

**Governing Document**  
**Credentialing Policy of the**  
**Medical Staff of Regions Hospital**  
 Adopted and amended by Board of Directors 02/28/18

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Governing Document:  
Credentialing Policy of the  
Medical Staff of Regions Hospital<sup>1</sup>  
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**ARTICLE 1**  
**SCOPE AND AUTHORITY**

**Section 1.** This Policy implements the provisions of Article 3 of the Bylaws of the Medical Staff of Regions Hospital (“Bylaws”). It provides the details associated with the basic steps stated in the Bylaws. This Policy is a Governing Document of the Medical Staff and may be adopted and amended only as provided in Article 7 of the Bylaws. The Governing Provisions of Article 8 of the Bylaws govern this Policy, as do the additional governing provisions stated in Article 10 of this Policy.

**ARTICLE 2**  
**CREDENTIALS COMMITTEE**

**Section 2.1 Function and purpose.** The Credentials Committee is a standing committee of the Medical Staff. The Committee advises the Medical Executive Committee (MEC) regarding appointment to the Medical Staff, granting clinical privileges, and investigating any alleged professional incompetence or misconduct. It performs the functions given it by this Policy, and other functions at the request of the MEC.

**Section 2.2 Composition.** The Credentials Committee consists of the following:

- 2.2.1.** The Medical Director for Credentialing;
- 2.2.2.** At least five but no more than nine Practitioners with clinical privileges at the Hospital appointed by the Chief of Staff (COS) and approved by the MEC. At least one, but no more than two, members of the Committee must be an Advance Practice Professional.
- 2.2.3.** Administrative staff may also attend and participate in meetings of the Credentials Committee as invited but have no vote.

**Section 2.3 Terms of service.**

- 2.3.1. Appointed members.** Members appointed by the COS serve terms as designated by the COS and approved by the MEC not to exceed three years in length. The COS must designate terms so that, as far as practical, approximately one-third of the terms of appointed members expire each year.

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<sup>1</sup> This Policy is a Governing Document of the Medical Staff. See Medical Staff Bylaws Article 7.A. As such, it has the same force and effect as the Bylaws and must be promulgated and amended in the same manner as the Medical Staff Bylaws.

**2.3.2. Term limits for appointed members.** An appointed member may be reappointed but may serve no more than six consecutive years on the Committee.

**2.3.3. Removal of members.** Any member of the Committee appointed by the COS may be removed by the COS if the member fails to participate satisfactorily in the Committee's work.

**Section 2.4 Chair.** The Medical Director for Credentialing serves as chair of the Credentials Committee and may be designated by the Committee to carry out certain of its duties as provided in this Policy.

**Section 2.5 Confidentiality.** All activities carried out under this Policy are covered by the Health Care Quality Improvement Act of 1986, codified at 42 U.S.C. § 11101, et seq., or Minnesota Statutes §§ 145.61 – 145.66, or both, and are subject to the provisions of these laws that prohibit or limit the disclosure of data, records, documents, and knowledge obtained or developed during the course of the activities.

### ARTICLE 3

#### QUALIFICATIONS FOR APPOINTMENT TO THE MEDICAL STAFF.

**Section 3.1 Qualifications for Active or Associate Staff.** In order to be considered for appointment to the Active or Associate Medical Staff of Regions Hospital ("Hospital") an applicant must meet all of the following criteria:

**3.1.1. Licensed.** Be licensed to practice in Minnesota as a doctor of medicine or osteopathy, doctor of dental medicine, or doctor of podiatric medicine.

**3.1.2. No licensing restrictions.** Not have any license limitation or restriction that would prohibit the applicant from exercising clinical privileges being sought at the Hospital.

**3.1.3. Malpractice insurance.** Have (a) professional liability insurance of at least \$1 million per occurrence / \$3 million aggregate that covers the clinical privileges the applicant seeks to exercise at the hospital, or (b) be covered by the Federal Tort Claims Act.

**3.1.4. DEA registration.** If the applicant needs to be able to prescribe controlled substances, possess a valid registration with the Drug Enforcement Agency in Minnesota.

**3.1.5. Criminal history.** Not have been convicted of, or pled guilty or no contest to, a felony involving health care fraud, sexual misconduct, or violence.

**3.1.6. Physically able.** Be able, with or without reasonable accommodation, to perform the essential functions of the privileges sought with acceptable skill and without posing significant health or safety risk to patients.

**3.1.7. Completion of residency.** Have successfully completed or be currently enrolled in a residency training program approved by the American College of Graduate Medical Education (ACGME), American Osteopathic Association (AOA), or similar professional organization. (An applicant for clinical privileges in general dentistry does not have to meet this qualification.)

**3.1.8. Board certification.** Except as provided below, be board certified, in the process of obtaining board certification, or participating in ongoing maintenance of certification

measures with the intent of maintaining board certification in a specialty in which the applicant is seeking clinical privileges.

- (a) This criterion does not apply to a Physician whose specialty does not have a certification process or to a resident who is not eligible to apply for board certification.
- (b) A Physician on the Medical Staff whose board certification lapses during an appointment to the medical staff, or prior to an application for reappointment, remains qualified to be a member of the Medical Staff and to apply for reappointment if:
  - (1) The Physician promptly notifies the Medical Staff Services Office that his or her board certification has lapsed;
  - (2) The Physician presents a plan, within 30 days of the lapse, to the Credentials Committee for becoming board certified at the earliest feasible opportunity;
  - (3) The Credentials Committee accepts the plan; and
  - (4) The Physician complies with the plan and becomes board certified within a reasonable period of time.
- (c) If the Credentials Committee does not accept the Physician's plan for becoming recertified, the Physician is no longer qualified to be on the Medical Staff and the Physician's application for appointment or reappointment will be administratively closed, and clinical privileges (if any) will be administratively suspended.

**3.1.9. Not excluded from government programs.** Not be excluded, limited, or otherwise ineligible from participation in Federal Health Care Programs funded in whole or in part by the federal government.

**3.1.10. Privileges requested.** Have applied for clinical privileges at the Hospital.

**3.1.11. Cross coverage.** Have adequate and appropriate arrangements to provide cross-coverage for the applicant's patients in the Hospital when the applicant is unavailable.

**Section 3.2 Qualifications for Honorary Status.** A Physician who does not have clinical privileges at the Hospital but who wishes to have an affiliation with the Hospital may request to be given Honorary Status. A Physician with Honorary Status may participate in Medical Staff educational and research activities as approved by the Medical Staff but is not a member of the Medical Staff and does not have clinical privileges. In considering whether to appoint a Physician to the Honorary Status, the Credentials Committee, MEC, and Board may consider any of the following factors:

- 3.2.1.** The Physician's history of association with and service to the Hospital.
- 3.2.2.** The Physician's reasons for wishing to be affiliated with the Hospital but not practice there.
- 3.2.3.** The Physician's commitment and ability to participate in the patient-care and educational missions of the Hospital as a non-practicing Practitioner.
- 3.2.4.** The Physician's general reputation and character.

**Section 3.3 No Entitlement.** No one is entitled to appointment to the Medical Staff or to the exercise of particular clinical privileges in the Hospital solely because the individual:

- 3.3.1.** Is licensed to practice in a profession in this or any other state;
- 3.3.2.** Is a member of any particular professional organization, or;
- 3.3.3.** Has had in the past, or currently has, Medical Staff appointment or privileges at any hospital.

**Section 3.4 Non-discrimination.** The following factors must not be considered in any decision made under this Policy: the applicant's race, color, creed or religion, national origin, sex (including sexual identity), marital status, or sexual orientation.

