



MOUNT CARMEL

**MEDICAL STAFF OF
MOUNT CARMEL HEALTH**

CREDENTIALING MANUAL

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ARTICLE I. INTRODUCTION

- 1.1 The Medical Staff, through its designated Departments, Councils, Committees and/or Officers, shall investigate and consider each application for appointment or reappointment to the Staff and each request for modification of Staff membership status, primary Hospital affiliation or privileges and shall adopt and transmit recommendations thereon to the Board.
- 1.2 The Medical Staff, through its designated Departments, Councils, Committees and/or officers, shall investigate and consider each application for clinical and non-clinical professionals who are not members of the Mount Carmel Medical Staff. These individuals may request affiliation through employment or contractual agreement with a physician member of the Medical Staff.
- 1.3 The Medical Executive Committee shall set the application fees, if any, and when applicable.

ARTICLE II. APPLICATION FOR INITIAL MEDICAL STAFF APPOINTMENT

2.1 Pre-Application Process

Each application for appointment to the Staff shall be in writing, submitted on the prescribed form, and signed by the applicant. When the practitioner requests an application, he/she will be sent a Pre-application to determine whether the applicant meets eligibility criterion established by each department. The pre-application process will be waived if the practitioner graduated from a Mount Carmel Residency program within the previous 12 months (or will graduate in the year the application is requested) The following categories of practitioners are *not* eligible to request an application to the Medical Staff:

- Practitioners who provide services currently provided under an exclusive hospital contract and who are not associated with the contracted group.
- Practitioners who provide services not currently available at Mount Carmel Health

2.2 Application Process

Upon receipt of a completed Pre-Application, a regular application will be sent to those practitioners who meet the basic requirements of membership as set forth in the Medical Staff Bylaws and as outlined in the respective Department Rules and Regulations. The application will include copies of the Medical Staff Bylaws, Department Rules and Regulations and Credentialing Manual. The completed application form will include, at least:

- A valid photo ID
- A statement that the applicant has received and read the Bylaws, Rules and Regulations of the Medical Staff and that he/she agrees to be bound by the terms thereof, including the confidentiality, immunity and release of liability provisions in Article XIII of the Medical Staff Bylaws, if granted membership and/or clinical privileges, and to be bound by the terms thereof in all matters relating to

- consideration of the application without regard to whether or not he/she is granted membership and/or clinical privileges.
- Detailed information concerning the applicant's qualifications, including information in satisfaction of the basic requirements set forth in Article III of the Medical Staff Bylaws, and any additional qualifications specified in the Bylaws for any particular Staff category to which the applicant requests appointment. This information to include, but not be limited to, medical education, training and post-training clinical experience, including an explanation of any time periods between Medical Education, training and post-training experience greater than 6 months.
 - Request for primary hospital affiliation
 - The names/addresses of 5 practitioners not currently or about to become partners with the applicant or personally related to the applicant who have personal knowledge of the applicant's current clinical ability, ethical character, health status, ability to work cooperatively with others, and other qualifications for appointment and who will provide specific written comments on these matters upon request from the Hospital or Medical Staff authorities. Any rating less than "Good" requires an explanation. The Department Chair shall contact the individual providing the less than "Good" rating to discuss any issues. In the event of a conflict of interest, a member of the Credentials Committee shall contact the individual to discuss their peer reference response. The conversation shall be documented by the caller. The named individuals must have acquired the requisite knowledge through recent observation of the applicant's professional performance within the previous three (3) years. At least one must be the applicant's current Department Chair, or program director if a recent graduate.
 - A Delineation of Privileges request form for the appropriate specialty. Privileges will be considered based on education, training, post-graduate experience and competency attestation by an existing Department Chair or Program Director.
 - Information as to whether any of the following have ever been or are in the process of being denied, revoked, suspended, reduced, not renewed, resigned or voluntarily relinquished.
 - Staff membership status or clinical privileges at any other Hospital or health care institution;
 - Membership/fellowship in local, state or national professional organizations;
 - Specialty Board certification/eligibility;
 - License to practice any profession in any jurisdiction;
 - DEA number;
 - Professional liability insurance.
 - If any of such actions ever occurred or are pending, a written explanation must be provided.
 - Information as to current health status and ability or inability to perform the privileges requested.
 - Evidence that the applicant carries professional liability insurance coverage that meets the limits and company financial rating requirements established by the Board of Trustees as well as information regarding any malpractice claims, whether pending or closed during the past five (5) years.
 - Release of Information, including a statement notifying the applicant of the scope and extent of the authorization, confidentiality, immunity and release provisions.

