provide complete information concerning professional liability insurance coverage, including but not limited to the Applicant's present professional liability insurance carrier, current limits of coverage, current types of coverage, any restrictions upon coverage, claims made, and whether the Applicant has maintained continuous coverage since first obtaining professional liability insurance.

5.2.7. Malpractice claims

The Applicant shall provide complete information concerning his malpractice claims history and experience, including but not limited to concluded and pending suits filed, the status of such suits, and settlements made.

5.2.8. Professional sanctions

The Applicant shall provide complete information concerning:

5.2.8.1. Any complaint or report concerning the Applicant filed with any state professional disciplinary board; any state medical, dental, or podiatric society; or any professional or specialty association;

5.2.8.2. Any previously successful or currently pending challenges to any licensure or to any DEA or other controlled substances registration;

5.2.8.3. Any pending or concluded action involving denial, revocation, suspension, reduction, limitation, probation, non-renewal, voluntary or involuntary relinquishment or termination of the Applicant's license or certificate to practice any profession in any state, jurisdiction or country; DEA or other controlled substances registration; membership or fellowship in local, state or national professional organizations; faculty membership at any medical or other professional school; and medical staff membership status, prerogatives or clinical privileges at any other hospital, clinic or health care provider;

5.2.8.4. Any threatened, pending, ongoing, or concluded investigation, reprimand, censure, admonishment, or sanction by any hospital, other health care organization, professional organization, or local, state or federal government agency;

5.2.8.5. Any current or past criminal charges against the Applicant, including the resolution of any past criminal charges;

5.2.8.6. Statements notifying the Applicant of the scope and extent of the authorization, confidentiality, immunity and release provisions of the Medical Staff Bylaws;

5.2.8.7. Application fee as determined by the Board;

5.2.8.8. Other items as deemed necessary by the Board upon recommendation of the Chair of the Department or President of the Medical Staff through and with the concurrence of the MEC;

5.2.8.9 Copy of government issued photo I.D. In addition to providing a copy, Fort Washington Medical Center will verify the applicant's identity in person against the government issued photo I.D.; and

5.2.8.10. Signature of the Applicant.

5.3. Effect of the Application

Upon signing the application, the Applicant:

5.3.1. Attests to the accuracy and completeness of all information furnished and agrees that any inaccuracy or omission is grounds for terminating the application process;

5.3.2. Signifies his willingness to appear for interviews in connection with his application, peer review, and performance improvement activities;

5.3.3. Agrees to abide by the terms of the Bylaws, rules and regulations, and policies and procedures of the Medical Staff and the Hospital, and any amendments thereto, if granted membership and/or Clinical Privileges, and to abide by the terms thereof in all matters relating to consideration of the application without regard to whether or not membership and/or Privileges are granted;

5.3.4. Pledges to provide for the continuous care of his patients;

5.3.5. Authorizes and consents to Hospital and Medical Staff representatives consulting with his prior and current Peers, associates and others who may have information bearing upon professional competence, character, ethical qualifications, ability to work cooperatively with others, ability to perform the Privileges requested, and other qualifications for membership or Clinical Privileges;

5.3.6. Consents to Hospital and Medical Staff representatives' inspection of all records and documents that may be material to an evaluation of his professional and ethical qualifications and competence to carry out the Clinical Privileges requested, including the Applicant's health status as it may relate to his ability to competently execute the Clinical Privileges for which he has applied and to competently perform other responsibilities of Medical Staff membership;

5.3.7. Extends immunity to and releases from all claims, damages, and liability the Hospital, the Medical Staff, and any employee, officer, director, agent, or representative thereof in accordance with Subsection 9.2. of the Bylaws;

5.3.8. Authorizes and consents to Hospital representatives providing other hospitals, medical associations, licensing boards, and other organizations concerned with Practitioner performance and the quality and efficiency of patient care, with any information relevant to such matters that the Hospital may have concerning him, and releases the Hospital and Hospital representatives from liability for so doing;

5.3.9. Signifies that he has read the current Medical Staff Bylaws and Manuals incorporated by reference therein, and agrees to abide by their provisions in regard to his application for Appointment to the Medical Staff; and

5.3.10. Agrees to provide to the MEC updated information concerning information requested on the original application and subsequent reapplications or Privilege request forms.

5.4. Applicant's Burden

5.4.1. The Applicant has the burden of producing adequate documentation from primary sources in order that the Hospital may verify, and the Hospital and the Medical Staff may conduct a proper evaluation of, the Applicant's licensure, specific training, experience, demonstrated ability, and current competence.

5.4.2. The Applicant bears the burden of resolving any doubts about these or any of the qualifications required for Staff membership or the requested Staff category, Department assignment(s), or Clinical Privileges, and of satisfying any reasonable

requests for information or clarification made by appropriate Medical Staff or Board authorities.

5.4.3. If there is any question concerning the Applicant's physical, mental, or emotional status that may have bearing upon the Applicant's ability to practice his profession and/or to competently perform the Clinical Privileges for which he has applied, the Hospital may require, at the Applicant's expense, an examination of the Applicant by an independent qualified practitioner acceptable to the MEC.

5.5. Preliminary Processing of the Application for Appointment

5.5.1. Completed applications for Medical Staff Appointment and requests for Clinical Privileges shall be submitted to the Administrator. The Administrator shall:

5.5.1.1. Open and maintain a separate file for each Applicant;

5.5.1.2. Contact all references in order to verify information concerning the Applicant's current professional competence, character, ethical qualifications, ability to work cooperatively with others, ability to perform the Privileges requested, and other qualifications for membership or the Clinical Privileges requested;

5.5.1.3. Verify, in person, government issued photo identification and verifying identity when photo identification is presented in person.

5.5.1.4. Verify additional information contained in the application, from primary sources whenever feasible, including but not limited to:

5.5.1.4.1. Information from all prior and current insurance carriers concerning claims, suits, and settlements (if any), including a determination if there has been an unusual pattern or excessive number of professional liability actions resulting in a final judgment;

5.5.1.4.2. Licensure status in all current or past states and jurisdictions of licensure;

5.5.1.4.3. Documentation of the Applicant's past clinical work experience;

5.5.1.4.4. Completion of medical, osteopathic, dental, or podiatric school and residency and fellowship programs;

5.5.1.4.5 DEA and MDDC registration status; and

5.5.1.4.6 Competence to perform privileges requested.

5.5.1.5. Request information from the Board of Physician Quality Assurance of the State of Maryland, and from the National Practitioner Data Bank, or the agency designated by the Secretary, Department of Health and Human Services, and gather other information deemed pertinent;

5.5.1.6. Notify the Applicant of any supporting documentation or verification not received within thirty (30) days of request. It is the Applicant's obligation to obtain all required information within such reasonable time frame as designated by the Administrator in accordance with such Department's policies and procedures. Failure to provide such information in a timely fashion, absent good cause, shall be deemed a withdrawal of the application for Appointment to the Medical Staff; and

5.5.1.7. Transmit the completed application and supporting documents to the Chair of the Department to which application for Appointment has been made within **five (5) days of the application's becoming complete**. An application shall be considered complete when:

5.5.1.7.1. All blanks on the application form are filled in and necessary additional explanations and supporting documentation are provided;

5.5.1.7.2. Verification of the information is complete; and

5.5.1.7.3. Responsive letters of reference and information from past hospitals and other affiliations have been received

5.6 Content Reports and Basis for Recommendations and Actions

The report of each individual or group, including the Board, required to act on an application for Appointment must include recommendations as to approval or denial of, and any special limitations on, Staff appointment, category of Staff membership, Department affiliation, and scope of Clinical Privileges. The reasons for each adverse recommendation or action taken must be specifically stated, with reference to the completed application and all other documentation considered. For the purposes of this Section 5, "adverse action" or "adverse recommendation" means an action or recommendation to deny Appointment, deny requested Staff category for which the Applicant is eligible, deny requested Department assignment, or to deny, restrict, or modify requested Clinical Privileges.

5.6.1. The respective Department Chair shall:

5.6.1.1. Review the completed application and supporting documents;

5.6.1.2. Interview the Applicant and complete an interview form approved by the MEC and the Board of Directors;

5.6.1.3. Assess the credentials of the Applicant; and

5.6.1.4. Prepare a written report and recommendation concerning whether the Applicant's credentials are satisfactory or unsatisfactory for the Appointment requested. If the Applicant's credentials are deemed satisfactory, the report shall also include recommendations concerning the specific Privileges to be granted to the Applicant.

5.7. Content of Reports and Basis for Recommendations and Actions

The report of each individual or group, including the Board, required to act on an application for

Appointment must include recommendations as to approval or denial of, and any special limitations on, Staff appointment, category of Staff membership, Department affiliation, and scope of Clinical Privileges. The reasons for each adverse recommendation or action taken must be specifically stated, with reference to the completed application and all other documentation considered. For the purposes of this Section 5, "adverse action" or "adverse recommendation" means an action or recommendation to deny Appointment, deny requested Staff category for which the Applicant is eligible, deny requested Department assignment, or to deny, restrict, or modify requested Clinical Privileges.

5.8. Expedited Credentialing Process

5.8.1. To the extent permitted by applicable laws, regulations, and accreditation standards, applications for Appointment to the Medical Staff shall be processed in the expedited fashion. In order to be eligible for the Expedited Credentialing Process, the applicant must have submitted an application that is deemed complete and the MEC must make a final recommendation that is not adverse or with limitations. Additionally criteria that may be evaluated on a case-by-case basis for the eligibility for this process are:

5.8.1.1. The Applicant's license to practice a health occupation in any jurisdiction or the applicant's DEA, MDDC, or other controlled substances registration as never been restricted, suspended, revoked, limited, or subject to probation or reprimand, and there is no current challenge to the Applicant's license or registration;

5.8.1.2. The Applicant was never suspended, censured, or otherwise reprimanded as a member of any other profession;

5.8.1.3. A complaint or report has never been filed against the Applicant with the Board of Physician Quality Assurance or with any other professional disciplinary body;

5.8.1.4. The Applicant was never excluded from participation in any federal health care program, and was never the subject of any civil or criminal investigation concerning alleged health care fraud and/or abuse;

5.8.1.5. The Applicant has never lost Board Certification for any reason;

5.8.1.6. The Applicant's privileges at any hospital were never voluntarily or involuntarily suspended, revoked, limited, denied, or subject to condition, probation, reprimand or warning, or not renewed, and the Applicant is not the subject of a current investigation at any hospital;

5.8.1.7. The Applicant's membership in any medical organization (including but not limited to a medical staff, ambulatory surgical center, HMO or PPO) has never been denied, revoked, or involuntarily terminated, and the Applicant has never been subject to any disciplinary proceedings in any medical organization;

5.8.1.8. There has never been a final judgment adverse to the Applicant in a professional liability action or in any other civil, criminal, administrative or other proceeding in any jurisdiction;

5.8.1.9. The Applicant has never had a malpractice claim settled on his behalf by a professional liability insurance carrier, even if no formal action was ever filed in a court or arbitration panel;

5.8.1.10. The Applicant was never expelled, suspended, placed on probation, requested to resign, requested to discontinue his/her studies, or otherwise disciplined for any reason while in college or professional school;

5.8.1.11. The Applicant has maintained continuous professional malpractice insurance, and the Applicant's malpractice insurance has never been limited, revoked, or not renewed by any company, medical society, or organization (other than because the carrier withdrew from the market); and

5.8.1.12. The Administrator, the Department Chair, the MEC, or a Member of the Board has identified no other aspect of the Applicant's history that may have an unfavorable bearing upon the Applicant's ability to practice his profession, to competently perform the Clinical Privileges for which he has applied including an unusual pattern of, or an excessive number of professional liability actions resulting in a final judgment against the applicant; and/or to fulfill the other responsibilities of Medical Staff membership.

5.8.2. Where an Applicant is eligible for expedited credentialing, the following procedures shall apply:

5.8.2.1. The respective Department Chair shall forward his written report and recommendation, the complete application, and supporting documents to the MEC within ten (10) days after his interview with the Applicant. If the Department Chair is unable to complete and submit his report within this time frame, he shall notify the Chair of the MEC and the Applicant of the delay, and shall indicate the reason(s) for the inability to report on the application.

5.8.2.2. The MEC shall review the application, supporting documentation, and the Department Chair's report and recommendations to ensure that the Applicant satisfies the established standards for Medical Staff membership and the requested Clinical Privileges, and that the Applicant is eligible for the expedited credentialing process. If the MEC so finds, it shall transmit its written report and recommendations, along with the report and recommendations of the respective Department Chair, the completed Application, and supporting documents to the Expedited Credentialing Process or Committee of the Board within thirty (30) days of receipt. If the MEC is unable to complete and submit its report and recommendation within this time frame, it shall notify the Board and the Applicant of the delay, and shall indicate the reason(s) for the inability to report on the application.