**Section 3.5 Duration of Appointment.** Appointment to the Medical Staff and granting clinical privileges must be for a definite period of time not to exceed 24 months. A duration of less than 24 months may be based on clinical or administrative considerations and is not a Professional Review Action. Honorary Status may be given for a definite or indefinite period as determined by the EMC upon the recommendation of the Credentials Committee.

## **ARTICLE 4**

### **APPLICATION PROCESS FOR APPOINTMENT AND PRIVILEGES**

**Section 4.1 Application materials.** Upon receiving a request for an application for appointment to the Medical Staff or clinical privileges, or at least five months prior to the expiration of the appointment of a current member of the Medical Staff, the applicant must be supplied with or given access to a complete set of Medical Staff Bylaws and Governing Documents, an application and other documents necessary to obtain the information needed to evaluate and process the application. Application materials may be provided in the form of paper documents, electronic documents, links to on-line electronic documents, or other formats as determined by the Medical Staff Services Office.

**Section 4.2 Contents of the application and disclosures.** The application must request the applicant to provide information documenting that the applicant meets the criteria for appointment required by this Policy, information necessary for the Credentials Committee, MEC, and Board to evaluate the application, and information necessary for the Medical Staff Services to administer the applicant's application, membership, and privileges. The applicant must disclose at least the following information. (The Minnesota Uniform Credentialing Application's "Disclosure Questions for Initial Questioning," as revised from time to time, is deemed to comply with paragraphs 1-17 of this Section.):

- 4.2.1. Adverse licensing action.** Whether the applicant has ever been subject to Adverse Licensing Action (as defined in Article 10).
- 4.2.2. License investigation.** Whether the applicant's professional license or registration is being or has ever been investigated and the result and status of any such investigation.
- 4.2.3. DEA certification.** Whether the Drug Enforcement Agency (DEA) has ever revoked, suspended, limited, or conditioned the applicant's DEA certification in any way, whether the

applicant has ever voluntarily relinquished his or her DEA registration, and whether the DEA is currently considering taking any such action.

**4.2.4. Disciplinary Action.** Whether the applicant has been subject to Disciplinary Action by a Health Care Organization (as those terms are defined in Article 10) and whether any Health Care Organization is currently considering taking such action.

**4.2.5. Voluntary relinquishment.** Whether the applicant has voluntarily relinquished membership, participation, clinical privileges, or request for privileges, employment, a professional license or registration (a) in lieu of Disciplinary Action or investigation, or (b) during an investigation into the applicant's professional conduct or competency.

**4.2.6. Involuntary relinquishment.** Whether the applicant has ever involuntarily relinquished membership, participation, clinical privileges or request for privileges, employment, professional license or registration.

**4.2.7. Membership in professional organization.** Whether the applicant's membership or fellowship in a professional organization or specialty board certification has ever been voluntarily or involuntarily denied, terminated, restricted, limited, suspended, or revoked.

**4.2.8. Other discipline.** Whether the applicant has ever been reprimanded, censored, or otherwise disciplined by, or been subject to a corrective action agreement or corrective action plan with a licensing board or Health Care Organization.

**4.2.9. Participation in government programs.** Whether the applicant's certificate or participation in any private, federal (e.g., Medicare, Medicaid, Tricare, etc.), or state health insurance program (e.g., Minnesota Medical Assistance, MinnesotaCare, Badger Care) has ever been revoked or otherwise limited or restricted or is currently under investigation or subject to a proceeding with respect to an investigation.

**4.2.10. Criminal history.** Whether the applicant is or ever has ever been charged with a felony, gross misdemeanor, or misdemeanor (other than a minor traffic violation) and a description of all such charges and their disposition.

**4.2.11. Sexual misconduct.** Whether the applicant has ever been found criminally guilty, civilly liable, or otherwise responsible for sexual misconduct of any kind, or sexual harassment, and a description of all such occurrences.

**4.2.12. Malpractice history.** A list and description of every professional liability claim or lawsuit that concerned care provided by the applicant, even if the applicant is not personally named as a defendant. , includes (a) any claims or lawsuits pending on the date the application is submitted, and (b) claims or lawsuits that have been dropped, dismissed, settled, or resulted in judgment, whether in favor of or adverse to the applicant.

**4.2.13. Denial of malpractice insurance.** Whether the applicant has ever had professional liability insurance refused, canceled, or been excluded from coverage for exercising privileges within the applicant's specialty.

**4.2.14. Practice while not covered by insurance.** Whether the applicant has ever practiced while not covered by professional liability insurance.

**4.2.15. Physical and mental ability.** Whether the applicant has a physical or mental condition that would affect the applicant's ability, with or without reasonable accommodation, to provide appropriate care to patients and otherwise perform the essential functions of a practitioner in the applicant's area of practice without posing a health or safety risk to the Practitioner's patients, and whether, if accommodation is necessary, what accommodations would enable the Practitioner to provide appropriate care to patients and perform other essential functions.

**4.2.16. Alcohol and drug use.** Whether the applicant believes or has been told by others that the applicant's use of alcohol or drugs affects the applicant's ability to provide appropriate care to patients and otherwise perform the essential functions of the applicant's area of practice without posing a health risk to patients, and what, if any, accommodations would help the applicant to provide appropriate care and perform the essential functions of the applicant's area of practice.

**4.2.17. Illegal drug use.** Whether the applicant is currently using illegal drugs, including unlawful use of a prescription controlled substance but not including use of any drug taken under supervision of a licensed health care professional other than the applicant.

**4.2.18. Professional and employment history.** A complete chronology of the applicant's professional and educational appointments, employment or positions, including the names and complete addresses of all hospitals or other institutions at which the applicant has worked or trained and an explanation of any chronological gap of greater than three\_ months in the applicant's practice history.

**4.2.19. Other training or experience.** Information concerning any additional experience or training that relate to the applicant's clinical competence.

**4.2.20. Infectious disease testing.** The most recent results of tests for infectious diseases required by the Hospital.

**4.2.21. Membership in exclusive contract group.** If the applicant is asking for privileges in a specialty for which the Hospital has an exclusive contract with an entity, evidence that the applicant is associated with the entity or will be at the time the appointment is made.

**Section 4.3 Agreements required of Applicants.** An applicant and appointee is deemed to have agreed to and must, upon request give further evidence of that agreement by sign forms provided for this purpose, to the following:

**4.3.1. Bylaws and Governing Documents.** That the applicant has read the Medical Staff Bylaws and Governing Documents and is familiar with the principles, standards and ethics of the national, state and local associations that apply to and govern the Practitioner's specialty and profession.



**4.3.2. Follow Hospital policies.** To be bound by the principles, standards and ethics of the Hospital, and to agree to abide by all current and future hospital policies, and the Medical Staff Governing and Operational Documents.

**4.3.3. Notice.** To provide notice to the Medical Staff Services Office of each of the following:

- (a) **Adverse Licensing Action.** Any Adverse Licensing Action or proposed action within 10 days of its occurrence.
- (b) **Malpractice claims.** Any professional liability claim that concerns care provided by the applicant within five business days of learning of the claim, even if the applicant is not personally named as a defendant, regardless of whether the claim involved care provided in the Hospital and regardless of whether the applicant notified a professional liability carrier of the claim.
- (c) **Change of employment status.** Termination of employment with any employer that provides professional liability insurance coverage or cross coverage for the Practitioner's patients no later than five business days of termination, and prior to termination if feasible.
- (d) **Charge or conviction of crime.** Being charged with, indicted for, or convicted of (including pleading guilty or no contest to) a felony or gross misdemeanor involving healthcare fraud, sexual misconduct, violence, or drugs (including alcohol) within one business day of the event
- (e) **Lack of threshold qualifications.** Any fact that makes the applicant unqualified to be appointed to the Medical Staff under section 3.1.

