University Hospitals
Parma Medical Center

UNIVERSITY HOSPITALS
PARMA MEDICAL CENTER

PRIVILEGING POLICY FOR LICENSED INDEPENDENT AFFILIATE HEALTH CARE PRACTITIONERS (LIAP) AND ALLIED HEALTH PROFESSIONALS (AHP)

Privileging Policy for Licensed Independent Affiliate Health Care Practitioners (LIAP) and Allied Health Professionals (AHP)

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1.0 DEFINITIONS. The following definitions apply to the provisions of this policy.

1.1 **ADMINISTRATION** refers to the Hospital President and other Officers within the General Administration of Hospital.

1.2 **ALLIED HEALTH PROFESSIONAL or AHP** (for purposes of this policy) refers to certified registered nurse anesthetists, anesthesia assistants, physician assistants, and others as approved by the Board of Directors, authorized to provide clinical services in the Hospital, who may or may not be Hospital employees, and who are not members of the Medical Staff, but who are employed by and/or supervised by an active member, in good standing, of the Medical Staff who is in the same specialty,.

1.3 **BOARD OF DIRECTORS (or Board)** refers to the Board of Directors of University Hospitals Parma Medical Center.

1.4 **CHIEF MEDICAL OFFICER (CMO)** refers to the UH appointed Chief Medical Officer of the Hospital or his or her designee.

1.5 **CREDENTIALS REVIEW COMMITTEE** is the multidisciplinary committee that evaluates the education, training, experience, clinical competence, and credentials (e.g., licensure, board certification) of applicant for initial, renewed, or revised clinical privileges and makes recommendations to the Medical Executive Committee for approval or denial of privileges.

1.6 **HOSPITAL** refers to University Hospitals Parma Medical Center.

1.7 **HOSPITAL EMPLOYEE or HOSPITAL AHP or LIAP** means employees of University Hospitals Parma Medical Center.

1.8 **HUMAN RESOURCES (HR)** refers to the Human Resources Department of University Hospitals.

1.9 **LICENSED INDEPENDENT AFFILIATE HEALTH CARE PRACTITIONER or LIAP** (for purposes of this policy) refers to clinical nurse specialists, nurse practitioners, and others as approved by the Board of Directors, authorized to independently practice or provide clinical services in the Hospital who may or may not be Hospital employees, who are employed by and/or in collaboration with an active member, in good standing, of the Medical Staff who is in the same specialty.

1.10 **LICENSED INDEPENDENT PRACTITIONER (LIP)** refers to any individual permitted by law and by the organization to provide care, treatment, and services, without direction or supervision, within the scope of the individual's license and consistent with individually granted clinical privileges.

1.11 **MEDICAL STAFF** refers to duly licensed physicians, dentists, oral and maxillofacial surgeons, podiatrists, psychologists, and other licensed independent practitioners as defined by the Medical Executive committee and Board of Directors, including members of the Active, Courtesy, Consulting, Affiliate**,** Provisional and Honorary categories of the Medical Staff of University Hospitals Parma Medical Center and who (except for Honorary Staff) participate in the care of patients, teaching and/or research at Hospital.

1.12 **NON-HOSPITAL EMPLOYED LIAP or NON-HOSPITAL LIAP** refers to LIAPs who are granted clinical privileges to practice at the Hospital under this Policy and who are employed by the University Hospitals Medical Group, University Hospitals Medical Practices, or a member of the Hospital's active Medical Staff or who have an affiliation with one or more professionals or groups who are affiliated with the Hospital through Medical Staff membership, contract, employment or otherwise.

1.13 **NOTICE** means written notification sent by certified mail, return receipt requested or by hand-delivery service.

1.14 **POLICIES AND PROCEDURES** refer to the Policies and Procedures of University Hospitals Parma Medical Center, its clinical departments, its Medical Staff, and University Hospitals Health System.

1.15 **PRIVILEGING** refers to the process whereby a specific scope and content of patient care services (that is, clinical privileges) are authorized for a health care practitioner by a health care organization based on evaluation of the individual's credentials and performance. (*See licensed independent practitioner.*)

1.16 **UH** refers to University Hospitals Health System.

2.0 SCOPE AND OVERVIEW OF POLICY

2.1 This policy addresses those LIAPs and AHPs who are permitted to practice or provide services in the Hospital, and are credentialed and privileged through Medical Staff mechanisms. Only those types of LIAPs and AHPs that have been approved by the Board of Directors shall be permitted to practice at the Hospital. LIAPs and AHPs practice or provide services at the Hospital at the discretion of the Board of Directors or its designee, and, as such, may be denied access and/or terminated at will by the Board of Directors or its designee.

2.2 Permission to practice or provide services in the Hospital as a LIAP or AHP is a privilege which shall be extended only to those individuals who have successfully completed the application process, been approved for specific clinical privileges, continually meet the qualifications, standards, requirements, and competencies set forth in this Policy and shall be limited to the needs of the patient population served by the Hospital as determined by the Board of Directors.

2.3 This Policy may be supplemented by separate Hospital policies and delineations of privileges that address the requirements for specific types of LIAPs and AHPs that are authorized to practice or provide services in the Hospital. These policies and delineations of privileges articulate:

2.3.1 Any specific qualifications, training, and/or competencies that a practitioner must possess beyond those set forth in this Policy;

2.3.2 Detailed description of authorized delineation of privileges for a given type of practitioner

2.3.3 Any specific conditions that apply to the practitioner's functioning within the Hospital; and

2.3.4 Any supervision or collaboration requirements

3.0 ELIGIBILITY AND QUALIFICATIONS

3.1 No applicant for LIAP or AHP status shall be entitled to practice or provide services in the Hospital solely by virtue of:

3.1.1 being licensed/registered/certified to practice in the State of Ohio or in any other state; or

3.1.2 being a member of any professional organization, or certified by any professional board; or

3.1.3 currently holding or having previously held employment, medical staff membership, affiliation, or clinical privileges with the Hospital or another health care organization; or

3.1.4 having an affiliation with one or more physician or non-physician health care professionals or groups who are affiliated with the Hospital through Medical Staff membership, contract, employment or otherwise.

3.2 Permission to practice or provide services within the Hospital will neither be granted nor denied on the basis of race, color, religion, creed, gender, sexual orientation, national origin, marital or family status, presence of any disability, age, ancestry, veteran's status or financial resources.

3.3 Minimum requirements for clinical privileges for a LIAP or AHP shall include the following:

3.3.1 Current licensure/certification/registration in the State of Ohio, as required by law, with the same legal name as set forth on the LIAP's or AHP's application for clinical privileges;

3.3.2 Successful completion of an accredited training requirement, if any, as defined by the delineation of privileges;

3.3.3 Professional certification requirements, if any, as defined by the delineation of privileges;

3.3.4 Current experience and demonstrated competence in area of privileges requested;

3.3.5 Ability to perform all of the physical or mental health functions related to the delineation of privileges requested as an LIAP or AHP, with or without accommodation;

3.3.6 Documented proof (in the form of peer references) of current clinical competence, strict adherence to professional ethics, the ability to work cooperatively with others and of willingness to participate in the discharge of responsibilities of the position;

3.3.7 Maintains proof of legal permanent residency or a proper visa for the clinical privileges requested, if not a United States citizen;

3.3.8 Evidence of current professional liability insurance as defined by University Hospitals Parma Medical Center Policy on Professional Liability Insurance;

3.3.9 Compliance with the Hospital Communicable Diseases Policy;

3.3.10 Compliance with University Hospitals Health System Corporate Compliance Program and Guidelines;

3.3.11 Current ability to participate in Medicare, Medicaid and all other applicable federal or state healthcare programs, without any limitations, restrictions, sanctions, or exclusions;

3.3.12 Compliance with Hospital policy requiring LIAPs and AHPs to maintain a personal, confidential electronic mail (e-mail) address to monitor critical communications from UHHS or Administration;

3.3.13 <u>In addition, for nurse practitioners and clinical nurse specialists</u>

3.3.13.1 Current, fully-executed standard care arrangement with member of the Hospital's Active Medical Staff, in good standing, privileged in the same specialty.

3.3.13.2 Current certificate of authority from Ohio Board of Nursing;

3.3.14 In addition, for certified registered nurse anesthetists

3.3.14.1 Current certificate of authority from Ohio Board of Nursing;

3.3.15 In addition, for physician assistants

3.3.15.1 Current supervision agreement approved by the State Medical Board of Ohio;

3.3.16 For Hospital LIAPs and AHPs: adherence to this Policy, applicable job title-specific sub-policies, the Hospital's employment policies and procedures, and applicable Policies and Procedures.

3.3.17 For non-Hospital LIAPs and AHPs: adherence to this Policy, applicable job title-specific sub-policies, and applicable Policies and Procedures.

4.0 RESPONSIBILITIES OF THE LIAP AND AHP

4.1 Applicants shall demonstrate, with sufficient adequacy, that they will provide care to patients at least at the generally recognized professional level of quality, in an economically-efficient manner, taking into account patients' needs, the available Hospital facilities and resources, and the utilization standards which may be in effect at the Hospital, from time to time.

4.2 Upon approval to practice or provide services as a LIAP or AHP, the practitioner agrees to:

4.2.1 Provide his/her patients with care that is recognized as a professional level of quality, efficiency, and competency;

4.2.2 Embrace the Hospital's Mission, Vision and Values, adopted by the Board of Directors.

4.2.3 LIAPs only:

4.2.3.1 Maintain and abide by a standard care arrangement in compliance with Hospital standards.

4.2.3.2 Report any revisions in content of standard care arrangement or assignment of collaborating physician(s) to parties identified on the standard care arrangement.

4.2.4 For Hospital LIAPs and AHPs: adherence to this Policy, applicable job title-specific sub-policies, the Hospital's employment policies and procedures, applicable Policies and Procedures and University Hospitals Health System Organizational Integrity.
For non-Hospital LIAPs and AHPs: adherence to this Policy, applicable job title-specific sub-policies, applicable Policies and

Procedures, and University Hospitals Health System Organizational Integrity.