5.8.2.3. The Expedited Credentialing Process or Committee of the Board shall be a committee duly formed in accordance with the Hospital's Bylaws and shall consist of at least two (2) members of the Board. The Expedited Credentialing Process or Committee, acting on behalf of the Board, shall make the final decision on the application within ten (10) days of receipt. The full Board of Directors shall be notified of Medical Staff Appointments that have been made pursuant to this expedited process at its next regularly scheduled meeting,

and such notification shall be reflected in the minutes of the Board meeting.

5.9. Non-Expedited Credentialing Process

5.9.1. All applications for Appointment other than those described in subsection 5.7.1. above shall be reviewed and acted upon in accordance with the non-expedited credentialing process set forth in this subsection 5.8. In addition, any application originally identified as eligible for the expedited credentialing process shall revert to the non-expedited process described herein if the Department Chair, MEC, or Expedited Credentialing Process or Committee of the Board makes a recommendation or takes an action adverse to the Applicant in any respect, identifies an aspect of the application rendering it ineligible for expedited treatment, or determines that action upon the application must be deferred pending receipt of additional information.

5.9.2. When an application for Appointment is or becomes ineligible for the expedited credentialing process, the following procedures shall apply:

5.9.2.1. The respective Department Chair shall forward his written report and recommendation to the MEC within fifteen (15) days of his interview with the Applicant. If the Department Chair is unable to complete and submit his report within this time frame, he shall notify the Chair of the MEC and the Applicant of the delay, and shall indicate the reason(s) for his inability to report on the application.

5.9.2.2. The MEC shall consider the application at its next regularly scheduled meeting following receipt of the Department Chair's report and recommendations, the complete application, and supporting documents. The MEC shall review all materials to ensure that the Applicant satisfies the established standards for Medical Staff membership and the requested Clinical Privileges. The MEC may, at its discretion, conduct an interview with the Applicant, or designate one or more of its members to do so. Within thirty (30) days of receipt of the completed application, supporting documents, and the report and recommendations of the Department Chair, the MEC shall take one of the following three (3) actions:

5.9.2.2.1. Favorable recommendation: If the MEC's recommendation is favorable to the Applicant in all respects, the MEC shall forward its written report and recommendation; dissenting views, if any; the report and recommendations of the Department Chair; the application; and all supporting documentation to the Board.

5.9.2.2.2. Adverse recommendation: If the MEC's recommendation is adverse to the Applicant in any respect, the President of the Medical Staff shall provide the Applicant with Special Notice of the adverse recommendation, and the Applicant shall be entitled to the procedural rights set forth in the Fair Hearing Manual. The MEC shall forward its written report and recommendation; dissenting views, if any; the report and recommendations of the Department

Chair; the application, and all supporting documentation to the Board.

5.9.2.2.3. Deferral: Action by the MEC to defer an application for further consideration must be followed within thirty (30) days by its written report and recommendations to the Board. The Administrator shall provide an Applicant with Special Notice of such a deferral, including a request for the specific data/explanation, if any, required from the Applicant.

5.9.2.3. The Board of Directors shall consider the application; supporting documentation; and the reports, recommendations, and dissenting views, if any, of the Department Chair and the MEC.

5.9.2.3.1. The Board may, at its discretion, conduct an interview with the Applicant, or designate one or more of its members to do so.

5.9.2.3.2. The Board may adopt or reject, in whole or in part, a recommendation from the MEC, or may remand the recommendation to the MEC for further consideration, stating the reason(s) for such remand and establishing a time limit within which a subsequent recommendation must be made.

5.9.2.3.3. Within sixty (60) days of receipt of the MEC's initial report and recommendation, the Board shall take one of the following actions: (1) Appointment granted, requested Privileges granted; (2) Appointment granted, requested Privileges denied in whole or in part; or (3) Appointment denied.

5.9.2.3.4. If the Board's action with respect to an application for Medical Staff Appointment and/or Clinical Privileges is adverse to the Applicant in any respect, the President of the Hospital shall promptly provide the Applicant with Special Notice of such action, and the Applicant shall be entitled to the procedural rights set forth in the Fair Hearing Manual.

5.10. Time Periods for Action on Applications for Appointment

The time periods specified in this Section 5 are intended as a guide for achieving efficient completion of the Medical Staff Appointment and delineation of Clinical Privileges process. The Hospital or Medical Staff's lack of strict adherence to these guidelines does not entitle the Applicant to due process, hearing, or appeal rights and does not constitute a violation of this Credentialing Manual.

5.11. Special Notice of Final Decision

5.11.1. The Board, or in a case eligible for the expedited credentialing process, the

Expedited Credentialing Process or Committee of the Board, through the Administrator, shall notify the MEC and the Department Chair concerned of its final decision in writing, and shall provide the Applicant with Special Notice of such decision.

5.11.2 If the final decision of the Board, or in a case eligible for expedited credentialing, the final decision of the Expedited Credentialing Process or Committee of the Board, is to grant Medical Staff Appointment, Special Notice of such action to the Applicant shall include:

5.11.2.1. The Department(s) to which the Applicant is assigned;

5.11.2.2. The Clinical Privileges the Applicant may exercise; and

5.11.2.3. Any special conditions attached to the Appointment. Any Applicant who is not yet Board Certified may only be appointed for a term that does not extend beyond the five year period described in subsection 2.2.1.4. for obtaining Board Certification. If Board Certification is not yet obtained within the specified five-year period, the Member's membership and privileges shall automatically expire at the conclusion of that term of appointment. The Applicant cannot submit any application for reappointment until Board Certification is obtained. The contents of this subsection shall be set forth as Special Conditions attached to the Appointment.

5.11.3. If the Board's final decision is adverse to the Applicant in any respect, the Board's Special Notice of such action to the Applicant shall include:

5.11.3.1. The reason(s) for the adverse action; and

5.11.3.2. The Applicant's right to a hearing and appeal in accordance with the Fair Hearing Manual.

5.12. Reapplication after Adverse Action

5.12.1. An Applicant who has received Special Notice of a final adverse action regarding Medical Staff Appointment, Department assignment, or Clinical Privileges delineation is not eligible to reapply to the Medical Staff or for the denied Appointment, assignment, or Privileges delineation for a period of two (2) years. Any such reapplication is processed as an initial Application for Appointment.

5.12.2. Any Medical Staff Member who has been deemed to "voluntarily resign" for failure to apply for Reappointment, pay dues, or otherwise fulfill his obligations as a Member of the Medical Staff shall not be eligible to reapply to the Medical Staff for a period of one (1) year. Any such reapplication is processed as an initial Application for Appointment.

SECTION 6. REAPPOINTMENT TO THE MEDICAL STAFF

6.1. Requirement of Reappointment

Except as specified in subsection 2.6.5., at the conclusion of the term of a Medical Staff Member's Appointment or Reappointment, the Member must be affirmatively reappointed to the Medical Staff in order to continue to exercise the prerogatives and responsibilities of Medical Staff membership.

6.2. Basis of Reappointment

No member of the Medical Staff shall be reappointed to the same or another category of the Medical Staff, or shall be granted the same or increased Clinical Privileges without prior specific review and evaluation of the Member's performance and qualifications as specified in this Article. Each recommendation concerning the Reappointment of a Medical Staff Member and the Clinical Privileges to be granted upon Reappointment shall be based upon such Member's satisfaction of the qualifications for Medical Staff membership set forth in Section 2 of this Credentialing Manual and the addendum document (OPPE and FPPE policy manual).

6.3. Application for Reappointment

6.3.1. On or before six (6) months prior to the date of expiration of a Medical Staff Member's Appointment or Reappointment, the Administrator shall notify him of the date of expiration.

6.3.2. At least four (4) months prior to the expiration of his term of Appointment or Reappointment, the Member shall submit a written application for Reappointment to the Administrator on a form approved by the Board of Directors.

6.3.3. The application for Reappointment shall include or be accompanied by, without limitation, the following information:

6.3.3.1. The Medical Staff category and Department(s) to which Reappointment is requested, including justification for any changes in such assignment(s);

6.3.3.2. The specific Clinical Privileges, if any, that the Applicant is requesting, including justification for any change in requested Clinical Privileges from those granted during the current term of Appointment or Reappointment;

6.3.3.3. Information necessary to update the Applicant's immediately preceding application for Appointment or Reappointment to the Medical Staff, verified by primary sources whenever feasible, including but not limited to information concerning:

6.3.3.3.1. The Applicant's physical, mental, or emotional status to the extent that such status may have bearing upon the Applicant's ability to competently execute the Clinical Privileges for which he has applied, or to competently execute the other responsibilities of Medical Staff membership;

6.3.3.3.2. Any other hospital or health care institution or practice where the Applicant has been employed, appointed, and/or granted clinical

privileges during the current term of Appointment or Reappointment; and

6.3.3.3.3. Continuing medical education and training that the Applicant completed during the current term of Appointment or Reappointment;

6.3.3.4. Any pending or concluded action involving denial, revocation, suspension, reduction, limitation, probation, non-renewal or voluntary relinquishment of the Applicant's license or certificate to practice any profession in any state or country; DEA or other controlled substances registration; membership or fellowship in local, state or national professional organizations; faculty membership at any medical or other professional school; and medical staff membership status, prerogatives or clinical privileges at any other hospital, clinic or health care provider; and

6.3.3.5. Signature of the Applicant.

6.3.4. Effect of the Application

Upon signing the application, the Applicant:

6.3.4.1. Attests to the accuracy and completeness of all information furnished and agrees that any inaccuracy or omission is grounds for terminating the application process;

6.3.4.2. Signifies his willingness to appear for interviews in connection with his application, peer review, and performance improvement activities;

6.3.4.3. Agrees to abide by the terms of the Bylaws, rules and regulations, and policies and procedures of the Medical Staff and the Hospital, and any amendment thereto, if granted Reappointment and/or Clinical Privileges, and to abide by the terms thereof in all matters relating to consideration of the application without regard to whether or not Reappointment and/or Privileges are granted;

6.3.4.4. Pledges to provide for the continuous care of his patients;

6.3.4.5. Authorizes and consents to Hospital and Medical Staff representatives consulting with his prior and current Peers, associates and others who may have information bearing upon professional competence, character, ethical qualifications, ability to work cooperatively with others, ability to perform the Privileges requested, and other qualifications for Reappointment or Clinical Privileges;

6.3.4.6. Consents to Hospital and Medical Staff representatives' inspection of all records and documents that may be material to an evaluation of his professional and ethical qualifications and competence to carry out the Clinical Privileges requested, including the Applicant's health status as it may relate to his ability to competently execute the Clinical Privileges for which he has applied and to competently perform other responsibilities of Medical Staff membership;

6.3.4.7. Extends immunity to and releases from all claims, damages, and liability the Hospital, the Medical Staff, and any employee, officer, director, agent, or representative thereof;

6.3.4.8. Authorizes and consents to Hospital representatives providing other hospitals, medical associations, licensing boards, and other organizations concerned with Practitioner performance and the quality and efficiency of patient care, with any information relevant to such matters that the Hospital may have concerning him, and releases the Hospital and Hospital representatives from liability for so doing;

6.3.4.9. Signifies that he has read the current Medical Staff Bylaws and Manuals incorporated by reference therein, has completed the Medical Staff Orientation packet and agrees to abide by their provisions in regard to his application for Reappointment to the Medical Staff and for delineation of Clinical Privileges; and

6.3.4.10. Agrees to provide to the Administrator updated information concerning information requested on the Reappointment application or Privileges request form.

6.3.4.11 Signs all release of information regarding volume and activity at affiliate hospitals, quality and patient safety outcomes data, provide information to validate competency for continued privileges (i.e. low volume activity at FWMC).

6.3.5. Applicant's Burden

6.3.5.1. The Administrator shall notify the Applicant of any information or verification deficiencies concerning the application for Reappointment. The Applicant has the burden of producing adequate information and/or verification within thirty (30) days prior to the conclusion of the current term of Appointment or Reappointment.

6.3.5.2. The Applicant bears the burden of resolving any doubts about any qualifications for Medical Staff membership or the requested Staff category, Department assignment(s), or Clinical Privileges, and of satisfying any reasonable request for information or clarification made by appropriate Medical Staff or Board authorities.

6.3.5.3. If there is any question concerning the Applicant's physical, mental, or emotional status that may have bearing upon the Applicant's ability to practice his profession and/or to competently perform the Clinical Privileges for which he has applied, the Hospital may require, at the Applicant's expense, an examination of the Applicant by an independent qualified practitioner acceptable to the MEC.