**4.3.4. Authorization to disclose information; release of liability.** To authorize the Hospital and its Medical Staff or their representatives to disclose information requested by any other Health Care Organization, licensing board, medical malpractice insurance carrier, or other organization concerned with provider performance regarding the applicant's professional status, including information about Disciplinary Action, and to not hold the Hospital, its Medical Staff, or their officers, directors, or representatives liable if the information was provided in good faith and without malice.

**4.3.5. Authorization to consult with others.** To authorize representatives of the Hospital and its Medical Staff to consult with and receive information – including documents and medical records – from any other Health Care Organization with which the applicant has been associated (including any present and past professional liability carrier) about the applicant's professional competence, health, character, and ethical qualifications.

**4.3.6. Release of liability for credentialing activities.** To not hold the Hospital, its officers, directors, Medical Staff or representatives liable for actions made in good faith and without malice in evaluating the applicant's application, credentials, and qualifications, and to not hold any other individual or organization liable for providing information in good faith and without malice to the Hospital, its Medical Staff, or their representatives concerning the

applicant's professional competence, physical and mental health, ethics, character and other qualifications.

**4.3.7. Acceptance of burden to produce.** To accept the burden of producing all information needed to properly evaluate the applicant's professional competence, health, character and ethics, and to resolve any doubts about such qualifications, to appear for interviews regarding the application, and to submit to a health examination, if requested.

**4.3.8. Ethical conduct.** To comply with the Hospital's Code of Conduct.

**4.3.9. Respect of patient rights.** To respect the rights of and provide continuous care and supervision for his or her patients and to treat every patient, staff member, hospital employee, and visitor with respect and courtesy at all times, including during times of stress and disagreement.

**4.3.10. Participation in Medical Staff affairs.** To accept committee and consultation assignments made by the Chief of Staff (COS) or Vice President of Medical Affairs (VPMA).

**4.3.11. Board certification not sufficient for privileges.** To acknowledge that certification by a Board does not necessarily qualify the applicant to perform certain procedures.

**4.3.12. Assignment of credentialing functions.** To acknowledge that the Hospital may delegate or assign some or all of its credentialing and peer review activities to one or more other organizations and that any such organization, and its respective officers, directors, Medical Staff, representatives and employees, are considered representatives of the Hospital for purposes of this Policy.

**4.3.13. Posting information on web site.** To authorize the Hospital to post information about the applicant's affiliation with the Hospital on the Hospital's website which the applicant understands is available to the public.

**4.3.14. Group Health employees.** If the applicant is an employee of or under contract with Group Health Plan, Inc. or any of its related organizations (collectively, "GHI") , or if the applicant has applied for employment or a contract with GHI:

(a) To authorize the Hospital to disclose credentialing and peer review information to representatives of GHI for the purposes of credentialing, re-credentialing and ongoing peer review activities by GHI; and

(b) To authorize representatives of GHI to release credentialing information to any and all third party payors that contract with GHI.

**4.3.15. Quality improvement.** To participate in peer review and quality improvement activities.

**4.3.16. Execute documents.** To execute documents as requested to demonstrate compliance with the Hospital's policies and Medical Staff's Governing Documents, including the Medical Staff Standards of Professional Conduct, HIPAA-Patient Privacy Policy, Medical Staff Management of Secondary Interests Policy, and other policies.

**4.3.17. Affirmation of completeness and accuracy.** To certify that all the information in the application is complete and accurate to the best of the applicant's knowledge and to affirm that the applicant understands that any material misstatement or omission on the application, whenever discovered, is cause for denial or revocation of membership on the Medical Staff and clinical privileges.

#### **Section 4.4 Returning the application; applicant's responsibility**

**4.4.1. Applicant's Responsibility.** The applicant for appointment or reappointment must return the following to the Medical Staff Services Office within 30 days of receiving the Application Materials:

- (a) A legible, completed, and signed copy of all documents in the Application Packet;
- (b) If privileges are requested, a legible, completed and signed privilege delineation request.
- (c) Proof of current professional liability insurance coverage of at least \$1 million per occurrence / \$3 million aggregate (or of current coverage under the Federal Tort Claims Act) that covers the Practitioner's practice at the Hospital;
- (d) The names of and contact information for at least two professional peers (one, if applying for reappointment) familiar with the applicant's current clinical competence; and
- (e) The application processing fee.

**4.4.2. Duty to update.** If any information provided in an application changes while the application is under review or during the course of an appointment, the applicant has an affirmative duty to promptly notify the Medical Staff Services Office of the updated information.

**4.4.3. Timely provision of additional information.** The applicant has sole responsibility for producing, in a timely manner:

- (a) all information explicitly required by this Policy;
- (b) additional information that the Hospital or Medical Staff requests in order to evaluate the application and to resolve any questions about the applicant's qualifications, and
- (c) upon request, evidence verifying that all the statements made and information given on the application are true and current.

**4.4.4. Consequences of delay.** If the Medical Staff Services Office, Section Head, Credentials Committee, chair of the Credentials Committee, or MEC ask for additional information, the applicant must provide the information as soon as possible, and in no case more than 10 days from the date of the request. If an applicant does not provide information promptly, the processing of the application may be delayed and may result in the applicant's appointment and clinical privileges expiring before the application can be approved by the Board. After consultation with the chair of the Credentials Committee, the Medical Staff

Services Office is authorized to discontinue processing an application and close the applicant's file if the applicant does not provide requested information in a timely manner.

**Section 4.5 Credentialing Verification Organization.** The Medical Staff may arrange with a Credentialing Verification Organization (such as the HealthPartners Credentialing Services Bureau) to perform some or all of the duties assigned to the Medical Staff Services Office in this Policy. If such arrangements have been made, the term "Medical Staff Services Office" should be read as "Medical Staff Services Office or Credentialing Verification Organization."

## ARTICLE 5

### VERIFICATION, CLASSIFICATION, REVIEW, AND DECISION ON APPLICATIONS

#### Section 5.1 Verification of information.

**5.1.1.** Upon receiving a completed application from an applicant, the Medical Staff Services Office (or a Credentialing Verification Organization with whom the Medical Staff Services Office has made arrangements) must verify with original sources (or reliable secondary sources) information provided in the application in the following categories:

- (a) Professional licensure information.
- (b) National Practitioner Data Bank reports.
- (c) Drug Enforcement Agency information.
- (d) Hospital affiliation information.
- (e) Professional liability insurance.
- (f) Malpractice claims information.
- (g) Exclusion from Federal Health Care programs.
- (h) Board specialty certification information.
- (i) Employment history.
- (j) Education and training.

**5.1.2.** The Medical Staff Services Office must also verify that the applicant has signed all documents included in the Application Materials and submitted the appropriate application fee.

**5.1.3.** The Medical Staff Services Office may reverify any information previously verified at any time if there is a question as to whether the verified information remains true.

**Section 5.2 Assignment to a Section.** The Medical Staff Services Office, in consultation with the chair of the Credentials Committee, will assign an applicant to one or more Sections based upon the clinical privileges requested.

**Section 5.3 Classification of applications.** Upon receiving a completed application and verifying the information in it, the Medical Staff Services Office must classify the application according to this section.

**5.3.1. Class 1.**

(a) Initial appointment. An initial application for appointment and clinical privileges may be assigned as Class 1 only if *all* of the following are true:

(a) **Primary source verification.** The Medical Staff Services Office has verified all information provided in the application with a primary source of the information or a reliable secondary source. ( )

(b) **Appropriate privileges requested.** The clinical privileges requested by the Practitioner are consistent with the specialty and the criteria established by the Hospital.

