METHODODIST HEALTHCARE
- MEMPHIS HOSPITALS &
METHODIST HEALTHCARE
OLIVE BRANCH HOSPITAL

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CREDENTIALS POLICIES

The responsibility for credentials, including medical staff appointments and privileging, lies with the Board of Directors acting upon recommendation of the MEC.

Gender, race, creed, and national origin are not used in making decisions regarding the granting or denying of medical staff membership and/or clinical privileges.

These credentials policies have been developed to describe and define the procedures related to appointment, reappointment, privileges, temporary privileges, disaster privileges, leaves of absence, and privileging of practitioners who are not eligible for medical staff membership.

For purposes of these credentials policies, the terms:

“Consolidated Credentials Committee” and “Credentials Committee” shall be synonymous and shall mean the Committee serving both MH-MH and MHOBH, whose members are appointed by MH-MH Medical Staff President and MHOBH Associate Chief.

“Facility” shall mean either Methodist Healthcare- Memphis Hospitals (“MH-MH”), Methodist Healthcare – Olive Branch Hospital (“MHOBH”), and/or Provider-based clinics, depending upon the selections designated in a Practitioner’s appointment or reappointment application. If the Practitioner has designated MH-MH and MHOBH, the application shall be processed in accordance with Tennessee and Mississippi state laws, rules and regulations applicable to medical staff membership and/or privileges.

Except as otherwise specified, no practitioner shall exercise clinical privileges at Facility until that person applies for and receives appointment to the Facility medical staff and/or is granted privileges as set forth in the bylaws and these credentials policies.

These credentials policies are supplemental to the medical staff bylaws.

1. ELIGIBILITY

1.1 EDUCATION

Members of the medical staff shall be graduates of:

- A medical school accredited by the Liaison Committee on Medical Education (LCME); or
- A college of osteopathic medicine recognized and approved by the American Osteopathic Association (AOA); or
- A foreign medical school recognized by the Educational Commission for Foreign Medical Graduates; or
- A dental school approved by the Council on Dental Education of the American Dental Association; or
1.2 BASIC PROFESSIONAL REQUIREMENTS
Applicants must:

- hold a current, valid and legal medical or dental license in the state in which the Facility is located as described and set forth in the medical staff rules, regulations, credentials policies, medical staff policies, and related documents and;
- document training, experience, and current clinical competence for the clinical privileges requested at appointment, reappointment, and renewal or revision of clinical privileges;
- document their adherence to the ethics of their profession, their reputation, their physical and mental health status, and their ability to work well with others;
- practice in the community within a reasonable distance of MH-MH or MHOBH, or within 35 miles of the main campus for provider-based clinics;
- maintain continuous and uninterrupted professional liability insurance coverage in amounts established by the board without periods of non-coverage, and including either extended reporting (“tail”) or retroactive (“prior acts”) coverage from an insurance company licensed and approved to do business in the state in which the Facility is located or have Federal Tort Claims Act (FTCA) coverage, or be covered by state tort claims coverage. The insurance coverage must be effective for all types of clinical privileges to be exercised.

1.3 CATEGORIES OF MEDICAL LICENSES ACCEPTABLE FOR MEDICAL STAFF MEMBERSHIP

A. Only physicians holding one or more of the following types of medical licenses in the state in which the Facility is located (hereafter referred to as state) shall be considered for medical staff membership.

1. Full licensure (TN)
2. Distinguished Faculty Member (TN)
3. Single Purpose License (TN) – Required for all preceptorship arrangements in which either the physician trainee is licensed outside the state or the preceptor is licensed outside of the state. A preceptorship arrangement is defined as a training program, designed as an advanced study in a particular field of medicine in the state, or to teach or demonstrate a new medical technique to medical professionals in the state. A medical staff member requesting a single purpose license in order to precept physician trainees must hold Active Staff Privileges and comply with all state laws, rules and regulations applicable to such preceptorships in the state in which the preceptorship arrangement shall take place. License fees must be submitted to the hospital along with a completed application.
4. Telemedicine (TN) – Practitioners who diagnose or treat patients via telemedicine link to the hospital are required to have state telemedicine licenses and are subject to the credentialing and privileging processes outlined in the medical staff bylaws.
5. Permanent License (MS)
6. Temporary License – Short-Term Training Permit (MS) for out-of-state physicians who wish to expand their professional knowledge and expertise by training with a MS physician
B. Membership and clinical privileges of members having licenses in categories 3, 4, 5, and 6 may be rescinded without right of hearing or appellate review by the CEO or his designee upon the advice of the Chief of Staff, Chair of the Credentials Committee or Department Chair of the relevant clinical department.

NOTE: Interns, residents and clinical fellows practicing under training licenses or licensure exemption do not have independent privileges to admit or treat patients at the Facility and are not eligible for medical staff membership and clinical privileges; the scope of their practice is defined by the Graduate Medical Education Program. A clinical fellow may be eligible for medical staff membership if he/she holds a full medical license and meets all the other requirements for medical staff membership, but any such clinical privileges granted pursuant thereto shall not be applicable to such physician’s practice in the clinical fellowship program. Interns, residents and clinical fellows will act under the supervision and credentials of a medical staff member in accordance with all applicable Facility policies.

1.4 PRACTITIONERS WHO ARE ELIGIBLE FOR APPOINTMENT TO THE MEDICAL STAFF AND/OR PRIVILEGES

<table>
<thead>
<tr>
<th>Type of Practitioner</th>
<th>Licensed Independent Practitioners-Membership Appointment &amp; Privileges</th>
<th>AHPs: Providers with Complex Privileges - Privileges Only</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician (M.D. or D.O.)</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Dentist or Oral Surgeon</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Podiatrist</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Psychologist</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Nurse Practitioner</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Certified Registered Nurse Anesthetist</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Certified Physician Assistant</td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>

Allied Health Professionals (AHPs) are providers with complex privileges (licensed independent practitioners as well as supervised practitioners with complex privileges) who are not members of the medical staff but are credentialed and privileged according to its credentials policies. Due process rights for AHPs are described in the credentials policies.

2.0 APPLICANT'S BURDEN

2.1 COMPLETED APPLICATION

In all matters pertaining to the candidate’s application for initial appointment and privileges, and for reappointment, renewal, and/or updating of privileges, including obtaining and validation of supporting information, medical records, references, and responses from prior affiliations, the burden is upon the applicant. The applicant must produce the information for an adequate evaluation of qualifications and suitability for clinical privileges and membership, of resolving any reasonable doubts about these matters, and of satisfying requests for information. The applicant’s failure to sustain this burden shall be grounds for declaring the application to be incomplete, and therefore, not subject to further processing.
2.2 PSYCHOLOGICAL EXAMINATION
To the extent consistent with law, this burden may include submission to a medical or
psychological examination, at the applicant’s expense, if deemed appropriate by the Facility
MEC.

2.3 PROCESSING
A. Processing of the application cannot begin until all required information is on file and
validated (“complete application”). The applicant shall have the burden of producing
adequate information for a proper evaluation of the applicant’s competence, character, ethics,
and other qualifications, and for resolving any doubts about such qualifications.

B. In the event that an initial applicant
   1. has any pending investigation, corrective action, suspension, restriction, revocation,
      peer review hearing, appeal, or litigation involving his/her licensure or membership
      and/or privileges at any healthcare Facility or managed care plan, or
   2. has had a prior investigation, corrective action, suspension, restriction, revocation,
      peer review hearing, appeal, or litigation involving his/her licensure or membership
      and/or privileges at any healthcare Facility or managed care plan, and the full details
      of reasons and/or results of such actions are not available from a primary source for
      review and evaluation by this hospital for any reason (including sealing by any court
      of law), then the applicant shall be deemed “ineligible” if this is discovered during
      the application process.

If the information about pending or prior matters is discovered during the application
process, then the application shall be deemed incomplete and closed. There will be no
further processing of the application and it will not be acted upon by the MEC or the
Board of Directors.

Application cannot occur until such time as all required information regarding the
results of the completed matter is made available from the primary source for review.

3.0 APPOINTMENT TO THE MEDICAL STAFF
3.1 APPLICATION

MH-MH & MHOBH may at its discretion designate a Centralized Credentials Office (CCO) to
process applications for primary source verifications. In this case, the CCO application may be
utilized to request Facility staff membership and clinical privileges.

The receipt of an application by the CCO from the applicant requesting that application,
credentials and privileging information be submitted to the Facility in no way obligates the
Facility to process the application. If at any time during the processing of an application the
Facility determines that an applicant does not meet the minimum qualifications for membership
and/or clinical privileges, the application process may be terminated.

In the event the application is not processed due to failure to meet the minimum qualifications of
the hospital or clinical department, or any other reason, including an incomplete application form,
the applicant will be notified and as provided elsewhere in the medical staff governing
documents, no hearing and appellate review procedures are applicable in this event.
All decisions concerning medical/professional staff membership and the granting of medical and/or clinical privileges or credentialed status remain solely the responsibility of the Facility.

3.2 APPLICATION FORM

Each applicant shall submit the completed application in the required/approved format with the fee currently required, and at least the following:

- names, and addresses of professional references who have firsthand knowledge of the applicant’s current professional competence in the clinical area in which privileges are sought; if applying directly from training or within five (5) years of training, the program director shall be listed, if currently in practice, the Chief of Staff or Department Chair at the most active current hospital affiliation shall be listed
- information regarding professional school diploma, post-graduate training, past and present licenses to practice, and DEA registration; No separate Mississippi DEA registration is required for pathologists, radiologists and cardiologists who perform professional services for OBH patients solely through remote interpretation; provided, however that the practitioner has medical staff membership and privileges at MHMH and a Tennessee DEA number. The practitioner is specifically limited to remote interpretation services only for OBH patients and if the practitioner’s services require personal presence at the OBH, a Mississippi DEA will be required
- information as to whether the applicant’s professional license, or medical staff appointment, or clinical privileges at another hospital have ever been encumbered, placed on probation, reduced, revoked, suspended, not renewed, or voluntarily relinquished, and if applications for staff appointment and/or privileges at other hospitals have been denied;
- information on whether any leave of absence has ever been taken for disciplinary reasons, such as to avoid an adverse action, investigation, or resignation, or taken while the practitioner is under investigation related to professional competency or conduct;
- information on the applicant’s health status as it relates to the practitioner’s ability to perform privileges requested;
- information about current professional liability coverage and the coverage for the previous five years (post graduate training);
- a consent to the release of information from past and present liability insurance carriers and information about all past and current malpractice judgments, suits, claims, and settlements. This information must be provided by the physician; information provided by the insurance carrier or the physician’s attorney is not acceptable;
- information of all criminal convictions other than minor traffic offenses;
- names and addresses of all other hospitals or institutions at which the applicant has practiced since medical/professional school graduation;
  - affiliation verifications will be obtained at the time of initial appointment for the previous five years;
  - the practitioner will provide a complete history and additional verifications may be obtained when circumstances warrant
- any additional information required by the MEC, relevant clinical department, Credentials Committee, or Board to adequately evaluate the applicant.
- provide proof of immigration status, when applicable;
- ACLS/ATLS/APLS/PALS certification if specified in privilege criteria;
- specialty and subspecialty Board Certification and re-certification status;
• continuing medical education related in part to the delineation of clinical privileges;
• the completed Access Request Form for the Electronic Medical Record (an application is considered incomplete until this form has been returned and approved);
• recent clinical inpatient experience with neonates, infants, and children if applicable to privileges requested; and
• provide positive proof of identification with a government issued photo ID. The applicant must provide this identification to the CCO, its designee, or Medical Staff Services Department in person. Membership and privileges cannot be exercised until such positive identification occurs. For contracted telemedicine practitioners, the telemedicine policy shall apply.
• An email address is required to make application complete.

3.3 INCOMPLETE APPLICATION
Any initial application that is incomplete after at least four (4) months may be closed without further processing, after approval of the Credentials Committee, provided that the applicant has received at least one (1) certified letter notification of incomplete status at least thirty (30) days prior to closing the application.

3.4 FAILURE TO PROVIDE TRUTHFUL, ACCURATE, COMPLETE INFORMATION
Failure by the applicant to provide truthful, accurate, and complete information shall in itself be grounds for denial, or revocation of staff membership/appointment, reappointment and clinical privileges, without right to hearing or appellate review. The applicant may not reapply for at least one (1) year, unless the Board determines otherwise.