- A statement whereby the applicant agrees that, when an adverse ruling is made with respect to his staff membership, status and/or clinical privileges, he/she will exhaust the administrative remedies afforded in the Medical Staff Bylaws before resorting to legal actions.

2.3 Responsibility of the Applicant

By applying for appointment/reappointment to the Medical Staff, each applicant:

- Attests to the correctness and completeness of all information furnished and acknowledges that any significant misstatement in or omissions from the application constitutes a voluntary withdrawal of application or for summary dismissal from the Staff;
- Signifies his/her willingness to appear for interview in regard to his/her application;
- Authorizes Hospital representatives to consult with others who have been associated with him/her and/or who may have information bearing on the applicant's competence and qualifications;
- Consents to Hospital representatives inspecting all records and documents that may be material to an evaluation of his/her professional qualifications and competence to carry out the clinical privileges he/she requests, or his/her physical and mental health status and of his/her professional ethical qualifications;
- Releases from any liability all Hospital representatives for their acts performed in good faith and without malice in connection with evaluating the applicant and his/her credentials;
- Releases from any liability all individuals and organizations who provide information, including otherwise privileged or confidential information, to Hospital representatives in good faith and without malice concerning the applicant's competence, professional ethics, character, physical and mental health, emotional stability and other qualifications for Staff appointment and clinical privileges;
- Authorizes and consents to Hospital representatives providing other Hospitals, medical associations, licensing boards, and other organizations concerned with practitioner performance and the quality and efficiency of patient care with any information relevant to such matters that the Hospital may have concerning him/her, and release Hospital representatives from liability for so doing, provided that such furnishing of information is done in good faith and without malice.

2.4 Burden of Proof

The applicant will be notified of any problems in obtaining the information required, and it shall then be the applicant's obligation to obtain the required information. The applicant shall have the burden of producing adequate information for a proper evaluation of his/her experience, background, training, demonstrated ability, and physical and mental health status, and of resolving any doubts about these or any of the other qualifications for Staff membership or for a specific staff category or clinical privileges. Failure to respond to requests for information from the Medical Staff Office, Department Chair, Clinical Department Council(s), Central Credentials Committee, Medical Executive Committee or Board of Trustees, without good cause, within the time period specified shall be deemed a voluntary withdrawal of the application.

2.5 Time Period for Processing Applications

For initial applications, the Department Chair, or designee, will review the application and supporting documentation, conduct and document a personal interview with the applicant, and transmit to the Central Credentials Committee, on the prescribed written form, a report and recommendation as to Staff appointment, status, primary hospital affiliation and clinical privileges to be granted, and any special conditions to be attached to the appointment.

- A “clean” application (by policy definition) may be forwarded to the Credentials Committee and the Medical Executive Committee pending an interview by the Department Chair or designee. No application shall be presented to the Board of Trustees without a complete and approving interview by the Department Chair or designee.
- This recommendation shall be transmitted within 60 days of receipt of the application. If the 60-day time limit is not met, the application will move to the Central Credentials Committee without the recommendation of the Department Chair or designee.
- Completed applications for staff appointment shall be considered in a timely and good faith manner by all individuals and groups required by these Bylaws to act thereon and except for good cause, such as, but not limited to, a deferral to obtain additional information, shall be processed within the time periods specified below:

Department Chair, or designee	60 days
Central Credentials Committee	60 days
Medical Executive Committee	60 days

The time periods specified above are to assist those named in accomplishing their tasks and are not deemed to create any absolute right for the applicant to have his/her application processed to final decision within those periods.