(c) **Support of references.** Each reference provided gives unqualified support for the applicant.

(d) **No pending malpractice litigation.** The applicant is not involved in any currently pending professional liability claim or lawsuit.

(e) **Physically and mentally able.** The application raises no reasonable doubt that the applicant is currently physically and mentally capable of exercising the privileges being sought, with or without accommodation.

(f) **No malpractice judgment.** No professional liability monetary settlement, judgment, or award has been paid by or on behalf of the applicant.

(g) **No Disciplinary or Adverse Licensing Action.** The applicant has not been the subject of any Disciplinary Action or Adverse Licensing Action.<sup>2</sup>

(h) **Criminal history.** The applicant has not been charged with, indicted for, convicted of, or pled guilty or no contest to: (a) any felony or (b) a misdemeanor involving dishonesty, deceit, fraud, violence, sexual misconduct, or drugs or alcohol.

(b) **Reappointment.** An application for reappointment may be assigned as Class I if the applicant meets all of the criteria in paragraphs (a) – (e), and if the facts or events described in paragraphs (f)– (h) are true for the course of the applicant’s current period of appointment.

**5.3.2. Class 2.** Any application that does not meet the criteria for Class 1 is classified as Class 2.

**5.3.3. Classification is discretionary.** The Chair of the Credentials Committee has the discretion to classify any application as Class 2 and to require consideration by the Credentials Committee even if the application is eligible to be Class 1.

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<sup>2</sup> See section 10.2 and 10.3 for definitions of these terms.

## **Section 5.4 Approval process.**

**5.4.1. Section Head's review.** When the Medical Staff Services Office has completed its evaluation of an application and determined it is complete and ready for further review, it must promptly forward it to the appropriate Section Head for review. (If a Division does not have sections, the Division Head must perform the duties of the Section Head throughout the credentialing process.)

(a) **Factors to consider.** The Section Head must determine whether the applicant has the education, training, experience, and current clinical competence to exercise the privileges requested. The Section Head may consult with others before making this determination. The Section Head must take into consideration the ability of the Hospital to provide adequate facilities and supportive services for the applicant and his or her patients.

(b) **Section Head's recommendation.** The Section Head must make a written recommendation on the appointment and request for clinical privileges to the Chair of the Credentials Committee on a form provided by the Medical Staff Services Office.

(a) **Positive recommendation.** A recommendation that an application be approved may include an explanation of any concern the Section Head may have had but resolved in favor of approval.

(b) **Negative recommendation.** If the Section Head's recommendation is to deny the application, in whole or in part, the Section Head must indicate in writing the reasons for the recommendation that refer specifically to the criteria for appointment or clinical privileges that the Section Head finds are not met.

(c) **Referral for additional information.** The Section Head may refer the application back to the Medical Staff Services Office for additional information if the Section Head believes more information is necessary to evaluate the application.

**5.4.2. Credentials Committee review and recommendation to the MEC.** Upon receiving the written recommendation of the Section Head, the chair of the Credentials Committee must review each application and refer it to either the MEC or Credentials Committee as follows:

(a) **Class 1 application with favorable recommendation.** For a Class 1 application where the Section Head recommends unqualified approval, the chair of the Credentials Committee may review the application and forward a recommendation for approval to the MEC without review by the Credentials Committee. The chair has the discretion to refer any Class 1 application to the Credentials Committee for review before it is sent to the MEC.

(b) **Class 2 application and Class 1 application with unfavorable recommendation.** For a Class 2 application, and any application for which the Section Head has recommended anything other than unqualified approval, the chair of the Credentials Committee must review the application file and forward it (and any additional relevant information) to the

Credentials Committee for consideration along with any additional report or recommendation that the chair finds appropriate.

(c) **Credentials Committee action.** If an application is referred to the Credentials Committee for consideration and action, the Committee must determine whether the applicant has demonstrated that the applicant is qualified to be appointed to the Medical Staff and can exercise the requested clinical privileges competently. The Credentials Committee must, by majority vote, recommend to the MEC that the application be approved or denied, in whole or in part (for example, recommending appointment and the granting of some privileges requested, but not other, or recommending appointment for a period of less than two years), and provide a brief statement of the reasons for the decision.

**5.4.3. MEC review and recommendation to the Board.** The MEC must review the Credentials Committee's recommendation and make a recommendation to the Board on every application for appointment, reappointment, and clinical privileges.

(a) **Class 1; favorable recommendation.** The MEC may consider and approve recommendations on Class 1 applications and requests under Section 5.4.2(a) without discussion of individual applications unless one or more members of the MEC objects, in which case the application objected to must be considered by the MEC individually. If the MEC approves the report or any individual application, the application must be forwarded to the Board with the MEC's recommendation for final approval. The MEC may include an explanation for a recommendation on any application if appropriate.

(b) **Class 2; favorable recommendation.** The MEC must review, consider, and make a recommendation on a Class 2 application individually. All recommendations to grant and application or request must be forwarded to the Board for final approval. The MEC may include an explanation for its recommendation if appropriate.

(c) **Unfavorable recommendation by Credentials Committee.** If the Credentials Committee's recommendation on any application is for anything other than unqualified approval of the application or request, the MEC must review, consider, and make a recommendation on the application or request to the Board.

(d) **Adverse recommendation by the MEC.** If the MEC proposes a recommendation to the Board that entitles an applicant to request a hearing under the Fair Hearing Policy, a Notice of Proposed Action must be sent to the applicant as required by the Fair Hearing Policy. The MEC must not forward its recommendation to the Board until (1) the applicant waives his or her right to request a hearing, (2) a hearing is terminated prior to a final decision, or (3) the Hearing Panel submits its final report to the Board, whichever occurs first.

## **Section 5.5 Board Action on Appointments**

**5.5.1. Expedited Board approval of Class 1 applications.** The Board may appoint a committee of two or more of its voting members (which may include the CEO and the COS, if

they are members of the Board) to act on the Board's behalf to consider and approve favorable recommendations by the MEC for Class 1 applications. The committee must regularly report its actions to the Board. The committee has the authority to decline to approve any Class I application and to refer the application for consideration by the entire Board.

**5.5.2. Class 2 applications ineligible for expedited approval.** Class 2 applications are not eligible for the expedited approval process described in paragraph 5.5.1.

**5.5.3. Board may adopt or reject the MEC's recommendation.** For any application not approved under the expedited process described in paragraph 5.5.1, the Board may adopt or reject, in whole or in part, any MEC recommendation on any application or request. The Board may also refer an application back to the MEC or Credentials Committee for further consideration. The Board must state the reasons for a referral and set a time limit for the Committees to make a subsequent recommendation.

**5.5.4. Favorable action effective immediately.** Favorable action by the Board (including action under the expedited process described in paragraph 5.5.1) is effective immediately as its final decision unless the Board states otherwise.

**5.5.5. Adverse action recommended by Board.** If the Board's action is one that would entitle the applicant to request a hearing under the Fair Hearing Policy, the Board must provide the applicant with a Notice of Proposed Action as required by the Fair Hearing Policy before taking final action.

- (a) The Board's action becomes final immediately if the applicant waives his or her right to request a hearing or terminates a hearing prior to a final decision by the Hearing Panel.
- (b) If a hearing is requested and held and the Hearing Panel submits a final report to the Board, the Board's action becomes final only after the Board acts on the Hearing Panel's recommendation and any appeal that may be taken under the Fair Hearing Policy.