4.0 EFFECT OF APPLICATION
4.1 APPLICANT'S AGREEMENT
Appointment/Reappointment - Privileges Initial, Renewal and/or Increase
In addition to matters set forth in the bylaws, by applying for appointment/reappointment to the medical staff and/or for clinical privileges or for AHP privileges, each applicant acknowledges:

• that the applicant has access to, and agrees to be bound by these bylaws, rules and regulations;
• that the applicant is willing to appear for an interview as part of the applicant process;
• that the applicant authorizes hospital representative to obtain validation of information supplied in support of the application, and consents to the release of such information;
• that the applicant consents to inspection of records and documents that may be material to an evaluation of the applicant’s qualifications and ability to carry out clinical privileges requested, and authorizes all individuals and organizations in custody of such records and documents, including but not limited to, those considered by and/or provided by medical review committees, to permit inspection and copying;
• that the applicant releases from liability all hospital and medical staff representatives who evaluate the applicant and the applicant’s qualifications;
• that the applicant releases from liability all individuals, and organizations who provide information relevant to the application, unless such information is false and the person providing it had actual knowledge that the information is false;
that the applicant is responsible for truth, accuracy, and completeness of information provided;

that the applicant is responsible for notifying the Facility or its agent within 10 days of any material changes to the information provided in the application or authorized to be released pursuant to the credentialing process. Corrections to the application are permitted at any time prior to a consideration of membership and/or privileges or affiliation by the consolidated Credentials Committee, and must be submitted online or in writing and dated and signed by the applicant;

that the applicant authorizes and consents to hospital representatives providing to other individuals, hospitals, professional associations, and other organizations concerning with provider performance, and the quality and efficiency of patient care, with any information the hospital may have concerning the applicant, and releases from liability the hospital, and all representatives of this hospital, and its medical staff who provide information concerning the applicant to such individuals, associations, and/or organizations in connection with an evaluation of the applicant for this organization, or any other organization or association;

that the applicant acknowledges the provisions of medical staff bylaws relating to confidentiality and release from liability as express conditions to application for, and acceptance of, medical staff membership, and the continuation of such membership, and to exercise of clinical privileges;

that the applicant pledges to provide for continuous quality care of patients;

that the applicant pledges to be bound by the medical staff bylaws and governing documents that are in effect now and hereafter adopted;

that the applicant agrees, in the event of adverse recommendation or decision, to exhaust any and all administrative remedies which may be available under these medical staff bylaws before utilizing any other means of obtaining staff status and clinical privileges, including but not limited to legal action.

4.2 VERIFICATION OF INFORMATION
The applicant shall submit a complete, signed, dated application in the required/approved format. Payment of any applicable fees shall be due within fifteen (15) days of receipt of application. The Medical Staff Services Department or their designated CCO shall expeditiously seek to collect or verify the references, licensure status, and other evidence in support of the application. Information will be verified via primary source as per regulatory and accreditation standards. A criminal background check and evaluation of eligibility for participation in federal programs will also be completed. The applicant shall be notified of any problems in obtaining the information required, and it shall be the applicant’s obligation to assist with obtaining any requested information. The CCO will provide all information to the Facility for consideration for Facility membership and/or clinical privileges.

If the applicant holds current membership and privileges at any MLH hospital entity, all static verifications on file will be used to facilitate the verification process; i.e. education and training. Additionally, verifications on file for affiliations and/or employment, background check, current signed professional code, current certificate of insurance, and claims history from recent appointment will also be utilized. For any applicant who is an active staff member with clinical privileges at any MLH hospital, evidence of current clinical competence and recent peer reference (if within the previous nine months) supporting the privileges requested will also be used to complete the file.
4.3 ROUTE OF THE COMPLETED APPLICATION
A completed appointment/reappointment application file, as well as inclusion of all necessary attachments (including, but not limited to, all required verifications, case logs, clarifications, and references), must be received by the Medical Staff Services Department two-weeks prior to the Credentials Committee meeting in order to be considered. Any completed application file received after this time frame will be considered with the next scheduled Credentials Committee cycle. Any expiring re-appointments or failures to reapply will be subject to current medical staff bylaws and governance documents.

The completed initial application file including but not limited to, its required verifications, clarifications, and references is acted upon as soon as is practical, but in no event later than within 60 days of completion, by the Credentials Committee. The Credentials Committee recommendation is forwarded to the MEC. The MEC acts as soon as is practical, but in no event later than 60 days after receiving the recommendation of the consolidated Credentials Committee, and forwards its recommendation to the Governing Body. The Governing Body acts as soon as is practical, but in no event later that 90 days after receiving the MEC’s recommendation, unless the MEC has made an adverse recommendation and the applicant has exercised or is in the process of exercising the right to a hearing.

4.4 EXPEDITED CREDENTIALING
When the Governing Body is not scheduled for its regular monthly meeting and the MEC has made a recommendation for approval, an application for appointment/reappointment shall be submitted to a Special Credentials Committee designated by the Governing Body for approval, provided that any of the following has not occurred:

A. The applicant has submitted an incomplete application;
B. The MEC makes a final recommendation that is adverse or has limitations;
C. There is a current challenge or a previously successful challenge to licensure or registration;
D. The applicant has received an involuntary termination of medical staff membership at another organization;
E. The applicant has received involuntary limitation, reduction, denial, or loss of clinical privileges;
   OR
F. The hospital determines that there has been either an unusual pattern of, or an excessive number of, professional liability actions resulting in a final judgment against the applicant which has not been resolved satisfactorily;

The medical staff uses the criteria developed for the expedited process when recommending privileges.

5.0 TERMS OF APPOINTMENT
5.1 INITIAL
A. Initial appointment to the medical staff shall be made on a provisional basis by the Board of Directors, upon recommendation of the MEC, for a maximum period of one (1) year. During the provisional term, the staff member shall not be eligible to vote, to hold office, and shall not serve on medical staff committees, except as an ex officio member.
B. The provisional designation is removed if and when the MEC and Board receive satisfactory assurance that the practitioner is capable and willing to fulfill the responsibilities of appointment in the practitioner’s chosen area of clinical practice.

C. The provisional period may be extended once, for good cause, at the recommendation of the MEC and approval of the Board. Such extension can be for no longer than one year.

D. If the practitioner’s performance is not satisfactory at the end of the extension, then appointment, privileges, or a specific privilege, whatever has been the subject of the extension, shall not be granted. In that case, the applicant shall be entitled to rights of hearing and appellate review.

5.2 REAPPOINTMENT

Formal application for membership reappointment and privileges delineation must be made at the end of the provisional period and shall be for a period of time that is consistent with current accreditation and regulatory requirements but not longer than 24 months.
6.0 BETWEEN ROUTINE REAPPOINTMENT DATES

6.1 COMPLIANCE AND COOPERATION
Practitioners shall comply and cooperate with the hospital’s peer review, quality assurance, and performance improvement activities, and shall immediately furnish to the hospital, whenever applicable:

- information if the practitioner’s professional license or DEA has been placed on probation, limited, revoked, restricted, suspended, not renewed, or voluntarily or involuntarily relinquished; provisions in the bylaws will apply;
- information if professional liability insurance is canceled or lapses without renewal; provisions in the bylaws will apply;
- information about restrictions on, voluntary or involuntary relinquishment of, or revocation of staff membership and/or privileges at any Facility;
- information about malpractice judgments, claims, suits, or settlements;
- information about current health status which relates to the practitioner’s ability to perform clinical privileges requested or granted;
- any information reasonably required by the MEC, administration, and/or Board to adequately evaluate the staff member; and
- upon request by the MEC or Board demonstrate adequately qualified and privileged backup coverage for their patients, acceptable to the MEC, in case of absence or unavailability.

7.0 REAPPOINTMENT

7.1 REAPPOINTMENT
A. The Board reviews and acts on MEC recommendations regarding reappointment and renewal of clinical privileges. The MEC and Board may also consider whether the individual has actually exercised all the requested privileges with sufficient frequency since the time of initial appointment or last reappointment to indicate current competency.

B. From time to time, the MEC may recommend a period of reappointment of less than two years. Reappointments may be extended after a shortened reappointment without completion of a new application, provided the shortened appointment periods total less than one year. An attestation must be completed verifying no changes in the application information.

C. Each medical staff member receives an application for renewal of appointment and clinical privileges.

D. The reappointment shall provide an opportunity:
- to request continuation of present staff status;
• to request a change in medical staff category or clinical department assignment;
• to request either an addition to, or a deletion from specific clinical privileges;
• to provide updated information regarding appointments;
• to request assignment to particular committees or activities of the medical staff organization;
• to request that medical staff membership, and privileges be terminated; and
• to provide information as to whether professional license, DEA, medical staff membership or clinical privileges at another institution have been placed on probation, reduced, revoked, suspended, not renewed, denied, or voluntarily or involuntarily relinquished, or any leave of absence taken.

E. The reappointment shall include:
• opportunity for the recommendation of the Chair of the clinical department to which the individual is currently assigned. The recommendation is based on an evaluation of information reflecting clinical knowledge, skills, and performance (as indicated by the results of performance improvement activities and other reasonable indicators of continuing qualifications); relationship with other physicians, the hospital, its employees, and with patients; ethical behavior; availability; mental and physical stability; technical proficiency and efficiency; and degree of participation in business and educational meetings.

• required continuing medical education, and other staff activities;
• evidence of continuous and uninterrupted professional liability insurance without periods of non-coverage, and including either extended (tail) or retroactive (prior acts) coverage, in amounts established by the Board, with MEC input;
• verification of the professional license;
• all applications for reappointment must contain information about current professional liability coverage;
• information about all malpractice claims, suits, judgments or settlements that have occurred since the previous appointment period; This information must be provided by the physician; information provided by the insurance carrier or the physician's attorney is not acceptable;
• information about practice at other institutions with which the applicant for reappointment is or has been affiliated since last reappointment
• such other information as the MEC and/or Board may require;
• information as to whether professional license, DEA, medical staff membership, or clinical privileges at another institution have been encumbered, placed on probation, reduced, revoked, suspended, not renewed, denied, or voluntarily or involuntarily relinquished, or any leave of absence taken;

• proof of immigration status, when applicable;

• ACLS/ATLS/PALS certification if specified in privilege criteria;
• specialty and subspecialty Board Certification and re-certification status;
• required continuing medical education related in part to the delineation of clinical privileges;
• recent clinical inpatient experience with neonates, infants, and children, if applicable to privileges requested;
• current fee; and
• an email address is required at reappointment to make application complete.

7.2 ACCURATE INFORMATION
Failure by the applicant to provide truthful, accurate, and complete information shall in itself be grounds for denial or revocation of staff membership/appointment, reappointment and clinical privileges, without right to hearing or appellate review.

The applicant may not reapply for at least one (1) year, unless the Board determines otherwise.

7.3 FAILURE TO REAPPLY

A. Timeliness - A completed appointment/reappointment application, as well as inclusion of all necessary attachments and verifications, must be received by the Medical Staff Services Department two-weeks prior to the Credentials Committee meeting in order to be considered. Any completed application received after this time frame will be considered with the next scheduled Credentials Committee cycle. Any expiring re-appointments or failures to reapply will be subject to current medical staff bylaws.

B. The failure of a member to submit a completed reappointment application, as well as inclusion of all necessary documentation, within 45 days of the date for expiration of the appointment term shall be deemed an automatic resignation of staff membership and privileges, without right of hearing or appellate review. The member must request an application and follow the initial appointment process before either membership or any clinical privileges may again be exercised.

7.4 FAILURE TO COMPLETE OPPE

If a practitioner (who has previously relinquished privileges and membership due to incomplete OPPE) subsequently submits an approved plan to successfully complete OPPE, the practitioner may again apply for initial membership and privileges. If OPPE is again incomplete at the end of one year, the practitioner shall voluntarily relinquish membership and privileges; such action shall not trigger an NPDB report. Unless a change in practice model, affiliation, and/or employment occurs that would facilitate OPPE completion (and is approved by MEC) the practitioner may not again apply for 1 year. An approved OPPE plan must be submitted at that time.

8.0 MISCELLANEOUS ISSUES ASSOCIATED WITH SUBMISSION OF APPLICATIONS, REAPPLICATIONS, AND OTHER CHANGES IN STATUS

8.1 VERIFICATION OF POST GRADUATE TRAINING
When an applicant makes a request for medical staff membership and clinical privileges before completion of a residency or fellowship and completion is scheduled within 60 days, the credentials committee may review the file and make a recommendation. The file will be presented to the Credentials Committee as “pending verification”. Upon completion of the post graduate training, primary source verification will be obtained from the post graduate training program within 7 days of program completion. The applicant, with the assistance of the credentialing specialist, will be responsible for the verification. Membership and privileges will become valid only upon receipt of the verification.
8.2 PHYSICIANS WITH LOW VOLUME
(Less than 25 patient encounters per year at Facility)

Applications for reappointment for courtesy staff physicians (less than 25 admissions, procedures, or consultations per year at hospital Facility and associated facilities in the service area including, but not limited to, outpatient surgical treatment facilities located in the same service area, must be accompanied by the name of the department chair of the Facility where the practitioner is an active staff member in order to obtain a peer evaluation. If the practitioner is not an active staff member at any Facility, the names of two current Facility active staff members should be submitted. It will be the responsibility of the physician to ensure these peer evaluations are received by the medical staff office. The application will be considered incomplete without appropriately completed evaluation forms.