6.3.5.4. Absent good cause, an Applicant's failure to provide requested information or verification by the conclusion of the current term of Appointment or Reappointment shall result in automatic suspension of Medical Staff

membership for a period not to exceed thirty (30) days. The Applicant's failure to provide the requested information or verification by the end of the suspension period shall be deemed a voluntary resignation from the Medical Staff. Once the Member has been deemed to have voluntarily resigned from the Medical Staff, he must reapply for Initial Appointment and Clinical Privileges in accordance with Section 5 of this Credentialing Manual.

6.4. Additional Information Collection and Verification

6.4.1. Information from Internal Sources

The Administrator shall collect for each Applicant's credentials file relevant information regarding the Applicant's professional and collegial activities during the current term of Appointment or Reappointment, including without limitation:

6.4.1.1. Quality of patient care as demonstrated by performance improvement and peer review activity data and findings, including FPPE and OPPE;

6.4.1.2. Participation in relevant internal teaching and continuing education activities;

6.4.1.3. Number of Patient Encounters at the Hospital;

6.4.1.4. Sanctions imposed or pending and other such actions;

6.4.1.5. Attendance at general Medical Staff meetings, Departmental meetings, and committee meetings;

6.4.1.6. Fulfillment of any applicable Departmental on-call emergency department coverage responsibilities;

6.4.1.7. Timely and accurate completion of medical records;

6.4.1.8. Cooperation working with other Practitioners and Hospital personnel;

6.4.1.9. Professional conduct toward patients;

6.4.1.10. Professional conduct in furtherance of Hospital and Medical Staff purposes, programs and objectives;

6.4.1.11. Compliance with all applicable Bylaws, rules, regulations, policies and procedures of the Hospital and Medical Staff;

6.4.1.12. Two peer recommendations will be obtained for applicants with insufficient peer review activity at the hospital.

6.4.1.13. Relevant practitioner specific data compared to aggregated data, when available; and

6.4.1.14. Morbidity and mortality data, when available.

6.4.2. Information from External Sources

The Administrator shall collect for each Applicant's credentials file, and verify from primary sources whenever feasible, information concerning, without limitation:

6.4.2.1. Licensure and Board Certification during the current term of Appointment or Reappointment;

6.4.2.2. DEA and MDDC registration during the current term of Appointment or Reappointment;

6.4.2.3. Professional liability insurance coverage, including but not limited to the Applicant's present professional liability insurance carrier, current limits of coverage, current types of coverage, any restrictions upon coverage, claims made during the current term of Appointment or Reappointment, and whether the Applicant has maintained continuous coverage during the current term of Appointment or Reappointment;

6.4.2.4. Professional malpractice claims filed against the Applicant during the current term of Appointment or Reappointment, including evidence of unusual pattern or an excessive number of professional liability actions resulting in a final judgment of the applicant;

6.4.2.5. Complaints or professional sanctions concerning the Applicant during the current term of Appointment or Reappointment, including without limitation all such complaints or sanctions as set forth in subsection 5.2.8. of this Credentialing Manual;

6.4.2.6. Activities at other hospitals or health care facilities during the current term of Appointment or Reappointment, including voluntary or involuntary termination of medical staff membership or voluntary or involuntary limitation, reduction or loss of clinical privileges; and

6.4.2.7. Information from the Maryland State Board of Physician Quality Assurance and the National Practitioner Data Bank, or such other agency designated by the Secretary, Department of Health and Human Services, concerning the Practitioner or the Practitioner's activity during the current term of Appointment or Reappointment.

6.4.2.8. Verify the individual requesting privileges is the same individual identified in the credentialing documents by requesting photo identification, if necessary. If the applicant declines to submit a photo ID, the Credentials Committee will determine other suitable means to verify the applicant's identification.

6.5. Initial Review of Application for Reappointment

6.5.1. The Administrator shall transmit the completed application and all supporting documents to the Chair of the Department to which application for Reappointment has been made within five (5) days of the application's becoming complete. An application shall be considered complete when:

6.5.1.1. All blanks on the application form are filled in and necessary additional

explanations and supporting documentation are provided; and

6.5.1.2. The Administrator has received all additional information from internal and external sources and has verified all information from primary sources whenever feasible.

6.5.2. The respective Department Chair shall:

6.5.2.1. Review the completed application and supporting documents;

6.5.2.2. Interview the Applicant if desired, and, if such interview is conducted, complete an interview form approved by the MEC and the Board of Directors;

6.5.2.3. Assess the credentials of the Applicant; and

6.5.2.4. Prepare a written report and recommendation concerning whether the Applicant's credentials are satisfactory or unsatisfactory for the Reappointment and Clinical Privileges requested. If the Applicant's credentials are deemed satisfactory, the report shall include recommendations concerning the specific Privileges to be granted to the Applicant.

6.6. Content of Reports and Basis for Recommendations and Actions

The report of each individual or group, including the Board, required to act on an application for Reappointment must include recommendations as to approval or denial of, and any special limitations on, Staff appointment, category of Staff membership, Department affiliation, and scope of Clinical Privileges. The reasons for each adverse recommendation or action taken must be specifically stated, with reference to the completed application and all other documentation considered. For the purposes of this Section 6, "adverse action" or "adverse recommendation" means an action or recommendation to deny Reappointment, deny the requested Staff category for which the Applicant is eligible, deny the requested Department assignment, or deny, restrict, or modify the requested Clinical Privileges.

6.7. Expedited Credentialing Process

6.7.1. To the extent permitted by applicable laws, regulations, and accreditation standards, applications for Reappointment to the Medical Staff shall be processed in the expedited fashion. In order to be eligible for the Expedited Credentialing Process, the applicant must have submitted an application that is deemed complete and the MEC must make a final recommendation that is not adverse or with limitations. Additionally criteria that may be evaluated on a case-by-case basis for the eligibility for this process are:

6.7.1.1. The Applicant's license to practice a health occupation in any jurisdiction, or the applicant's DEA, MDDC, or other controlled substances registration, has not been restricted, suspended, revoked, limited, or subject to probation or reprimand during the current term of Appointment or Reappointment, and there is no current challenge to such license or registration;

6.7.1.2. A complaint or report was not filed against the Applicant with the Board of Physician Quality Assurance or with any other medical disciplinary body during the current term of Appointment or Reappointment;

6.7.1.3. The Applicant was not excluded from participation in any federal health care program, and was not the subject of any civil or criminal investigation concerning alleged health care fraud and/or abuse during the current term of Appointment or Reappointment;

6.7.1.4. The Applicant has not lost Board Certification during the current term of Appointment or Reappointment;

6.7.1.5 The Applicant's privileges at any hospital were not voluntarily or involuntarily suspended, revoked, limited, denied, or subject to condition, probation, reprimand or warning, or not renewed, and the Applicant was not the subject of an investigation at any hospital, during the current term of Appointment or Reappointment;

6.7.1.6. The Applicant's membership in any medical organization (including but not limited to a medical staff, ambulatory surgical center, HMO or PPO) has not been denied, revoked, or involuntarily terminated, and the Applicant has not been subject to any disciplinary proceedings in any medical organization during the current term of Appointment or Reappointment;

6.7.1.7. There has not been a final judgment adverse to the Applicant in a professional liability action or in any other civil, criminal, administrative or other proceeding in any jurisdiction during the current term of Appointment or Reappointment;

6.7.1.8. The Applicant has not had a malpractice claim settled on his behalf by a professional liability insurance carrier, even if no formal action was filed in a court or arbitration panel, during the current term of Appointment or Reappointment;

6.7.1.9. The Applicant has maintained continuous professional malpractice insurance, and the Applicant's malpractice insurance has not been limited, revoked, or not renewed by any company, medical society, or organization (other than because the carrier withdrew from the market) during the current term of Appointment or Reappointment; and

6.7.1.10. The Administrator, the Department Chair, the MEC, or a Member of the Board has identified no other aspect of the Applicant's performance as a Medical Staff Member during the current term of Appointment or Reappointment that may have an unfavorable bearing upon the Applicant's ability to practice his profession including an unusual pattern of, or an excessive number of professional liability actions resulting in a final judgment against the applicant; to competently perform the Clinical Privileges for which he has applied; and/or to fulfill the other responsibilities of Medical Staff membership.

6.7.2. Where an Applicant is eligible for expedited credentialing, the following procedures shall apply:

6.7.2.1. The respective Department Chair shall forward his written report and recommendation, the completed application, and supporting documents to the Chair of the MEC within ten (10) days of his receipt of the completed application and credentials file. If the Department Chair is unable to complete

and submit his report within this time frame, he shall notify the Chair of the MEC and the Applicant of the delay, and shall indicate the reason(s) for the inability to report on the application.

6.7.2.2. The MEC shall review the application, supporting documentation, and the Department Chair's report and recommendations to ensure that the Applicant satisfies the established standards for Medical Staff membership and the requested Clinical Privileges, and that the Applicant is eligible for the expedited credentialing process. If the MEC so finds, it shall transmit its written report and recommendations, along with the reports and recommendations of the respective Department Chair, the completed Application, and supporting documents to the Expedited Credentialing Process or Committee of the Board within thirty (30) days of receipt. If the MEC is unable to complete and submit its report and recommendation within this time frame, it shall notify the Board and the Applicant of the delay, and all indicate the reason(s) for the inability to submit its report and recommendations on the application.

6.7.2.3. The Expedited Credentialing Committee of the Board shall be a committee duly formed in accordance with the Hospital's Bylaws and shall consist of at least two (2) members of the Board. The Expedited Credentialing Process or Committee, acting on behalf of the Board, shall make the final decision on the application within ten (10) days of receipt. The full Board of Directors shall be notified of Medical Staff Reappointments that have been made pursuant to this expedited process at its next regularly scheduled meeting, and such notification shall be reflected in the minutes of the Board meeting.

6.8. Non-Expedited Credentialing Process

6.8.1. All applications for Reappointment other than those described in subsection 6.7.1. above shall be reviewed and acted upon in accordance with the non-expedited credentialing process set forth in this subsection 6.8. In addition, any application originally identified as eligible for the expedited credentialing process shall revert to the non-expedited process described herein if the Department Chair, MEC, or Expedited Credentialing Process/Committee of the Board makes a recommendation or takes an action adverse to the Applicant in any respect, identifies an aspect of the application rendering it ineligible for expedited treatment, or determines that action upon the application must be deferred pending receipt of additional information.

6.8.2. When an application for Reappointment is or becomes ineligible for the expedited credentialing process, the following procedures shall apply:

6.8.2.1. The respective Department Chair shall forward his written report and recommendations to the MEC within fifteen (15) days of his receipt of the complete application and credentials file. If the Department Chair is unable to complete and submit his report within this time frame, he shall notify the Chair of the MEC and the Applicant of the delay, and shall indicate the reason(s) for his inability to report on the application.

6.8.2.2. The MEC shall consider the application at its next regularly scheduled meeting following receipt of the Department Chair's report and recommendation, the

complete application, and supporting documents. The MEC shall review all materials to ensure that the Applicant satisfies the established standards for Medical Staff membership and the Clinical Privileges requested. The MEC may, at its discretion, conduct an interview with the Applicant, or designate one or more of its members to do so. Within thirty (30) days of receipt of the completed application, supporting documents, and the report and recommendations of the Department Chair, the MEC shall take one of the following three (3) actions:

6.8.2.2.1. Favorable recommendation: If the MEC's recommendations are favorable to the Applicant in all respects, the MEC shall forward its written report and recommendations; dissenting views, if any; the report and recommendations of the Department Chair; the application; and all supporting documentation to the Board.

6.8.2.2.2. Adverse recommendation: If the MEC's recommendations are adverse to the Applicant in any respect, the President of the Medical Staff shall provide the Applicant with Special Notice of the adverse recommendations, and the Applicant shall be entitled to the procedural rights set forth in the **Fair Hearing Manual**. The MEC shall forward its written report and recommendations; dissenting views, if any; the report and recommendations of the Department Chair; the application, **and all supporting documentation to the Board.**

6.8.2.2.3. Deferral: **Action by the MEC to defer an application for further consideration must be followed within thirty (30) days by its written report and recommendations to the Board.** The Administrator shall provide an Applicant with Special Notice of such a deferral, including a request for the specific data/explanation, if any, required from the Applicant.

6.8.2.3. The Board of Directors shall consider the application; supporting documentation; and the reports, recommendations, and dissenting views, if any, of the Department Chair and the MEC.

6.8.2.3.1. The Board may, at its discretion, conduct an interview with the Applicant, or designate one or more of its members to do so.

6.8.2.3.2. The Board may adopt or reject, in whole or in part, a recommendation from the MEC, or may remand the recommendation to the MEC for further consideration, stating the reason(s) for such remand and establishing a time limit within which a subsequent recommendation must be made.

6.8.2.3.3. Within sixty (60) days of receipt of the MEC's initial report and recommendations, the Board shall take one of the following actions: (1) Reappointment granted, requested Privileges granted; (2) Reappointment granted, requested Privileges denied in whole or in part; or (3) Reappointment denied.