**5.5.6. Notice of Final Decision of Appointment.** When the Board has taken final action on any credentialing matter, the CEO (or the CEO's designee) must promptly notify each applicant and applicable Section Head. If the Board's final decision is inconsistent with the MEC's recommendation, the CEO must also notify the MEC of the Board's decision. A decision and notice of appointment must include:

- (a) The staff category to which the applicant is appointed;
- (b) The section(s) to which the applicant is assigned;
- (c) The clinical privileges the applicant may exercise;
- (d) Notice of the requirement to pay Medical Staff dues;
- (e) Notice that the Hospital must verify that the applicant is the person identified in the credentialing documents by requiring the applicant to present a current picture hospital identification card or a valid picture identification document issued by a state or federal agency;



- (f) A notice of the duration of the appointment (which may not exceed 24 months); and
- (g) Any conditions that may apply to the appointment or clinical privileges.

## **Section 5.6 Processing time guidelines.**

**5.6.1. Guidelines.** Individuals and committees referred to in this Policy must act on applications promptly and, to the extent feasible, in accord with the guidelines in this section. Failure to comply with these guidelines does not entitle an applicant to appointment or clinical privileges, a hearing under the Fair Hearing Policy, or any other remedy. The timelines suggested here begin to run only when the applicant has submitted a complete application and the Medical Staff Services Office has verified with primary sources the information on the application. If an applicant submits a complete application and, based on the application, the Medical Staff Services Office, Section Head, Credentials Committee, MEC, or the Board requests the applicant to supply additional information, the application is deemed incomplete until the applicant supplies the information.

- (a) **Medical Staff Services Office.** The Medical Staff Services Office should complete its review of an application, including primary source verification, and forward it to the Section Head within 45 days of receiving a complete application for initial appointment, and no later than 60 days before the expiration of the appointment of a Practitioner currently on the Medical Staff.
- (b) **Section Head.** The Section Head should review a completed application within 15 days of receiving it from the Medical Staff Services Office.
- (c) **Credentials Committee chair.** The chair of the Credentials Committee should complete review of a Class I application within 15 days of receiving it.
- (d) **Credentials Committee.** The Credentials Committee should complete its review of an application it is required to review within 30 days of the day the chair of the Committee receives it from the Section Head.
- (e) **MEC.** The MEC should complete its review of recommendations from the Credentials Committee within 30 days of receiving it from the Credentials Committee or the Medical Director of Credentialing, if applicable.
- (f) **Board.** If the Board appoints a committee to approve Class I applications under the expedited process described in section 5.5.1, the committee should complete its review of recommendations from the MEC within 15 days of the MEC's decision. Applications that require review and approval of the entire Board should be reviewed within 60 days of receiving the recommendation from the MEC.

## **ARTICLE 6 CLINICAL PRIVILEGES**

### **Section 6.1 General provisions.**

**6.1.1. No entitlement to privileges.** Appointment to the Medical Staff does not confer any clinical privileges or right to practice at the Hospital. Privileges may be granted to a Physician or other Practitioner only as provided in this Policy.

**6.1.2. Responsibility is on the applicant.** The applicant has the responsibility to demonstrate that the applicant is qualified and competent to exercise the clinical privileges requested.

**6.1.3. Privileges requested simultaneously with an application for appointment or reappointment.** A request for privileges must accompany every application from a Physician for appointment or reappointment to the Active or Associate Medical Staff and must be reviewed and considered along with and in the same manner as an application for appointment or reappointment.

**6.1.4. Request for expanded privileges.** A Practitioner who has clinical privileges may ask for additional or expanded privileges at any time.

(a) A request for expanded privileges must be made on a form provided for that purpose by the Medical Staff Services Office and be accompanied by a privilege delineation form, the answers to disclosure questions that would accompany an application for reappointment, the authorization required in section 4.3.4, and the release required by 4.3.6.

(b) The Medical Staff Services Office must conduct primary source verification and collect and process all documents and other information related to the request for additional or expanded privileges. The request for additional or expanded privileges must be evaluated and follow the approval process based on the information provided on the request for expanded privileges.

**6.1.5. Obligation to provide EMTALA coverage.** Every Practitioner with clinical privileges is obliged to accept on-call coverage as provided by the Hospital's EMTALA (Emergency Medical Treatment and Active Labor Act) policy.

**Section 6.2 Basis for granting privileges.** A recommendation or decision concerning clinical privileges must be based on the following:

**6.2.1.** The applicant's current licensure or certification status, as appropriate;

**6.2.2.** The applicant's specific relevant training;

**6.2.3.** The applicant's health and physical ability to perform the requested privilege;

**6.2.4.** Data collected from professional practice review conducted at the Hospital and by any other Health Care Organization with which the applicant currently has privileges, to the extent that the data are available;

**6.2.5.** Recommendations from peers or teachers regarding the Practitioner's current

(a) Medical and clinical knowledge;

(b) Technical and clinical skills;

- (c) Clinical judgment;
- (d) Interpersonal skills;
- (e) Communication skills; and
- (f) Professionalism;

**6.2.6.** If the applicant currently exercises privileges in the Hospital, review of the applicant's performance within the Hospital;

**6.2.7.** The applicant's history of Adverse Licensing Action or Disciplinary Action;

**6.2.8.** The number and pattern of professional liability judgments against the applicant;

**6.2.9.** Morbidity and mortality data, to the extent the data are available; and

**6.2.10.** The Hospital's resources and personnel necessary for the competent exercise of the privileges being sought.

### **Section 6.3 Clinical privileges for specialties for which the Hospital has an exclusive contract.**

**6.3.1. Applicant must be affiliated with contracted entity.** If the Hospital has an exclusive contracting arrangement with a medical group or other entity to provide services in one or more specialties, an applicant seeking clinical privileges in those specialties is not eligible for privileges unless the applicant is a member of the entity with which the Hospital has an exclusive contract.

**6.3.2. Practitioner ceases to be affiliated with contracted group; termination of contract.** If a Practitioner with privileges ceases to be a member of an entity that has an exclusive contract, or if the Hospital's contract with the entity terminates, the Practitioner's appointment and privileges are administratively revoked unless the applicant has or obtains clinical privileges in another specialty that is not subject to the exclusive contract. Denial of an application or administrative revocation of appointment and privileges for this reason are not based on the applicant's clinical competence or professional conduct and therefore do not entitle the member or applicant to request a hearing under the Fair Hearing Policy.

**Section 6.4 Advance Practice Professional and Allied Health Professional.** A request for privileges from an Advance Practice Professional (APP) or Allied Health Professional (AHP) is processed in the same way as a request from a Physician.

**Section 6.5 Clinical privileges after Age 70.** Every Practitioner with clinical privileges must provide evidence of a physical and mental examination annually beginning in the year that the Practitioner turns 70 years old that addresses whether the Practitioner is physically and mentally able to exercise clinical privileges safely and competently. Focused Professional Practice Evaluation (FPPE) will be conducted for every Practitioner age 70 or older to ensure that the Practitioner's practice continues to be safe and competent.

**Section 6.6 Temporary privileges.** Temporary privileges may be exercised prior to or in lieu of Board approval only as provided in this section. Granting temporary privileges does not constitute appointment to the Medical Staff.

**6.6.1. Temporary privileges to meet important patient care need.** Upon the recommendation of the VPMA or chair of the Credentials Committee, and the concurrence of the relevant Section Head, the CEO may grant a Practitioner temporary privileges for up to 120 days in order (a) to care for a particular patient for the duration of the patient's hospitalization or (b) to enable the Hospital to meet an acute staffing need for a limited period of time. The CEO may grant a Practitioner temporary privileges under this section only if the Practitioner is licensed to provide the services and demonstrates current competence to do so.