Physicians in certain specialties who are entirely office based may be eligible to apply for Affiliate or Provider-based Affiliate status, in accordance with the bylaws. So that peer evaluations may be obtained, Affiliate and Provider-based Affiliate staff members should submit either the name of the hospitalist who provides inpatient care for their patients or a member of the facilities’ medical staff (Active, Courtesy, Affiliate, or Provider-based Affiliate) who has knowledge of their current clinical competencies. It is the responsibility of the physician to ensure these peer evaluations are received by the medical staff office. The application will be considered incomplete without appropriately completed evaluation forms.

8.3 PEER REVIEW OVERSIGHT COMMITTEE SUPPORT OF CREDENTIALS COMMITTEE REGARDING PHYSICIANS

The Peer Review Oversight Committee will serve in an advisory capacity to the Credentials Committee regarding any physician or healthcare practitioner under review. This advisory support should be in writing and should include information on the current status of the review of the practitioner and other appropriate and pertinent information in this regard.

8.4 CHANGE IN STAFF STATUS OR PRIMARY LOCATION

When a physician makes a request to the Medical Staff Services Department to change staff status and/or primary location (for call purposes) he/she shall designate a start time that this change would take place. A minimum of 90 days’ notice and compatibility with current applicable rules and regulations are required.

That physician's level of activity and staff status will be assessed annually. The physician’s staff status (active, courtesy, etc.) will be automatically changed to reflect current patient encounters according to the current medical staff bylaws, rules and regulations, and other governing documents.

8.5 CERNER TRAINING REQUIREMENTS

New medical staff members (except those in Affiliate & Telemedicine status) and AHP staff (except psychologists) must complete all mandatory EMR training and competencies (as required) prior to activation of any clinical privileges.
New medical staff members in Affiliate status must complete Basic Cerner training prior to activation of their status or any clinical privileges.

Current medical staff members (except those in Affiliate status) and AHP staff must complete all mandatory EMR training and competencies (as required) during their current appointment cycle. Reappointment for either group will not be considered until these training obligations are fulfilled. New medical staff members in Affiliate status must complete Basic Cerner training prior to activation of their status or any clinical privileges. Current medical staff members in Affiliate status must complete Basic Cerner training during their current appointment cycle.

Mandatory EMR training includes at a minimum (but is not limited to):

- Basic Cerner
- CPOE
- Electronic Medication Reconciliation
- Electronic Transfer Orders Process
- Documentation - when designated as the primary means of documentation at the provider’s primary hospital or at any Facility/location where the provider practices.
- Additional mandatory training (as defined by MEC) as additional functionality is added to the EMR

8.6 HIGH RELIABILITY ORGANIZING (HRO) MANDATORY TRAINING

New medical staff members/applicants (except those in Telemedicine status) and new AHP staff/applicants must complete all computer-based HRO training prior to activation of any clinical privileges. After completion of all mandatory computer-based training, privileges may be granted as “temporary privileges” for 120 days until both Onboarding and HRO Classroom training are successfully completed. If temporary privileges expire prior to completion of either Onboarding or HRO Classroom training, then the provider must reapply after fulfilling both obligations.

Current medical staff members, AHP staff, and all providers privileged through the Medical Staff process must complete all mandatory HRO training and competencies (as required) during their current appointment cycle. Reappointments for medical staff and AHP staff will not be considered until these training obligations are fulfilled.

9.0 CLINICAL PRIVILEGES

9.1 OBLIGATIONS
Practitioners request only those clinical privileges that are within the scope of their current licensure training, and experience and exercise them only after they are granted by the Board upon recommendation of the MEC. The Board’s grant of membership and privileges entails general clinical obligations including but not limited to:

- complete patients’ medical records as specified in the medical staff rules and regulations and policies governing patient records;
- be subject to the rules and regulations of all clinical departments in which privileges are held, and to the authority of the Department Chair;
be included in reviews of quality, efficiency, appropriateness, and accessibility of patient care;

cooperate with procedures for timely renewal of clinical privileges

All privileges, independent and dependent, are to be within the scope of the clinical privileges granted after the recommendation of the MEC and the approval of the Board and are separate and distinct from the decision regarding medical staff appointment/reappointment.

9.2 PRIVILEGES

Clinical privileges shall not be limited by department assignment. Members may admit patients as appropriate to their delineated clinical privileges.

Affiliate staff privileges do not allow practitioners to admit, document inpatient orders, or perform hospital procedures. Practitioners may refer and follow patients in the hospital and may order outpatient treatments and services, including rehabilitation and respiratory therapy.

Other practitioners who are not members of the medical staff are also granted privileges as set forth in the AHP section of this policy.

9.3 INITIAL PRIVILEGES

Each applicant, as part of the initial application procedure, shall request those specific clinical privileges which he/she wishes to exercise within the scope of such applicant’s license. It is the applicant’s burden to provide objective evidence of current competence and qualifications in these clinical areas.

9.4 REQUEST FOR ADDITIONAL PRIVILEGES

Recommendations for increase of clinical privileges shall be based on:

- relevant recent training;
- observation of patient care provided;
- review of the records of patients treated in this or other hospitals;
- results of the hospital’s performance improvement activities; and
- the scope of privileges permissible under the practitioner’s license and other reasonable indicators of the individual’s current qualifications and competency for the privileges sought.

Requests for additional clinical privileges will not be considered if a practitioner currently has a shortened reappointment or is undergoing Focused Professional Practice Evaluation (FPPE) for any reason other than the initial FPPE requirement when a new privilege is granted.

9.5 PERIODIC RENEWAL OF CLINICAL PRIVILEGES

At reappointment time, delineations of specific clinical privileges must be requested by the practitioner and approved by the board, after recommendations by the Department Chair and the MEC. Criteria will include at a minimum, relevant training (including sufficient specificity of training to perform well in the clinical areas requested), experience, current demonstrated
competence, health status, quality of care and ongoing quality monitoring of information regarding the practitioner’s professional performance and conduct, judgment, clinical, and/or technical skills.

9.6 PROCESSING CLINICAL PRIVILEGE REQUESTS

Requests for clinical privileges will be processed only when the potential applicant meets the board’s current minimum threshold criteria. Requests that do not meet these criteria will not be submitted to the Department Chair or the Credentials Committee.

Prior to granting a privilege, the resources necessary to support the requested privilege are determined to be currently available or available within a specified timeframe. The board, upon recommendation of the MEC, shall determine that new privileges are added to the scope of services of the organization based upon available resources, equipment, financial considerations, and types of personnel necessary to support the requested privileges. The hospital and medical staff utilize the processes described in the New Medical Technology Policy to support these determinations.

In the event a privilege request is received that does not involve New Medical Technology and for which there are no approved criteria, the Procedure for Developing Clinical Privilege Criteria will be followed.

9.7 PROCEDURE FOR DEVELOPING CLINICAL PRIVILEGE CRITERIA

A. When a privilege request for which there are no applicable criteria is received, the Credentials Committee will decide whether to develop criteria for the privilege.

When the Credential Committee decides to develop criteria for a new privilege, it will use the following procedure to coordinate the development of applicable criteria.

1. The Credentials Committee will:
   - identify the specialty/subspecialties that might be interested in this clinical issue;
   - outline the positions of specialty societies or academies concerning the issue if available
   - identify the type of practitioners already performing/treating this clinical issue in other similar hospitals; and
   - any other relevant issues.

2.1 If the privilege involves one specialty, the Credentials Committee will request the Department Chair to provide the review and recommend the appropriate criteria.

2.2 If the privilege involves more than one specialty, the Credentials Committee will submit the results of its findings to an ad hoc task force composed of subject matter experts, for example:
   - a multi-specialty group composed of physicians with a true interest and knowledge of the issue facilitated by a representative of the Credentials Committee; or
the individual departments/subspecialties that are expected to provide advice to the Credentials Committee concerning this clinical issue.

3. The Credentials Committee will give the department chair and/or ad hoc task force approximately 30 days to provide advice concerning the criteria it should require of those applying for the clinical privilege. Specifically, the Credentials Committee should ask the department chair/task force to provide advice concerning:
   - type of basic education and, if necessary, continuing education
   - type and number of years of formal training
   - training that would be required if an applicant’s postgraduate residency program did not include training in the clinical privilege area (for example, the task force should indicate whether the completion of an approved residency program should be followed by some years of fellowship and/or a certain number of hours of approved postgraduate training in a university or other educational setting);
   - amount of recent, direct or indirect experience, if necessary, such as general hospital experience in the specialty during the past 12 months or specific experience in the diagnosis/procedure during the past 12 months; and
   - type of references that will be necessary to process the request

B. INSTRUCTIONS FOR DEVELOPING PRIVILEGE CRITERIA

1. One form should be finalized for each area in which privileges are requested or granted - either by general category or by specific privilege.

2. State the amount of education, training, and experience that is necessary to engage in the specific clinical activity under consideration. List all possible combinations of qualifications.

   Please determine:

   - What degree must the applicant have (MD, DO, DDS)
   - How many years of approved postgraduate residency or fellowship training are required, and in what types of programs?
   - Must the applicant be board certified/board eligible?
   - How much recent direct or indirect experience in the procedure, illness, or related field (within the past 12 - 24 months) must the applicant demonstrate?
   - How many and what type of references are required to permit evaluation of ability, judgment, and current competence?

   Note: If a particular category is not required, indicate with “NA”

3. Unless otherwise specified:
   - All required education must have taken place in an institution approved by ACGME
• All experience must have occurred within the past 12 months in a TJC accredited Facility

10.0 EMERGENCY (CONDITION) PRIVILEGES
In case of an emergency, any staff member, to the degree permitted by his license and regardless of staff status, department assignment, or clinical privilege delineation may, indeed should, assist in the care of the patient.

For the purpose of this, "emergency" refers to a condition in which serious or permanent harm might result to a patient, or in which the life of the patient is in immediate danger, if there is any delay in administering treatment.

11.0 GUIDELINES FOR GRANTING TEMPORARY PRIVILEGES

The medical staff bylaws provides that temporary privileges may be granted for patient specific purposes or during the processing of an application, provided certain specified conditions are met. The granting of such privileges under such circumstances is consistent with The Joint Commission standards. This applies to all individuals who are subject to the credentialing process.

11.1. IMPORTANT PATIENT CARE OR SERVICE NEEDS
Temporary privileges may be granted, upon the appropriate recommendations set forth in the medical staff bylaws, to fulfill an important patient care need or service need (e.g., a practitioner becomes ill or takes a leave of absence and needs another practitioner to cover his or her practice, or a specific practitioner possesses urgently needed skills) or any other situation in which the needs of our patients are best met by the granting of such privileges to an applicant. Prior to the granting of privileges under this Section, the Medical Staff Services Department must obtain and/or verify information, as applicable, regarding the following items:
• current unencumbered licensure;
• completed initial application
• verification of current hospital affiliation and former hospital affiliations for at least the past twelve (12) months to determine relevant training or experience, current clinical competence and ability to perform the requested privileges;
• no current or previously successful challenge to licensure/registration;
• Current NPDB report obtained. The applicant must not have been subject to involuntary termination of medical membership at another organization or involuntary limitation, reduction, denial, or loss of clinical privileges;
• medical malpractice insurance coverage requirements;
• freedom from prior criminal conviction;
• freedom from current sanction by a branch of the federal or state government (OIG cumulative sanctions report);
• medical malpractice claims history with an absence of a pattern of malpractice suits or any significant claim(s) or settlement(s) raising concern about competence; and
• Written request from a current member requesting that an individual be given temporary privileges and specifying the scope of the requested privileges (including the patient and any surgical or invasive procedures involved)
• Recommendation from the President of the medical staff or chief of staff recommending the practitioner for temporary privileges.

A practitioner who has been granted temporary privileges pursuant to this Section shall not be assigned to a staff category as such privileges are granted only for a specific purpose and short duration. Temporary privileges granted pursuant to this Section shall not preclude the necessity for the Medical Staff Services Department to continue processing all information that is necessary for a COMPLETE application as that term is defined in the definitions of the medical staff bylaws for eventual action by the Credentials Committee, Medical Executive Committee and the Board. The Medical Staff Services Department must immediately report any adverse information discovered during such processing to the Chair of the Credentials Committee and the Facility CEO for recommendations concerning review and/or action, including the revocation of temporary privileges.