6.8.2.3.4. If the Board's action with respect to an application for Medical Staff Reappointment and/or Clinical Privileges is adverse to the Applicant in any respect, the President of the Hospital shall promptly provide the Applicant with Special Notice of such action, and the Applicant shall be entitled to the procedural rights set forth in the Fair Hearing Manual.

6.9. Time Periods for Action on Applications for Reappointment

6.9.1. The time periods specified in this Section 6 are intended as a guide for achieving efficient completion of the Reappointment process. If Reappointment processing has not been completed by the expiration of a Medical Staff Member's current term of Appointment or Reappointment, through no fault of the Medical Staff Member, the Member shall maintain his current membership status and Clinical Privileges until the time that processing is completed and the Board, or the Expedited Credentialing Committee of the Board, takes final action on the application for Reappointment, unless corrective action is taken with respect to all or any part thereof.

6.9.2. If the delay is attributable to the Medical Staff Member's failure to provide information required to complete the Reappointment process, his Staff membership shall terminate on the last day of the current term of Appointment or Reappointment

6.10. Special Notice of Final Decision

6.10.1. The Board, or in a case eligible for the expedited credentialing process, the Expedited Credentialing Committee of the Board, through the Administrator, shall notify the MEC and the Chair of each Department concerned of its final decision in writing, and shall provide the Applicant with Special Notice of such decision.

6.10.2. If the final decision of the Board, or in a case eligible for expedited credentialing, the final decision of the Expedited Credentialing Committee of the Board, is to grant Medical Staff Reappointment, Special Notice of such action to the Applicant shall include:

6.10.2.1. The Department(s) to which the Applicant is assigned;

6.10.2.2. The Clinical Privileges the Applicant may exercise; and

6.10.2.3. Any special conditions attached to the Appointment. Any Applicant who is not yet Board Certified may only be appointed for a term that does not extend beyond the five-year period described in subsection 2.2.1.4. for obtaining Board Certification. If Board Certification is not yet obtained within the specified five-year period, the Member's membership and privileges shall automatically expire at the conclusion of that term of appointment. The Applicant cannot submit any application for reappointment until Board Certification is obtained. The contents of this subsection shall be set forth as Special Conditions attached to the Appointment.

6.10.3. If the Board's final decision is adverse to the Applicant in any respect, the Board's Special Notice to the Applicant of such action shall include:

6.10.3.1. The reason(s) for the adverse action; and

6.10.3.2. The Applicant's right to a hearing and appeal in accordance with the Fair Hearing Manual.

6.11. Reapplication after Adverse Action

6.11.1. An Applicant who has received Special Notice of a final adverse action regarding Medical Staff Reappointment, Department assignment, or Clinical Privileges delineation is not eligible to reapply for the denied Reappointment, assignment, or Privileges delineation for a period of two (2) years. Any such reapplication is processed as an initial Application for Appointment.

6.11.2. Any Medical Staff Member who has been deemed to have voluntarily resigned for failure to apply for Reappointment, pay dues, or otherwise fulfill his obligations as a Member of the Medical Staff shall not be eligible to reapply to the Medical Staff for a period of one (1) year. Any such reapplication is processed as an initial Application for Appointment.

SECTION 7. CLINICAL PRIVILEGES

7.1. Clinical Privileges Restricted

7.1.1. Practitioners practicing at Fort Washington Medical Center shall be entitled to exercise only those Clinical Privileges specifically granted by the Board of Directors, or the Expedited Credentialing Committee of the Board, upon the recommendation of the MEC, except as otherwise specified in this Credentialing Manual.

7.1.2. A Practitioner's exercise of Clinical Privileges within any Department is subject to the Medical Staff Rules and Regulations and the OPPE and FPPE policy manual.

7.2. Application for Clinical Privileges

7.2.1. Application for Staff Appointment or Reappointment must contain a request for the specific delineation of Clinical Privileges desired by the Applicant or Member, if any, and the Applicant's or Member's current licensure, relevant training or experience, current competence, and other qualifications that relate to the Applicant's ability to perform the requested Privileges. Requests for delineation of Privileges must be submitted in writing on a prescribed form furnished by the Hospital and approved by the Board, and shall be processed concurrently with and in the same manner as applications for Appointment or Reappointment to the Medical Staff, as appropriate.

7.2.2. Requests for additional or revised Clinical Privileges may be made during a term of Appointment or Reappointment and shall be processed in the same manner as an application for Reappointment as set forth in Section 6 of this Credentialing Manual, but do not substitute for an upcoming Reappointment.

7.2.3. The Applicant shall have the burden of establishing his qualifications and competence with regard to the requested Clinical Privileges.

7.3. Delineation of Clinical Privileges

Upon recommendation of the MEC, the Board of Directors shall grant Clinical Privileges in accordance with the Applicant's demonstrated current ability to exercise such Privileges in a manner consistent with quality patient care. Factors to be considered in granting Clinical Privileges include without limitation the Applicant's current licensure, relevant training and continuing education, documented experience in the treatment area or procedure, treatment outcomes, conclusions drawn from Hospital performance improvement activities when available, Board Certification, and/or other indication of current competence and ability to exercise the Privileges requested.

7.4. Emergencies

7.4.1. In the case of an emergency, any Member of the Medical Staff, to the degree permitted by his license and regardless of service or Staff status, shall be permitted, encouraged and assisted to do everything possible to save the life of a patient, using every facility of the Hospital necessary, including requests for any consultation necessary or desirable.

7.4.2. When an emergency situation no longer exists, such Medical Staff Member must request the Privileges necessary to continue to treat the patient. In the event such Privileges are denied or the Medical Staff Member does not desire to request the

Privileges necessary to continue to treat the patient, the patient shall be assigned to an appropriate Member of the Medical Staff.

7.4.3. For the purpose of this subsection 7.4, an "emergency" is defined as a condition in which serious permanent harm would result to a patient or in which the life of a patient is in immediate danger and any delay in administering treatment would add to that danger.

7.5. Special Conditions for Dental Privileges

7.5.1. The scope and extent of surgical procedures that each dentist Staff Member may perform shall be specifically delineated and granted in the same manner as all other surgical procedures for all other Practitioners. Dental Practitioners shall provide the same level of care as Physicians when performing the same procedures.

7.5.2. Dental Members of the Medical Staff may be granted Privileges to admit dental patients to the Hospital. At the time of admission, the Dentist must designate a Physician who will have primary medical responsibility for the patient. The names of both the admitting dentist and the designated Physician are required on the admitting form.

7.5.3. All dental patients must have an admission dental history and physical examination. All dental patients shall have the same basic medical appraisal as other patients admitted to the Hospital. The designated Physician Member of the Medical Staff shall be responsible for the care of any medical problem that may be present at the time of admission or that may arise during hospitalization.

7.5.4. Oral surgeons who admit a patient without medical problems may solely admit the patient, may complete an admission history and physical examination and may assess the medical risks of the procedure to the patient if qualified and approved to do so by the Board of Directors.

7.6. Special Conditions for Podiatric Privileges

7.6.1. The scope and extent of surgical procedures that each podiatrist Staff Member may perform shall be specifically delineated and granted in the same manner as all other surgical procedures for all other Practitioners. No Privileges may be delineated that entitle a Podiatrist licensed by the Maryland Board of Podiatry Examiners to perform podiatric acts that are beyond the scope of the license held. Podiatric Practitioners shall provide the same level of care as Physicians when performing the same procedures.

7.6.2. Podiatric Members of the Medical Staff may be granted Privileges to admit podiatric patients to the Hospital. At the time of admission, the podiatrist must designate a Physician who will have primary medical responsibility for the patient. The names of both the admitting podiatrist and the designated Physician are required on the admitting form.

7.6.3. All podiatric patients must have a podiatric admission history and physical examination. All podiatric patients shall have the same basic medical appraisal as other patients admitted to the Hospital. The designated Physician Member of the Medical Staff shall be responsible for the care of any medical problem that may be present at the time of

admission or that may arise during hospitalization.

7.6.4. No podiatrist shall be responsible for the care of any medical problem or condition of a podiatric patient. The designated Physician Practitioner must perform all medical duties related to the care of a podiatric patient, including the determination of the risk and effect of any podiatric procedure to the patient.

7.7. Development of New or Revised Privileging Criteria

7.7.1. Any Practitioner, upon the approval of his Department Chair, may initiate a recommendation for the development of professional criteria for Clinical Privileges in an area for which no approved privileging criteria currently exist, or for the revision of existing criteria for specific Clinical Privileges.

7.7.2. If the area for which the development or revision of privileging criteria is sought involves the use of new technology or a new treatment procedure or protocol, the Practitioner(s) initiating the recommendation shall provide the MEC with a full briefing of the technique or procedure, as outlined in the "Privileging for New Techniques/Procedures" policy, including:

7.7.2.1. Information concerning the development of the new technology, procedure, or protocol;

7.7.2.2. The names of other hospitals in which it is used;

7.7.2.3. Any peer reviewed research demonstrating the risks and benefits of the technology, procedure, or protocol;

7.7.2.4. Any product literature or educational syllabus addressing the technology, procedure, or protocol; and

7.7.2.5. The names of any residency training directors responsible for providing training in the area.

7.7.3. The MEC shall consider the material and shall make a recommendations for final action by the Board of Directors concerning the establishment or revision of privileging criteria and proposal for new medical staff privileges. Such recommendation shall include without limitation whether the technology, procedure, or protocol should be conducted at the Hospital and, if so, shall propose new or revised criteria to be used in reviewing requests for Clinical Privileges in the area. Such criteria shall be developed in consultation with members of the relevant Department of the Medical Staff and shall be designed to ensure high quality patient care. The MEC and Hospital Leadership will meet to discuss new services and any new privileges associated with the new service line to discuss the impact of the proposed procedure/technique on hospital regulatory impact, financial impact, staffing needs, space needs, equipment needs, and training needs. Anyone on the leadership team has the authority and responsibility to bring recommendations and considerations related to hospital staff issues and support systems to the Leadership Team, MEC and the Governing Body at any time throughout the consideration of any new service line and recommendations for new medical staff privileges. When any member of the medical staff requests additional or new privileges, the medical staff office must run a current national practitioner data bank report within 30

days prior to approval of new or additional medical staff privileges.

7.8. Temporary Clinical Privileges

7.8.1. Temporary Clinical Privileges may be granted under the specific conditions set forth herein. No Medical Staff voting rights or due process, hearing, and appeal rights shall accrue to Clinical Privileges granted under this subsection 7.8.

7.8.2. The respective Department Chair may impose special supervision and reporting requirements upon any Practitioner granted Temporary Privileges pursuant to this subsection.

7.8.3 Temporary Privileges shall be immediately terminated by the President of the Hospital upon notice of the Practitioner's failure to comply with such special conditions, or to comply with Hospital and Medical Staff Bylaws, rules, regulations, policies, and procedures.

7.8.4. The President of the Hospital or his designee, upon recommendation of the respective Department Chair, or upon recommendation of the President of the Medical Staff, may grant Temporary Privileges to a Practitioner who does not hold a current Appointment or Reappointment to the Medical Staff if the granting of such Temporary Clinical Privileges is necessary to fulfill an important patient care need.

7.8.5. A grant of Temporary Privileges shall be limited in duration to the briefest period reasonably necessary to meet the important patient care need, and shall in no event exceed a period of one hundred twenty (120) days.

7.8.6. A request for Temporary Privileges must be accompanied by the following information:

7.8.6.1. A completed application for Medical Staff Appointment, signed by the Applicant;

7.8.6.2. A completed delineation of Privileges form for the applicable Department, signed by the Applicant and Department Chair;

7.8.6.3. Current copies of the Applicant's:

7.8.6.3.1. Maryland medical license, or in the case of Temporary Consulting Privileges and to the extent permitted by law, a license to practice medicine in another state of the United States;

7.8.6.3.2. DEA and MDDC registration;

7.8.6.3.3. Malpractice insurance policy;

7.8.6.3.4. Evidence of current competence; and

7.8.6.3.4. To the extent feasible, evidence of primary source verification of the information listed in subsection 6.4.2 above. When temporary privileges are granted for an important patient care need at a

minimum current licensure and current competency MUST be primary source verified prior to granting temporary privileges.

7.9 Disaster Privileges

Disaster clinical privileges may be granted under the specific conditions set forth herein and as described in the Emergency Management Operations Plan. No Medical staff voting rights or due process, hearing, and appeal rights shall accrue to Clinical Privileges granted under this subsection 7.9.