(a) **Privileges to treat a particular patient.** The CEO may grant a Practitioner temporary privileges to treat a particular patient if the Medical Staff Services office verifies the Practitioner currently has a valid license to practice in Minnesota and the Practitioner demonstrates current competence by:

- (1) Evidence that the Practitioner is a member in good standing of the active Medical Staff at another hospital currently has Medical Staff privileges at another hospital; and the temporary privileges being sought are substantially the same as privileges the Practitioner currently exercises at the other hospital; or
- (2) In some other way acceptable to the VPMA and COS.

(b) **Privileges to meet an acute staffing need.** An applicant for temporary privileges to meet an acute staffing need must submit a complete application on a form provided by the Medical Staff Services Office.

(1) The application must include at least the following:

- a. Evidence that the Practitioner is legally eligible to exercise the privileges in Minnesota;
- b. Evidence that the Practitioner is covered by professional liability insurance of at least \$1 million per occurrence / \$3 million aggregate that covers the clinical privileges the applicant seeks to exercise at the hospital, or is covered by the Federal Tort Claims Act;
- c. Evidence that the Practitioner is currently registered with the DEA in Minnesota if the privileges sought require prescribing drugs;
- d. A completed, legible request for privileges with all supporting documentation as may be required for the privileges being sought;
- e. The names and contact information for at least two professional peers familiar with the applicant's current competence.
- f. A statement signed by the applicant that, if the temporary privileges are granted, the application agrees to abide by the Medical Staff's Governing Documents, and all policies of the Hospital and Medical Staff.
- g. A signed acknowledgement that denial of a request for temporary privileges does not entitle the applicant to a hearing under the Fair Hearing Policy.

(2) **Primary source verification.** Upon receipt of a complete application the Medical Staff Services Office must verify information on it with primary sources as provided in section 5.1.1.

(3) **Time limit.** Primary source verification under this section must be conducted again if more than 120 days pass between the date the Medical Staff Services Office verified the information and the Practitioner is granted temporary privileges.

(4) **Notice.** The Medical Staff Services Office must notify the relevant Section Head and the chair of the Credentials committee when it has completed verification and evaluation of the applicant's request for temporary privileges. If satisfied that temporary privileges should be granted, the Section Head and Credentials Committee chair must notify the CEO and VPMA in writing of their recommendation. If the CEO grants the request for temporary privileges, and the CEO must notify the applicant in writing that temporary privileges have been granted.

**6.6.2. Temporary privileges for Class 1 applicants pending approval of the MEC and Board.** The CEO may grant an applicant for appointment and clinical privileges temporary privileges to practice at the hospital before the application has been acted on by the MEC or Board as provided in this section.

(a) **CEO approval.** If an applicant's application for appointment and clinical privileges is classified as Class 1, and the Section Head, chair of the Credentials Committee, and COS agree that temporary privileges should be granted pending approval by the MEC and the Board, they must notify the CEO in writing of their recommendation.

(b) **Notice.** If the CEO grants the request for temporary privileges, the CEO must notify the applicant in writing that temporary privileges pending approval by the MEC and Board have been granted for a period of 120 days or final Board action on the application, whichever is shorter. The CEO must also promptly notify the applicant if the CEO denies the request for temporary privileges.

(c) **Application continues to be reviewed.** The application of a Practitioner granted temporary privileges must continue to be reviewed according to Article 5 without regard as to whether the CEO grants temporary privileges. If the Board approves the application, the Practitioner's temporary privileges are automatically converted to standard privileges and continue for the duration of the Practitioner's appointment.

(d) **No hearing for denial.** Refusal to grant temporary privileges pending MEC and Board approval does not entitle a Practitioner to a hearing under the Fair Hearing Policy.

**6.6.3. Disaster privileges.** During a disaster, the CEO, VPMA, COS, or Medical Director of Credentialing have the authority to grant temporary disaster response and recovery privileges ("Disaster Privileges") to Volunteer Practitioners as follows.

(a) **Disaster plan activation.** Disaster Privileges may be granted only when the Hospital activates its Disaster Plan (Emergency Management Plan) and the Hospital is unable to meet immediate patient needs without granting privileges to non-members of the Medical Staff.

(b) **Identity verification.** Before Disaster Privileges are granted, the Hospital must obtain from the Practitioner a valid government-issued photo identification document identifying the Practitioner and at least one of the following:

(a) A current picture identification card from another health care organization that clearly identifies the Practitioner's professional designation;

- (b) A copy of the Practitioner's current license to practice or primary verification with the licensing authority that the Practitioner is licensed;
- (c) Identification indicating that the Practitioner is a member of a Disaster Medical Assistance Team, the Medical Reserve Corps, the Emergency System for Advance Registration of Volunteer Health Professionals, or other recognized state or federal response organization or group;
- (d) Identification indicating that the Practitioner has been granted authority by a government entity to provide patient care, treatment, or services in disaster circumstances; or
- (e) Confirmation by a Member of the Medical Staff currently privileged at the Hospital or another Hospital employee with personal knowledge of the Volunteer Practitioner's ability to act as a Volunteer Practitioner during a disaster.

(c) **Medical Staff oversight.** The Medical Staff retains its obligation to oversee the performance of a Practitioner with Disaster Privileges as it does with any other Practitioner. Based on its oversight of the Practitioner, the Hospital must determine within 72 hours of the Practitioner's arrival whether Disaster Privileges should continue.

(d) **Verification of credentials.** Medical Staff Services Office must begin the process of verifying the Practitioner's licensure, DEA registration, education and training, current employment, and malpractice coverage with primary sources as soon as possible and complete it within 72 hours from the time the volunteer Practitioner arrives at the Hospital. If extraordinary circumstances prevent primary source verification from being completed within this time, verification must be completed as soon as possible thereafter. If verification is not completed within 72 hours, the Medical Staff Services Office must document the following:

- (a) The extraordinary circumstances that made verification within 72 hours of arrival impossible.
- (b) Evidence of the Volunteer Practitioner's demonstrated ability to continue to provide adequate care, treatment, and services.
- (c) Evidence of the Hospital's attempts to perform primary source verification as soon as possible.

(e) **Record retention.** The Medical Staff Services Office must maintain a permanent record of Practitioners who have been granted Disaster Privileges. The Department must distribute copies of the list to Division Heads, the Command Center, the Emergency Department, the Admissions Department, and Hospital Administration.

(f) **Identification badges.** A Practitioner granted Disaster Privileges must wear identification at all times so that staff and other personnel are quickly able to identify the Practitioner as a health care worker assisting during the disaster.

(g) **Malpractice coverage.** A Practitioner who is covered by the Federal Tort Claims Act is exempt from the requirement to have professional liability insurance. Disaster Privileges granted to Practitioners who are acting as agents of the federal government are limited in their privileges at the Hospital to the scope of their federal employment.

(h) **Privileges terminate when plan deactivated.** When the hospital declares that the Emergency Management Plan is no longer in effect, all Disaster Privileges immediately terminate.

## ARTICLE 7

### ADMINISTRATIVE SUSPENSION OF CLINICAL PRIVILEGES

**Section 7.1 Circumstances that automatically suspend privileges.** A Practitioner's clinical privileges are automatically and administratively suspended whenever any of the following occurs. An administrative suspension under sections 7.1.1 through 7.1.5 inclusive is effective on the date of the occurrence of the event, whether or not the Medical Staff has notified the Practitioner of the suspension. An administrative suspension for any other reason is effective upon written notice to the Practitioner by the VPMA or COS or CEO. Every Practitioner has an affirmative duty under section 4.4.2 to immediately notify the Medical Staff Services office of any of the following:

**7.1.1. No license.** The Practitioner does not possess a current, valid license to practice in Minnesota, including because a previously valid license has expired, lapsed, or has been suspended or revoked, or otherwise ceases to meet the qualification stated in section 3.1.1.