11.2 COMPLETED APPLICATION PENDING BOARD APPROVAL
Temporary privileges may also be granted for initial applicants, upon the appropriate recommendations set forth in the medical staff bylaws, during the processing of an application provided the applicant has a COMPLETE (as defined in medical staff bylaws) and CLEAN application and has been approved by the Credentials Committee and is only awaiting review and approval of the medical executive committee and the governing body. A CLEAN application is verification by the Medical Staff Services Department of the following items:

• current licensure;
• relevant training or experience;
• current clinical competence;
• ability to perform the requested privileges;
• NPDB report obtained;
• no current or previously successful challenge to licensure/registration;
• not been subject to involuntary termination of medical membership at another organization;
• not been subject to involuntary limitation, reduction, denial, or loss of clinical privileges;
• medical malpractice insurance coverage requirements;
• freedom from prior criminal conviction;
• freedom from current sanction by a branch of the federal or state government (OIG cumulative sanctions report); and
• medical malpractice claims history with an absence of a pattern of malpractice suits or any significant claim(s) or settlement(s) raising concern about competence.

A practitioner who has been granted temporary privileges pursuant to this Section shall be assigned to the appropriate staff category.
The items to be verified must be accomplished via primary source.

The Facility Chief Executive Officer ("CEO") or his/her designee may grant temporary privileges under the above two circumstances. If a specific time is not specified by the CEO in granting the privileges, temporary privileges shall expire within the maximum time frame allowed by current regulatory standards but not to exceed 120 days, unless revocation has occurred. As set forth in the medical staff bylaws, temporary privileges may be rescinded by the CEO or designee at any time prior to the expiration of the temporary period, without fair hearing process, upon the advice of the Chief of Staff, Chair of the Credentials Committee or Chair of the relevant clinical department.

11.3 LOCUM TENENS

Locum tenens privileges may be granted to a physician or dentist who meets the eligibility requirements outlined in the bylaws, Section 2.1, and credentials policies, Section 1. Applicants will be considered only upon recommendations of the Department Chair, Credentials Committee Chair, Medical Staff President and Chief of Staff, or their designees. Upon recommendation of the MEC and approval of the Governing Body, clinical privileges may be granted for a period of up to six months and may be renewed upon recommendation of the MEC and approval of the Governing Body for subsequent six month periods or shorter time intervals as circumstances warrant.

Locum tenens privileges may be granted to a physician or dentist who meets the eligibility requirements outlined in the bylaws, Section 2.1, and credentials policies, Section 1. Applicants will be considered only at the request of a Member and upon recommendations of the Department Chair, Credentials Committee Chair, Medical Staff President and Chief of Staff, or their designees. The Chief Executive Officer may grant admitting and clinical privileges for a period not to exceed 120 days. The Member may request such privileges be extended when the Member requires additional locum tenens coverage during a specified period of time, subject to recommendation of the MEC and approval of the Governing Board. Granting locum tenens privileges is not a right and shall be judiciously used.

A physician or dentist granted locum tenens privileges shall not be a Member of the medical staff, shall not have access to any of the rights or prerogatives of membership, and shall abide by all applicable medical staff bylaws, credentials policies, rules and regulations, and all other medical staff policies. Focused Professional Performance Evaluation shall be completed within 30 days.

A provider requesting locum tenens privileges must submit an initial application form. The application shall be identical to the Member application and processed in the same manner as outlined for Members in the medical staff bylaws and credentials policies, except that the applicant shall document it is for locum tenens privileges and not medical staff membership. The applicant shall also specify the dates for which privileges are requested. Applications for locum tenens privileges must be received at least sixty days prior to the date for which privileges are requested.
12.0 FOCUSED PROFESSIONAL PRACTICE EVALUATION POLICY

Purpose
To establish a systematic process:
- to evaluate practitioners’ ability and competence to perform newly requested privileges;
  or
- to evaluate practitioners’ performance of existing privileges when there is a potential problem or when questions arise, even if a single event, or if further study is warranted.

This process is known as focused professional practice evaluation (“FPPE” or “focused evaluation”).

Definition of FPPE
Focused professional practice evaluation is defined as a period during which the organization evaluates a practitioner’s professional ability and competence to perform privileges. FPPE will occur with all requests for new privileges (either new applicants or new privileges for existing practitioners) and when there are concerns regarding the provision of safe, high quality care by a current medical staff member, as recognized through the peer review process or through the Ongoing Professional Practice Evaluation (OPPE) process.

This process may include an assessment of proficiency in the following six areas of general competencies:

1. Patient care.
2. Medical and clinical knowledge
3. Practice-based learning and improvement
4. Interpersonal and communication skills
5. Professionalism
6. Systems-based practice

Information for this evaluation may be derived from the following:

1. Discussion with other individuals involved in the care of each patient (e.g. consulting physician, assistants in surgery, nursing, or administrative personnel)
2. Chart review
3. Monitoring clinical practice patterns, diagnostic and treatment techniques
4. Proctoring
5. Direct observation
6. External review

Responsibilities
The department chair shall be responsible for overseeing the FPPE process for all applicants or staff members assigned to their department or division.
The credentials committee is charged with the responsibility of monitoring compliance with this policy. It accomplishes this by receiving regular status reports on the progress of all practitioners undergoing focused evaluation as well as any issues or problems involving the implementation of this policy. The committee will receive reports of all practitioners as they complete their FPPE period. Performance problems during a FPPE period shall be reported to the credentials committee as they occur and also referred to the PROC and department peer review committee, as appropriate.

**Performance of FPPE**

The type of focused professional performance evaluation to be used will be determined by the department chair based on the individual practitioner’s circumstance using the following guidelines:

1. **New applicant.**
   a. Peer recommendations from previous institutions will be confirmed by the department chair.
   b. Performance indicators or aggregate data within the department will be monitored.
   c. Procedure and clinical activity logs will be reviewed from previous institutions and/or training programs. A multi-tiered approach may be utilized by the department chair according to different levels of documented training and experience:
      - practitioners coming directly from outside residency program
      - practitioners coming directly from residencies supervised at the Facility
      - practitioners with a documented record of performance of the privilege and its associated outcomes
      - practitioners with no record of performance of the privilege and its associated outcomes.
      - FPPE will be conducted on the first five episodes of care available for review or according to the criteria set by the department, at the discretion of the department chair. If no outliers are identified upon completion of the FPPE, this evaluation shall be deemed successfully completed.

2. **New privilege for existing staff member**
   If a newly requested privilege is significantly different from one’s current practice and demonstrated competence, then training in the new privilege and FPPE should be arranged and completed. This process and the number of cases necessary should be determined by the department chair and the credentials committee. If new technology is involved, then CSC New Technology committee recommendations should be considered.

3. **Focused review for new privileges evaluated by retrospective proctoring**
   To facilitate focused review for new privileges that are primarily evaluated by retrospective proctoring/chart review, the provider (either medical staff or AHP member)
shall provide a case log to the medical staff office as soon as possible after the patient encounter. The case log format is located on MethodistMD.

FPPE for Moderate Sedation privileges shall be completed at the time of reappointment provided case logs are submitted with no trends in adverse outcomes.

4. Low volume or no volume of new privileges/failure to provide case logs

If activity levels are insufficient to complete FPPE, this shall be reported to the credentials committee.

**AHP Practitioner:** No additional privileges/procedures will be permitted until initial FPPE is complete. If there is insufficient activity/FPPE at the end of one year, the AHP practitioner shall voluntarily relinquish privileges and such action shall not trigger an NPDB report.

- If an AHP (who has previously relinquished privileges due to insufficient FPPE) subsequently submits an approved plan to successfully complete FPPE, the AHP may again apply for initial membership and privileges. If FPPE is again incomplete at the end of one year, the AHP shall voluntarily relinquish privileges; such action shall not trigger an NPDB report. Unless a change in practice model, affiliation, and/or employment occurs that would facilitate FPPE completion (and is approved by MEC) the AHP may not again apply for 1 year. An approved FPPE plan must be submitted at that time.

**Medical Staff Practitioner - newly appointed:** If there is insufficient activity at the end of one year, the medical staff practitioner shall be required to provide at least one peer reference attesting to current ability and competence to perform these privileges from an organization/Facility where these privileges are currently exercised and shall also receive a shortened reappointment for only one additional year to complete FPPE. If there is insufficient activity/FPPE at the end of this period, the medical staff practitioner shall voluntarily relinquish privileges and such action shall not trigger an NPDB report.

**Medical Staff Practitioner - additional privileges:** No additional privileges will be permitted if FPPE required for initial core privileges granted remains incomplete.

When additional privileges are granted to any practitioner, FPPE for the additional privileges should be completed within one year.

**Failure of Medical Staff Practitioner to Complete FPPE**

Attempts to complete FPPE within required time periods shall continue;

If FPPE is not completed within the required time period, actions will occur, including, but not limited to:

- placing the privilege(s) in abeyance (which shall not trigger a hearing or a NPDB report) and

- notifying the practitioner that if he/she wishes to reactivate privilege(s), he/she must request time-limited reactivation for specific patient encounters and provide a timely case log of those encounters
privilege(s) placed in abeyance shall be voluntarily relinquished during the next reappointment cycle if FPPE has not been completed.

If a practitioner (who has previously relinquished privileges and membership due to incomplete FPPE) subsequently submits an approved plan to successfully complete FPPE, the practitioner may again apply for initial membership and privileges. If FPPE is again incomplete at the end of one year, the practitioner shall voluntarily relinquish membership and privileges; such action shall not trigger an NPDB report. Unless a change in practice model, affiliation, and/or employment occurs that would facilitate FPPE completion (and is approved by MEC) the practitioner may not again apply for 1 year. An approved FPPE plan must be submitted at that time.

The Hospital reserves the right to continue any privilege if the organization and/or community have need of this privilege. In this case, the practitioner shall notify the Medical Staff Services Department prior to performing this privilege and focused review shall be triggered when the practitioner actually performs the privilege.

5. FPPE for new privileges shall be retained with the practitioner’s credentials file.

6. FPPE when questions arise or issues are identified that affect safe, high quality patient care
   a. Criteria that trigger FPPE are described in the peer review policies. They may include a clinical/outcome trend, significant deviation from standards of care, significant complaint(s), repeated failure to follow hospital policy, adverse or negative OPPE for 3 or more months, a peer review trend, or a single incident or sentinel event.
   b. The focused or intensified review is determined by the PROC or by recommendation from the Department Chair or MEC. This determination includes the monitoring method, criteria, and duration.
   c. Monitoring criteria will be driven by the privilege type. Cognitive privilege concerns will include retrospective (chart) and/or prospective review. Procedural privilege concerns will include prospective, retrospective, direct observation or any combination thereof. The decision for a period of FPPE is based on current clinical competence, practice behavior, and ability to perform the requested privilege.
   d. Monitoring from an external source will be sought when there is no other qualified practitioner or when those available would be biased.
   e. Measures to resolve concerns will be proactively identified and may include successful performance after either 3 or 6 months, depending on volume and activity. Additional education may also be required, if appropriate.
   f. FPPE does not constitute adverse action and does not trigger the hearing process; it is a method of gathering more information.
   g. If the focused evaluation does not satisfactorily resolve the concerns or questions, recommendations may be made to the credentials committee to restrict or revoke privileges, as appropriate, or to the physician well-being committee.
h. Request for immediate action, according to the medical staff bylaws, can be taken at any time during the OPPE process. This request can occur as a result of a single incident or trending of quality and safety issues that impact the safety of patients. Immediate actions may include forwarding concerns to the following committees:

- Credentials Committee
- Physician Well Being Committee
- Medical Executive Committee

i. FPPE of this type shall be retained with the practitioner’s Quality file.

Supervision of FPPE
Assignment of focused professional practice evaluations will be the responsibility of the department chair. The chair may appoint active staff members to complete the appropriate tasks. Medical directors should be utilized, as appropriate. It is recommended that each department establish a panel of proctors.

Proctor Qualifications
When concurrent proctoring is required, the following guidelines should be used:

1. Proctors should be
   - medical staff members with full privileges (without limitations and/or pending FPPE) to perform the procedure being concurrently proctored
   - OR
   - In cases of new technology or additional privileges for new technology, proctors shall be certified as an External Proctor through the authorization process

2. Proctors will be mutually agreed upon between the department chair and the physician being proctored.

3. The proctor may be a member of the same practice group as the physician being proctored.

Responsibilities of Proctors

1. Proctor shall directly observe the procedure being performed, concurrently observe medical management and/or retrospectively review the completed medical record following discharge.

2. Proctors will:
   - complete appropriate forms,
   - ensure confidentiality of proctor results and forms,
   - submit completed forms to the medical staff office, and
   - submit a summary report at conclusion of proctoring period.