4.2.5 Discharge such Department, Division, Committee and Hospital functions for which he/she is responsible;

4.2.6 Abide by the ethical principles of his/her profession, including, but not limited to: refraining from fee splitting or other inducements relating to patient referral; providing for continuous care of his/her patients (within his/her area of professional competence); refraining from delegating the responsibility for diagnosis or care of patients to a practitioner who is not qualified to undertake this responsibility, and/or who is not adequately supervised; and seeking consultation whenever necessary. Immediately notify the Chief Medical Officer, or his/her designee, of the following:

- 4.2.6.1 any change in the status of the collaborating physician which affects the LIAP's ability to practice or any change in the supervising physician which affects the AHP's ability to provide services, in accordance with the Ohio Revised Code and/or Hospital Policies and Procedures;
- 4.2.6.2 the revocation, suspension, or limitation of the LIAP's or AHP's professional license/registration/certification or DEA registration;
- 4.2.6.3 the imposition of terms of probation or limitation of practice by any State;
- 4.2.6.4 imposition of any limitations, sanctions, restrictions or exclusion from participation in the Medicare, Medicare, or other applicable Federal or State healthcare programs;
- 4.2.6.5 removal from the provider panel of any managed care organization or third party payor;
- 4.2.6.6 A material change in practice or his/her loss or restriction of medical staff membership, clinical privileges, employment, or scope of practice at any hospital, other health care organization, or physician practice;
- 4.2.6.7 the commencement of a formal investigation, or the filing of charges, by the Department of Health and Human Services, or any law enforcement agency or health regulatory agency of the United States or by any State or governmental authority;
- 4.2.6.8 the filing of a claim against the practitioner alleging professional liability;

4.2.7 Provide services to all patients regardless of their ability to pay;

4.2.8 Participate in teaching programs conducted by the Hospital, when requested;

4.2.9 Involvement in performance improvement initiatives of the Hospital;

4.2.10 Participate in the Hospital's annual safety programs;

4.2.11 Participate in educational or instructional programs deemed mandatory by the Chief Medical Officer and the President; and

4.2.12 Refrain from any conduct or acts that are or could reasonably be interpreted as being beyond, or an attempt to exceed, the delineation of privileges or scope of practice authorized within the Hospital or by law.

5.0 CONDITIONS AND DURATION OF CLINICAL PRIVILEGES

5.1 All LIAPs or AHPs are assigned to at least one clinical department with corresponding clinical privileges and may be granted privileges in other clinical departments. Approval of clinical privileges as an LIAP or AHP shall be made by the Board of Directors, subject to any Hospital employment Policies for Hospital employees, after recommendation by the Division Chief and/or Department Chairman, the Credentials Committee, and the Medical Executive Committee. Approval of clinical privileges shall be for a period of no longer than two (2) years. LIAPs and AHPs are required to reapply for privileges at least every two (2) years.

5.2 After recommendation by the Chairman and the Chief Medical Officer, the President (or in the absence of the President, when necessary, his/her designee) may grant interim clinical privileges to the LIAP or AHP meeting approved criteria for a period not to exceed 120 days in order to complete the approval process.

5.3 Each initial privileging or renewal of privileges shall be valid only for the period stated on the clinical privileging form, unless otherwise curtailed or restricted as provided herein. Any change in status or clinical privileges shall apply only to the remainder of the then current privileging period.

5.4 In the event of termination, LIAPs or AHPs not considered employees of UH Parma Medical Center as defined in this Policy are granted only those fair hearing rights outlined in Section 12. Only Hospital employees are subject to Hospital Policies governing termination.

5.5 <u>Contractual Relationships.</u>

5.5.1 The clinical privileges of any LIAP or AHP who has a contractual relationship with the Hospital, or is either an employee, partner, or principal of, or in, an entity which has a contractual relationship with the Hospital relating to providing services to patients at the Hospital are defined through Medical Staff mechanisms. These privileges shall terminate automatically and immediately, unless the contract specifies otherwise, upon:

5.5.1.1 the expiration or other termination of the contractual relationship with the Hospital; or

5.5.1.2 the expiration or other termination of the relationship of the LIAP or AHP with the entity that has a contractual relationship with the Hospital.

5.5.2 For LIAPs and AHPs, such termination shall be considered a voluntary resignation.

5.5.3 In the event of such termination of clinical privileges or other contractual relationship with the Hospital, there shall be no fair hearing rights as outlined in Section 12 for LIAPs or AHPs not considered UHC employees as defined in this Policy. Only Hospital employees are subject to Hospital Policies governing termination.

6.0 PROCEDURES FOR APPLICATION FOR INITIAL CLINICAL PRIVILEGES BY THE LIAP OR AHP

6.1 Conditions of Application. By applying for clinical privileges as an LIAP or AHP, the applicant:

6.1.1 Agrees to appear for interviews in regard to his/her application, as requested;

6.1.2 Agrees to produce sufficient information and/or appear for verification of personal identity;

6.1.3 Authorizes Hospital representatives to consult with others who have been associated with him/her, and who may have information bearing on his/her competence and qualifications;

6.1.4 Consents to the inspection by Hospital representatives of all records and documents pertinent to his/her licensure/certification/registration, specific training, experience, current competence and ability to carry out the clinical privileges he/she requests, and relationships with peers and patients, as well as of his/her ethical qualifications.

6.1.5 Releases from liability the Hospital, its agents, employees and representatives for their acts performed in good faith in connection with evaluating the applicant and his/her credentials;

6.1.6 Releases from all liability all individuals and organizations who provide information, including otherwise privileged or confidential information, to Hospital representatives in good faith concerning the applicant's ability, professional ethics, character, ability to perform any of the physical or mental health functions related to the specific clinical privileges requested as a LIAP or AHP, with or without accommodation and other qualifications for practice and clinical privileges;

6.1.7 Agrees that any lawsuit brought by the applicant against an individual or organization providing information to a Hospital representative, or against a Hospital representative, shall be brought in a court, Federal or State, in the State of Ohio;

6.1.8 Agrees to limit his/her activities to those described in his/her license, certificate, or registration by the State of Ohio;

6.1.9 Agrees that completion of the credentialing and privileging process is a prerequisite to practice or provide services as a LIAP or AHP in the Hospital, regardless of employment status; and

6.1.10 Pledges to provide for continuous quality care for his or her patients.

6.2 Initiation of the Application Process.

All LIAP or AHP applicants shall initiate a request for clinical privileges to the Division Chief and/or Chairman of that specialty to which he/she wishes to apply for clinical privileges.

The LIAP or AHP application for clinical privileges is a separate process and is in addition to any employment requirements of the Hospital, physician, or practice group.

A complete application shall be submitted and shall contain the following:

6.2.1 a completed application form consisting of the credentialing application form prescribed by the Ohio Department of Insurance and the University Hospitals Health System Application for Initial Privileging;

6.2.2 a signed UHHS Condition of Application/Release and Immunity Statement;

6.2.3 current demographic information, including a personal, confidential electronic mail (e-mail) address to monitor critical communications from UHHS or Administration;

6.2.4 current curriculum vitae (CV);

6.2.5 if DEA registration is held, copy of a current, unrestricted DEA registration, valid in the State of Ohio, signed DEA pharmacy cards;

6.2.6 proof of legal permanent residency or proper visa for the clinical privileges requested, if not a United States citizen;

6.2.7 description of education, training, professional experience, current and all former licensure, and other qualifications;

6.2.8 written explanation of gaps in work history of more than two (2) months;

6.2.9 information regarding any former or current malpractice actions, including but not limited to litigation, arbitration or mediation, regardless of status, method, or outcome;

6.2.10 professional certification (if applicable);

6.2.11 completed privilege delineation form;

6.2.12 any documentation needed to support the request for clinical privileges that require special training or experience (as indicated on the privilege delineation form);

6.2.13 professional liability history and current certificate of insurance coverage per University Hospitals Parma Medical Center Policy on Professional Liability Insurance, showing effective and expiration dates, individual coverage limits and named insured;

6.2.14 information regarding ability to perform any of the physical or mental health functions related to the delineation of privileges requested as a LIAP or AHP, with or without accommodation;

6.2.15 information regarding previously filed or currently pending disciplinary actions or challenges to any licensure, certification, or registration (state or district, Drug Enforcement Administration if applicable) or the voluntary or involuntary limitation or relinquishment of such licensure, certification, or registration;

6.2.16 any voluntary or involuntary termination of any health care organization, physician, or physician practice affiliation or employment, or voluntary or involuntary limitation, reduction, or loss of practice privileges at another health care organization;

6.2.17 any conviction of a violation of law other than a minor traffic violation, regardless of date of occurrence or severity;

6.2.18 proof of compliance with the Hospital Communicable Diseases Policy;

6.2.19 signed University Hospitals Health System Corporate Compliance Certification;

6.2.20 <u>In addition for nurse practitioners and clinical nurse specialists:</u>
- 6.2.20.1 current, fully executed standard care arrangement with member of the Hospital's Active Medical Staff, in good standing, privileged in the same specialty;
- 6.2.20.2 current certificate of authority from Ohio Board of Nursing;
- 6.2.20.3 current Ohio Board of Nursing prescriptive authority certification if requesting prescriptive privileges;

6.2.21 <u>In addition for certified registered nurse anesthetists:</u>
- 6.2.21.1 current certificate of authority from Ohio Board of Nursing;

6.2.22 <u>In addition for physician assistants:</u>
- 6.2.22.1 current supervision agreement approved by the State Medical Board of Ohio;
- 6.2.22.2 meet all requirements stated on the privilege delineation form as approved by the Board of Directors, the ORC 4730.39 and current State Medical Board of Ohio requirements if requesting physician-delegated prescriptive authority privileges;

6.2.23 any other necessary documentation requested to adequately evaluate the applicant.

6.3 Processing Application.

6.3.1 Assessment. Following submission of a completed application, Medical Staff Services shall review the file for thoroughness and receipt of all required documentation. Medical Staff Services has the right to request additional information or clarification of information presented by the applicant.