2.6 Medical Executive Committee Action

- When a recommendation of the MEC is favorable to the applicant, the President of the Medical Staff shall present it to the Board. The Board, or appropriate Committee of the Board, shall then take action on the application at its next regular meeting.
- When the recommendation of the MEC is adverse to the applicant, the President of the Medical Staff shall so inform the practitioner promptly by special notice, and he/she shall be entitled to the procedural rights as provided in Article X of the Medical Staff Bylaws and in the Fair Hearing Plan. In the case of an adverse MEC recommendation or an adverse Board decision, the Board shall take final action in the matter only after the applicant has exhausted or has waived his/her procedural rights as provided in Article XI of the Medical Staff Bylaws and in the Fair Hearing Plan. Action thus taken shall be the conclusive decision of the

Board, except that the Board may defer final determination by referring the matter back for further reconsideration. Any such referral shall state the reasons therefore, shall set a time limit within which a subsequent recommendation to the Board shall be made, and may include a directive that an additional hearing be conducted to clarify issues which are in doubt. After receipt of such subsequent recommendation and of new evidence in the matter, if any, the Board shall make a final decision.

2.7 Notice of the Board of Trustees' Final Decision

Notice of the Board's final decision shall be given, through the Chief Executive Officer, to the Chairman of the MEC, CCC and CDC's, the Chairman of Each Department concerned, and to the applicant by means of special notice. A decision and notice to appoint shall include (1) the Hospital designated as his primary affiliation; (2) the Staff category to which the applicant is appointed; (3) the department to which he is assigned at each Hospital; (4) the clinical privileges he may exercise; and (5) any special conditions attached to the appointment.

- Upon a favorable decision by the Board, a new applicant will be notified by certified mail of his/her appointment to the Medical Staff, staff status, Department assignment, primary hospital affiliation and clinical privileges granted and any specific conditions attached to the appointment. The newly appointed Staff member will also be given information regarding, but not limited to, meeting attendance requirements (including date, time, location of meetings), computer identification number, and instructions for obtaining an identification badge and orientation tour.
- An unfavorable decision by the Board, may entitle the practitioner to due process. Refer to the Fair Hearing Plan in the Medical Staff Bylaws.

ARTICLE III. APPLICATION FOR MEDICAL STAFF REAPPOINTMENT

3.1 Reappointment Eligibility

A reappointment application packet will be sent to each staff member approximately ninety (90) days prior to the expiration date of his/her current appointment. A Medical Staff member's appointment will not exceed a two-year period.

- Eligible staff members who desire reappointment, shall return his/her reappointment application to the Medical Staff Office. Failure, without good cause, to return the reappointment application 45 days prior to the expiration of the current appointment, may be deemed a voluntary resignation from the staff and may result in automatic termination of membership at the expiration of the member's current term. A practitioner, whose membership is so terminated, shall be entitled to the procedural rights provided in Article X and in the Fair Hearing Plan for the sole purpose of determining the issue of good cause.

- Practitioners who received a certified warning letter regarding non-compliance with Medical Staff policies and who failed to meet those requirements in the specified time frame are not eligible to receive a reappointment application. Physicians who are not eligible for reappointment will be notified after the Medical Executive Committee meeting at which support for the expiration of their privileges is given. At this time, the member will be notified of his/her right to Due Process under the Fair Hearing Plan of the Medical Staff.

3.2 Reappointment Applications

The reappointment application form will request data necessary to update the Medical Staff file on the Staff member's health care related activities. The form will include, but not be limited to, information pertaining to the following:

- Continuing training, education and experience that qualifies the Staff member for the privileges sought on reappointment;
- Current physical and mental health status;
- The name and address of any other health care organization or practice setting where the Staff member provided clinical services during the preceding period;
- Membership, awards, or other recognition conferred or granted by any professional health care societies, institutions, or organizations;
- Board Certification or re-certification obtained in the preceding two (2) year period;
- Sanctions of any kind imposed or pending by any other health care institution, professional health care organization, or licensing authority;
- Malpractice insurance coverage (including cancellations, non-renewals and limits), and written explanation of any and all claims, suits and settlements within the preceding two (2) year period;
- Other specifics about the Staff member's professional ethics, qualifications, interpersonal skills, and ability that may bear on his ability to provide good patient care in the Hospital.

3.3 Information Collection and Verification Process

During reappointment, the Medical Staff Office will also collect for each Staff member's credentials file all relevant information regarding the individual's professional and collegial activities, performance and conduct in this Hospital as defined by staff Status. If the staff member has inadequate activity at Mount Carmel, such information will be requested from the practitioner's primary hospital. Such information may include, but is not limited to, patterns of care as demonstrated in findings of quality assurance and other review, evaluation and monitoring activities, review of office records, participation in relevant internal teaching and continuing education activities, status, attendance at required Medical Staff, Department and Committee meetings; participation as a Staff official; Committee member/Chair or proctor, and in specialty coverage for the emergency room; timely and accurate completion and preparation of medical records; cooperation in working with other practitioners, patients, and staff; compliance with all applicable Bylaws, policies, rules, regulations and procedures of the Hospital and staff.