3. If at any time during the proctoring period the proctor has concerns about the practitioner’s competency to perform specific clinical privileges or care related to specific patients, the proctor shall promptly notify the department chair.
Medical Staff's Ethical Position on Proctoring
Concurrent proctoring is one method that may be utilized for evaluation of procedural competency. The proctor is an agent of the hospital. The proctor shall receive no compensation from any patient for this service. The credentialed, privileged proctor, however, should nonetheless render emergency medical care to the patient for medical complications arising from the care provided by the proctored practitioner. The hospital will defend and indemnify any privileged practitioner who is subjected to a claim or suit arising from his or her acts or omissions in the role of proctor.

13.0 TELEMEDICINE POLICY
Definitions
Telemedicine is the use of medical information exchanged from one site to another via electronic communications for the health and education of the patient or health care provider and for the purpose of improving patient care, treatment and services.

Originating site is the site at which the patient is receiving care.

Distant site is the site at which the practitioner providing the professional service is located.

It is the policy of the Facility that telemedicine services will be provided at this Facility as an originating site that seeks to ensure a high level of care.

In regard to telemedicine privileges, practitioners providing telemedicine must be granted privileges at the Facility if these services include care and treatment of patients. Requests for telemedicine privileges will be processed through established credentialing processes.

Credentialing information may be utilized from the distant site if the following conditions are fulfilled:
- The distant site is TJC accredited
- The practitioner is privileged at the distant site for those services to be provided at the originating hospital
- The distant site hospital has evidence of an internal review of the practitioner’s performance of these privileges and sends to the originating site information that is useful to assess the practitioner’s quality of care and services for use in privileging and performance improvement. At a minimum, this information will include all adverse outcomes related to sentinel events considered reviewable by the TJC; and complaints about the distant site’s LIPs from patients, LIPs or staff at the originating site.
- Proof of positive identification (from the distant site)

14.0 DENTISTS
Regardless of staff category or department assignment, surgical procedures performed by dentists are under the overall supervision of the Chairman of the Department of Surgery. Dentists may document orders within the scope of their license to practice and within the scope of rules and regulations.

The medical history and physical examination of the patient, as well as the responsibility for the treatment of specific concomitant medical disease throughout the period of hospitalization, are
the responsibility of a consulting physician, except that qualified oral and maxillofacial surgeons may do their own histories and physicals.

15.0 MEDICO-ADMISTRATIVE POSITIONS
Physicians whose duties include both administrative and clinical activities must be members of the medical staff, and must obtain clinical privileges as appropriate in the same manner as any other medical staff member.

16.0 DISASTER CREDENTIALING POLICY

Purpose
To ensure that physicians and other Licensed independent Practitioners (LIPs) who do not possess medical staff membership and privileges may be granted privileges at the Facility in response to a disaster (when the Emergency Operations plan has been activated) and the Facility is unable to meet immediate patient needs. A disaster is defined as any officially declared emergency, whether local, state, or national, that due to its complexity, scope, or duration, threatens the organization’s capabilities and requires outside assistance to sustain patient care, safety, or security functions.

16.1 POLICY
Any volunteer LIP providing patient care must be granted privileges prior to providing patient care, even in a disaster/emergency situation. The CEO, Executive Medical Staff Leaders, Department Chairs and Service Chiefs or their designee(s) have the option to grant disaster privileges on a case-by-case basis at their discretion.

16.2 PROCEDURE
Before a volunteer is considered eligible to function as a volunteer LIP, the Facility obtains his/her valid government-issued photo identification (e.g. driver’s license or passport) and at least one of the following (as defined by the Joint Commission) below:
1. Current photo ID card from a health care organization that clearly identifies the professional designation
2. Current professional license to practice
3. Primary source verification of license
4. ID indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT), the Medical Reserve Corps (MRC), the Emergency System for Advance Registration of Volunteer Health Professionals (SAR-VHP), or other recognized state or federal response organizations or groups
5. ID indicating that a government entity has granted the individual the authority to administer patient care, treatment, services in disaster situations
6. Presentation by a licensed independent practitioner currently providing care, treatment and services at the organization or a staff member with personal knowledge of the volunteer practitioner’s ability to act as a licensed independent practitioner during a disaster

Medical staff affiliation (membership and privileges) of other local hospitals, verified by a current medical staff roster supplied by the affiliated hospital may be used supplementally with the required identification listed above to assist in granting disaster privileges.
Additionally, if possible, the practitioner will be asked to provide information about other hospital affiliations and malpractice liability coverage.

A record of this information should be retained with the disaster privileges form. Copies of the form shall be distributed to all hospital departments involved in the disaster as soon as possible.

Primary source verification of licensure shall occur as soon as possible by the Medical Staff Services Department (as soon as the disaster is under control or within 72 hours of the volunteer LIP presenting to the Facility, whichever comes first), except in extraordinary circumstances; and the National Practitioner Data Bank will be queried (if possible). In these extraordinary circumstances (when verification cannot be completed), there must be documentation of the following: why primary source verification could not be performed in the required timeframe; evidence of the volunteer LIP’s demonstrated ability to continue to provide adequate care, treatment, and services; and an attempt to rectify the situation as soon as possible.

Once granted disaster privileges, the volunteer LIP shall be assigned to a medical staff department to whom the practitioner shall report for assignment. Oversight for the volunteer LIP’s performance shall be provided by the department chair or designee during the disaster privileging appointment. Supervision may occur by direct observation, mentoring, and/or clinical record review. Based upon its oversight of each volunteer licensed independent practitioner, the Facility’s medical staff determines within 72 hours of the practitioner’s arrival if granted disaster privileges should continue.

When the disaster situation no longer exists, as determined by the CEO or designee, these disaster privileges terminate. Termination of disaster privileges will not give rise to a medical staff hearing.
17.0 LEAVE OF ABSENCE

A member of the medical staff may obtain a voluntary leave of absence by submitting written notice to the chief of staff, for transmittal to the appropriate department chair and the chief operating officer. The notice must state the approximate time period of the leave, which may not exceed one year, except for military service. Members shall be required to inform the Chief of Staff and the Medical Staff Services Department of any absence expected to continue for longer than 90 days and to request a leave of absence.

During the period of a leave of absence, the member’s clinical privileges, prerogatives and responsibilities are held in abeyance. The medical staff member must, at least 60 days prior to termination of a leave, or at any earlier time, request reinstatement by sending written notice to the medical staff office for the executive committee’s consideration. The medical staff member must submit a written summary of relevant activities during the leave if the medical executive committee or governing board so requests. The medical executive committee makes a recommendation to the governing board concerning reinstatement.

Upon application for return from leave of absence, the practitioner may be required to submit evidence of continued and current clinical competence, and of health status as it relates to the privileges requested, which shall be reviewed and acted upon by the Board following the recommendation of the Department Chair, Credentials Committee, and MEC.

If reappointment time occurs while the member is on leave of absence, the member will be notified by certified mail, with the request that the member notify the hospital in writing within thirty (30) days following receipt whether or not the member intends to resume practice at the hospital when the leave of absence ends. The member’s appointment will lapse at the end of the current appointment period, and any later request for reinstatement will be reviewed with a new Reappointment Application prepared at that time. Failure to respond within the time provided, or a negative response, will result in the member being deemed to have resigned as of the end of the current appointment period.

Failure of a practitioner to return, or make application to the Chief of Staff for extension of the leave for an additional year, or return reappointment forms in the time provided, shall constitute resignation from the medical staff, and shall not be subject to any hearings or appellate review. Resignation in this manner does not preclude re-applying through the usual initial appointment procedure.

18.0 PRECEPTORSHIPS

A preceptorship is defined as an educational program in which a physician preceptor provides supervised training to a physician preceptee seeking training and the preceptee acquires additional skills by performing hands-on care and treatment for the patient. The preceptor providing the training has primary responsibility for the patient’s care.

Policy
Preceptors: Physician preceptors must be appropriately privileged and have documented clinical experience in the procedure(s) and/or techniques(s) in the particular field of expertise. A physician preceptor who does not currently possess medical staff membership and privileges must first apply for and be granted privileges at the Facility to conduct direct patient care for either
invasive or non-invasive procedures. These privileges may be granted on a temporary basis for the term of the preceptorship.

Preceptees: All preceptees must have background knowledge, basic skills, and clinical experience relevant to the tasks to be learned and should be required to provide documentation of the above. A physician preceptee who does not currently possess medical staff membership and privileges must first apply for and be granted staff privileges at the Facility to conduct direct patient care during invasive and non-invasive procedures. These privileges may be granted on a temporary basis for the term of the preceptorship.

In addition, any physician participating in a preceptorship, as either a preceptor or preceptee, seeking temporary privileges for the term of the preceptorship must have a current license to practice medicine in the applicable state where the preceptorship will occur (Single Purpose License acceptable) and be able to provide evidence of current liability coverage, hold current clinical privileges in an accredited healthcare institution, and should have completed an accredited residency training program or its equivalent as determined by the educational entity conducting the activity.

19.0 POST RESIDENCY INTENSIVE TRAINING PRECEPTORSHIPS:
(formerly known as NON ACGME FELLOWSHIPS)

Definition: A Physician who is board certified or board eligible in the specialty in which they practice and are seeking advanced training where additional subspecialty certification is not available. However, these physicians do not receive any form of certification from the Facility. These physicians shall be fully licensed and have medical staff privileges in the general area of their professional work.

Department Responsibilities: Each Department shall submit to be reviewed and approved by the Credentials Committee a written description of their intensive training program. Such description shall include a detailed description of the program, duration of the program, the responsible Preceptor(s), the clinical activities or core privileges that are to be supervised by the Preceptor(s) and any clinical activities or core privileges which could be performed independently. The role and responsibilities of the Preceptor and Preceptee within patient care activities should be delineated.

Each Department shall also provide to the medical staff office a list of physician participants at the time of application to the program and shall notify the medical staff office at the time a Preceptee participant completes the program or is no longer participating in the program, or if the assigned Preceptor(s) is changed.

Preceptor Responsibilities: The assigned Preceptor is responsible for appropriately supervising the specialized clinical activities or core privileges for which the Preceptee is seeking advanced training.

Preceptee Responsibilities: Each Preceptee shall notify the medical staff office of their participation in an intensive training preceptorship. The Preceptee are expected to participate in care at the level commensurate with their individual degree of competence and advancement within the advanced training program under the general supervision of the Preceptor(s). Preceptees will not be restricted from performing clinical activities within the areas of competence achieved by previous documented training.
20.0 SUPERVISION OF ALLIED CAREGIVERS/ALLIED HEALTH PROFESSIONALS
For those physicians providing supervision for Allied Health Caregivers and Allied Health Professionals, an AHC/AHP Supervision delineation of privileges form shall be completed and approved by Board of Directors and/or its delegates. A separate delineation of privilege must be used for AHCs and AHPs.

21.0 FAMILY MEDICINE PRACTITIONERS AND OBSTETRICAL PRIVILEGES

Family Medicine Obstetrical/C-Section Core Privileges

The practitioner must document evidence of training, experience, and current clinical competence as specified on the Delineation of Privileges.

Consultation with an obstetrician is mandatory when a patient becomes no longer low risk. Some of the conditions that mandate an OB Consultation are listed below. The criteria listed do not represent a complete list. It is therefore recommended that obstetrical consultation be requested (physician to physician) and documented within the medical record when the status of either the mother or fetus is in doubt. Criteria/conditions identified are:

- known or suspected coagulopathy
- HELLP syndrome
- hypertension; both chronic pre-gestational and pregnancy induced
- insulin dependent diabetes; both pre-gestational and gestational
- labor disorders not responding to active management
- malpresentations – breech, shoulder, face
- medical illness of pregnancy including (but not limited to) hyperthyroidism, adrenal disease, myasthenia gravis, cardiac disease, pulmonary disease, connective tissue disease, renal insufficiency, ulcerative colitis
- morbid obesity
- multiple gestation
- oligohydramnios, polyhydramnios
- suspected placenta previa
- postpartum hemorrhage from suspected retained placenta/products
- pre-eclampsia, eclampsia
- pre-term labor and delivery (less than 34 weeks)
- premature rupture of membranes
- suspected sepsis, chorioamnionitis
- third trimester bleeding of undetermined etiology
- trophoblastic disease (molar pregnancy, choriocarcinoma, etc.)
- suspected uterine rupture

22.0 SECOND ED PHYSICIAN COVERAGE
Emergency Department second physician coverage may be granted to applicants who are enrolled in clinical training programs accredited by the ACGME or ABMS. These resident privileges are limited to senior residents working as second physician coverage in the ED. Second physician coverage privileges may be granted under the following circumstances:

1. There shall always be a Class III ED staff Physician on duty simultaneously with the Second ED physician coverage. The applicant shall never be the sole physician in the ED.

2. The applicant has a full and unrestricted medical license issued by the applicable state.

3. Evidence that the applicant has malpractice coverage in the amounts required by the medical staff bylaws to cover professional activities outside of the clinical training program.