6.3.2 Burden of Proof. An application is considered incomplete until all required documentation and information have been submitted. The applicant has the following responsibilities:

6.3.2.1 to produce sufficient information and/or appear for verification of personal identity;

6.3.2.2 to produce sufficient information for a proper evaluation of his/her training, experience, current competence, prior health care organization affiliations or employment, liability history, and health status;

6.3.2.3 to resolve any questions about these or any of the qualifications for authorization to practice or provide services as a LIAP or AHP;

6.3.2.4 to satisfy any requests by the Hospital for additional information or clarification of information presented; and

6.3.2.5 submit to any reasonable evidence of current health status that may be requested by the Hospital.

6.3.3 Verification of Information. Prior to routing to the Credentialing Committee, the following is verified from the primary source, according to listing of approved sources for primary source verification, when feasible:

6.3.3.1 professional education and relevant training;

6.3.3.2 current and former licensure, certification, or registration, including certificate(s) of authority and prescriptive authority or utilization plan (as applicable);

6.3.3.3 professional certification(s);

6.3.3.4 previous professional experience and work history;

6.3.3.5 settlements or judgments paid by or on behalf of practitioner;

6.3.3.6 gaps in professional career of six months or more in duration;

6.3.3.7 National Provider Identifier (NPI)

6.3.3.8 The current clinical competence of an applicant is verified by obtaining evaluations from hospitals or other health care entities where he/she has trained, held clinical assignments within the past five years, and from collaborating, supervising and/or employing physicians, as appropriate and within confines of applicable law. If the applicant's experience is limited, personal peer references will be obtained to meet a minimum of three (3) current clinical competence evaluations. Peer is defined as appropriate practitioner in the same

professional discipline as the applicant who has firsthand knowledge of the applicant;

6.3.3.9 if attempts to contact primary sources are not successful, approved equivalent sources or other reliable secondary sources may be used to verify licensure, training, experience, and current competence;

6.3.3.10 unsuccessful attempts to reach primary sources are documented in the credentials file.

6.3.4 Queries for Information. The following entities are queried:

6.3.4.1 Federation of State Medical Boards for physician assistants;

6.3.4.2 National Practitioner Data Bank;

6.3.4.3 The applicable State of Ohio licensure board(s) and other state licensure boards, if applicable;

6.3.4.4 Source for professional background check.

6.3.5 Missing Information. The applicant is promptly informed of any missing information or problems in obtaining verification of information. The applicant is ultimately responsible for ensuring the receipt of this information. Action on an individual's application shall be withheld until the above information is available and verified.

6.3.6 Each applicant, and the clinical department to which the clinical privileges are being processed, may be informed of the status of his/her application, upon request.

6.3.7 Time Periods for Processing. All individuals and groups required to act on a complete application for a LIAP or AHP must do so in a timely and good faith manner. Except for obtaining required information, or for other good cause, each application should be processed within 180 days of receipt of a complete application including all applicable components noted in 6.2.1 through 6.2.24 above.

6.4 Department Action. After receipt of the application, the Division Director and/or Department Chairman or appropriate committee of each department to which the application is submitted, shall review the application and supporting documentation, and may conduct a personal interview with the applicant at their discretion. The Chair or appropriate committee shall evaluate all matters deemed relevant to a recommendation, including information concerning the applicant's provision of services within the scope of privileges requested, and shall transmit to the Credentials Review Committee a written report and recommendation as to appointment and, if appointment is recommended, as to membership category, department affiliation, clinical privileges to be granted, and any special conditions to be attached. The Chair may also request that the Medical Executive Committee defer action on the application for a specified period of time based upon specific reasons as enumerated by the Chair.

6.5 Credentials Review Committee. The Credentials Review Committee shall review the application, evaluate and verify the supporting

documentation, the department Chair's report and recommendations, and other relevant information. The Credentials Review Committee may elect to interview the applicant and seek additional information. The Credentials Review Committee shall transmit to the Medical Executive Committee its recommendations as to appointment and, if appointment is recommended, as to the department affiliation and clinical privileges to be granted, and any special conditions to be attached to the appointment.

6.5.1 If the Credentials Review Committee determines that substantive matters are jeopardizing the applicant, the Credentialing Committee shall so notify the applicant and provide him with an opportunity to respond to the matter or such other action as is appropriate under the circumstances.

6.5.2 The Credentials Review Committee may also recommend that the Medical Executive Committee defer action on the application for a specified period of time based upon specific reasons as enumerated by the Committee

6.5.3 An applicant's complete application may be forwarded to the Medical Executive Committee without a Credentials committee review if the application is a clean application as defined by the absence of:

6.5.3.1 An involuntary termination of employment, if applicable, at another institution;
6.5.3.2 An involuntary limitation, reduction, denial, or loss of clinical privileges at any institution; or
6.5.3.3 A final judgment adverse to the applicant in a professional liability action.
6.5.3.4 Any current challenge or previously successful challenge to licensure or registration.

6.6 Medical Executive Committee Action. The Medical Executive Committee shall consider the report and any other relevant information. The Medical Executive Committee may request additional information, return the matter to the Credentials Review Committee for further investigation, elect to interview the applicant or otherwise take action and make a recommendation to the Board following receipt of the report. The committee may also defer action on the application for a specified period of time. The reasons for each action and recommendation shall be stated.

6.6.1 Favorable Recommendation: When the recommendation of the Medical Executive Committee is favorable to the applicant, it shall be promptly forwarded, together with supporting documentation, to the Board.

6.6.2 Adverse Recommendation: When the recommendation of the Medical Executive Committee is adverse to the applicant, the

applicant shall be informed by written notice which notice shall include the basis for the adverse recommendation. Upon receipt of this notice the applicant shall be entitled to exercise his or her rights made by the hearing and appellate review procedures set forth in Section 12. The applicant's rights under Section 12 must either be waived or exhausted before the Board may take action.

6.7 Board Action on the Application. The Board may accept the recommendation of the Medical Executive Committee or may refer the matter back to the Medical Executive Committee for further consideration, stating the purpose for such referral. The following procedures shall thereafter apply with respect to action on the application:

6.7.1 If the Board concurs with the recommendation of the Medical Executive Committee, the decision of the Board shall be deemed final action.

6.7.2 If the Board does not concur with the recommendation of the Medical Executive Committee, and the proposed decision of the Board is adverse to the applicant, the applicant shall be informed by written notice which notice shall include the basis for the proposed adverse decision. The applicant shall then be entitled to the fair hearing and appellate review procedures set forth in Section 12. If the proposed decision constitutes adverse action, as defined in the regulations implementing the NPDB, the notice shall include the actual wording of a 600 character (or less) description of the underlying action which will be reported to the NPDB in the Adverse Action report if the proposed action is adopted by the Board.

6.8 Notice of Final Decision. Notice of the final decision, if adverse, shall be either hand delivered or sent by certified mail, return receipt requested to the applicant and, in addition, given to the CMO, the Medical Executive Committee, the Credentials Committee, the Chair of each department concerned, and the Hospital President.

6.8.1 A decision and notice to appoint or reappoint shall include, if applicable:
- 6.8.1.1 the staff category to which the applicant is appointed;
- 6.8.1.2 the department to which he is assigned;
- 6.8.1.3 the clinical privileges granted; and
- 6.8.1.4 any special conditions attached to the appointment.

7.0 PROCEDURES FOR RENEWAL OF CLINICAL PRIVILEGES BY THE LIAP OR AHP

7.1 General Requirements. Renewal of clinical privileges is based on a reappraisal of the LIAP or AHP at the time of renewal of clinical privileges at least every two (2) years on a staggered schedule by clinical department.

7.2 Conditions of Application. By applying for renewal of clinical privileges as a LIAP or AHP, the applicant:

7.2.1 Agrees to appear for interviews in regard to his/her application, as requested;

7.2.2 Authorizes Hospital representatives to consult with others who have been associated with him/her, and who may have information bearing on his/her competence and qualifications;

7.2.3 Consents to the inspection by Hospital representatives of all records and documents pertinent to his/her licensure/certification/ registration, specific training, experience, current competence and ability to carry out the clinical privileges he/she requests, and relationships with peers and patients, as well as of his/her ethical qualifications;

7.2.4 Releases from liability the Hospital, its agents, employees and representatives for their acts performed in good faith in connection with evaluating the applicant and his/her credentials;

7.2.5 Releases from all liability all individuals and organizations who provide information, including otherwise privileged or confidential information, to Hospital representatives in good faith concerning the applicant's ability, professional ethics, character, ability to perform any of the physical or mental health functions related to the specific clinical privileges requested as a LIAP or AHP, with or without accommodation and other qualifications for practice and clinical privileges;

7.2.6 For nurse practitioners and clinical nurse specialists:

7.2.6.1 Report any change in the standard care arrangement or identification of the collaborating physician(s);

7.2.7 For physician assistants:

7.2.7.1 Report any change in the supervision agreement approved by the State Medical Board of Ohio or identification of supervising physician(s);

7.2.8 Agrees that any lawsuit brought by the applicant against an individual or organization providing information to a Hospital representative, or against a Hospital representative, shall be brought in a court, Federal or State, in the State of Ohio;

7.2.9 Agrees to limit his/her activities to those described in his/her license, certificate, or registration by the State of Ohio; and

7.2.10 Pledges to provide for continuous quality care for his or her patients.

7.3 Initiation of the Renewal of Clinical Privileges Process.

7.3.1 Medical Staff Services will initiate the renewal of clinical privileges process with all current LIAPs and AHPs in the clinical departments in accordance with the staggered reappointment schedule. Application for renewal of clinical privileges is a separate process and in addition to any employment requirements for annual evaluation by the Hospital, physician, or practice group.