**7.1.2. No DEA registration.** The Practitioner does not possess a current, valid Minnesota registration with the Drug Enforcement Agency, including because a previously valid registration has lapsed, expired, or been suspended or revoked or otherwise ceases to meet the qualification stated in section 3.1.4. This criterion applies only to a Practitioner's privilege to prescribe controlled substances, and does not apply if the Practitioner's privileges do not require the Practitioner to have DEA registration.

**7.1.3. No malpractice insurance.** The Practitioner does not currently have professional liability insurance in the amounts required by the Credentialing Policy or otherwise ceases to meet the qualification stated in section 3.1.3.

**7.1.4. Exclusion from government programs.** The Practitioner is excluded from or limited in participation in a federal or state health care program.

**7.1.5. Criminal charges.** The Practitioner is charged with, indicted for, or convicted (including a pleas of guilty or no contest) of a crime involving violence, sexual misconduct, drugs (including alcohol), fraud, misrepresentation, or other crime involving dishonesty or deception.

**7.1.6. Incomplete medical records.** The Practitioner fails to complete medical records in accord with Governing or Operational Documents or Hospital policy after having been notified of the delinquency.

**7.1.7. Infectious disease testing documentation.** The Practitioner fails to submit proof of infectious disease testing or immunization required by the Hospital.

**7.1.8. Failure to pay dues.** The Practitioner fails to pay Medical Staff dues, special assessments, and similar financial obligations within 30 days of being notified that the payment is due.

**7.1.9. Failure to appear.** The Practitioner fails to appear at a meeting at which a special appearance is required.

**7.1.10. Noncooperation.** The Practitioner fails to participate in an evaluation of the Practitioner's qualifications, including if the Practitioner refuses to undergo a mental or physical examination when requested by the Credentialing Committee or the MEC.

**7.1.11. Failure to execute documents.** The Practitioner fails to execute a release, consent, or other document required by the Governing Documents or the MEC.

**7.1.12. Access to medical record system denied.** The Practitioner's ability to access or use the Hospital's medical record system is suspended or revoked.

**7.1.13. No cross-coverage.** The Practitioner fails to maintain adequate and appropriate cross-coverage of the Practitioner's patients in the Hospital when the Practitioner is not available.

**Section 7.2 Notification.** Immediately upon learning of a fact circumstance listed in section 7.1 that results in administrative suspension of privileges, the CEO must notify the suspended Practitioner and the Practitioner's Section Head in writing of the suspension, the circumstances that caused the suspension, and the time the Practitioner has to remedy the suspension.

### **Section 7.3 Care of patients during a suspension**

**7.3.1.** Immediately upon learning of a circumstance listed in section 7.1, the Practitioner's Section Head or the COS must assign another physician responsibility for care of the suspended Practitioner's patients who are already admitted to the Hospital. The assignment is effective until the patients are discharged or the suspension is lifted. The Section Head or COS must consider the wishes of the patient, to the extent they can be known, in making this assignment.

**7.3.2.** All Practitioners in the Hospital must cooperate with the COS, the Division Head (or designee), the Credentials Committee, and the CEO (or designee) in enforcing administrative suspensions.

**Section 7.4 Reinstatement.** Except as provided below, a Practitioner whose appointment or clinical privileges are administratively suspended under this Article may be reinstated without reapplying for appointment and clinical privileges if, within 30 days from the day the suspension started, the Practitioner supplies satisfactory evidence that the circumstance that caused the suspension no longer exists. If the Practitioner does not supply the evidence within 30 days of the suspension, the Practitioner is deemed to have voluntarily resigned from the Medical Staff and voluntarily relinquished clinical privileges, in which case the CEO must promptly notify the Practitioner and Section Head in



writing of the resignation and relinquishment. A Practitioner deemed to have resigned under this paragraph may submit an application for appointment and request for clinical privileges at any time after the Practitioner is once again qualified to be appointed.

**7.4.1. Reinstatement after completing medical records.** A Practitioner suspended for failure to prepare or complete medical records according to the Hospital's policy or Medical Staff's Governing or Operational Documents must be notified in writing that he or she has 10 days to complete the medical record obligation. If the records are completed within the 10 days, the suspension is rescinded and the CEO must notify the Practitioner and Section Head.

If the records are not completed within the 10 day period, the Practitioner is deemed to have voluntarily resigned from the staff and relinquished clinical privileges. The CEO must promptly notify the Practitioner and Section Head in writing of the resignation. A Practitioner deemed to have so resigned under this paragraph may submit an application for appointment at any time.

**7.4.2. Reinstatement after being charged with a crime.** A Practitioner suspended because the Practitioner was charged with or indicted for a crime described in section 7.1.5 may request to have privileges restored while the charges are pending as follows:

- (a) At the request of such Practitioner, the CEO, after consultation to the extent possible with the COS, VPMA, Chair of the Credentials Committee, and the appropriate Division Head, may stay the automatic suspension until the full committee of the MEC has the opportunity to make a recommendation. The request must be directed to the VPMA who must forward it to the MEC for consideration. The request must include an explanation of why privileges should be restored while the charges are pending.
- (b) The MEC must consider the Practitioner's request and may, but is not required to, permit the Practitioner to make a special appearance before it to discuss the request. Such a special appearance is not a hearing under the Fair Hearing Policy.
- (c) The MEC may recommend to the CEO that the suspension be rescinded, with or without conditions, if it determines that the Practitioner can exercise privileges without jeopardizing the health or safety of others or the safe, orderly, and legal operations of the Hospital.
- (d) The CEO must forward the MEC's recommendation and the CEO's recommendation, if any, to the Board's Executive Committee for a final decision.
- (e) Reinstatement of privileges while charges are pending does not preclude the Medical Staff from conducting an investigation of the Practitioner or taking any other action authorized by the Governing Documents.

## **ARTICLE 8 LEAVE OF ABSENCE.**

A Practitioner may request and be granted a temporary leave of absence from the Medical Staff and temporary relinquishment of clinical privileges as provided in this Article.

**Section 8.1 Purpose of a leave.** A leave may be granted for any purpose, including to improve the Practitioner’s physical or mental health and to improve the Practitioner’s ability to care for patients safely and competently.

**Section 8.2 Requesting a leave.** A Practitioner seeking a leave of absence must provide a written request for the leave to the COS stating the reasons for the leave and its estimated duration.

**8.2.1.** The COS must forward the request to the MEC for its consideration. The MEC may approve or deny the request, or modify and approve the modified request.

**8.2.2.** Denial of a request for a leave of absence is not a professional review action that entitles the Practitioner to request a hearing.

**Section 8.3 Obligations and prerogatives while on leave; effect on duration of current appointment.** If the MEC grants a leave of absence, the Practitioner is relieved of the obligations of a member of the Medical Staff during the leave and must not exercise privileges in the Hospital during the leave. A Leave of Absence does not extend or otherwise affect the expiration date of the Practitioner’s current appointment. If the Practitioner’s appointment is due to expire while the Practitioner is on leave, the appointment will expire automatically unless the Practitioner applies for reappointment and is reappointed to the Medical Staff before the current appointment expires.

**Section 8.4 Reinstatement after a leave.** At least 30 days prior to the termination of the leave, or at any earlier time, the Practitioner may request to have privileges reinstated by sending a written request for reinstatement to the COS who must forward the request to the MEC for its consideration and recommendation. The MEC may refer the request for reinstatement to the Credentials Committee. If the Practitioner’s appointment expired during the leave of absence, the Practitioner must apply for reappointment as well as reinstatement of privileges.