4. If the Facility is the sponsoring institution for the clinical training program and the Second ED physician coverage applicant is counted in the Hospital’s GME calculation, the applicant may not bill in his/her name except under an authorized moonlighting arrangement. Billing for professional services outside an authorized moonlighting arrangement must be conducted in accordance with the teaching and supervision requirements outlined in the Medicare rules and regulations issued by CMS. Generally, if the Second ED physician coverage applicant intended to bill his/her professional services, the applicant would be restricted to performance of services in outpatient departments within the hospital and the applicant's clinical duties must be conducted outside the scope of his/her training program. The Second ED physician coverage applicant's services are limited to services outside the applicant's clinical training program.

5. The granting of Second ED physician coverage privileges to senior residents are limited to a period of one year only during the applicant's final year of residency and may be suspended and/or revoked at any time at the discretion of the Facility Chief Executive Officer or the Facility MEC. Extensions under this section require a new application process.

6. The granting of Second ED physician coverage privileges to senior residents confer no medical staff membership rights upon the applicants; however the applicant is required to abide by the medical staff bylaws, rules and regulations as a condition of appointment.

7. The Medical Director of the Emergency Department where the senior resident is working will be required to certify that the hours worked as Second ED physician coverage do not add up to exceed the GME mandated maximum of 80 hours a week of total call and coverage.

Second ED physician coverage will have 10% of their charts reviewed monthly by members of the ED medical staff. Any variances noted will be referred though the peer review process.

23.0 COORDINATION OF CARE

Coordination of Care Privileges may be granted to members of St Jude Medical Staff. This privilege permits them to visit and assess their patients who are undergoing treatment/care at Le Bonheur Children’s Hospital or its transition services. Physicians with the Coordination of Care Privilege may not enter orders but may document notes in the electronic medical record and discuss the care plan with Methodist Le Bonheur attending physicians. Granting of this privilege does not confer MH-MH membership or rights. The Coordination of Care Privilege may be granted for a period of two years and is renewable with demonstrated need. Positive identification must be established as well as primary source
verification of current licensure, education, and training; one (1) peer reference is required. (A
credentialing agreement with St. Jude that provides static verifications may be used in lieu of
primary source verifications.)

24.0 EXTERNAL PROCTOR

External Proctors, whether vendor sponsored or identified by other means, will be allowed to
function without patient contact after having been appropriately authorized according to the
authorization process. This authorization will be processed administratively by the Medical Staff
Services Department.

External Proctors who are not privileged through the medical staff process may serve as proctors
in the following circumstances:

- the privileged practitioner has a documented record of successfully performing the
  privilege via another approach; and
- the privileged practitioner could reasonably expect to complete the procedure by an
  alternate approach without intervention by another practitioner.

External proctors may not admit, treat, examine, consult, give verbal orders, perform or assist
(except verbally) with procedures, document in the medical record, or otherwise participate
directly in the care of any patient. They shall not be members of the medical staff and shall not
have access to any of the rights or prerogatives of membership, and shall abide by all applicable
hospital and medical staff bylaws, rules and regulations and other governance documents.

The External Proctor application form and all required documentation will be forwarded to the
medical staff office at least 5 business days prior to the procedure to be proctored. The External
Proctor shall complete required proctor report.

25.0 RETURN TO PRACTICE PROGRAM (ACUTE CARE/HOSPITAL
PRACTICE/PROVIDER-BASED CLINICS)

Purpose:
To establish guidelines and standards for the process of granting/renewing privileges to
practitioners who wish to return to active clinical practice in the discipline in which they have
been previously trained after a period of absence from clinical activity.

To ensure that practitioners have retained their clinical competence or to enhance, broaden,
and/or develop clinical/medical skills.

Policy:
Privileges granted under this program will be monitored through the established FPPE processes,
in addition to the specific processes defined in this policy, to be completed during the provisional
appointment period and/or reappointment cycle. Department chairs will be responsible for
developing the plan with the practitioner to address specific needs. Practitioners granted
membership and privileges under this program will meet existing standards within the medical
staff governance documents.
Process:
Applicants or members requesting return to practice will be required to meet with the medical staff leadership prior to approval of their return to practice and/or application.

Program guidelines are outlined on the “Return to Practice” grid and based on the following components: (See Attachment 1)

1. Number of years out-of-practice
2. Education requirements
3. Supervision/proctoring requirements
4. Period of evaluation
5. Program supervision
6. Competency evaluation
7. Program monitoring/Feedback

26.0 ALLIED HEALTH PROFESSIONALS POLICIES

26.1 PURPOSE

The MEC and the Governing Body have identified certain categories of practitioners (hereinafter referred to as Allied Health Professionals) who provide patient care services at the Facility. It has been agreed by the Governing Body and the MEC that the medical staff organization should be directly involved in the credentialing process for specific categories of allied health professionals. These specific categories are defined within this document.

26.2 DEFINITIONS

**Allied Health Professional (AHPs)** means a practitioner other than a licensed physician or dentist medical staff member who provides complex patient care at the Facility. The AHP may be either a LIP or a supervised practitioner who has been credentialed and privileged through the medical staff organization. AHPs exercise judgment within the areas of documented professional competence and consistent with the applicable State Practice Act.

The Governing Body periodically determines the categories of individuals eligible for clinical privileges as an AHP. These categories are Podiatrists, Psychologists, Physician Assistants and Advanced Practice Registered Nurses (nurse practitioners, nurse anesthetists).

Allied Health Professionals are not eligible for medical staff membership.

AHPs may be employed by or contracted by the Facility or may be employed/sponsored by physician members of the medical staff organization.

**MEC** means the Medical Executive Committee of the Medical Staff Organization.

**Privileges** means the permission granted to an Allied Health Professional to render specific patient services. Privileges are based on the AHPs licensure, education, training, experience, and demonstrated competence, as well as the limitations defined by the Facility for operational or risk
management reasons. The performance of privileges may be subject to supervision requirements as well as limitations on the settings in which the services may be provided and the patient populations to which services may be provided.

Privilege forms include the standardized procedures that the AHP has requested and has been determined to be qualified to provide.

26.3 POLICY

In the interest of providing high quality of care at the Facility and meeting accreditation standards, and licensing and other regulatory requirements, this document was created to describe how AHPs who are credentialed via medical staff organization mechanisms are permitted to provide health care services at the Facility.

It should be noted that there are additional categories of healthcare professionals who provide services at the Facility who are authorized via alternative mechanisms, such as through the Human Resources Department of the hospital. Separate policies and procedures (such as employment or contractual services policies and procedures) cover those arrangements. This AHP Credentials Policy and Procedure is limited to describing credentialing and privileging processes for AHPs credentialed via medical staff organization mechanisms.

The AHP Credentials Policy and Procedure (AHP Credentials P&P) establishes guidelines for a process to assess, evaluate and review the qualifications, competency and professional conduct of and quality and appropriateness of care provided by the categories of AHPs covered in this AHP Credentials P&P.

This AHP Credentials P&P and all other related policies, procedures, rules, regulations and requirements related to the practice of AHPs at Methodist do not constitute a contract of any kind whatsoever and are subject to change at any time without notice to applicants or to AHPs who provide services at the Facility.

BASIC QUALIFICATIONS OF AHP’S

An AHP shall not be employed, granted authority to exercise privileges or given an application for credentialing unless and until the Governing Body has authorized and approved the provision of such services at the Facility by the category of AHP.

Categories of AHPs covered by this AHP Credentials Policy:
- Psychologists
- Podiatrists
- Physician Assistants
- Advanced Practice Registered Nurses
  - nurse practitioners
  - nurse anesthetists

An AHP within an approved AHP category shall not be granted authority to provide patient care services unless the AHP meets all applicable requirements and qualifications as stated in this AHP Credentialing P&P and the applicable AHP Category Privileging Description, and has been granted privileges in accordance with this AHP Credentialing P&P.
Only AHPs who continuously meet qualifications as determined under the processes outlined in this AHP Credentialing P&P are eligible to exercise privileges at the Facility.

A. PROFESSIONAL LIABILITY INSURANCE REQUIREMENTS

**AHPs employed by** the Facility are covered for professional liability for services provided as an employee under insurance policies/plans of the applicable organization. This is confirmed during the initial appointment and reappointment processes.

**AHPs employed by physicians** must be covered by the physician employer or through the AHP’s own insurance. This is confirmed during the initial appointment and reappointment processes.

**AHPs who are LIPs and not supervised** must be covered for professional liability for services provided to patients.

Each AHP must maintain continuous and uninterrupted professional liability insurance coverage in amounts established by the board without periods of non-coverage, and including either extended reporting ("tail") or retroactive ("prior acts") coverage from an insurance company licensed and approved to do business in Tennessee and/or Mississippi, as applicable, or have Federal Tort Claims Act (FTCA) or state tort claims coverage. The insurance coverage must be effective for all clinical privileges to be exercised.

B. BASIC RESPONSIBILITIES

Each AHP shall:

1. Provide patients with quality care at the generally recognized professional level of quality and efficiency in the community, to the extent authorized by his/her license, certification or other legal credentials, by the terms outlined in the AHP Category Privileges Description and by the privileges granted.

2. Abide by all applicable state and federal laws regulating health care providers, as well as by rules and regulations and all other lawful standards, policies and rules of the Facility.

3. Discharge functions assigned by the MEC, including, but not limited to, quality improvement, peer and professional review, patient care monitoring, utilization review, case management and other responsibilities.

4. Cooperate with and participate, as requested by the MEC, in committee activities.

5. Submit to such physical and/or mental examination(s) or provide verification of health status as may be required to verify the AHPs ability to fully meet his/her responsibilities and/or to perform the requested privileges.

6. Report to the MSSD immediately any action taken affecting licensure, certification, registration or DEA registration, including, but not limited to, probation, restriction, suspension, termination and voluntary or involuntary relinquishment of same.

7. Report to the MSSD immediately any change of their supervising or collaborating physician, including any employment changes.
8. Utilize Facility resources appropriately.

9. Treat all individuals at or associated with the Facility courteously, respectfully and with dignity at all times.

10. Comply with policies, procedures, rules, regulations and requirements which relate to the provision of services by AHPs at the Facility; apply with all applicable medical staff rules and regulations, rules and regulations, hospital and medical staff policies.

11. Document orders only as permitted by his/her licensure or certification and as outlined in the AHP Category Privileges Description and the privileges granted to the AHP.

12. Document in patient medical records in a complete and timely fashion to the extent authorized in the AHP Category Privileges Description and the privileges granted to the AHP.

13. Seek consultation, supervision and direction whenever appropriate or necessary and as required in the AHP Category Privileges Description and the privileges granted to the AHP.

14. Abide by the ethical principles of his/her profession.

15. At all times observe and promote the confidentiality of patient identifiable information.

16. Maintain all other qualifications for privileges set forth in this AHP Credentialing P&P or the applicable AHP Category Privileges Description.

C. RELATIONSHIP TO MEDICAL STAFF

AHPs are not members of the medical staff and do not have voting privileges at medical staff meetings or at medical staff committee meetings unless the privilege to vote is granted at the time the committee appointment is made. AHPs may attend medical staff meetings only when appointed to a committee or department or requested to attend by an authorized representative of the medical staff organization (officer, department chair or committee chair).

AHPs are required to comply with the bylaws, policies, rules and regulations of the medical staff which apply to the privileges provided by AHPs.

D. ELIGIBILITY FOR APPLICATION

AHPs must be credentialed in accordance with this AHP Credentials P&P. In order to be credentialed, AHPs must complete an AHP application form. Only those AHPs who meet the following eligibility criteria shall be provided with an application:

1. Practices within a category of AHPs approved by the board;
2. Has been offered employment or a contract by the Facility, is an employee/contractor of a physician member of the medical staff organization, or is an LIP;
3. Through a screening process, appears to meet licensing, certification, education, training and experience requirements of the applicable AHP category; and
4. Has not been excluded from any federal health program, including Medicare and Medicaid and/or TennCare.

E. DEMONSTRATION OF QUALIFICATIONS

At all times, the AHP is responsible for demonstrating the following qualifications:

1. Continued employment by or contracted services for the Facility or a physician member of the medical staff organization, or is an LIP
2. Requisite professional education and training (including continuing education), licensure and/or certification in the state(s) of his/her practice.
3. Demonstrated ability and judgment.
4. Relevant experience demonstrated by clinical activity.
5. Current competence to practice his/her profession and perform all requested clinical privileges.
6. Freedom from any significant physical, emotional or behavioral impairment (including the use of drugs or alcohol) which prevents the AHP from meeting the other qualifications for AHP status and the requested privileges.
7. Acceptable professional claims history.
8. Adherence to the lawful ethics of the AHPs profession.
9. The ability to work cooperatively with others in the organization and with health care professionals in a consistently cordial and productive manner.