7.4 Application. A complete renewal of clinical privileges application shall be submitted to Medical Staff Services and shall contain the following:

7.4.1 completed application form consisting of the credentialing application form prescribed by the Ohio Department of Insurance and the University Hospitals Health System Application for Renewal of Clinical Privileges;

7.4.2 a signed UHHS Condition of Application/Release and Immunity Statement;

7.4.3 current demographic information, including a personal, confidential electronic mail (e-mail) address to monitor critical communications from UHHS or Administration;

7.4.4 If held, copy of a current, unrestricted DEA registration, valid in the State of Ohio

7.4.5 proof of legal permanent residency or proper visa for the clinical privileges requested, if not a United States citizen;

7.4.6 description of education, training, professional experience, current and all former licensure, and other qualifications;

7.4.7 written explanation of gaps in work history of more than two (2) months;

7.4.8 information regarding any former or current malpractice actions, including but not limited to litigation, arbitration or mediation, regardless of status, method, or outcome;

7.4.9 copy of current curriculum vitae (CV);

7.4.10 evidence of professional continuing education;

7.4.11 professional certification (if applicable);

7.4.12 completed privilege delineation form;

7.4.13 any documentation needed to support the request for clinical privileges that require special training or experience (as indicated on the privilege delineation form);

7.4.14 professional liability history and current certificate of insurance coverage per University Hospitals Parma Medical Center Policy on Professional Liability Insurance showing effective and expiration dates, individual coverage limits and named insured;

7.4.15 information regarding ability to perform any of the physical or mental health functions related to the delineation of privileges requested as a LIAP or AHP, with or without accommodation;

7.4.16 information regarding previously successful or currently pending challenges to any licensure, certification, or registration (state or district, Drug Enforcement Administration if applicable) or the voluntary or involuntary relinquishment of such licensure, certification, or registration;

7.4.17 any voluntary or involuntary termination of any health care organization, physician, or physician practice affiliation or employment, or voluntary or involuntary limitation, reduction, or loss of practice privileges at another health care organization;

7.4.18 any conviction of a violation of law other than a minor traffic violation, regardless of date of occurrence or severity;

7.4.19 proof of compliance with the Hospital Communicable Diseases Policy;

7.4.20 signed University Hospitals Health System Corporate Compliance Certification;

7.4.21 <u>In addition for nurse practitioners and clinical nurse specialists:</u>

- 7.4.21.1 current, fully executed standard care arrangement with member of the Hospital's Active Medical Staff, in good standing, privileged in the same specialty;
- 7.4.21.2 current certificate of authority from Ohio Board of Nursing;
- 7.4.21.3 current Ohio Board of Nursing prescriptive authority certification if requesting prescriptive privileges;

7.4.22 <u>In addition for certified registered nurse anesthetists:</u>

- 7.4.22.1 current certificate of authority from Ohio Board of Nursing;

7.4.23 <u>In addition for physician assistants:</u>

- 7.4.23.1 current supervision agreement approved by the State Medical Board of Ohio;
- 7.4.23.2 meet all requirements stated on the privilege delineation form as approved by the Board of Directors, the ORC 4730.39 and current State Medical Board of Ohio requirements if requesting physician-delegated prescriptive authority privileges; and

7.4.24 any other necessary documentation requested by Medical Staff Services or the Credentials Review Committee to adequately evaluate the applicant.

7.5 Processing Application.

7.5.1 Assessment. Following submission of a completed application, the file will be reviewed for thoroughness and receipt of all required documentation. Medical Staff Services has the right to request additional information or clarification of information presented by the applicant.

7.5.2 Burden of Proof. An application is considered incomplete until all required documentation and information have been submitted. The applicant has the following responsibilities:

7.5.2.1 to produce sufficient information for a proper evaluation of his/her training, experience, current competence, prior health care organization affiliations or employment, liability history, and health status;

7.5.2.2 to resolve any questions about these or any of the qualifications for authorization to practice or provide services as an LIAP or AHP;

7.5.2.3 to satisfy any requests by the Hospital for additional information or clarification of information presented; and

7.5.2.4 submit to any reasonable evidence of current health status that may be requested by the Hospital.

7.5.3 Verification of Information. Prior to routing to the Credentialing Committee, Medical Staff Services verifies the following from the primary source, according to listing of approved sources for primary source verification ,when feasible:

7.5.3.1 any new training during the previous two(2) years;

7.5.3.2 current licensure, certification, or registration including certificate(s) of authority or supervision agreement;

7.5.3.3 professional certification;

7.5.3.4 current clinical competence of applicant by obtaining a peer evaluation from primary facility where he/she is affiliated; peer is defined as appropriate practitioner in the same professional discipline as the applicant who has firsthand knowledge of the applicant;

7.5.3.5 settlements or judgments paid by or on behalf of practitioner;

7.5.3.6 if attempts to contact primary sources are not successful, approved equivalent sources or other reliable secondary sources may be used to verify licensure, training, experience, and current competence;

7.5.3.7 unsuccessful attempts to reach primary sources are documented in the credentials file.

7.5.4 Queries for Information. The following entities are queried:

7.5.4.1 National Practitioner Data Bank;

7.5.4.2 the applicable State of Ohio licensure board(s) and other state licensure boards, if applicable;

7.5.4.3 source for professional background check, if not previously documented.

7.5.5 Each applicant, and the clinical department to which renewal of clinical privileges is being processed, may be informed of the status of his/her application, upon request.

7.5.6 Termination for Not Completing the Application Process. Medical Staff Services promptly informs the applicant of any missing information or problems in obtaining verification of information. The applicant is ultimately responsible for ensuring the receipt of this information. An incomplete renewal of clinical privileges application will result in the automatic termination of the LIAPs or AHPs clinical privileges at the end of the applicant's current approval period.

7.5.7 Time Periods for Processing. All individuals and groups required to act on a complete application for a LIAP or AHP must do so in a timely and good faith manner. Processing begins with receipt of a complete application, including all applicable components noted in 7.4.1 through 7.4.24 above and ending with submission to the Medical Executive Committee and Board of Directors for approval.

7.5.8 Deadline for return of Completed Application. Deadline for return of the completed application, privilege delineation form and all related documentation is no less than thirty (30) days prior to the date when clinical privileges expire. Failure of the applicant to submit a complete renewal of clinical privileges application by the deadline will result in the automatic termination of the LIAP's or AHP's clinical privileges at the end of the applicant's current approval period. This will be considered a voluntary resignation of clinical privileges.

7.6 Department Action. After receipt of the application, the Division Chief and/or Department Chairman or appropriate committee of each department to which the application is submitted, shall review the application and supporting documentation, and may conduct a personal interview with the applicant at their discretion. The Chair or appropriate committee shall evaluate all matters deemed relevant to a recommendation, including information concerning the applicant's provision of services within the scope of privileges requested, and shall transmit to the Credentials Committee a written report and recommendation as to appointment and, if appointment is recommended, as to membership category, department affiliation, clinical privileges to be granted, and any special conditions to be attached. The Chair may also request that the Medical Executive Committee defer action on the application for a specified period of time based upon specific reasons as enumerated by the Chair.

7.7 Credentials Review Committee. The Credentials Review Committee shall review the application, evaluate and verify the supporting

documentation, the department Chair's report and recommendations, and other relevant information. The Credentials Review Committee may elect to interview the applicant and seek additional information. The Credentials Review Committee shall transmit to the Medical Executive Committee its recommendations as to appointment and, if appointment is recommended, as to the department affiliation and clinical privileges to be granted, and any special conditions to be attached to the appointment.

7.7.1 If the Credentials Review Committee determines that substantive matters are jeopardizing the applicant, the Credentials Review Committee shall so notify the applicant and provide him with an opportunity to respond to the matter or such other action as is appropriate under the circumstances.

7.7.2 The Credentials Review Committee may also recommend that the Medical Executive Committee defer action on the application for a specified period of time based upon specific reasons as enumerated by the Committee

7.7.3 An applicant's complete application may be forwarded to the Medical Executive Committee without a Credentials Review Committee review if the application is a clean application as defined by the absence of:

7.7.3.1 An involuntary termination of employment, if applicable, at another institution;
7.7.3.2 An involuntary limitation, reduction, denial, or loss of clinical privileges at any institution; or
7.7.3.3 A final judgment adverse to the applicant in a professional liability action.
7.7.3.4 Any current challenge or previously successful challenge to licensure or registration.

7.8 Medical Executive Committee Action. The Medical Executive Committee shall consider the report and any other relevant information. The Medical Executive Committee may request additional information, return the matter to the Credentials Review Committee for further investigation, elect to interview the applicant or otherwise take action and make a recommendation to the Board following receipt of the report. The committee may also defer action on the application for a specified period of time. The reasons for each action and recommendation shall be stated.

7.8.1 Favorable Recommendation: When the recommendation of the Medical Executive Committee is favorable to the applicant, it shall be promptly forwarded, together with supporting documentation, to the Board.

7.8.2 Adverse Recommendation: When the recommendation of the Medical Executive Committee is adverse to the applicant, the

applicant shall be informed by written notice which notice shall include the basis for the adverse recommendation. Upon receipt of this notice the applicant shall be entitled to exercise his or her rights made by the hearing and appellate review procedures set forth in Section 12. The applicant's rights under Section 12 must either be waived or exhausted before the Board may take action.

7.9 Board Action on the Application. The Board may accept the recommendation of the Medical Executive Committee or may refer the matter back to the Medical Executive Committee for further consideration, stating the purpose for such referral. The following procedures shall thereafter apply with respect to action on the application:

7.9.1 If the Board concurs with the recommendation of the Medical Executive Committee, the decision of the Board shall be deemed final action.

7.9.2 If the Board does not concur with the recommendation of the Medical Executive Committee, and the proposed decision of the Board is adverse to the applicant, the applicant shall be informed by written notice which notice shall include the basis for the proposed adverse decision. The applicant shall then be entitled to the fair hearing and appellate review procedures set forth in Section 12. If the proposed decision constitutes adverse action, as defined in the regulations implementing the NPDB, the notice shall include the actual wording of a 600 character (or less) description of the underlying action which will be reported to the NPDB in the Adverse Action report if the proposed action is adopted by the Board.

7.10 Notice of Final Decision. Notice of the final decision, if adverse, shall be either hand delivered or sent by certified mail, return receipt requested to the applicant and, in addition, given to the CMO, the Medical Executive Committee, the Credentials Committee, the Chair of each department concerned, and the Hospital President.

7.10.1A decision and notice to appoint or reappoint shall include, if applicable:
- 7.10.1.1 the staff category to which the applicant is appointed;
- 7.10.1.2 the department to which he is assigned;
- 7.10.1.3 the clinical privileges granted; and
- 7.10.1.4 any special conditions attached to the appointment.