7.9.1 Implementation of Process - Disaster privileges will only be granted when the following two conditions are present:

7.9.1.1. The Emergency Management Operation Plan has been activated; and

7.9.1.2. The organization is unable to meet immediate patient needs.

7.9.2 Responsibility for Granting Disaster Privileges

7.9.2.1. Disaster privileges will be made on a case-by case basis in accordance with the needs of the organization and its patients, and on the qualifications of the VLIP.

7.9.2.2. The individual(s) responsible for assigning disaster privileges and responsible for granting privileges are, in the following order:

- President of the Medical Staff/Chief of Staff or his/her designee;
- Medical Staff member directing triage or his/her designee;
- Hospital Administrator or his/her designee;
- Chief Medical Officer or his/her designee.

7.9.3 Identification - Volunteer practitioners will be issued a Disaster Identification Badge when signing into the Command Center in accordance with the organization's Emergency Operations Management Plan. Badges will distinguish these individuals as volunteer practitioners.

7.9.4 Management and Oversight of Volunteer Licensed Independent Practitioners (VLIPs)

7.9.4.1 All volunteer practitioners will be expected to sign-in at the Command Center. A record will be made of name, professional affiliation/specialty, and any current hospital/clinic affiliations. The initial verification process as defined below will also be initiated.

7.9.4.2 The Incident Commander or Medical Director responsible for coordination of the Command Center or his/her designee, will assign volunteer practitioners to appropriate areas as needed in accordance with the hospital's Emergency Operations Management Plan and patient needs.

7.9.4.3 If possible, the volunteer practitioner will be paired with a current member of the medical staff with similar privileges.

7.9.4.4 Oversight of the professional performance of volunteer practitioners assigned disaster privileges will be through observation and clinical review by an assigned medical staff member. Feedback may also be requested from hospital staff working with the volunteer practitioner.

7.9.4.5 Volunteer practitioners will sign a statement attesting that the individual agrees to be bound by all hospital policies and rules/regulation.

7.9.5 Verification Process

Initial Verification Process

7.9.5.1. In order be eligible for disaster privileges, VLIPs must at a minimum present a valid government-issued photo identification issued by a state or federal agency (e.g., driver's license or passport) and at least one of the following:

- A current hospital picture identification card that clearly identifies the professional designation;
- A current license to practice;
- Primary source verification of the license;
- Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT), or Medical Reserve Corp (MRC), Emergency System Advance Registration of Volunteer Health Professionals (ESAR-VHP) or other recognized state or federal organizations or groups;
- Identification indicating that the individual has been granted authority by a government entity to provide patient care, treatment and services in disaster circumstances (such authority having been granted by a federal, state, or municipal entity); or
- Confirmation by a licensed independent practitioner currently privileged by the hospital or by a staff member with personal knowledge of the volunteer practitioners' ability to act as a licensed independent practitioner during a disaster.

Primary Source Verification

7.9.5.2. Primary source verification is only required if the volunteer practitioner provides care, treatment or services under the disaster privileges.

7.9.5.3. The Medical Staff Office Coordinator or his/her designee(s) are responsible for obtaining primary source verification. All elements required for temporary privileges will be primary source verified to the extent possible prior to granting disaster privileges.

7.9.5.4. Primary source verification of licensure begins as soon as the immediate situation is under control or within 72 hours from the time the volunteer practitioner presents to the organization, whichever comes first.

7.9.5.5. In the extraordinary circumstance that primary source verification cannot be completed within 72 hours (e.g., no means of communication or lack of resources), it is expected that primary source verification will be completed as

soon as possible. In these extraordinary circumstances, there must be documentation of the following:

- Reasons(s) it could not be performed within 72 hours of the volunteer practitioner's arrival;
- Evidence of the volunteer practitioner's demonstrated ability to continue to provide adequate care, treatment, and services; and
- Evidence of the organization's attempts to perform primary source verification as soon as possible.

7.9.6 Continuation/Suspension/Termination of Disaster Privileges

7.9.6.1. Within 72 hours of the volunteer practitioner being granted disaster privileges, the President of the Medical Staff/Chief of Staff or his/her designee will make a determination as to whether the volunteer practitioner disaster privileges should be continued as initially granted.

7.9.6.2. The President of the Medical Staff/Chief of Staff or his/her designee is responsible for making this determination based on information obtained regarding the professional practice of volunteer practitioner from the assigned medical staff member and hospital staff, as appropriate.

7.9.6.3. All disaster privileges are terminated when the Emergency Operations Management Plan is no longer activated.

7.9.6.4. On the discovery of any information or the occurrence of any event of a professionally questionable nature concerning a volunteer practitioner's qualifications or ability to exercise any or all of the disaster privileges granted, the President of the Medical Staff/Chief of Staff or his/her designee may terminate any or all of the volunteer practitioners disaster privileges. Where the life or well-being of a patient is endangered by continued treatment by the volunteer practitioner, the termination may be effected by any person entitled to impose summary suspensions as described in the Medical Staff Bylaws. In the event of any such termination, the volunteer practitioner's patients shall be assigned to another medical staff member by the President of the Medical Staff/Chief of Staff or his/her designee. The wishes of the patient shall be considered, if feasible, in choosing a substitute.

7.9.6.5. Individuals granted disaster privileges shall not be entitled to the procedural rights afforded by Medical Staff Bylaws.

7.10 Telemedicine Privileges

Per the Centers for Medicare and Medicaid Services (CMS), telemedicine is the provision of clinical services to patients by physicians and practitioners from a distant-site via electronic communication. The distant-site telemedicine physician, practitioner or entity provides clinical services to the Hospital either simultaneously, as may be the case in real-time consultations (synchronous) with patients (i.e. telepsych, teleintensivist or telestroke services), or non-simultaneously (asynchronous) as may be the case in teleradiology and telepathology.

7.10.1. The Hospital will have written agreements with distant-site hospitals or telemedicine entities in accordance CMS standards set forth at 42 CFR § 482.12 (a)(1) through (a)(9) and 42 CFR § 482.22 (a)(1) through (a)(4); and Joint Commission Standards MS.06.01.01 through MS.06.01.13;

7.10.2. The Board will grant privileges to each telemedicine physician or practitioner providing services at Fort Washington Medical Center (FWMC) under an agreement with the distant-site hospital or telemedicine entity before they may provide telemedicine services at FWMC.

7.10.3. The Medical Executive Committee in collaboration with Department Chairperson will evaluate the organization's ability to safely provide telemedicine services on an ongoing basis, to include recommending to the Board which clinical services are appropriately delivered by physicians or practitioners through this medium, the clinical services offered are consistent with commonly accepted quality standards, and applicable state regulations and scopes of practice are met.

7.10.4. Practitioners providing telemedicine services limited to second opinions do not require privileges at this Hospital.

7.10.5. Termination of the contract which carries with it termination of a telemedicine practitioner's privileges is not subject to the Fair Hearing Plan. If the distant-site's participation in Medicare is terminated, either voluntarily or involuntarily, at any time during the agreement with the receiving Hospital, then, as of the effective date of the termination, the Hospital may no longer receive telemedicine services under the agreement with the distant site, hospital, and provider or telemedicine entity.

7.10.6. Telemedicine credentials and privileges may be withdrawn by action of the President/CEO, the Board, or the Medical Executive Committee at any time and in accordance with defined contracts.

7.10.7. Telemedicine privileges will be granted pursuant to the following:

7.10.7.1 The option used for granting telemedicine privileges may be dependent on the scope of care, treatment and services provided. The option identified must be consistent for all requests from the same distant-site providing the same care, treatment and services.

7.10.7.2 The MEC will recommend to the Board the option to be utilized for granting telemedicine privileges for the distant-site. The Board will approve the option to be used for the distant site and the written agreement with the distant-site will include the option utilized and required elements concerning credentialing and privileging of telemedicine physicians and practitioners.

7.10.7.3 The options that may be used are as follows:

7.10.7.3.1. The practitioner is fully credentialed and privileged at FWMC in accordance with the FWMC Bylaws, Credentialing Manual, OPPE, FPPE, an the Rules and Regulations; or

7.10.7.3.2. When making recommendations to the Board, the medical staff may rely upon the credentialing and privileging decisions made by the distant-site hospital or entity. If this option is utilized all of the following requirements must be met:

7.10.7.3.2.1 The distant-site hospital or entity is Joint Commission accredited and is a Medicare participant, or if the distant site is a telemedicine entity (not a hospital), the distant site must be Joint Commission accredited; and

7.10.7.3.2.2 The individual distant-site physician or practitioner is privileged at the distant-site hospital or telemedicine entity; and

7.10.7.3.2.3 The distant-site hospital or entity providing the telemedicine services provides a current list of the distant-site physician's or practitioner's privileges at the distant-site and pertinent licensure information; and

7.10.7.3.2.4 The individual distant-site physician or practitioner holds a license issued or recognized by the state of Maryland; and

7.10.7.3.2.5 With respect to a distant-site physician or practitioner who holds current privileges at FWMC, FWMC will have evidence of an internal review of the distant-site physician's or practitioner's performance of these privileges and sends the distant-site such performance information for use in the periodic appraisal of the distant-site physician or practitioner. At a minimum, this information must include all adverse events that result from the telemedicine services provided by the distant-site physician or practitioner to FWMC's patients (including but not limited to adverse outcomes related to events considered reviewable by the Joint Commission) and all complaints the hospital has received about the distant-site physician or practitioner.

7.10.8. If the Board exercises the option to grant privileges based on its medical staff recommendations that rely upon the distant-site telemedicine entity or hospital, the FWMC medical staff office may, but is not required to, maintain a separate file on each telemedicine physician and practitioner, but may instead have a file on all telemedicine physicians and practitioners providing services at FWMC under each agreement with a distant-site, indicating which telemedicine service privileges FWMC has granted to each physician or practitioner on the list.

7.10.9 Telemedicine physicians are exempt from immunization requirements (i.e. PPD/Flu Vaccine) since these are remote physicians performing consults/orders and recommendations and do not function as an on site physician performing services within Fort Washington Medical Center.

7.10.10 Individuals applying for telemedicine privileges shall meet the qualifications for Medical Staff appointment outlined in this Credentialing Manual, **except for those** requirements relating to geographic residency, immunizations, coverage arrangements, and emergency call responsibilities.

7.10.11 Qualified applicants may be granted telemedicine privileges but shall not be appointed membership to the Medical Staff. Telemedicine privileges granted in conjunction with a contractual agreement shall be incident to and coterminous with the agreement.

7.10.12 Individuals granted telemedicine privileges shall be subject to the "receiving" Hospital's performance improvement, ongoing and focused professional practice evaluations and peer review activities.

7.10.13 All requests for privileges shall be processed in the same manner as all other requests for clinical privileges except for exemptions noted above. Verifications from facilities must be documented, with the facilities attesting to competencies of the physician. A practitioner must have a current and unrestricted Maryland medical license and a current, unrestricted license where he/she resides and must be privileged at the distant-site for those services to be provided at the Fort Washington Medical Center.

7.10.14 A practitioner requesting privileges will be required to be a legal resident and living in the United States. Any practitioner living outside of the United States will not be eligible.

7.10.15 To maintain assurance of quality, the Telemedicine distant site organization currently being utilized will forward quarterly quality reports for each Telemedicine practitioner who has current, unrestricted medical staff privileges at the Fort Washington Medical Center medical staff quality department, who will use this information for the OPPE re-credentialing and quality of care review process.

7.10.16 If Fort Washington Medical Center has a service agreement with Telemedicine hospital or entity to supply contracted telemedicine services to support the Fort Washington Medical Center based physicians. The Telemedicine hospital/entity shall comply with 42 CFR 482.12(e), which requires Contracted Services to be provided in a manner that permits the "receiving" Hospital to comply with all applicable Medicare Conditions of Participation (COPs) related to contracted services, as such may apply to Hospital and as may be amended from time to time (collectively, the Hospital Standards).

7.10.17 The Telemedicine Hospital or Entity shall remain accredited by The Joint Commission and shall provide the Fort Washington Medical Center with a copy of its then-current credentialing and privileging procedures upon request.

7.10.18 It is required that the ordering physician will be notified immediately if there are any discrepancies between the telemedicine physician performing consults or readings and the Fort Washington Medical Center based physician's reviewing the reading or treatment plan for the patient.

7.10.19 Upon recommendation of the Medical Executive Committee, the Board will review and approve telemedicine and tele-health services as needed.