F. APPLICATION PROCESS

**AHPs employed by the Facility:**
AHPs who have received an offer of employment are informed by the Human Resources Department of the Facility that employment as an AHP is contingent upon successful completion of the credentialing/privileging process administered by the medical staff organization of the Facility.

AHPs will be instructed by Human Resources of the Facility to contact the MSSD to obtain an AHP application and other application materials.

If the AHP begins employment prior to completion of the credentialing process, the AHP cannot exercise the requested clinical privileges (including functioning under standardized protocols/procedures) until the credentialing process has been successfully completed. During this interim period, the employed APRN may function as an RN at the Facility’s discretion.

All other AHPs: AHPs either employed or contracted by a physician member of the medical staff organization or contracted by the Facility, as well as LIPs, will be instructed to obtain application materials from the MSSD. They may not practice in the Facility until privileges have been appropriately granted.

**Verification Procedures and Evaluation and Decision-Making Process**

Verification procedures will be carried out by the MSSD in accordance with the procedures defined in the credentials policies.
**AHPs employed by the Facility:** The Human Resources Department of the Facility will be informed by the MSSD as soon as possible if an unfavorable recommendation is made by the Credentials Committee and/or the MEC.

**G. CREDENTIALS FILES/PERSONNEL FILES PROCEDURES**

Each AHP will have a credentials file which is maintained by the MSSD. AHPs employed by the Facility will also have personnel file maintained in accordance with the facilities’ policies and procedures.

**H. SUPERVISION PROCEDURES**

AHPs who are not LIPs must have a designated primary physician supervisor. The primary physician supervisor may be designated by the Chair of the Department to which the AHP is assigned.

The primary physician supervisor must be a member of the medical staff in good standing.

Supervising physicians must be licensed in the state in which the Facility is located and have appropriate staff privileges granted by such Facility as required and may only supervise AHP(s) in accordance with applicable state rules and regulations.

The primary physician supervisor must agree to participate as requested in the evaluation of competency (i.e., at the time of reappointment or an intervals between reappointment, as necessary) of the AHP(s) who he/she supervises.

The primary supervising physician must sign the privileges of the AHP that he/she supervises, in which he/she accepts responsibility for appropriate supervision of the services provided by each AHP under his/her supervision.

**I. EVALUATION PROCEDURES**

The quality of care provided by Facility employed AHPs is reviewed on an ongoing basis through the employment performance evaluation process of the Facility.

In addition, evaluation of performance of all AHPs will be performed via the quality improvement programs of the Facility, including without limitation, case management processes, and, as applicable, by committees of the medical staff. Any concerns regarding the quality or appropriateness of care provided by an AHP identified during such review processes shall be referred to an appropriate medical staff review committee. Any concerns regarding the supervision of an AHP by a physician shall be referred to the appropriate medical staff department or review committee.

**J. REAPPOINTMENT**

Reappointment procedures as defined in the credentials policies are followed for AHPs. This includes data that is gathered for all credentialed medical staff members and AHPs, as applicable to the services provided and available data.
During the reappointment process, the Department Chair/designee is permitted access to any performance evaluations (maintained in human resources files) that occurred during the previous two-year period of time immediately preceding the reappointment (applicable to Facility employed AHPs only). Copies of employment-related performance evaluations are not maintained in credentials files. Data maintained in credentials files is not available for individuals performing employment-related performance evaluations.

K. REVIEW OF SPECIFIC CONDUCT OF CARE/CORRECTIVE ACTION

Whenever the activities or professional conduct of an AHP adversely affects or is reasonably likely to adversely affect patient safety or the delivery of quality patient care or are disruptive to the organization’s operations, the matter may be referred to the Credentials Committee or its designee, who shall review the matter or designate an ad hoc or existing peer review body to investigate the matter. For Facility employed AHPs only, the matter may be handled by the hospital instead of referral to the Credentials Committee.

External third parties may be used by the Credentials Committee to conduct all or part of the investigation or to provide information to the investigating body. The investigation may include an interview of the AHP involved and an interview of other individuals or groups.

A report of the investigation shall be provided to the MEC for review and any appropriate action.

Before, during, or after an investigation, a suspension of any or all of an AHP’s clinical privileges may be invoked by the Chief of Staff, the CEO, the MEC, any of the medical staff executive officers, or the chairman of the board for any reason described in the medical staff bylaws or its other governing documents as reasons for precautionary suspension. Any such suspension shall be reported to the MEC for review and appropriate action.

Denial or termination of an AHP’s clinical privileges may be recommended by the MEC, subject to board review and action, after the AHP has either exercised or been deemed to have waived his right to the grievance process described in this policy.

L. AUTOMATIC TERMINATION

The privileges and status as an AHP shall terminate immediately, without review, in the event that the employment or contractual relationship of the AHP with the Facility is terminated for any reason or if the employment or contractual relationship of the AHP with the supervising physician member of the medical staff organization is terminated for any reason.

Automatic Suspensions/Terminations/ Voluntary Relinquishment of Privileges

See the medical staff bylaws for reasons related to automatic suspensions, terminations, or voluntary relinquishment of clinical privileges.

M. GRIEVANCE PROCEDURES

Nothing contained in the medical staff bylaws shall be interpreted to entitle an AHP to the procedural rights set forth in the medical staff bylaws. AHPs are not subject to the same hearing and appellate procedures afforded to members of the medical staff organization.
Grievance procedures as provided by the Facility for its employed AHPs shall be followed in the event of any actions that reduce, limit or deny privileges. Grievance or termination procedures for the Facility contracted AHPs shall be governed by the applicable contract.

Grievance procedures for AHPs who are self-employed or employed/contracted by a physician member of the medical staff organization are as follows:

An AHP shall have the right to dispute any action that denies, revokes, suspends, terminates, restricts or reduces the clinical duties that the AHP has been given permission to provide at the Facility unless the action denies, revokes, suspends, terminates, restricts or reduces the clinical duties of an entire classification of AHPs rather than being focused on an individual AHP.

(Exception: AHPs shall not have the right to dispute automatic termination. Automatic termination would occur if the license or other legal credential of the AHP expired or was revoked, if the AHP was excluded from Medicare/Medicaid, no longer employed by the Facility or the supervising physician, etc. Termination would occur if the AHP failed to continuously meet the eligibility criteria for his/her category.)

**Filing a Grievance**

The AHP may file a grievance with the MEC (or the body which may be formed to represent the MEC) within 15 days of such action. Upon receipt of the written grievance, the MEC or its designee shall determine if the AHP is entitled to file a grievance. If the AHP is so entitled, the MEC or its designee shall provide the AHP an opportunity for an interview concerning the grievance with individuals appointed by the MEC or its designee. Before the interview, the AHP shall be informed of the general nature and circumstances giving rise to the action, and the AHP may present information relevant thereto at the interview. This interview is not a hearing and no attorney for the AHP or the employer may be present.

A record of the interview shall be made. The MEC or its designee shall make a recommendation to the Board based on the interview and all other information available.

The AHP shall be informed in writing within 15 days of the Board’s decision.

AHPs have no appeal rights, but if privileges are restricted or terminated, they may reapply no sooner than one year after the board’s final decision, unless the Board provides otherwise.

N. **RESPONSIBILITY**

It is the responsibility of the Medical Executive Committee of the medical staff to assure that this policy is followed.

**27.0 CERTIFIED & GRADUATE REGISTERED NURSE ANESTHETISTS**

**Scope of Service and Responsibility:**

Scope of service is based upon education, clinical training, demonstrated skills and capacity to manage procedurally related complications in the categories of pre-anesthetic preparation and evaluation, anesthesia induction, maintenance, and emergence, post-anesthesia care, peri-anesthetic and clinical support functions.
The CRNA/GRNA shall be in compliance with all applicable state and hospital rules including, but not limited to, supervision and protocols.

**Minimum Qualifications:**
In order to be eligible for privileges as a CRNA the applicant must meet the following qualifications:

- Current unencumbered Tennessee, Mississippi or Multi-State license (as applicable to the Facility) to practice as a Registered Nurse
- Current unencumbered license to practice as a Certified Registered Nurse Anesthetist (APN) in the state(s) of his/her practice.
- Completed education from a program of nurse anesthesia education accredited by the Council on Accreditation of Nurse Anesthesia Educational Programs or its predecessor
- Current national board certification, and or recertification
- Case log documenting provision of anesthesia to 350 patients during the previous 12 months

In order to be eligible for privileges as a GRNA the applicant must meet the following qualifications:

- Current unencumbered Tennessee, Mississippi or Multi-State license (as applicable to the Facility) to practice as a Registered Nurse
- Completed education from a program of nurse anesthesia education accredited by the Council on Accreditation of Nurse Anesthesia Educational Programs or its predecessor
- No more than 12 months may have passed since educational program was completed
- Case log documenting provision of anesthesia to 350 patients during the previous 12 months
- Sign the board certification compliance form indicating voluntary resignation if certification is not completed

**Clinical Supervision Requirements:**

- The CRNA/GRNA will be supervised by an anesthesiologist who is a member of the medical staff and appropriately credentialed and privileged. The supervision of the CRNA/GRNA will be compliant with all applicable state rules and regulations.

**Clinical Privileges:**
CRNA/GRNA privileges will be specifically delineated on the approved form, and granted by the Board of Directors. Practitioner shall not exceed the scope of the privileges granted.

**28.0 PODIATRISTS**

**Scope of Service and Responsibility:**
Scope of service is based upon education, clinical training, and demonstrated skills.

**Minimum Qualifications:**
In order to be eligible for privileges as a Podiatrist, the applicant must meet the following qualifications:
• Board certification by the American Board of Podiatric Orthopedics and Primary Podiatric Medicine (ABPOPPM) and/or board certification by the American Board of Podiatric Surgery (ABPS).

Or
• Completion of a one-year surgical residency, or a one-year postgraduate training program in podiatric orthopedics, or a one-year postgraduate training program in primary podiatric medicine with the intent to become board certified by the ABPOPPM or the ABPS within 5 years of completing postgraduate training. All residencies and postgraduate training must be approved by the CPME.

Clinical Privileges:
The privileges of podiatrists do not include admitting privileges. Licensed podiatrists may examine, diagnose, and treat, the human foot, as defined by their approved privileges. Podiatrist privileges will be specifically delineated on the approved form, and granted by the Board of Directors. Practitioner shall not exceed the scope of the privileges granted. Podiatrists may document orders and prescribe medications within the limits of their Tennessee or Mississippi license.

29.0 NURSE PRACTITIONER SCOPE OF PRACTICE

Scope of Service and Responsibility:
Scope of service is based upon education, clinical training, demonstrated skills and capacity to manage procedurally related complications. The Nurse Practitioner will collaborate with the supervising physician in admitting, managing care in the hospital and/or provider-based clinic, and discharging patients from the hospital. The Nurse Practitioner shall be in compliance with all applicable state and hospital rules including, but not limited to, supervision, protocols, patient reviews, and prescriptions.

Minimum Qualifications:
In order to request Nurse Practitioner privileges, a nurse must meet all the following requirements:
• Current unencumbered Tennessee, Mississippi or Multi-State license (as applicable to the Facility) to practice as a Registered Nurse
• Current unencumbered license as a Nurse Practitioner (APN) in the state(s) of his/her practice.
• Graduation from a program conferring a masters degree or doctoral degree in nursing with preparation in the advanced practice specialty
• Current national certification in the appropriate advanced practice nursing specialty
• Current unencumbered Tennessee or Mississippi Nurse Practitioners (APN) Certificate with prescriptive authority (an exception shall be made for new Mississippi Nurse Practitioners, who prior to being granted prescriptive authority must complete 720 hours under direct physician supervision limited to their provisional year.)
• Current Drug Enforcement Agency (DEA) number authority (an exception shall be made for new Mississippi Nurse Practitioners, who prior to being granted prescriptive authority must complete 720 hours under direct physician supervision limited to their provisional year. Once supervision hours are completed, DEA shall be applied for and obtained.)

Clinical Supervision Requirements:
The supervision of the Nurse Practitioner will be compliant with all applicable state rules and regulations.
Including but not limited to:

- A supervising physician shall have experience and/or expertise in the same area of medicine as the certified nurse practitioner.
- Supervision does not require the continuous and constant presence of the supervising physician; however, the supervising physician must be available for consultation at all times (with the exception of new Nurse Practitioners completing their requirement of direct supervision for 720 hours in the state of Mississippi). Supervision may include Department Chairs, Associate Chief, Chief Medical Officer or their designee.
- Once every ten (10) business days the supervising physician shall make a personal review of the historical and therapeutic data and shall so certify by signature.