7.11 Late Penalties. Reinstatement of clinical privileges due to submission of a Request for Application and/or an application for renewal of clinical privileges after the final deadline requires approval by the Division Chief

and/or Department Chairman and each will be subject to a reinstatement fee.

8.0 OTHER LIAP AND AHP ACTIONS

8.1 Change in Status Between Approval Periods.

8.1.1 A LIAP or AHP may request a change in status between clinical privileges renewal periods, including but not limited to change in: clinical department assignment or clinical privileges requested.

8.1.2 A LIAP or AHP requesting to make a change in status between renewal periods must make application in writing, including the reason for the request, to the Chairman. The request shall be referred to Medical Staff Services for processing and referred for action to the Credentialing Committee and Chairman, who recommends to the Medical Executive Committee and the Board of Directors for final approval. The LIAP or AHP must provide evidence of training or experience in accordance with the applicable policies of the clinical department for those changes in status being requested. If clinical privileges are being voluntarily relinquished, no additional documentation is required.

8.2 Secondary Position. In order to obtain clinical privileges in a second department, the applicant must make application to the appropriate Chairman. Such application shall be processed in a similar manner as an initial application as outlined under Section 6.

8.3 Leave of Absence.

8.3.1 For Hospital LIAPs and AHPs: Subject to the Hospital's employment policies and Section 8.3.2 of this Policy. If a conflict is found between the policies, the Hospital's employment policies shall supersede this Section 8.3.2 for Hospital employees.

8.3.2 For non-Hospital LIAPs and AHPs:

8.3.2.1 Request for voluntary leave of absence from the LIAP or AHP shall be submitted in writing to the Chairman for a minimum of three (3) months, but not to exceed a one (1) year period. A leave of absence (LOA) may be granted to LIAP or AHP for any reason deemed appropriate by the Chairman, such as illness, personal reasons, further clinical or academic training or military duty.

8.3.2.2 A LIAP or AHP on LOA status shall not have authorization to practice in the Hospital during the LOA period. He/she shall be excused from liability insurance requirements of the Hospital and departmental responsibilities and all other duties.

8.3.2.3 In order to resume his/her previous authorization to practice or provide services, the LIAP or AHP must provide to Medical Staff Services:

8.3.2.3.1 documentation verifying liability insurance coverage per University Hospitals Parma

Medical Center Policy on Professional Liability Insurance;

8.3.2.3.2 if held, copy of current, unrestricted DEA registration valid in the State of Ohio;

8.3.2.3.3 information regarding his/her activities and whereabouts during the LOA for verification;

8.3.2.3.4 <u>In addition for nurse practitioners and clinical nurse specialists;</u>

8.3.2.3.4.1 current, fully-executed standard care arrangement with member of the Hospital's Active Medical Staff, in good standing, privileged in the same specialty.

8.3.2.3.4.2 current certificate of authority from Ohio Board of Nursing;

8.3.2.3.4.3 current Ohio Board of Nursing prescriptive authority certification if requesting prescriptive privileges;

8.3.2.3.5 <u>In addition for certified registered nurse anesthetists:</u>

8.3.2.3.5.1 current certificate of authority from Ohio Board of Nursing.

8.3.2.3.6 <u>In addition for physician assistants:</u>

8.3.2.3.6.1 current supervision agreement approved by the State Medical Board of Ohio;

8.3.2.3.6.2 meet all requirements stated on the privilege delineation form as approved by Medical Executive Committee and the Board of Directors, the ORC 4730.39 and current State Medical Board of Ohio requirements if requesting physician-delegated prescriptive authority privileges.

8.3.2.4 <u>Queries for Information.</u> The following entities are queried:

8.3.2.4.1 National Practitioner Data Bank;

8.3.2.4.2 the applicable State of Ohio licensure board(s) and other state licensure boards, if applicable;

8.3.2.4.3 source for professional background check, if not previously documented.

8.3.2.5 A requested return from LOA must be recommended by the Division Chief and/or Chairman, and reviewed by the Credentials Review Committee before an interim return from LOA becomes effective, subject to the criteria for interim clinical privileges, Section 6.4.1.1.

8.3.2.6 The Chairman shall make a preliminary recommendation for return from LOA and clinical privileges subject to further review by the Credentialing Committee. After review and favorable recommendation by the Credentials Review Committee and upon recommendation of the

Chairman and Chief Medical Officer, the President (or, in the absence of the President, when necessary, his/her designee) may grant an interim return from LOA and clinical privileges for a period not to exceed 120 days in order to complete the approval process. Medical Staff Services will notify applicant of the approval of his/her interim return from LOA and clinical privileges no later than sixty (60) days after Credentialing Committee approval.

8.3.2.7 Recommendations for return from LOA are submitted to the Medical Executive Committee and the Board of Directors for final approval.

8.3.2.8 Notification. Medical Staff Services shall notify applicant of the Board of Directors' approval of the request for return from LOA and clinical privileges.

8.3.2.9 It is the responsibility of the LIAP or AHP to submit a request to return from LOA prior to the LOA's expiration. If the LIAP or AHP does not submit a request to return from LOA or a letter of resignation prior to LOA expiration, the clinical department and/or Medical Staff Services has no responsibility and shall not be required to make any effort to locate the practitioner. If the practitioner is unable to be located prior to the LOA expiration, his/her clinical privileges shall be terminated upon recommendation from the Division Chief and/or Chairman and shall be reported to the Medical Executive Committee and Board of Directors. Termination of clinical privileges resulting from this Section 8.3.2.9 shall be considered a voluntary resignation.

8.4 Resignations and Terminations. (For additional information, refer to applicable policy in the HR Policy and Procedure Manual)

8.4.1 For Hospital LIAPs and AHPs: Subject to the Hospital's employment policies and Section 8.4.2 of this Policy.

8.4.2 For non-Hospital LIAPs and AHPs:

8.4.2.1 Resignations. Resignation of clinical privileges as a LIAP or AHP and the reason therefore shall be submitted in writing to Medical Staff Services. Such resignations shall be effective on the date indicated.

8.4.3 Terminations.

8.4.3.1 When a LIAP or AHP has left the geographic area without submitting a resignation letter and/or a forwarding address, his/her clinical privileges as a LIAP or AHP shall be terminated after approval of the Division Chief and/or Chairman. Such terminations are effective on the date of notification and shall be reported to the Medical Executive Committee and Board of Directors.

8.4.3.2 If a LIAP or AHP fails to apply for renewal of privileges within the required time and renewal of privileges therefore does not occur, the clinical privileges of the individual shall automatically be terminated. The

individual shall be notified of the termination and of the need to submit an initial application, if clinical privileges are sought.

8.4.3.3 If the LIAP or AHP should die, he/she shall be terminated as a LIAP or AHP effective with verification of the death by Medical Staff Services. Such terminations will be reported to the Medical Executive Committee and Board of Directors.

8.5 Reinstatement of Clinical Privileges.

8.5.1 Reinstatement of clinical privileges can occur up to ninety (90) days after resignation or termination provided, however, that in the event that such resignation or termination is the result of a suspension of six (6) months under Section 11.2.9, the LIAP or AHP shall be subject to the application process as provided under Section 6. Applicants shall initiate a request for reinstatement of clinical privileges to the Division Chief and/or Clinical Department to which he/she wishes to be reinstated. The Chairman shall then notify Medical Staff Services to begin the reinstatement process.

8.5.2 The applicant for reinstatement shall be required to submit updated information to supplement the original application and supply letters of reference for the period of time that the applicant for reinstatement was not granted clinical privileges, and submit information as requested by Medical Staff Services.

8.5.3 Reinstatement of clinical privileges may be subject to a reinstatement fee.

8.6 Address Changes. The LIAP or AHP shall be responsible for contacting his/her division chief and/or clinical department and Medical Staff Services with any changes in his/her office or home address or telephone number.

8.7 Electronic Mail (E-mail) Address Changes. The LIAP or AHP is responsible for contacting Medical Staff Services and his/her clinical department with any changes in his/her personal, confidential electronic mail (e-mail) address.

8.8 Changes in Professional Liability Insurance Coverage. The LIAP or AHP shall be responsible for contacting Medical Staff Services with any changes in his/her professional liability insurance coverage, including but not limited to name of carrier, limits of coverage, effective and expiration dates, and date of early termination, if any. The LIAP or AHP shall be responsible for obtaining appropriate tail or nose coverage with appropriate retroactive date when changing carriers, according to the University Hospitals Parma Medical Center Policy on Professional Liability Insurance.

9.0 ADMITTING PRIVILEGES

9.1 Upon recommendation of the Division Chief and/or Chairman with concurrence of the Medical Executive Committee, the Board of Directors

may grant admitting privileges in accordance with state law. Refer to the Board of Directors-approved delineation of clinical privileges for the specific type of practitioner. LIAPs and AHPs with admitting privileges may only admit to the service of physicians with whom they have a standard care arrangement or a supervisory agreement.

10.0 CLINICAL PRIVILEGES

10.1 Exercise of Clinical Privileges. Every LIAP or AHP providing direct clinical services at the Hospital, shall, in connection with such practice, be entitled to exercise only those setting-specific clinical privileges that are specifically granted to him/her by the Board of Directors.

10.1.1 Every application for initial or renewal of clinical privileges by a LIAP or AHP must contain a request for the particular clinical privileges desired by the applicant. The clinical privilege request shall be specific, accurate, precise, and describe in detail the scope of practice permitted at the Hospital. Clinical privileges are organization- and setting-specific and the evaluation of such requests shall be based upon the applicant's education, training, experience, demonstrated current competence, ability, peer references, and other relevant information, as appraised by the Credentialing Committee and Division Chief and/or Chairman. Each applicant must meet the appropriate training/experience requirements as outlined in the privilege delineation form and any specific subpolicies approved by the Board of Directors. However, special exceptions to these requirements may be requested at the discretion of the Division Chief and/or Chairman. Exceptions shall be submitted in writing for approval to the Chief Medical Officer and the President (or, in the absence of the President, his/her designee), who will forward approved requests to Medical Staff Services for processing; this documentation shall become part of the credentialing file. The applicant shall have the responsibility of establishing his/her qualifications and competency in the area of clinical privileges requested.