Telemedicine Definitions:

1. Telemedicine: Centers for Medicare and Medicaid Services (CMS): (42 CFR 410.78) a two-way, real-time, interactive communication between a patient and a physician or practitioner at a distant site through telecommunications equipment that includes as a minimum audio and visual equipment
2. Teleconsultation: The provision of advice on a diagnosis, prognosis, and/or therapy from a licensed independent provider to another licensed independent provider using electronic communications and information technology to support the care provided when distance separates the participants, and where hand-offs on care is delivered at the site of the patient by a licensed independent health care provider
3. Telemedicine Services: as it pertains to the delivery of health care services, means the use of interactive audio, video, or other electronic media used for the purpose of diagnosis, consultation, or treatment. "Telemedicine services" do not include an audio-only telephone, electronic mail message, or facsimile transmission.
4. Distant Site Hospital/Physician/Provider/Entity: CMS requires that reported telemedicine services include both a distant site and an originating site. A distant site or entity is the site at which the physician or other licensed practitioner or entity delivering the service is located at the time the service is provided via a telecommunications system.
5. Originating Site or Receiving Hospital/Location: An originating site facility or hospital is the location of the patient at the time the service being furnished via a telecommunications system occurs.
6. Synchronous or Interactive audio and video telecommunications system: real-time interactive video teleconferencing that involves the live presence of the provider and patient in an interactive environment. The provider actually sees the patient, so that two-way communication (sight and sound) can take place. In addition, documents, computer-displayed information, and whiteboards can be shared.
7. Asynchronous, or store and forward, applications: the use of a camera (e.g., audio clips, video clips, still images) to record (store) an image that is transmitted (forwarded) to another site for review at a later time
8. Remote patient monitoring (RPM)/Telehealth: including home telehealth services, uses devices to remotely collect and send data to a home health agency or a remote diagnostic testing facility (RDTF) for interpretation. Such applications might include a specific vital sign, such as blood glucose or heart ECG or a variety of indicators for homebound patients. Such services can be used to supplement the use of visiting nurses.
9. Mobile Health (mHealth): Health care and public health practice supported by mobile communication devices such as cell phones, tablet computers, and PDAs. Applications can range from targeted text messages that promote healthy behavior to secure videoconferencing for medical services to wide-scale alerts about disease outbreaks

SECTION 8. PRACTITIONER HEALTH AND IMPAIRMENT

8.1. Definition

In accordance with the Medical Staff Bylaws and for the purposes of this Section 8 of the Credentialing Manual, an “Impaired Practitioner” is a Practitioner who is unable to practice his or her profession in accordance with the criteria set forth in the Medical Staff Bylaws or practices in a manner which may be detrimental to patient safety or to the delivery of quality patient care because of physical or mental illness, including, but not limited to, deterioration through the aging process or loss of motor skill, or excessive use or abuse of drugs including alcohol.

8.2. Philosophy

The Hospital and the Medical Staff are committed to providing patients with quality care and have an obligation to protect patients from harm. The quality of patient care may be compromised and patients may be harmed if a Member of the Medical Staff is an Impaired Practitioner.

8.3. Practitioner Health Policy

The Hospital and Medical Staff have adopted a Practitioner Health Policy that pertains to all matters regarding impaired Practitioners, including reporting, investigation, informal resolution, rehabilitation programs, reinstatement and restrictions. That Policy will control all matters pertaining to impaired Practitioners.

SECTION 9. INVESTIGATIONS AND REQUESTS FOR CORRECTIVE ACTION

9.1. Criteria for Initiation

Corrective action against a Medical Staff Member may be requested whenever that Practitioner engages in, makes or exhibits acts, statements, demeanor or professional conduct either within or outside of the Hospital, which are or are reasonably likely to be:

9.1.1. Detrimental to patient safety or to the delivery of quality patient care within the Hospital;

9.1.2. Disruptive to Hospital operations; or

9.1.3. Contrary to the Bylaws, rules, regulations or policies of the Hospital or Medical Staff.

9.2. Initiation

9.2.1. A request for corrective action against a Practitioner must be made in writing. Such request may be made by an officer of the Medical Staff, the Chair of any Department to which the Practitioner has been appointed or reappointed, the Chair of any standing committee of the Medical Staff, the President of the Hospital; or a member of the Board of Directors.

9.2.2. Proposed corrective action may be initiated either by the MEC on its own initiative or by a written request which is submitted to the MEC and identifies the specific activities or conduct which are alleged to constitute the grounds for proposing specific corrective action.

9.2.3. The President of the Medical Staff shall promptly notify the President of the Hospital and Board of Directors of all proposals for corrective action so initiated and shall continue to keep them fully informed of all action taken in conjunction therewith.

9.3. Investigation

9.3.1. Upon receipt of a request for corrective action, the MEC may direct that an investigation be undertaken. The MEC may conduct the investigation itself or may assign this task to an appropriately charged officer or to a standing or special committee of the Medical Staff. No such investigative process shall be deemed to be a "hearing" as that term is used in the Fair Hearing Manual and other provisions of the Medical Staff Bylaws.

9.3.2. If the investigation is delegated to an officer or committee other than the MEC, such officer or committee shall forward a written report of the investigation, including findings of fact, conclusions and recommendations, to the MEC within sixty (60) days after the assignment to investigate has been made. The report shall include a record of an interview with the affected Practitioner. Prior to the interview, the investigating committee shall provide the affected Practitioner with written Special Notice of the time and place of the interview. The interview shall not constitute a hearing as defined in the Fair Hearing Manual and no procedural rights shall apply. Failure of the affected Practitioner to cooperate with the investigative committee may be grounds for further corrective action, including automatic suspension or termination of Privileges.

9.4. MEC Recommendation

9.4.1. As soon as practicable after the conclusion of the investigative process, if any, but in any event within sixty (60) days after the initiation of proposed corrective action, unless deferred pursuant to subsection 9.5. below, the MEC shall make recommendations based on the investigation. The MEC may, without limitation, recommend:

9.4.1.1. No corrective action;

9.4.1.2. Modification of the proposed corrective action;

9.4.1.3. Letter of admonition, reprimand or warning to be sent to the Practitioner and placed in the Practitioner's credentials file;

9.4.1.4. Terms of probation or individual requirements of consultation, including but not limited to the exercise of Clinical Privileges subject to the oversight of a proctor approved by the MEC;

9.4.1.5. Reduction or revocation of Clinical Privileges;

9.4.1.6. Suspension of Clinical Privileges until completion of specific conditions or requirements;

9.4.1.7. Reduction of membership status or limitation of any prerogatives directly related to the Practitioner's delivery of patient care;

9.4.1.8. Suspension of Medical Staff membership until completion of specific conditions or requirements;

9.4.1.9. Revocation of Medical Staff membership; or

9.4.1.10. Other actions appropriate to the facts that prompted the investigation.

9.4.2. Nothing set forth in this Section shall inhibit the MEC from implementing summary suspension at any time in the exercise of its discretion pursuant to subsection 9.7. below.

9.5. Deferral

If additional information is needed to complete the investigative process, the MEC may defer action on the request for corrective action, and shall so notify the affected Practitioner. A subsequent recommendation for any one or more of the actions provided in subsection 9.4. above must be made within the time specified by the MEC; and if no such time is specified then within thirty (30) days of the deferral.

9.6. Further Action

9.6.1. Any recommendation by the MEC or the Board of Directors which constitutes grounds for a hearing as set forth in Section 4 of the Fair Hearing Manual shall entitle the affected Practitioner to the procedural rights as provided in the Fair Hearing Manual. In such cases, the MEC or the Board of Directors, as applicable, shall give

the Practitioner written Special Notice of the Adverse Action or Adverse Recommendation and of his right to request a hearing in the manner specified in Section 5 of the Fair Hearing Manual.

9.6.2. Should the Board of Directors determine that the MEC has failed to act in timely fashion on the proposed corrective action, the Board of Directors, after consulting with the MEC, may take action on its own initiative. If such action is favorable to the Practitioner, or constitutes an admonition, reprimand or warning to the Practitioner, it shall become effective as the final decision of the Board of Directors. If such action is an Adverse Action or Adverse Recommendation as set forth in Section 4 of the Fair Hearing Manual, the Board of Directors shall give the Practitioner written Special Notice of:

9.6.2.1. The Adverse Action or Recommendation;

9.6.2.2. The Practitioner's right to request a hearing in the manner specified in Section 5 of the Fair Hearing Manual; and

9.6.2.3. The Practitioner's procedural rights as provided in the Fair Hearing Process Manual.

9.7. Summary Suspension

9.7.1. Criteria for Initiation

Whenever a Practitioner's conduct requires that immediate action be taken to reduce a substantial likelihood of imminent impairment of the health or safety of any patient, prospective patient, employee or other person present in the Hospital, the President of the Medical Staff, or in his absence, the President-Elect, or in the absence of both the President of the Medical Staff and the President-Elect, the respective Department Chair, or in any event the MEC shall have the authority to summarily suspend the Practitioner's Medical Staff membership or all or any portion of the Practitioner's Clinical Privileges.

9.7.2. Effective Date and Special Notice

9.7.2.1. Summary suspension shall become effective immediately upon imposition.

9.7.2.2. The person or body responsible for imposition of the summary suspension shall promptly give written Special Notice of such suspension to the Practitioner, Board of Directors, MEC and President of the Hospital, in accordance with subsection 5.1. of the Fair Hearing Process.

9.7.3. Care of Practitioner's Patients

In the event of a Practitioner's summary suspension, the President of the Medical Staff or the respective Department Chair shall assign the Practitioner's patients whose treatment by such Practitioner is terminated by the summary suspension to another Practitioner. The wishes of the patient shall be considered, where feasible, in choosing a substitute Practitioner.

9.7.4. Temporary Waiver by MEC

9.7.4.1. Within ten (10) days after receipt of a Special Notice of summary suspension,

the affected Practitioner may make a written request for an interview with the MEC for the purpose of determining whether or not the summary suspension should be terminated pending the evidentiary hearing. Such evidentiary hearing must be simultaneously requested in accordance with the provisions of subsection 5.2. of the Fair Hearing Manual.

9.7.4.2. The interview shall be convened as soon as reasonably possible under all of the circumstances. The interview shall not constitute an evidentiary hearing, and the procedural rights applicable to evidentiary hearings, including but not limited to the right to be represented by counsel, shall not apply.

9.7.4.3. The MEC may thereafter modify, continue or terminate the terms of the summary suspension. The MEC may modify or terminate the summary suspension only if it finds that:

9.7.4.3.1. The charges against the affected Practitioner are frivolous; or

9.7.4.3.2. The charges, which for the purposes of this subsection shall be assumed to be true, do not involve conduct that constitutes a substantial likelihood of imminent impairment to the health or safety of a patient, prospective patient, employee, or other person present in the Hospital.

9.7.4.4. The MEC shall provide the Practitioner with written Special Notice of its decision.

9.8. Automatic Termination or Suspension

9.8.1. License

9.8.1.1. Revocation or Expiration

Whenever a Practitioner's license that authorizes him to practice in this State is revoked, has expired, or is otherwise rendered invalid, his Medical Staff membership, prerogatives, and Clinical Privileges shall be immediately and automatically terminated. The Practitioner shall immediately provide the President of the Hospital and President of the Medical Staff with written Special Notice of the revocation, expiration, or invalidation of his license.

9.8.1.2. Restriction

Whenever a Practitioner's license which authorizes him to practice in this State is limited or restricted by the applicable licensing authority, those Clinical Privileges which he has been granted rights to perform, and which are within the scope of said license limitation or restriction, shall be immediately and automatically terminated. The Practitioner shall immediately provide the President of the Hospital and the President of the Medical Staff with written Special Notice of any such limitation or restriction of his license.

9.8.1.3. Suspension

Whenever a Practitioner's license that authorizes him to practice in this State is

suspended, his Staff membership and Clinical Privileges shall be automatically suspended effective upon, and for at least the term of, the licensure suspension. The Practitioner shall immediately provide the President of the Hospital and President of the Medical Staff with written Special Notice of any such suspension of his license.

9.8.1.4. Probation

Whenever a Practitioner is placed on probation by the applicable licensing authority, his applicable membership status, prerogatives, Privileges and responsibilities, if any, shall automatically become subject to the terms of probation effective upon, and for at least the term of, the probation. The Practitioner shall immediately provide the President of the Hospital and President of the Medical Staff with written Special Notice of any such probation.

9.8.2. Drug Enforcement Administration

9.8.2.1. Revocation or Expiration

Whenever a Practitioner's DEA Certificate or MDDC Certificate is revoked or has expired, he shall immediately and automatically be divested of his right to prescribe medications covered by the Certificate at the Hospital or for Hospital patients. A Practitioner shall immediately provide the President of the Hospital and President of the Medical Staff with written Special Notice of any such DEA or MDDC revocation or expiration.

9.8.2.2. Suspension

Whenever a Practitioner's DEA Certificate or MDDC Certificate is suspended, he shall be divested, at a minimum, of his right to prescribe medications covered by the Certificate at the Hospital or for Hospital patients effective upon, and for at least the term of, the suspension. A Practitioner shall immediately provide the President of the Hospital and President of the Medical Staff with written Special Notice of any such DEA or MDDC suspension.