3.4 Time Period for Processing

The applicant shall deliver a completed (re)application to include payment of the processing fee (as applicable), to the Medical Staff Office, which shall, in a timely fashion, seek to collect and verify the information contained in the (re)application and required by the accreditation and regulatory standards and the Central Credentials Committee. Thereafter, and except for good cause, each person, Department, Council and Committee required to act thereon will complete such action in a timely fashion so that all reports and recommendations concerning the reappointment of staff membership and clinical privileges shall have been transmitted to the MEC for its consideration and action and to the Board for its action prior to the expiration date of Staff membership of those members being considered for reappointment.

3.5 Expiration of Membership and Privileges

If the processing has not been completed by the expiration date of the appointment, the Staff member's membership and privileges will expire.

3.6 Collection and Verification of Information

The applicant will be notified of any problems in obtaining the information required, and it shall then be the applicant's obligation to obtain the required information. The applicant shall have the burden of producing adequate information for a proper evaluation of his/her experience, background, training, demonstrated ability, and physical and mental health status, and of resolving any doubts about these or any of the other qualifications for Staff membership or for a specific staff category or clinical privileges. Failure to respond to requests for information from the Medical Staff Office, Department Chair, Clinical Department Council(s), Central Credentials Committee, Medical Executive Committee or Board of Trustees, without good cause, within the time period specified shall be deemed a voluntary withdrawal of the application. Automatic termination of membership at the expiration of the member's current term will occur if failure to respond to requests for additional information during the reappointment process. A practitioner whose membership is so terminated shall be entitled to the procedural rights provided in Article X of the Medical Staff Bylaws and in the Fair Hearing Plan for the sole purpose of determining the issue of good cause.

When collection and verification is accomplished, the Medical Staff Office shall transmit the (re)application and all supporting material to the Chairperson, or designee, of the department in which the applicant seeks privileges.

3.7 Department Chairperson Action

For reapplications, the Department Chair will forward a recommendation, on the prescribed written form, as to status, primary hospital affiliation and clinical privileges to be granted, to the Clinical Department Council (CDC) at the practitioner's primary hospital. If the practitioner has Dual hospital designation, the Department Chairs at both hospitals will review the information and make a recommendation to their

respective CDC. The CDC's will then forward their recommendation(s) to the Central Credentials Committee.

3.8 Committee Action

The Central Credentials Committee (CCC) will review the recommendations of the Department Chair(s) and shall forward its recommendation to the Medical Executive Committee (MEC). If at any time during the review process additional information is requested by the Department Chair, Clinical Department Council, Central Credentials Committee, Medical Executive Committee and/or Board of Trustees, the Staff member will be notified of the information requested and the time frame for responding. Failure to respond to any request for additional information will be considered a voluntary withdrawal of the application and voluntary termination of membership at the expiration of a staff member's current term, if during the reappointment process.

The reappointed staff member will be notified of his/her reappointment to the Medical Staff. This notice will include staff status, primary hospital affiliation and privileges granted each member, and any limitations imposed thereon. Physicians who have failed to meet attendance requirements or medical record completion requirements will be notified of this failure and informed of the possible outcomes of continued failures.

ARTICLE IV. REQUESTS FOR MODIFICATION OF MEMBERSHIP, PRIMARY AFFILIATION, STATUS, OR PRIVILEGES

4.1 Process

A Staff member may, either in connection with reappointment or at any other time, request modification of his Staff category, Department assignment, primary Hospital affiliation or clinical privileges by submitting a written request to the President of the Medical Staff. A practitioner is required to meet all medical staff responsibilities until such request has been approved by the Board of Trustees.

A practitioner may be recommended for Honorary status by another member of the medical staff, the Clinical Department Council, the Medical Executive Committee, or by the Board of Trustees.

4.2 Eligibility Determination and Approval Process

Requests that meet eligibility criteria will be presented for review and recommendation to the respective Department Chair, Central Credentials Committee, Medical Executive Committee and for final approval by the Board of Trustees.