10.1.2 All advance practice registered nurses (APRNs) must have a current standard care arrangement on file with the Medical Staff Office. The standard care arrangement must be signed by all physicians collaborating with the APRN or, where appropriate, by a designated physician representative authorized to sign on behalf of other physicians on the Medical Staff.

10.1.3 All physician assistants (Pas) must have a current supervision agreement on file with the Medical Staff Office.

10.1.3.1 PAs who are not employed by the hospital must also provide the Medical Staff Office with the Supervisory Plan filed by their supervising physicians with the State Medical Board of Ohio.

10.1.3.2 PAs who are employed by the hospital, when initiating a medical order, will identify that this has been done under

the supervising physician providing coverage for that particular shift by writing "authorized by SA on file" in the hospital chart for each such order.

10.1.4 Hospital-employed APRNs and PAs will function under the authorization of the supervising/collaborating physicians on file with the Medical Staff Office. The Chief Medical Officer or his/her designee shall ensure that a sufficient number of supervising/collaborating physicians are present in the hospital at all times at which APRNs/PAs are on duty, in order to ensure that adequate collaboration/supervision coverage is maintained as required under Ohio law. Hospital-employed APRNs and PAs must collaborate in accordance with the following:

10.1.4.1 If assisting in the operating room, must collaborate with the physicians they assist.

10.1.4.2 If working in the ICU, must collaborate with intensivists, hospitalist staff, and the Chief Medical Officer.

10.1.4.3 If working in the Emergency Department, must collaborate with Emergency Department physicians and the Chief Medical Officer.

10.1.4.4 If providing house coverage on the medical/surgical floors, must collaborate with the hospitalist staff, Chief Medical Officer, and Chairman of the Department of Medicine.

10.1.5 Attending physicians may delegate to APRNs and PAs who are either employed by them or who are employed by the hospital. APRNs and PAs are responsible for coordinating care with the attending physicians of patients under their care, regardless of whether they are collaborating with/supervised by the attending in question. Coordination of care requires that APRNs and PAs communicate with the attending physician in certain situations, including

10.1.5.1 when there are appropriate questions regarding the plan of care;

10.1.5.2 when there are significant changes in the patient's status; and

10.1.5.3 at the request of the attending.

If the attending can't be reached, the APRN or PA shall seek guidance from their collaborating/supervising physician.

10.2 If the Hospital lacks adequate facilities, equipment, number and types of qualified support personnel, or other resources for a specific service or procedure, clinical privileges are not granted in those areas.

10.3 There are mechanisms to ensure that LIAPs and AHPs provide services within the scope of privileges delineated.

10.4 Temporary Clinical Privileges. Temporary privileges are those that are granted on a case by case basis when an important patient care need mandates an immediate authorization to practice or provide service.

Temporary privileges may be granted to LIAPs or AHPs who are not privileged by the Medical Staff for the purpose of teaching, research, providing replacement services for full time practitioners on leave (*locum tenens*), or under special circumstances approved by the President (or, in the absence of the President, when necessary, his/her designee) upon recommendation of the Chief Medical Officer and Division Chief and/or Chairman of the applicable clinical department. Temporary privileges are granted on a time limited basis; in most cases, these privileges are granted for one to two days, or are granted to allow performance of a limited number of procedures, or *locum tenens* services over a period of time not to exceed 120 days. Temporary privileges are not intended to be utilized by current applicants for clinical privileges at the Hospital who have not yet received them. Granting of temporary clinical privileges may be subject to a processing fee and the discretion of the Hospital.

10.4.1 Procedure. The following procedures shall be followed and criteria shall be met prior to the granting of temporary clinical privileges:

10.4.1.1 A written request for temporary privileges shall be submitted to the Chief Medical Officer by the Division Chief and/or Chairman; the Chief Medical Officer shall forward such request to the President (or, in the absence of the President, his/her designee) with his/her recommendation. The following information shall be included in the request:

10.4.1.1.1 reason for the request;

10.4.1.1.2 name of the LIAP or AHP requesting temporary privileges;

10.4.1.1.3 specific clinical privileges being requested

10.4.1.1.3.1 if duration of temporary privileges requested is greater than thirty (30) days, the applicant shall complete the applicable privilege delineation form and submit appropriate documentation for specialized procedures; and

10.4.1.1.4 date and time (duration) privileges are needed.

10.4.1.2 The following documents shall be attached to the request and forwarded to the Chief Medical Officer's office or Medical Staff Services:

10.4.1.2.1 copy of current Ohio professional license;

10.4.1.2.2 current certificate of professional liability insurance covering the scope of privileges requested, in compliance with University Hospitals Case Medical Center Policy on Professional Liability Insurance;

10.4.1.2.3 current curriculum vitae (CV);

10.4.1.2.4 proof of legal permanent residency or proper visa for the clinical privileges requested, if not a United States citizen;

10.4.1.2.5 documentation demonstrating current competence in the area of privileges requested;

10.4.1.2.6 completed temporary privileges application

10.4.1.2.6.1 if duration of temporary privileges requested is greater than thirty (30) days, the applicant shall complete the credentialing application form prescribed by the Ohio Department of Insurance and UHHS Initial Credentialing Application; and

10.4.1.2.7 signed University Hospitals Health System Corporate Compliance Certification;

10.4.1.2.8 Nurse practitioners and clinical nurse specialists. Current, fully-executed standard care arrangement with member of the Hospital's Active Medical Staff, in good standing, privileged in the same specialty.

10.4.1.2.9 Physician assistants. Current, fully-executed supervision agreement, approved by the State Medical Board of Ohio, authorizing as supervising physician a member(s) of the Hospital's Active Medical Staff, in good standing, privileged in the same specialty.

10.4.2 If approved by the President (or, in the absence of the President, when necessary, his/her designee), the written request and/or documents shall be forwarded to Medical Staff Services for processing and filing.

10.4.3 Medical Staff Services is responsible for querying the National Practitioner Data Bank, if applicable; verifying Ohio licensure, criminal background check, liability insurance, and clinical competence; entering the information into the applicable information system; and notifying the appropriate Hospital departments.

10.4.4 Any practitioner for whom temporary privileges are requested must satisfy the requirements of the Hospital Communicable Diseases Policy. Temporary privileges will only be granted when the practitioner provides written results of Hepatitis B and TB screening (in accordance with the Hospital Communicable Diseases Policy) to the Hospital's Employee Health Service.

10.4.5 A minimum of one week's advance notice shall be required for processing temporary privilege requests. Granting of temporary privileges is contingent upon satisfaction of all above criteria.

10.4.6 Medical Staff Services will notify the applicant of approval of his/her request for temporary privileges no later than sixty (60) days after approval.

10.4.7 The denial, termination, reduction or restriction of temporary privileges shall not give rise to any right to a hearing or appellate review under Section 12.0.

10.5 Medical Staff Plan for Disaster Privileging. During a local, state, or national disaster in which the Hospital's emergency management plan has been activated, disaster privileges may be granted to volunteers eligible to be licensed independent practitioners who are not privileged by the Medical Staff when the Hospital is unable to handle the immediate patient needs.

10.5.1 Policy and Prerequisites. Any practitioner providing patient care must be granted privileges prior to providing patient care, even in an emergency/disaster situation. The practitioner granted disaster privileges (a modified credentialing and privileging process) is assigned to a department of the Medical Staff and paired with a Member of the Active Medical Staff in the same specialty. Disaster privileges are granted on a time-limited basis, for the duration dictated by the emergency management plan. Disaster privileges do not confer any status on the Medical Staff or at the Hospital.

10.5.2 Types of Practices Covered. Any physician, oral and maxillofacial surgeon, dentist, psychologist, podiatrist, physicians assistant or advanced practice nurse not privileged by the Medical Staff, or other licensed independent practitioners approved by the Hospital President and Medical Staff President, and presenting themselves as volunteers to render their services during an emergency or disaster shall be processed accordingly.

10.5.3 Who May Grant Disaster Privileges ("Privileging Authority"). The Hospital President, or CMO, or their designee, has Privileging Authority to grant Disaster Privileges.

10.5.4 Responsibilities of Privileging Authority.

10.5.4.1 The Privileging Authority is not required to grant privileges to any individual;

10.5.4.2 Granting of disaster privileges is on a case-by-case basis when an emergent patient care need mandates an immediate authorization to practice;

10.5.4.3 The Privileging Authority will grant authorization based on, at a minimum, receipt of a key identification document (see below), completion of the Disaster Privileges Request Form and the applicant's acknowledgement of Disaster Privileging: Practitioner Responsibilities.

10.5.4.4 The Privileging Authority will assign or appoint a designee to assign the volunteer practitioner to a department and assign a Member of the same discipline to pair with/supervise the volunteer practitioner for the duration of the disaster privileges.

10.5.4.5 The Privileging Authority will document initial authorization to practice.

10.5.4.6 The Privileging Authority will review verified credentials once the immediate situation is under control.

10.5.4.7 The Privileging Authority will include responsibilities of the privileging authority and the mechanism for managing individuals who receive disaster privileges in the Hospital's emergency management plan.

10.5.5 Mechanism for Managing Individuals Who Receive Disaster Privileges. The practitioner shall first be routed to the Medical Staff Office (or specific) area for:

10.5.5.1 Identification;
10.5.5.2 Pairing;
10.5.5.3 Authorization;
10.5.5.4 Verification; and
10.5.5.5 Documentation.

10.5.6 Disaster Privileging Process Identification.

10.5.6.1 Personal Identification and Authorization to Practice, evidenced by 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:

10.5.6.1.1 Current Hospital/entity identification card that clearly identifies the professional designation;

10.5.6.1.2 Proof of current license to practice (e.g., documentation from Ohio licensure board);

10.5.6.1.3 Primary source verification of the license;

10.5.6.1.4 Identification indicating that individual is a member of a Disaster Medical Assistant Team (DMAT), or MRC, ESAR-VHP, or other recognized state or federal organizations or groups;

10.5.6.1.5 Identification indicating that individual has been granted authority to render patient care in disaster circumstances, such authority having been granted by a federal, state, or municipal entity; or

10.5.6.1.6 Identified by a current member of the Hospital or Medical Staff member who possesses personal knowledge regarding practitioner's ability to act as a licensed independent practitioner during a disaster.