**8.4.1.** A Practitioner who was granted a leave of absence for health reasons must provide a written statement from the Practitioner’s physician stating that the physician has examined the Practitioner within the last 30 days and that the Practitioner is physically and mentally capable of exercising clinical privileges and assuming the obligations of membership on the Medical Staff. The Practitioner must also consent to his or her physician answering any questions that the Credentials Committee, MEC, or Board may have as part of considering the request for reinstatement.

**8.4.2.** At the request of the Credentials Committee, MEC, or the Board, the Practitioner must provide a written summary of relevant activities during the leave.

**8.4.3.** The MEC must make a recommendation to the Board concerning reinstatement, including any conditions that the MEC determines should be attached to reinstatement.

**8.4.4.** The Board must approve any request for reinstatement before reinstatement is effective.

**8.4.5.** Any reinstatement of membership or privileges after a leave of absence must be followed with a period of Focused Professional Practice Evaluation.

## ARTICLE 9

## **ADVANCE PRACTICE PROFESSIONALS AND ALLIED HEALTH PROFESSIONALS.**

**Section 9.1 Advance Practice Professional.** An Advance Practice Professional (APP) is an individual, other than a Physician, who provides direct patient care services in the Hospital within the scope of a license, registration, or certification, without direction or supervision. The Hospital recognizes the following categories of APPs:

- (a) Advanced practice registered nurse
- (b) Physician assistant.
- (c) Licensed psychologist.
- (d) Licensed independent clinical social worker who seeks privileges to
  - (1) assess, diagnose, and establish a treatment plan for persons with mental, behavioral, or emotional disorders;
  - (2) provide individual psychotherapy, family, couples, and group therapy;
  - (3) intervene in urgent and emergent mental health problems;
  - (4) conduct chemical health screening; or
  - (5) conduct biofeedback without direction or supervision by a Physician.

**9.1.1. APP must be privileged by the Medical Staff.** An APP may exercise in the Hospital only those privileges granted by the Board upon the recommendation of the MEC.

- (a) **Qualifications.** An APP is eligible to apply for clinical privileges if the APP:
  - (a) Is licensed, registered, or certified by the State of Minnesota or otherwise be legally eligible to practice in Minnesota;
  - (b) Does not have any limitation or restriction on the APP's license, registration, or certification that would prohibit the APP from exercising clinical privileges being sought at the Hospital;
  - (c) Has professional liability insurance of at least \$1 million per occurrence / \$3 million aggregate that covers the clinical privileges the applicant seeks to exercise at the hospital, or is covered by the Federal Tort Claims Act;
  - (d) Possesses a valid registration with the Drug Enforcement Agency in Minnesota if the APP seeks privileges that include prescribing controlled substances;
  - (e) Has not been convicted of, or pled guilty or no contest to, a felony involving dishonesty, fraud, deceit, misrepresentation, sexual misconduct, or violence;
  - (f) Is able, with or without reasonable accommodation, to perform the essential functions of his or her practice with acceptable skill and without posing significant health or safety risk to patients; and

(g) Is not excluded or otherwise ineligible from participation in Federal Health Care Programs, funded in whole or in part by the federal government, including but not limited to Medicare and Medicaid.

(b) **Process for requesting and being granted privileges.** A request by an APP for clinical privileges must be made and processed in the same manner as an application for privileges by a Physician as provided in this Policy.

(c) **Focused and Ongoing Professional Practice Evaluation.** An APP is subject to Focused Professional Practice Evaluation (FPPE) and Ongoing Professional Practice Evaluation (OPPE) as provided in the Peer Review Policy in the same fashion as a Physician.

**Section 9.2 Allied Health Professionals.** An Allied Health Professional (AHP), for purposes of this Policy, is a Practitioner who is licensed, registered, or certified and provides direct patient care services in the Hospital within the scope of a license, registration, or certification under the direction or supervision of a Physician who has clinical privileges in the Hospital.

**9.2.1. Confirmation of qualifications and competencies.** Except as provided in the following paragraph, an AHP's qualifications and competencies must be confirmed by (a) the Hospital's human resources department or (b) if the AHP is not an employee of the Hospital or another HealthPartners' entity, by the Hospital's human resources department through the Physician who brings the AHP into the Hospital.

**9.2.2. Exception: Perfusionists.** A Perfusionist who is not employed by the Hospital or a HealthPartners entity who is brought into the Hospital by a Physician must be privileged by the Medical Staff in the same fashion as an APP.

## **ARTICLE 10 ADOPTION AND AMENDMENT; RELATIONSHIP TO BYLAWS; DEFINITIONS**

**Section 10.1 Adoption and amendment.** This Policy may be adopted and amended in the same manner as provided in Article 7 of the Bylaws.

**Section 10.2 Governing provisions.** The Governing Provisions of Article 8 of the Medical Staff Bylaws govern this Policy.<sup>3</sup> In addition to the definitions contained in Article 8 of the Bylaws, the following definitions apply to this Policy.

**10.2.1.** "Application" means both an application for appointment to the Medical Staff and a request for clinical privileges, unless the context indicates otherwise.

**10.2.2.** "Adverse Licensing Action" means any of the following when the reason for the action is related to the Practitioner's professional competence or conduct:

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<sup>3</sup> This includes Article 8.B.4 which permits any duty assigned to an individual to be performed by that individual's designee.

- (a) Any unfavorable action taken by a governmental licensing agency against a Practitioner's professional license or certificate, including denial, nonrenewal, revocation, suspension, conditioning, limitation, or imposition of probation or supervision; or
- (b) Voluntary relinquishment of a license or certificate in lieu of Adverse Licensing Action; or
- (c) Voluntary relinquishment of a license while under an investigation that could lead to Adverse Licensing Action; or
- (d) Any limitation or condition on a license pursuant to a stipulation or agreement between the Practitioner and the licensing agency.

**10.2.3.** "Disciplinary Action" means any action taken by a Health Care Organization to deny or limit the Practitioner's membership or participation in the organization – including the exercise of clinical privileges – when the reason for the action is related to the Practitioner's professional competence or conduct. Disciplinary Action includes the following:

- (a) Termination, revocation, suspension, conditioning, or imposition of probation or supervision; or
- (b) Voluntary resignation or separation in lieu of other Disciplinary Action or while under investigation that could lead to Disciplinary Action.

**10.2.4.** "Health Care Organization" means an organization engaged in providing, financing, improving, supervising, evaluating, or other activity related to health care. The term includes but is not limited to a hospital, clinic, organized medical staff, medical group, health maintenance organization, insurer or other third-party payor, medical or other professional organization, peer review organization, and specialty board.

**10.2.5.** "Medical Staff Services Office" means the unit of the Hospital that provides administrative services to the Medical Staff, and includes any credentialing verification organization that the Hospital may engage to assist the Medical Staff Services Office.

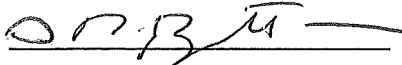
**10.2.6.** "Writing," "written", or "in writing" means a communication using letters and words in a form for which an exact, tangible record of the communication can be preserved. Examples of "writing" include hand-written, typed, or printed communication, and electronic communication such as electronic mail, fax, and similar transmissions.

**10.2.7.** "CEO" means the Chief Executive Officer of the Hospital or the CEO's designee.

*Adopted and amended by Regions Hospital Credentials Committee: 05/14/15; 09/26/17*

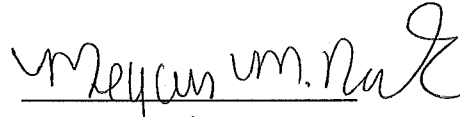
*Adopted and amended by Regions Hospital MEC: 07/06/15; 12/04/17*

*Adopted and amended by Regions Hospital Board: 10/28/15; 02/28/18*



Susan Truman, MD

Chief of Staff



Megan Remark

Chief Executive Officer