4.3 Relinquishment of Clinical Privileges

A Staff member who determines to no longer exercise or wishes to restrict or limit the exercise of particular privileges which he/she has been granted shall send written notice to the Medical Staff President and the appropriate Department Chair indicating the same and identifying the limitation. A request to relinquish clinical privileges will be presented for review and recommendation to the respective Department Chair, Central

Credentials Committee, and Medical Executive Committee and for final approval by the Board of Trustees.

ARTICLE V. REAPPLICATION AFTER ADVERSE CREDENTIALS DECISION

5.1 Exceptions and Limitations

Except as provided in the Medical Staff Bylaws or as determined by the Medical Executive Committee in light of exceptional circumstances, an applicant or Staff member who has received a final adverse decision, or who has voluntarily resigned or withdrawn an application for appointment, reappointment, Staff category, Department assignment, primary Hospital affiliation, or clinical privileges is not eligible to reapply for a period of one (1) year from the date of the notice of the final adverse decision or the effective date of the resignation or application withdrawal.

5.2 Reapplication Process

Any such reapplication is processed as an initial application, and the practitioner must submit such additional information as the Medical Staff leadership and the Board may reasonably require in demonstration that the basis for the earlier adverse action no longer exists. The practitioner is subject to current credentialing and regulatory standards. Any previous waivers or exemptions will no longer apply. If such information is not provided, the reapplication will be considered incomplete and will not be further processed.

ARTICLE VI. HOUSE PHYSICIANS

6.1 Eligibility

Approval to work as a House Physician will be granted to professionally competent individuals who meet the qualifications, standards and requirements of their respective licensure, certification, or other legal authorization and the criteria established through the Central Credentials Committee of Mount Carmel Health and approved by the Board of Trustees. Applications will be provided to qualified individuals who meet the criteria to function as a House Physician as outlined in the appropriate job description. All House Physicians are required to abide by all hospital policies and regulatory requirements. All House Physicians will be required to comply with hospital, JCAHO, and other regulatory agency annual requirements (including, but not limited to, TB skin testing, safety education, age specific education, etc.). Failure to comply will be considered a voluntary withdrawal of his/her request.

6.2 Complete Applications

A completed application will be defined as:

- being legible
- having complete addresses
- notarized copy of diploma
- notarized copy of Ohio licensure or registration

- additional certification as applicable (i.e. ACLS, BLS, etc.)
- signed and dated release of information
- signed and dated receipt for the Medical Staff Bylaws, Ethical & Religious Directives, appropriate job description, and other regulatory documents
- curriculum vitae or resume
- signed and dated confidentiality agreement

No application will be processed unless it is considered complete.

6.3 Application Process

Upon receipt of a completed application for appointment as a House Physician the Medical Staff Coordinator will perform the following duties:

- obtain appropriate references from current Program Director and 3 additional Attending Physicians.
- verify licensure
- query the National Practitioner Data Bank (for applicants with professional licensure registration)
- query the Medicare/Medicaid Sanction report
- obtain a malpractice claims history

6.4 Requirements for Staff Membership

If an applicant has completed Post Graduate Training or a Fellowship, he/she must apply for Provisional Staff membership and privileges pursuant to the Bylaws of the Medical Staff. Physicians who must apply for Provisional staff membership will have until September 1st of the review year to provide a completed application for privileges. Failure to do so by that date will be considered a voluntary resignation from Mount Carmel Health.

In the event that a House Physician or resident is joining a previous Program Director or Department Chair in a clinical practice, the Program Director or the Department Chair may provide a professional reference if there are no other alternatives available at the time the reference is needed. The House Physician's supervisor may also provide the information needed from a Department Chair if the supervisor is the most qualified and knowledgeable individual to provide the reference. All other required references must also be obtained through the verification process.

6.5 Approval Process

Once all information is verified and the application is deemed complete, it will be forwarded for review by the respective Department Chair or designee. The Department Chair or designee will review all submitted information and in cases where it is deemed appropriate, further investigate the character, qualification and professional competence of the applicant. Recommendations will then be forwarded to the Central Credentials Committee, the Medical Executive Committee and the Board of Trustees.

6.6 Administrative Process

Upon approval to work as a House Physician, the Medical Staff Office will forward the appropriate paperwork to Professional Billing Services.

6.7 Requests for Temporary Approval

Following a favorable recommendation from the Department Chair or designee, and a representative of the Credentials Committee, a request for temporary approval may be presented to the President of the Medical Staff prior to action by the Board of Trustees.