10.5.6.2 After completion of the personal identification process detailed above, the practitioner shall be given the standardized regional Disaster Privileges badge by Medical Staff Office to ensure ready identification of the volunteer. The badge shall include name, degree/title, ID number, start date of disaster privileges, any limitations, name of Medical Staff member paired with volunteer, name of issuing Medical Staff Office staff, and authorization to practice by the Privileging Authority if clinical practice approved for immediate situation, prior to completion of credentials verification.

10.5.7 Disaster Privileging Process; Pairing.

10.5.7.1 The Medical Staff shall oversee the professional practice (care, treatment, and services provided) of volunteer licensed independent practitioners through direct observation, mentoring, and clinical record review. The privileging authority or designee shall assign the volunteer practitioner to a department and assign a member of the active Medical Staff in the same specialty to pair with/supervise the volunteer practitioner for the duration of the disaster privileges.

10.5.8 Disaster Privileging Process: Verification of Credentials and Privileges

10.5.8.1 A disaster privileges credentials file shall be maintained by Medical Staff Office for each practitioner granted disaster privileges;

10.5.8.2 Practitioner shall fully complete a Disaster Privileges Request Form, including attestation;

10.5.8.3 Practitioner shall present proof of Ohio licensure, DEA and current certificate of liability insurance, where feasible.

10.5.8.4 Medical Staff Office shall primary source verify the Ohio professional licensure/certification/registration as soon as the immediate situation is under control, within 72 hours from the time the volunteer presents

to the Hospital. If extraordinary circumstances prevent primary source verification within 72 hours (e.g. no means of communication or lack of resources), verification will be done as soon as possible. Medical Staff Office shall document

10.5.8.4.1 why the verification could not be performed in the required time frame;
10.5.8.4.2 evidence of a demonstrated ability to continue to provide adequate care, treatment, or services; and
10.5.8.4.3 an attempt to rectify the situation as soon as possible.

10.5.8.5 Medical Staff Office shall verify/query the following when possible:
10.5.8.5.1 Ohio professional licensure;
10.5.8.5.2 Current certificate of professional liability insurance;
10.5.8.5.3 DEA certification;
10.5.8.5.4 Board certification or education and training if not board certified;
10.5.8.5.5 Privileges and status at primary hospital/entity; and
10.5.8.5.6 NPDB.

10.5.8.6 The Privileging Authority or designee will review and sign off on the credentials file of each practitioner granted disaster privileges.

10.5.8.7 Medical Staff Office shall notify appropriate Hospital departments, when feasible.

10.5.8.8 If any negative information is obtained during the credentials verification process, the Privileging Authority may require the practitioner to immediately cease and desist clinical services, relinquish the standardized regional Disaster Privileges badge, and submit documentation of all clinical activities performed on the patient treatment documentation form.

10.5.8.9 The denial, termination, reduction or restriction of disaster privileges shall not give rise to any rights contained in the entity's Bylaws, rules, or policies and procedures of the entity and Medical Staff, including but not limited to a hearing or appellate review.

10.5.9 Disaster Privileging Process: Documentation

10.5.9.1 When feasible, a Disaster privileges credentials file will be created by and maintained in Medical Staff Credentialing for each practitioner. It should contain the following:

10.5.9.1.1 Completed Disaster Privileges Request Form with credentials checklist;
10.5.9.1.2 Signed Disaster Privileging: Practitioner Responsibilities;
10.5.9.1.3 Copy of personal identification listed above;
10.5.9.1.4 Verification of Ohio licensure or exemption per Ohio Revised Code §4731.36;
10.5.9.1.5 Verification of board certification or education and training;
10.5.9.1.6 Verification of status at primary hospital/entity;
10.5.9.1.7 Verification of professional liability insurance coverage;
10.5.9.1.8 Verification of DEA certification;
10.5.9.1.9 NPDB Query;
10.5.9.1.10 Approval of Privileging Authority; and
10.5.9.1.11 Patient Treatment Documentation Form.

10.5.10 Duration of Disaster Privileges. Disaster privileges are valid only for the duration of the declared emergency and terminate automatically when the emergency is over.

10.5.11 List of Patients Treated. A list of patients treated by the practitioner granted disaster privileges shall be documented by Hospital on the Disaster Privileges Patient Documentation Form and maintained in the practitioner's credentials file.

10.6 Emergency Privileges for Existing LIAPs or AHPs. In the case of an emergency, any individual LIAP or AHP with clinical privileges is "temporary privileged" to provide any type of patient care necessary as a life-saving measure or to prevent serious harm—regardless of his or her current clinical privileges—if the care provided is within the scope of his/her license/certification/registration.

10.7 LIAP-AHP Proctoring Program. Clinical privileges with supervision may be granted to a LIAP or AHP in accordance with Hospital policy. Proctoring shall not be considered an adverse privileging action, provided that the action is for an evaluative or teaching purpose.

10.8 Policy Exceptions. Any qualifications, requirements or limitations in this section or any other section of this Policy not required by law or

governmental regulation, may be waived at the discretion of the President (or, in the absence of the President, when necessary, his/her designee), upon determination that such waiver will serve the best interests of the patients and of the Hospital, and provided that the Chief Medical Officer has given prior approval of such request. All such requests shall be submitted in writing to the Chief Medical Officer.

11.0 CORRECTIVE ACTION

11.1 Corrective Action. All LIAPs and AHPs (regardless of employer) are subject to the provisions as outlined in the University Hospitals Corrective Action Policy HR-72. .

11.2 Automatic Suspension and Revocation.

11.2.1 License/Certification/Registration: If a LIAP's or AHP's license/certification/registration to practice his/her profession in the State of Ohio is revoked or suspended, or otherwise limited in any way, or if a LIAP's or AHP's respective licensing board limits the LIAPs or AHP's authority to practice without actually restricting or limiting the provider's license/certification/registration, or if he/she fails to renew such license/certification/registration, then the clinical privileges of such LIAP or AHP shall immediately and automatically be suspended. If a LIAP's or AHP's license/ certification/registration to practice his/her profession in the State of Ohio is revoked, then the clinical privileges and admitting privileges, if granted, of such LIAP or AHP shall immediately and automatically be revoked.

11.2.2 Drug Enforcement Administration Registration:

11.2.2.1 A practitioner whose DEA registration is revoked or suspended or voluntarily relinquished shall have his/her clinical privileges suspended immediately and automatically. As soon as reasonably possible after such automatic suspension, the Chair of the Credentialing Committee and the Chairman shall convene to review and consider the facts under which the DEA registration was revoked or suspended or relinquished. The Chair of the Credentialing Committee and the Chairman may then recommend to the Chief Medical Officer such further corrective action as is appropriate to the facts disclosed in their investigation.

11.2.3 Conviction of a Felony: Upon exhaustion of appeals after conviction of a felony of a LIAP or AHP, or upon the practitioner's plea of guilty thereto, in any court in the United States, either federal or state, the LIAP's or AHP's clinical privileges and admitting privileges, if granted, shall be automatically revoked. Revocation pursuant to this Section of the Policy does not preclude the LIAP or AHP from subsequently applying for clinical privileges.

11.2.4 Program Exclusion. A LIAP's or AHP's clinical privileges and admitting privileges, if granted, shall be automatically suspended in the event the practitioner is excluded or debarred from

participation in Medicare, Medicaid or any other federal or state health care program.

11.2.5 Communicable Disease Policy. All LIAPs and AHPs (regardless of employer) are subject to the provisions as outlined in UH Policy CP-29 Communicable Diseases In the Workplace I. An LIAP or AHP who does not comply with this policy shall have his/her clinical privileges and admitting privileges, if granted, suspended immediately and automatically until the LIAP or AHP has complied with such communicable diseases policy.

11.2.6 University Hospitals Health System Corporate Compliance. A LIAP or AHP who has failed to comply with the training and reporting requirements of any Hospital or University Hospitals Health System Organizational Integrity and/or Corporate Compliance Program or Policy, in accordance with the stated program or policy, shall have his/her clinical privileges and admitting privileges, if granted, suspended immediately and automatically until the LIAP or AHP has complied with all such requirements.

11.2.7 Professional Liability Insurance Coverage. A LIAP or AHP who does not provide evidence of current professional liability insurance coverage in accordance with University Hospitals Parma Medical Center Policy on Professional Liability Insurance, shall have his/her clinical privileges and admitting privileges, if granted, suspended immediately and automatically until the LIAP or AHP has complied with such policy.

11.2.8 Mandatory Professional Education. A LIAP or AHP who does not provide satisfactory evidence of completing Hospital mandatory professional education programs, as defined by the Chief Medical Officer and the President, shall have his/her clinical privileges and admitting privileges, if granted, suspended immediately and automatically until the LIAP or AHP has provided such evidence.

11.2.9 Six-Month Limit for Suspensions. In the event that a LIAP or AHP has failed to cure the violation resulting in his or her automatic suspension within six (6) months, the clinical privileges of such LIAP or AHP shall be automatically terminated. Such LIAP or AHP shall be considered to have voluntarily resigned the privileges.

11.2.10 Fair Hearing Rights. A LIAP or AHP whose authorization to practice been automatically suspended or revoked by operation of this Section 11 may request the fair hearing outlined in Section 12 to establish that the automatic suspension or revocation was in error. The invoking of an automatic suspension does not preclude initiation of corrective action pursuant to this Section 11.

11.3 Continuity of Patient Care. Upon the imposition of the LIAP's or AHP's suspension or the occurrence of an automatic suspension, the Chairman of the Clinical Department to which the suspended LIAP or AHP is assigned shall provide for alternative coverage of the Hospital patients assigned to the suspended LIAP or AHP.