9.8.2.3. Probation

Whenever a Practitioner's DEA Certificate or MDDC Certificate is subject to an order of probation, his right to prescribe medications covered by the Certificate at the Hospital or for Hospital patients shall automatically become subject to the terms of the probation effective upon, and for at least the term of, the probation. A Practitioner shall immediately provide the President of the Hospital and President of the Medical Staff with written Special Notice of any such DEA or MDDC probation.

9.8.3. Federal Health Care Program Exclusion

Whenever a Practitioner is excluded from participation in any federal health care program, as defined under 42 U.S.C. 1320a-7b(f), such Practitioner’s Medical Staff membership and Clinical Privileges shall be automatically suspended effective upon, and for at least the term of, the period of exclusion. The Practitioner shall immediately provide the President of the Hospital and President of the Medical Staff with written Special Notice of any such exclusion.

9.8.4. Failure to Satisfy Special Appearance Requirements

Whenever a Practitioner fails, without good cause, to satisfy the Special Appearance requirements set forth in Article 7 of the Bylaws, the Practitioner's Medical Staff membership and Clinical Privileges shall be automatically suspended for such period as shall be determined by the MEC.

9.8.5. Procedural Rights upon Automatic Suspension or Termination Involving License, DEA, MDDC, Federal Health Care Program Exclusion, or Failure to Satisfy Special Appearance

9.8.5.1. Practitioners whose Medical Staff membership or Privileges have been suspended or terminated pursuant to subsections 9.8.1, 9.8.2, 9.8.3, or 9.8.4 of this Credentialing Manual shall not be entitled to the procedural rights afforded by the Fair Hearing Manual.

9.8.5.2. As soon as practicable after automatic suspension of Medical Staff membership or Clinical Privileges pursuant to subsections 9.8.1, 9.8.2, 9.8.3, or 9.8.4 of this Credentialing Manual, the MEC shall convene to review and consider the facts upon which such automatic suspension was predicated. The MEC may then recommend such further corrective action as may be appropriate based upon information disclosed or otherwise made available to it, and/or it may direct that an investigation be undertaken pursuant to subsection 9.3. of this Credentialing Manual. Any further corrective action recommended by the MEC shall be subject to the procedural rights afforded by the Fair Hearing Manual.

9.8.6. Medical Records

9.8.6.1. Whenever a Practitioner fails without good cause to complete Medical Records within the time limits established by the Medical Staff Rules and Regulations and Hospital policies, the Practitioner's Clinical Privileges, including his rights to admit patients and to provide any other professional services, shall be automatically suspended upon the expiration of forty-five (45) days after initiation of administrative suspension in accordance with Medical Staff Rules and Regulations, and shall remain so suspended until all delinquent Medical Records are completed.

9.8.6.2. A failure to complete the Medical Records within three (3) months after the date on which suspension pursuant to this subsection became effective may be considered a cause for revocation of Medical Staff membership and Privileges by action of the Board upon recommendation by the MEC in accordance with this Credentialing Manual and the Fair Hearing Manual.

9.8.7. Malpractice Insurance

Whenever a Practitioner fails to maintain the amount of professional liability insurance, if any, required under subsection 2.2. of this Credentialing Manual, the Practitioner's Medical Staff membership and Clinical Privileges shall be automatically suspended immediately upon notice of such failure, and shall remain so suspended until the Practitioner provides evidence to the

MEC that he has secured professional liability coverage in the amount required under subsection 2.2. A failure to provide such evidence within six (6) months after the date the automatic suspension became effective shall be deemed to be a voluntary resignation of the Practitioner's Medical Staff membership.

9.8.8. Failure to Pay Dues

Whenever a Practitioner fails without good cause to pay dues, if any, as required under Section 4 of this Credentialing Manual, the Practitioner's Medical Staff membership and Clinical Privileges shall be automatically suspended forty-five (45) days after Special Notice of delinquency, and shall remain so suspended until the Practitioner pays the delinquent dues. A failure to pay such dues within six (6) months after the date the automatic suspension became effective shall be deemed to be a voluntary resignation of the Practitioner's Medical Staff membership.

9.8.9. Failure to Request Leave of Absence or Termination of Leave of Absence

Whenever a Practitioner shall be absent from active practice for a period exceeding three (3) months and fails without good cause to request a voluntary leave of absence and termination of leave of absence in accordance with Section 3 of this Credentialing Manual, the Practitioner shall be deemed to have voluntarily resigned his Medical Staff membership and his Clinical Privileges shall be automatically terminated.

9.8.10. Procedural Rights upon Automatic Suspension or Voluntary Resignation Involving Medical Records, Malpractice Insurance, Failure to Pay Dues, Failure to Request Leave of Absence or Termination of Leave of Absence.

Practitioners whose Clinical Privileges and Medical Staff membership are automatically suspended and/or who have resigned their Medical Staff membership pursuant to the provisions of subsections 9.8.6., 9.8.7., 9.8.8., or 9.8.9. shall not be entitled to the procedural rights set forth in the Fair Hearing Manual, except that where the absence of good cause is a prerequisite to such suspension or deemed resignation status, the Practitioner shall be entitled to such procedural rights for the sole purpose of determining the existence of good cause.

9.8.11. Contract Termination

Practitioners whose membership and clinical privileges are contingent on the continuance of the member’s contract with the hospital and not upon the requirements pertaining to appointment and reappointment shall automatically terminate upon termination of the contract.

9.8.12. Failure to Report or Provide Requested Information for Renewal

Failure to report any pending or concluded action involving denial, revocation, suspension, reduction, limitation, probation, non-renewal or voluntary relinquishment of the applicant’s license or certificate to practice medicine in any state or jurisdiction; DEA or other controlled substances registration; membership or fellowship in local, state or national professional organizations, faculty membership at any medical or other professional school; and medical staff membership status, prerogatives or clinical privileges at any other hospital, clinic or health provider.

9.8.13. Failure to Obtain Board Certification

If Board Certification is not obtained within the specified five-year term period, membership and privileges shall automatically expire at the conclusion of that term of appointment. The applicant cannot submit any application for reappointment until Board Certification is obtained.

9.8.14. Special Notice of Automatic Suspension

Whenever a Practitioner's Medical Staff membership or Privileges are automatically suspended in whole or part, Special Notice of such suspension shall be provided to the Practitioner, the MEC, the President of the Hospital, and the Board of Directors. The provision of such Special Notice shall not, however, be required in order for the automatic suspension to take effect.

Addendum to Credentialing Manual: Fort Washington's OPPE and FPPE Manual

SOURCES:

1. American Telemedicine Association. "Telemedicine Defined." Available online at www.americantelemed.org/i4a/pages/index.cfm?pageid=3333.
2. Centers for Medicare and Medicaid Services. "Telemedicine and Telehealth." Available online at www.cms.gov/telemedicine.

This Credentialing Manual of the Medical Staff was reviewed in entirety, updated and revised by the MEC on September 17, 2015, and October 15, 2015, recommended for approval to the Board of Directors on October 26, 2015. This manual was approved by the Board of Directors in October 2015.

This manual must be next reviewed and approved by the Board of Directors no later than October 1, 2017.
Reviewed/Revised: December 15, 2011
Reviewed/Revised: February 16, 2012
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MEC Approved August 2017
Board Approved September 2017

Next Review/Approval Date no later than September 2019

Date	Brief Summary of Revision(s) Made, When Applicable
August 2017	MEC Approval
September 2017	Board Approval
	The following revisions were recommended by the Medical Executive Committee. • Modified Name of Manual from Credentialing Manual to "Credentialing and Privileging Manual" • Modified Table of Contents-Section 4 SECTION 4. CATEGORIES OF THE MEDICAL STAFF ..... 4.1. Assignment to a Category ..... 4.2 Active Membership 4.3. Associate Membership ..... 4.4. Affiliate Membership ..... **Error! Bo** 4.5. Emeritus Membership..... 4.6. Allied Health Practitioners Membership ..... 4.7 Administrative Staff Membership
	Page 1 Definitions **1. Medical Staff Membership**: FWMC Medical Staff Membership includes, but not limited to doctors of medicine (MD) or osteopathy (DO), In accordance with state law, medical staff membership is also composed of other advanced degree professionals and allied health practitioners such as dentists, podiatrists, chiropractors, advanced practice registered nurses (nurse practitioners (NP) and nurse midwives), certified registered nurse anesthetists (CRNA), physician assistants (PA), psychologists, optometrists. 2. Patient Encounters: "Patient Encounters" are defined as admissions, consultations, diagnostic procedures, surgical procedures and emergency department visits in both the inpatient and outpatient settings. Referrals for testing, procedures and diagnostics are not considered "Encounters". Page 3-Modified Section 2.2.3 No Physician, dentist, podiatrist, Advanced

	Practice Professional or Allied Health Practitioner (AHP) as defined above Page 1--Added Section 2.1 Medical Staff Composition (CMS MLN 2004) The Medical Staff must be composed of doctors of medicine (MD) or osteopathy (DO) and, in accordance with state law, may also be composed of other practitioners appointed by the Governing Body. These other practitioners may include, but are not limited to dentists, podiatrists, chiropractors, advanced practice registered nurses (nurse practitioners (NP) and nurse midwives), certified registered nurse anesthetists (CRNA), physician assistants (PA), psychologists, optometrists, etc. The Medical Staff, as a group is responsible for the quality of care provided to patients by the hospital, for establishing the bylaws, rules, regulations, policies, etc. for the medical staff and for overseeing the quality of care provided by all the individual practitioners who provide a medical level of care or who conduct invasive, non-invasive and surgical procedures at the hospital. Membership on the Medical Staff of Fort Washington Medical Center is a privilege that shall be extended to professionally competent doctors of medicine (MD) or osteopathy (DO). In accordance with state law, medical staff membership is also composed of other advanced degree professionals and allied health practitioners such as dentists, podiatrists, chiropractors, advanced practice registered nurses (nurse practitioners (NP) and nurse midwives), certified registered nurse anesthetists (CRNA), physician assistants (PA), psychologists, optometrists, etc. Appointment to and membership on the Medical Staff shall confer upon the appointee or member only such Clinical Privileges and prerogatives as have been granted by the Board, or a committee thereof, in accordance with this Credentialing Manual. Page 2 Modified the following sections (2.2.1.0 and 2.2.1.1) 2.2.1.0 Be a qualified graduate of an approved accredited Advanced Practitioner Degree or Allied Health Program. 2.2.1.1 Possess a current, valid license to practice within the scope of practice for medicine, dentistry, podiatry and advanced practice professionals and allied health practitioners in the State of Maryland; Page 5 Section 2.5.1 .....period of at least 3 months and an extension of the FPPE period for up to 12 consecutive months. Refer to the Fort Washington Medical Center FPPE and OPPE Policy Manual which is entered as an addendum to this Credentialing and Privileging Manual) 2.5.3 Reappointment to the Medical Staff shall be for a period of not more than two (2) Medical Staff years. Page 3-Modified Section 2.3

2.3.1 The requirements for hospital accreditation as specified by the Joint Commission or other accrediting and certification bodies the hospital participates in;
2.3.2 Applicable federal, State, and local statutes, rules, and regulations; and
2.3.3 The medical staff and hospital wide policy on **"Disruptive Behavior and Physician Practice Expectation Document:"**

Page 6—Section 4

4.1.1. The medical staff membership categories of the Medical Staff shall include the following:

- Active Staff
- Associate Staff
- Affiliate Staff
- Advanced Practice and Allied Health Practitioner (AHPs) Staff
- Emeritus Staff
- Administrative Staff

4.1.2. At the time of each Member's Appointment or Reappointment, the Member shall be assigned to one such category in accordance with the criteria set forth in this Credentialing Manual, and shall be subject to the responsibilities and prerogatives of that category as set forth herein. The prerogatives set forth under each category are general in nature and may be subject to limitations or special conditions for individual Members imposed in accordance with the provisions of this Credentialing Manual

4.2 New members of the medical staff will be required to complete an individualized Focused Practitioner Practice Evaluation period for at least 3 months. This FPPE review period may be extended as outlined in the Medical Staff approved OPPE and FPPE policy manual. Reappointment of privileges will consist of an Ongoing Practitioner Performance Evaluation (OPPE) during the reappointment process and every 8 months during the 2 year reappointment period at which time an evaluation is conducted by the Medical Staff Department Chairs,, Division Chairs, MEC and Board regarding continuation or possible revision of current medical staff privileges based on quality outcomes and trended quality data.

Page 7 Section 4

4.3.2.8 The following are issues not pertaining to individual peer review, formal investigations of professional performance or conduct, denial of requests for appointment or clinical privileges, or any other matter relating to individual membership or privileges.