6.8 DEA Requirements

All House Physicians must have their own DEA certificates upon application or evidence that a DEA has been applied for.

6.9 Cause for Termination

Failure to abide by hospital policies may result in immediate termination of House Physician approval. A House Physician so terminated is not entitled to the procedural rights afforded by the Fair Hearing Plan of the Medical Staff Bylaws.

6.10 Annual Re-evaluation Process

House Physicians shall be re-evaluated annually. Physicians will be given thirty (30) days to respond to inquiry regarding continuation of services. Failure to respond within 30 days will be considered a voluntarily resignation of House Physician status.

Approximately one month prior to the annual review, the following process will be initiated:

- a. Job performance reviews will be conducted by the Department Chairperson or his/her designee.
- b. Verification of medical license will be conducted by the Medical Staff Office.
- c. Query of National Practitioner Data Bank will be conducted by the Medical Staff Office.
- d. Copy of DEA will be requested from the Physician by the Medical Staff Office.
- e. Claims history update will be obtained by the Medical Staff Office.
- f. Evidence of progress in training or completion of the training program will be requested from the House Physician, if appropriate. If the physician has completed his/her training program and wishes to continue as a House Physician, he/she will be approved for an additional year; after which he/she will be required to apply for Provisional Staff membership. (See Section 6.4)

6.11 Recommendations for renewal or continued service as a House Physician shall be carried out as outlined in Section 6.5.

6.12 House Physicians are required to accurately document and complete all medical records in a timely fashion and shall be accountable to the same timelines and requirements as the members of the Medical Staff. Medical records must be complete within thirty (30)

days of discharge. A complete record is defined as a record that is both dictated and signed within thirty days of discharge. Failure to complete medical records within thirty days may result in the inability to work as a House Physician until all delinquencies are satisfied.

ARTICLE VII. LICENSED DEPENDENT PRACTITIONERS

7.1 Definition

Licensed dependent practitioners (LDPs) are defined as Advanced Practice Nurses, Physicians' Assistants, Certified Nurse Midwives, or Certified Registered Nurse Anesthetists with clinical privileges. All LDPs must be employed by the hospital or by a member of the medical staff and must have a collaborative agreement with a member of the Medical Staff of Mount Carmel Health.

7.2 Role of the Supervising Physician

The supervising physician of an LDP must exercise oversight, control and direction of the LDP pursuant to the definitions of the appropriate Ohio licensing board. In supervising an LDP, the supervising physician must be continuously available for direct communication with the practitioner. Other requirements are defined and outlined on the practitioner's privilege set.

7.3 Limitations

The LDP shall not perform functions or acts including, but not limited to, the following:

- Admit patients to or release patients from the hospital independent of the employing physician;
- Sign a physician's name for the purpose of authenticating any prescriptions, orders, recordings; or sign the physician's name in any situation where the physician's signature gives the appearance of physician's approval.
- Maintain an office within the hospital.
- Delegate a function to be performed by him/her as assigned by the employing physician without knowledge of the physician.
- Represent him/herself in any way as being able to perform beyond the specific functions set forth in the standard of care arrangement executed pursuant to Ohio Revised Code and the Board of Trustees of Mount Carmel Health.
- Supplant the employing physician in making visits; although he/she may make visits in addition to those of the employing physician.

7.4 Annual Re-evaluation

Individuals are subject to an annual renewal and routine competency evaluations. This may be accomplished by the supervising physician using the requirements of the authorized licensing Board and Scope of Practice approved by the medical staff.

7.5 Medical Record Documentation and Completion

Licensed Dependent Practitioners are required to complete all medical records in a timely manner and shall be accountable to the same timelines and requirements as the members of the Medical Staff. Failure to complete records within thirty (30) days of discharge may result in the inability to work within the hospital until all delinquent records are complete. A complete record is defined as a record that is both dictated and signed within thirty days of discharge.

7.6 Right to An Appeal

Licensed Dependent Practitioners with clinical privileges (PA, CNP, CRNA, CNM, CNS) and who are employed by a member of the Mount Carmel Medical Staff are entitled to an Appeals Process through the medical staff structure. Advanced Practice Nurses (CRNA, CNM, CNS, and CNP) who are employed by Mount Carmel are entitled to due process afforded them through People Services. Clinical disagreements shall be managed according to the process outlined in the Medical Staff Policy, Resolution of Clinical Disagreement between APN or PA and Collaborative Physician.