12.0 FAIR HEARING RIGHTS

12.1 The following recommendations or actions shall, if deemed adverse pursuant to Section 12.2, entitle the LIAP or AHP to fair hearing rights outlined in Section 12.3:

12.1.1 Denial of initial clinical privileges;

12.1.2 Denial of renewal of clinical privileges;

12.1.3 Revocation of clinical privileges;

12.1.4 Reduction or restriction of clinical privileges; or

12.1.5 Terms of probation.

12.2 When Deemed Adverse

12.2.1 Recommended by the Medical Executive Committee; or

12.2.2 Suspension continued in effect after review by the Medical Executive Committee and/or Board of Directors; or

12.2.3 Taken by the Board of Directors

12.2.4 Imposed automatically under Section 11.

12.3 Fair Hearing Rights

12.3.1 The LIAP applicant (and his/her collaborating physician, as appropriate) or AHP applicant (and his/her supervising physician, as appropriate) shall have the right to meet personally with a Review Committee formed of the pertinent Chairman, Chairman of the Credentials Review Committee, and chaired by the Chief Medical Officer (or his/her designee) to discuss the recommendation or action. The Chief Medical Officer may appoint additional members to this committee at his/her discretion.

12.3.2 The LIAP or AHP applicant must request such a meeting in writing to the Chief Medical Officer within 10 days of receiving notice of the recommendation or action.

12.3.3 The Chief Medical Officer shall promptly schedule the meeting with parties enumerated in 12.3.1.

12.3.4 At the meeting, the applicant may discuss, explain, or refute the recommendation or action, but such a meeting shall not constitute a hearing and none of the procedural rules provided for in the Medical Staff Bylaws, corporate bylaws, or other Hospital policy with respect to hearings shall apply.

12.4 The Chief Medical Officer shall submit the Review Committee's recommendation to sustain, reduce or revoke the action taken pursuant

to Section 12.2 to the next scheduled Clinical Council and Board of Directors.

12.5 LIAPs and AHPs employed by the Hospital are entitled to any rights as determined by the Hospital's employment policies and procedures.

12.6 Non-Hospital LIAPs follow the procedures of their employing organizations.

13.0 RESPONSIBILITIES OF THE COLLABORATING OR SUPERVISING PHYSICIAN

13.1 Licensure.

13.1.1 Each collaborating or supervising physician shall maintain, without restriction or condition, his/her license to independently practice medicine in the State of Ohio.

13.1.2 The collaborating or supervising physician is responsible for advising all LIAPs with whom he/she collaborates and all AHPs whom he/she supervises of any change in status of licensure.

13.2 Medical Staff membership.

13.2.1 Each collaborating or supervising physician shall be a member in good standing of the University Hospitals Parma Medical Center Active Medical Staff, with clinical privileges and actively practicing in same or similar specialty as the LIAP or AHP.

13.2.2 The collaborating or supervising physician is responsible for advising all LIAPs with whom he/she collaborates and all AHPs whom he/she supervises of any change in Medical Staff status, including but not limited to termination, LOA, suspension of privileges, and change from Active Medical Staff.

13.3 Standard care arrangement for Nurse Practitioners and Clinical Nurse Specialists (LIAP).

13.3.1 The collaborating physician shall enter into and abide by criteria in the LIAP's specific standard care arrangement for each LIAP with whom he/she collaborates, according to Ohio Revised Code 4731.27. The standard care arrangement shall comply with Hospital standards.

13.3.2 Prescriptive authority.

13.3.2.1 The standard care arrangement shall include a written supplement establishing arrangement for prescribing drugs and therapeutic devices, as applicable. The standard care arrangement shall comply with Hospital standards.

13.3.2.2 The collaborating physician shall collaborate with not more than three LIAPs at the same time in the prescribing component of the LIAPs' practices.

13.4 Supervision Agreement for Physician Assistants.

13.4.1 The supervising physician shall enter into and abide by criteria in the physician assistant's supervision agreement for each physician assistant he/she supervises, according to the Ohio Revised Code Section 4730.21. The supervision agreement shall be approved by the State Medical Board of Ohio and comply with Hospital standards.

13.4.2 The supervising physician shall comply with O.A.C. 4730-2 when delegating prescriptive authority to a physician assistant with a certificate to prescribe from the State Medical Board of Ohio.

13.5 Arrange for coverage in absence. The Medical Staff member is responsible for notifying the LIAP and arranging for a substitute collaborating physician and notifying the AHP and arranging for a substitute supervising physician when the Medical Staff member is unable to fulfill those responsibilities.

13.6 Ohio Revised Code. The collaborating or supervising physician shall be knowledgeable of and comply with all sections of the most current Ohio Revised Code that apply to LIAPs and AHPs practice and responsibilities of the collaborating or supervising physician.

14.0 IMMMUNITY FROM LIABILITY

14.1 The following shall be express conditions to any LIAP's or AHP's application for, or exercise of, clinical privileges at the Hospital.

14.2 The LIAP or AHP authorizes representatives of the Hospital and its administrative staff to solicit, provide and act upon information bearing or reasonably believed to bear upon, his/her professional ability, qualifications, competence, and conduct.. Representative means the Board of Directors and any member or committee thereof, the Chief Medical Officer, the Medical Staff organization, the Chief Nursing Officer, and any member, officer, department, division, service or committee thereof, and any individual authorized by any of the foregoing to perform specific information gathering or disseminating functions.

14.3 The LIAP or AHP agrees to be bound by the provisions of this Section 14 and agrees that he/she will not commence a legal action against the Medical Staff or any department, committee, subdivision or member of the Medical Staff of Hospital, or an employee of Hospital, or the Board or any member thereof, for any investigation or action taken in accordance with the provisions of this Policy.

14.4 The LIAP or AHP acknowledges that the provisions of this Section 14 are express conditions to his/her application for, or acceptance of, his/her exercise of clinical privileges at the Hospital.

14.5 The LIAP or AHP agrees and acknowledges that Hospital may confidentially share any information about the LIAP or AHP, including, but not limited to credentialing, privileging, peer review, and/or disciplinary information about the LIAP or AHP, with any other University Hospital Health System

hospital or entity regardless of whether that information has been forwarded to the Ohio State Medical Board, Ohio Board of Nursing, or the National Practitioner Data Bank.

14.6 Confidentiality of Information. Medical Staff, department, division, or committee minutes, files, and records, including information regarding any current or applicant for clinical privileges as a LIAP or AHP, shall be confidential as mandated by Ohio Revised Code Section 2305.24 et seq. Dissemination of such information and records shall only be made where expressly required by law, or pursuant to officially adopted policies of the Medical Staff or Hospital, which at all times shall be consistent with Ohio Revised Code Section 2305.24 et seq. Disclosure of information may only be done as required by law.

14.7 Breach of Confidentiality. Inasmuch as effective peer review and consideration of the qualifications of members and applicants to perform specific procedures must be based on free and candid discussions, any breach of confidentiality of the discussions or deliberations of medical staff departments, divisions, or committees, except in conjunction with another hospital, professional society, or licensing authority, is outside appropriate standards of conduct for the LIAP or AHP and may violate provisions of the Ohio Revised Code, imposing civil liability. If it is determined that such a breach has occurred, the Clinical Council, or the Board, may undertake such corrective action as it deems appropriate.

14.8 Immunity from Liability for Action Taken. Each representative of the Medical Staff and Hospital shall be exempt, to the fullest extent permitted by law, from liability to an applicant or privileged LIAP or AHP for damages or other relief for any action taken or statements or recommendations made within the scope of his duties as a representative of the Medical Staff or Hospital.

14.9 Immunity from Liability for Providing Information. Each representative of the medical staff and Hospital and all third parties shall be exempt as mandated by Ohio Revised Code Sections 2305.24 et seq. and 42 U.S.C. 11111, from liability to an applicant or a privileged LIAP or AHP for damages for providing information to a representative of the Medical Staff or Hospital concerning such individual who is, or has been, an applicant or privileged LIAP or AHP or who did, or does, exercise clinical privileges or provide services at this Hospital

14.10 Activities Covered. The confidentiality and immunity provided by this Section 14 shall apply to all acts, communications, reports, recommendations, or disclosures performed or made in connection with the activities of this or any other educational or health-related institution or organization concerning, but not limited to:

14.10.1 Applications for clinical privileges;

14.10.2 Periodic reappraisals for renewal of clinical privileges;

14.10.3 Corrective action, including summary suspension;

14.10.4 Fair hearing rights;

14.10.5 Performance improvement activities;

14.10.6 Utilization reviews;

14.10.7 Participation in the UHHS or Hospital's delegated credentialing program;

14.10.8 Other Hospital, department, division, committee and subcommittee activities related to monitoring and maintaining quality patient care and appropriate professional conduct; and

14.10.9 Peer review and patient safety organizations, State Medical Board of Ohio, Ohio Board of Nursing and similar reports

14.11 Information Covered. The acts, communications, reports, recommendations, disclosures and other information referred to in this Section 14 may relate to a LIAP's or AHP's professional qualifications, clinical ability, judgment, character, information regarding ability to perform any of the physical or mental health functions related to the specific clinical privileges requested as a LIAP or AHP, with or without accommodation, professional ethics, ability to work cooperatively with others, economic efficiency or any other matter that might directly or indirectly affect patient care or the efficient functioning of an institution or organization.

14.12 Releases. Each LIAP and AHP shall, upon request of the Hospital, execute general and specific releases in accordance with the scope and importance of this Section 14, in favor of the individuals and organizations specified above. Such releases or copies thereof may be submitted to third parties from which information is sought. Each current or applicant for clinical privileges as a LIAP or AHP shall, upon request of the Medical Staff or Hospital, execute general and specific releases in accordance with the expressed provisions and general intent of this Section 14. Execution of such releases shall not be deemed a prerequisite to the effectiveness of this Section

15.0 ADOPTION

This Privileging Policy for Licensed Independent Affiliate Healthcare Practitioners (LIAP) and Allied Health Professionals (AHP) is adopted and made effective upon the approval by the Board of Directors, upon recommendation of the Medical Executive Committee, superseding and/or replacing any and all other provisions of the Hospital Medical Staff Bylaws, Rules and Regulations, or Hospital Policies and Procedures which are inconsistent with the foregoing.

APPROVED:

Medical Executive Committee: 5/04/15
QPAC: 5/14/15