1) To meet with the MEC on matters relevant to the responsibilities of the MEC. In the event the practitioner is unable to resolve a matter of concern after working with his or her department or division chair or other appropriate medical staff leader(s), that practitioner may, on written

	notice to the Chief Medical Officer or President of the Medical Staff two weeks in advance of a regular meeting, meet with the MEC to discuss the issue; Pages 8 – 12 Medical Staff Category Updates 4.3.3. Responsibilities of Active Staff A Member of the Active Staff shall be obligated to: 4.3.3.1.Execute all applicable general responsibilities of Medical Staff membership as set forth in subsection 2.4. of this Credentialing Manual; 4.3.3.2. Have a minimum of 12 patient encounters per 12 month period 4.3.3.5. Satisfy special appearance requirements as set forth in Article 7 of the Bylaws; 4.3.3.6. Provide emergency department on-call coverage in accordance with the on-call coverage schedule of his respective Department; 4.3.3.7. Provide consultation to other Staff Members consistent with his delineation of Privileges; 4.3.3.8. Assist with FPPE performance assessment as requested by the President of the Medical Staff, CMO or Department Chair; 4.3.3.9. Pay all Staff dues and assessments promptly; and 4.3.3.10. Fulfill such other Medical Staff functions as may be reasonably required of Members of the Active Medical Staff. 4.4. **Associate Staff** ***Definition.*** Associate Medical Staff are those Physicians who do not regularly admit, perform procedures, and/or provide care to patients at the Hospital, but who wish to have the right to admit and treat a limited number of patients at the Hospital or ambulatory care setting. Refer patients to other physicians on staff at the Hospital or those who order diagnostic or therapeutic services at the Hospital. Associate Staff must fulfill the focused and/or ongoing professional performance evaluation requirements specified in the Bylaws/ Procedures, Medical Staff Quality Plan, and any specific requirements outlined in the pertinent Departmental Rules and Regulations. 4.4.1. Qualifications of Associate Staff shall consist of Members who: 4.4.1.4. Satisfy all of the general Medical Staff membership qualifications set forth in subsection 2.2. of this Credentialing Manual; 4.4.1.5. Have satisfactorily completed the FPPE Period; 4.4.1.6. Are members in good standing of the Medical Staff of another hospital that requires peer review and performance improvement activities of a substance

	and character similar to those at Fort Washington Medical Center as evidenced by accreditation; 4.4.2. Prerogatives of Associate Medical Staff member 4.4.2.1. A Member of the Associate Staff shall be entitled to: 4.4.2.1.1. Admit, attend, treat, and **perform consultations** and procedures for, inpatients and outpatients of the Hospital. Must have at least one patient encounter as defined in the "definitions section" of this manual 4.4.2.1.2 May have access to data on their patients within the Hospital and its medical records and information systems. 4.4.1.3. May attend, with voice and vote, all meetings of the Medical Staff. 4.4.1.4 Are eligible for appointment to all Medical Staff Committees but may not serve as Chair of any such Committees. 4.4.1.5 Are <u>not eligible</u> to serve as a Medical Staff Officer or Clinical Department Chair. 4.4.1.6 May attend Hospital-sponsored and Medical Staff-sponsored continuing professional education activities, receive Medical Staff publications and communications, and attend Medical Staff social functions. 4.4.4. Responsibilities and Obligations of an Associate Staff member A Member of the Associate Medical Staff members shall be obligated to: 4.4.3.1. Execute all applicable general responsibilities of Medical Staff membership as set forth in subsection 2.4. of this Credentialing Manual; 4.4.3.2. Satisfy special appearance requirements as set forth in Article 7 of the Bylaws; 4.4.3.3. Provide **consultation to other Staff Members** consistent with his delineation of Privileges; 4.4.3.4. Pay all Staff dues and assessments promptly; and 4.4.3.5. Fulfill such other Medical Staff functions as may be reasonably required of Members of the Associate Staff. 4.4.3.6 Attend at least one quarterly Medical Staff meeting per year. 4.4.3.7 Participate in Clinical Department, Medical Staff, and Hospital quality improvement and performance improvement activities, as requested, and cooperate with all such activities. 4.4.3.8 Serve on Medical Staff Committees, as reasonably requested and subject to availability in light of private practice and other hospital responsibilities.

4.5. Affiliate Staff

4.5.1. ***Qualifications for Affiliate Staff.*** The Affiliate Staff member is a **"refer and review"** category and shall consists of physicians, dentists, Allied Health Practitioners, Advance Practice Professionals, podiatrists and other professionals defined in Section 2 of the Credentialing Manual and who:

4.5.1.1.Meet all qualifications for membership on the Medical Staff, but hold no privileges and are exempt from the routine hospital verification process including verification of:

4.5.1.2 Current malpractice coverage

4.5.1.3 Current Federal DEA certificate

4.5.1.4 CME credits

4.5.1.5 Refer patients to other physicians on staff at the Hospital or those who order diagnostic or therapeutic services at the Hospital.

This Affiliate Staff Category will require licensure verification when referring patients for admission, testing and procedures. Fort Washington Medical Center medical staff has adopted an Outpatient Referral Licensure Verification and OIG Sanction Check process for all providers referring patients for testing (Refer to medical staff policy on licensure verification. This category does not require participation in the OPPE/FPPE process.

4.5.2. Prerogatives: Members of the Affiliate Staff who routinely refer and review may:

4.5.2.1 May visit their referred patients in the Hospital, review their patients medical records and receive information concerning their patients' medical condition and treatment.

4.5.2.2 May write outpatient and referral orders for diagnostic testing, labs, ancillary services and other treatment modalities

4.5.2.3 May attend departmental and General Medical Staff meetings.

Members of the Affiliate Medical Staff may **NOT:**

4.5.2.4 Vote or hold office.

4.5.2.5 Make any entries in the Medical record.

4.5.2.6 Admit, write orders for inpatient care, perform surgical or invasive procedures or otherwise treat patients in the Hospital.

4.5.2.7 Have delineated clinical privileges.

4.5.2.8 Participate in the hospital's OPPE/FPPE review process

4.5.3 Responsibilities. The responsibilities of an Affiliate member of the medical staff who routinely refers and reviews patients are to abide by the Bylaws and Procedures of the Medical Staff and the Hospital.

A Member of the Affiliate Staff shall be obligated to:

4.5.3.1. Execute all applicable general responsibilities of Medical Staff membership as set forth in subsection 2.4. of this Credentialing Manual;

4.5.3.2. Except as otherwise noted above under Section 4.5 satisfy special appearance requirements as set forth in Article 7 of the Bylaws;

4.6. Advanced Practice Professionals and Allied Health Practitioners

***Definition*:** "Advanced Practice Professionals" ("APPs") and Allied Health Practitioners (AHPs) means Clinical Psychologists, Certified Nurse Midwives, Certified Nurse Practitioners, Certified Physician Assistants, Certified Register Nurse Anesthetists, Chiropractors, Midwives, and any other health care practitioners defined above in Section 2 (Medical Staff Membership) with expert knowledge and experience in fields of medicine who the Hospital declares eligible for Membership on the Medical Staff and to receive clinical privileges in accordance with the Bylaws and Credentials manual/policies.

4.6.1 Prerogatives and Responsibilities. Advanced Practice Professionals and Allied Health Practitioner medical staff members:

4.6.1.1 May attend the Full Medical Staff Committee (without vote)

4.6.1.2 May attend educational activities sponsored by the Medical Staff and the Hospital;

4.6.1.3 `May exercise such clinical privileges as are granted to them;

4.6.1.4 May serve on medical staff and hospital committees (with vote);

4.6.1.5 May actively participate in and shall cooperate in the professional practice evaluation and performance improvement processes;

4.6.1.6 May not hold office or serve as department or committee chairs

4.6.1.7 Must pay applicable fees, dues and assessments;

4.6.1.8 Are excused from providing coverage for the Emergency Department and providing care for unassigned patients unless the MEC declares a need for such coverage or services; and

4.6.1.9 May admit patients or perform consultations under the supervision of the sponsoring physician and in accordance with the Medical Staff Bylaws and governance documents.

4.7 Administrative Staff Membership These are physicians (i.e. Chief Medical Officer) who by virtue of contract with the hospital have some administrative duties in addition to their clinical duties. They shall be members of the Medical Staff and shall meet the requirements for continuing membership. Contractual services shall be governed by

	the terms of the contract with hospital and corporation and **shall not** be subject to appeal as provided by these bylaws. Termination of the employment contract or relationship shall result in the automatic termination of Medical Staff membership as specified in the contract. 4.7.1 Members of this Medical Staff Category are charged with assisting the Medical Staff in carrying out medical-administrative functions, including, but not limited to quality assessment and improvement and utilization review functions. Administrative Staff includes members who qualify through one of the following categories: 4.7.1.1 Serves in a medical-administrative leadership position of the hospital 4.7.1.2 Functions in a Hospital leadership position requiring medical staff membership as requested by Hospital and Administration; and/or 4.7.1.3 Serves as the oversight medical director of any Residency Program or affiliate School of Medicine program and is required to maintain Medical Staff membership; or 4.7.2 Prerogatives of Administrative Medical Staff Status: Administrative Medical Staff appointees: 4.7.2.1 May attend meetings of the Medical Staff and the Clinical Department of which he/she is a member; 4.7.2.2 May hold office in the Medical Staff organization; 4.7.2.3 Serve as a voting member of Medical Staff Committees; 4.7.2.4 Access the electronic health record; 4.7.2.5 **May not** admit, treat or otherwise consult on patients; and 4.7.3.6 **May not** exercise Clinical Privileges. 4.8 Emeritus Membership ***Definition: Emeritus*** Medical Staff are those Physicians who have retired from the practice of medicine, have at least ten (10) years of continuous service as members of the Medical Staff, and whom the Medical Executive Committee and Board wishes to recognize and honor for their distinguished service to the Hospital and its patients. The MEC will recommend to the Board recommendations for Emeritus Status. ***4.8.1 Prerogatives for Emeritus*** Medical Staff Members: 4.8.1.1 May attend, with voice but no vote, all meetings of the Medical Staff. 4.8.1.2 Are eligible for appointment to all Medical Staff Committees except the Medical Executive Committee but may not serve as Chair of any such Committees; provided, however, that one member of the Emeritus Medical Staff may be appointed by the President of the Medical Staff to serve on the Medical Executive Committee as provided in the Bylaws. 4.8.1.3 May attend Hospital-sponsored and Medical

	Staff sponsored continuing professional education activities, receive Medical Staff publications and communications, and attend Medical Staff social functions. 4.8.1.4 Members may attend Medical Staff, Department, and educational meetings. They may not admit patients nor exercise clinical privileges and they shall not be eligible to vote or to hold office. 4.8.1.5 Emeritus Medical Staff members shall be exempt from any liability coverage requirements deemed necessary by the Board of Directors. ***4.8.2 Obligations*** Emeritus Medical Staff Members may participate in the activities described above in their sole discretion, but shall have no other obligations as a member of the Emeritus Medical Staff. Members of the Emeritus Staff shall not have clinical privileges and shall not be subject to the regular reappointment processes. 4.9. Change in Medical Staff Category, Department Assignment during Term of Reappointment The MEC may, upon its own initiative, upon recommendation of the Department Chair, or upon request of a Member, recommend to the Board that the Member's Medical Staff Category or Department assignment be changed prior to the conclusion of the Member's term of Reappointment, provided that the Member satisfies all qualifications for the Medical Staff Status Category and meet the requirements for the Department to which reassignment is recommended or requested. A request for change in Medical Staff category or Department assignment is processed in the same manner as an application for Reappointment as set forth in Section 6 of this Credentialing Manual, but does not substitute for an upcoming Reappointment. Page 27-Section 6.4.1.3 Changed "Patient Contacts" to "Patient Encounters" Page 37 Section 7.7.3 The MEC shall consider the material and shall make recommendations for final action by the Board of Directors concerning the establishment or revision of privileging criteria and proposal for new medical staff privileges. Such recommendation shall include without limitation whether the technology, procedure, or protocol should be conducted at the Hospital and, if so, shall propose new or revised criteria to be used in reviewing requests for Clinical Privileges in the area. Such criteria shall be developed in consultation with members of the relevant Department of the Medical Staff and shall be designed to ensure high quality patient care. The MEC and Hospital Leadership will meet to discuss new services and any new privileges associated with the new service line to discuss the impact of the proposed procedure/technique on hospital regulatory impact, financial impact, staffing needs, space needs, equipment needs, and training needs. Anyone on the leadership team has the authority and responsibility to bring recommendations and considerations related to hospital staff issues and

	support systems to the Leadership Team, MEC and the Governing Body at any time throughout the consideration of any new service line and recommendations for new medical staff privileges. When any member of the medical staff request additional or new privileges, the medical staff office must run a current national practitioner data bank report within 30 days prior to approval of new or additional medical staff privileges.
	Approved by Board.