Protocol Requirements:
The supervision of the Nurse Practitioner requiring protocols will be compliant with all applicable state rules and regulations.

In addition:
Protocols for the Nurse Practitioner requesting privileges at the Facility require approval by the appropriate Department Chair, Credentials Committee, the MEC, and the Board of Directors. Any changes to protocols or additional protocols are to be submitted for approval through the same committee process as stated above. Copies of protocols shall be made available upon request for inspection by the hospital. When situations arise for which protocols are not currently specified in writing as stated above, the Nurse Practitioner shall contact the supervising physician and may employ therapeutic modalities under his/her supervision.

Clinical Privileges:
Consistent with the intent of the state rules and regulations, privileges serve the purpose to maximize the collaborative practice of Nurse Practitioners and supervising physicians in a manner consistent with quality health care delivery. Therefore, documented protocols developed jointly by the supervising physician and the Nurse Practitioner will guide the ongoing medical management of patients. Nurse Practitioner privileges will be specifically delineated on the approved form, and granted by the Board of Directors. Practitioner shall not exceed the scope of the privileges granted. Nurse Practitioners may document orders and prescribe medications within the limits of their state license including rehabilitation and respiratory therapy treatments/services (both inpatient and outpatient). The privileges of Nurse Practitioners do not include admitting privileges.

30.0 PHYSICIAN ASSISTANT SCOPE OF PRACTICE

Scope of Service and Responsibility:
Scope of service is based upon education, clinical training, demonstrated skills and capacity to manage procedurally related complications. The PA-C will collaborate with the supervising physician in admitting, managing care, in the hospital and/or provider-based clinic, and discharging patients from the hospital and provide select medical/surgical services when within their training and skills when delegated by the physician that are a component of the supervising physician’s scope of practice.

The PA-C shall be in compliance with all applicable state and hospital rules including, but not limited to, supervision, protocols, patient reviews, and prescriptions.

Minimum Qualifications:
In order to be eligible for privileges as a Certified Physician assistant, the applicant must:
- Current unencumbered Tennessee or Mississippi license to practice as a Certified Physician Assistant, in the state of his/her practice, as applicable to the requested core privileges.
- Graduated from an CAHEA, CAAHEP or ARC-PA accredited physician assistant program or, in addition possess master’s degree in health related science field, if required by state licensure
- Current national board certification as a physician assistant from the (NCCPA) or (NCOPA)
- Current Drug Enforcement Agency (DEA) number and state registration, as applicable

**Clinical Supervision Requirements:**
The supervision of the Physician Assistant will be compliant with all applicable state rules and regulations, including but not limited to:
- A physician assistant shall function only under the control and responsibility of a licensed physician. The supervising physician has complete and absolute authority over any action of the physician assistant. There shall, at all times, be a physician who is answerable for the actions of the physician assistant and who has the duty of assuring that there is proper supervision and control of the physician assistant and that the assistant's activities are otherwise appropriate.
- Once every ten (10) business days the supervising physician shall make a personal review of the historical and therapeutic data and shall so certify by signature.

**Protocol Requirements:**
The Certified Physicians Assistant in collaboration with the supervising physicians identifies the evidence-based resources, texts, and reference documents that are applicable standards of care and provide the applicable process protocols for care management

**Clinical Privileges:**
Physician Assistant privileges will be specifically delineated on the approved form, and granted by the Board of Directors, including rehabilitation and respiratory therapy treatments/services (both inpatient and outpatient). Practitioner shall not exceed the scope of the privileges granted.

**31.0 PSYCHOLOGISTS**

**Scope of Service and Responsibility:**
Scope of service is based upon education, clinical training, and demonstrated skills. Psychologists will provide services when consulted by a physician member of the medical staff and consistent with the limitations of license and training.

**Minimum Qualifications:**
In order to be eligible for privileges as a Psychologist, the applicant must meet the following qualifications:

1. Graduate of an APA accredited doctoral program in psychology
2. Current license as a clinical psychologist in the state of his/her practice
3. An APA approved internship in a clinical psychology or counseling
4. Diplomate status with the American Board of Professional Psychology is desired
5. Individuals applying for Clinical Psychology privileges must be free from any pending legal or ethical charges by any state board of licensing or local, state or national professional organization of psychologists.

Clinical Privileges:
The privileges of the psychologists do not include admitting privileges. Psychologist privileges will be specifically delineated on the approved form, and granted by the Board of Directors. Practitioner shall not exceed the scope of the privileges granted.

32.0 RADIOLOGY SERVICES IN PROVIDER-BASED CLINICS

If granted privileges for limited diagnostic radiology interpretation, primary care providers in designated provider-based clinics may interpret the following diagnostic x-rays performed in their clinic: chest x-ray, extremities, spine, skull, and sinus.

These privileges are subject to interrater reliability/overread sampling by MLH credentialed radiologist(s). These providers shall have at least 6 hours of category 1 CME, every two years, related to clinical interpretation of x-rays, including one hour in radiation safety.

Supervision of the radiology services should be performed by MLH credentialed radiologist(s) and include:

- Ensuring that radiology reports are signed by the practitioner who interpreted them
- Assigning duties to radiology personnel appropriate to their level of training and experience
- Ensuring that files, scans and other image records are kept (in accordance to state and federal laws) in a secure area and are readily retrievable
- Training radiology staff on how to operate the equipment safely, perform tests offered by the facility and on the management of emergency radiation hazards and accidents

Additionally, x-ray technologists performing these procedures should have and maintain licensure from the State of Tennessee, Tennessee Board of Medical Examiners - certification as a Medical x-Ray Operator. This would be for “limited licensure” or as a Medical X-Ray Operator with a limited scope of practice.

ATTACHMENT 1 – RETURN TO PRACTICE: PROGRAM GUIDELINES

<table>
<thead>
<tr>
<th>Years Out of Practice</th>
<th>Education</th>
<th>Supervision/ Proctoring</th>
<th>Period of Evaluation</th>
<th>Supervision</th>
<th>Competency Evaluation</th>
<th>Program Monitoring/ Feedback</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;1</td>
<td>CME current</td>
<td>Established FPPE for initial applicants/procedure</td>
<td>3 months</td>
<td>Department Chair</td>
<td>Retrospective review based on established criteria</td>
<td>Chair review, Cred Committee report</td>
</tr>
<tr>
<td>1 to 2</td>
<td>50 hours specialty specific CME within the previous 12 months or equivalent education</td>
<td>Established FPPE for initial applicants/procedure</td>
<td>6 months</td>
<td>Department Chair</td>
<td>Retrospective review based on established criteria</td>
<td>Chair review, Cred Committee report</td>
</tr>
<tr>
<td>2 to 5</td>
<td>100 hours specialty</td>
<td>Established FPPE for initial applicants/procedure</td>
<td>6 months</td>
<td>Department</td>
<td>FPPE evaluation</td>
<td>Chair review,</td>
</tr>
<tr>
<td>Category</td>
<td>Specific CME Within Previous 24 Months</td>
<td>Initial Applicants/Procedure</td>
<td>Concurrent Proctoring in Accordance with Plan Developed by the Department Chair by Active Medical Staff Member Willing to Facilitate RTP</td>
<td>Chair &amp; Medical Staff Proctor Forms Completed by Proctor</td>
<td>Retrospective Review Based on Established Criteria</td>
<td>Cred Committee Report</td>
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<tr>
<td>&gt;5</td>
<td>50 Hours Specialty Specific CME and Completion of a Board Certification Review Course Within the Previous 12 Months</td>
<td>Established FPPE for Initial Applicants/Procedure</td>
<td>Concurrent Proctoring in Accordance with Plan Developed with the Department Chair by Active Medical Staff Member Willing to Facilitate RTP</td>
<td>Department Chair &amp; Medical Staff Proctor FPPE Evaluation Forms Completed by Proctor</td>
<td>Retrospective Review Based on Established Criteria</td>
<td>Chair Review, Cred Committee Report</td>
</tr>
<tr>
<td>Office-Based Pediatricians Wishing to Provide In-Patient Well-Baby Newborn Care</td>
<td>CME Current Established FPPE for Initial Applicants/Procedure</td>
<td>Length of Time Required to Complete FPPE of Five Cases of Evaluation and Management of Newborn</td>
<td>Department Chair Retrospective Review of FPPE Cases</td>
<td>Chair Review, Cred Committee Report</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## REVISION LOG

<table>
<thead>
<tr>
<th>Revision #</th>
<th>Document</th>
<th>Reference</th>
<th>Subject of Revision</th>
<th>Board Approved</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Entire Document</td>
<td>Changes to the MHMH Credentials Policies have been made to align with MHOBH Gov. documents</td>
<td>July 19, 2013</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Locum Tenents</td>
<td>Section 1.3 revised and added section 11.3 This language defines the process for privileging Locum Tenens physicians and specifies that they are not granted membership.</td>
<td>March 19, 2014</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Application Form</td>
<td>Revised initial appointment verification for the previous five years (instead of ten)</td>
<td>April 16, 2014</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Verification of Information</td>
<td>Added language for verification requirement streamlining for current members applying as initial applicants to another MLH hospital entity.</td>
<td>April 16, 2014</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Nurse Practitioners</td>
<td>Revision to allow an MS NP to be granted initial privileges at Olive Branch Hospital without prescriptive authority or a MS DEA number. MS requires new NP to complete 720 hours of directly supervised clinical activity prior to being granted prescriptive authority or the ability to apply for a MS DEA number.</td>
<td>August 20, 2014</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Return to Practice Program</td>
<td>Relocated the Return to Practice Program and Attachment 1 from the medical staff policies to the credentials policies</td>
<td>September 17, 2014</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Entire document</td>
<td>Corrected capitalization throughout document</td>
<td>November 19, 2014</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Entire document</td>
<td>Replaced MHOBH Medical Staff President with MHOBH Associate Chief of Staff To incorporate MHOBH requirements added from Bylaws</td>
<td>November 19, 2014</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Entire document</td>
<td>Removed the word “Facility” when referencing MEC. With the Unification there will only be one Medical Executive Committee</td>
<td>November 19, 2014</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>FPPE Policy</td>
<td>12.0 (4) This addition to the FPPE policy for physicians and AHP’s addresses practitioners who have previously relinquished membership and privileges due to incomplete FPPE.</td>
<td>October 21, 2015</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Addition – Failure To Complete OPPE</td>
<td>7.4 This addition addresses practitioners who have previously relinquished membership and privileges due to lack of OPPE.</td>
<td>October 21, 2015</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Addition –</td>
<td>23.0 This privilege may be granted to members of St.</td>
<td>February 17, 2016</td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>Revisions throughout the document</td>
<td>Preamble, 1.2, 3.2.8, 8.2, 3.0, 25.0, 29.0, 30.0, 23.0, 25.0, 29.0, 30.0</td>
<td>These revisions primarily relate to the CMS required changes for including provider-based clinics under the Hospital license.</td>
<td>September 21, 2016</td>
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<tr>
<td>12</td>
<td>Application Form</td>
<td>3.2</td>
<td>The revision for section 3.2 relates to remote interpretation services for Olive Branch</td>
<td>September 21, 2016</td>
</tr>
<tr>
<td>13</td>
<td>Addition – Radiology Services in Provider-based Clinics</td>
<td>3.2</td>
<td>“In provider-based primary care clinics where x-rays are performed, practitioners with appropriate education, training and competence may be privileged to interpret these x-rays. These are limited to chest x-ray, extremities, spine, skull and sinuses.”</td>
<td>November 16, 2016</td>
</tr>
<tr>
<td>14</td>
<td>32.0 Radiology Services in PBC</td>
<td>32.0</td>
<td>These modifications note the requirement of 6 hours of category 1CME related to clinical interpretation of x-rays, including one hour in radiation safety every two years.</td>
<td>December 21, 2016</td>
</tr>
<tr>
<td>15</td>
<td>8.6 High Reliability Organizing Mandatory Training</td>
<td>8.6 Addition</td>
<td>This addition addresses that all medical staff, AHP staff, and everyone credentialed through the medical staff process are required to complete the mandatory 2-hour computer based training and 2-hour face-to-face training.</td>
<td>December 21, 2016</td>
</tr>
<tr>
<td>16</td>
<td>11.3 Locum Tenens Revision</td>
<td>Locum Tenens clinical privileges can be granted for a six-month period with a renewal upon MEC recommendation an Board approval for subsequent six-month periods or shorter intervals as circumstances warrant.</td>
<td>September 20, 2017</td>
<td></td>
</tr>
<tr>
<td>17</td>
<td>Attachment 1 Return to Practice Guidelines Addition</td>
<td>Addition of a return to practice guideline for office based pediatricians who provide newborn care to well babies as their only hospital activity/privilege.</td>
<td>September 20, 2017</td>
<td></td>
</tr>
</tbody>
</table>