ARTICLE VIII. CERTIFIED NURSE PRACTITIONERS IN THE EMERGENCY DEPARTMENT

- 8.1 All Certified Nurse Practitioners (CNP) in this position must be employed and supervised by a member of the Department of Emergency Medicine of Mount Carmel Health, and must hold a current license and certification by the Ohio Board of Nursing. The CNP/ED/Ambulatory Care may practice only in accordance with a standard of care arrangement, executed pursuant to Ohio Revised Code, and entered into with each physician with whom the nurse collaborates. A copy of the standard care arrangement must be provided to the Medical Staff Office with application.
- 8.2 A nurse authorized to practice as a Certified Nurse Practitioner in the Emergency Department manages a caseload of ambulatory patients with consultation, collaboration, and general supervision from one or more Emergency Department physicians and shall undertake the following:
- Assess the physical and psychosocial status of ambulatory patients by means of interview and history, physical exam, and diagnostic tests.
 - Exercise independent judgment in assessment, diagnosis, initiation of delegated medical procedures, and evaluation in a manner consistent with institutional guidelines, Section 4723 of the Ohio Revised Code, any applicable rules of the State Board of Nursing, and the CNP's education and experience.
 - Use resources of the Emergency Department and consultations with physicians and other health care professionals to maintain appropriate care.
- 8.3 A Certified Nurse Practitioner, practicing in the ambulatory care setting of the Emergency Department, who holds a Certificate to Prescribe under section 4723.48 of the Ohio Revised Code may, in collaboration with one or more physicians who are members of the Department of Emergency Medicine, Mount Carmel Health, prescribe drugs and therapeutic devices in accordance with Section 4723.481 of the Ohio Revised Code. Without this Certificate to prescribe, the CNP shall not prescribe medication, sign

or stamp prescriptions on behalf of the employing physician; have prescription blanks available that have been pre-signed or stamped by the physician, although the employing physicians order for medication may be carried out or relayed by the CNP in accordance with existing drug laws.

- 8.4 Quality of care is enhanced by the interdependent practice of the supervising physician and the CNP in the ambulatory care setting of the Emergency Department. This does not imply the physical presence of the physician at the bedside is always necessary when care is given by the CNP to ambulatory patients. However, ultimate responsibility for the patient's care lies with the supervising physician. In accordance with this, the physician must:
- Be immediately and continuously physically available to provide consultation when requested, and to intervene when necessary; and
 - Assume total responsibility for the care of any ambulatory patient when requested by the CNP or required by policy, or in the interest of patient care.

SECTION IX: CERTIFIED NURSE PRACTITIONER IN AN AMBULATORY SETTING

- 9.1 All Certified Nurse Practitioners (CNP) in this position must be employed by either the Physician or the Hospital and supervised by a member of the Medical Staff of Mount Carmel Health, and must hold a current license and certification by the Ohio Board of Nursing. The CNP may practice only in accordance with a standard of care arrangement, executed pursuant to Ohio Revised Code, and entered into with each physician with whom the nurse collaborates. A copy of the standard care arrangement must be provided to the Medical Staff Office with the application for approval.
- 9.2 A nurse authorized to practice as a Certified Nurse Practitioner in an ambulatory setting manages a caseload of ambulatory patients and shall undertake the following:
- Function under practice guidelines/protocols established with the collaborating physician.
 - Exercise independent judgment in assessment, diagnosis, initiation of delegated medical procedures, and evaluation in a manner consistent with institutional guidelines, Section 4723, 4730 and 4731-4 of the Ohio Revised Code, any applicable rules of the State Board of Nursing, and the CNP's education and experience.
- 9.3 A Certified Nurse Practitioner, practicing in the ambulatory care setting, who holds a Certificate to Prescribe under section 4723.48 of the Ohio Revised Code may, in collaboration with the physician(s), prescribe drugs and therapeutic devices in accordance with Section 4723.481 of the Ohio Revised Code. Without this Certificate to prescribe, the CNP shall not prescribe medication, sign or stamp prescriptions on behalf of the collaborating physician; have prescription blanks available that have been pre-signed or stamped by the physician, although the collaborating physicians' order for medication may be carried out or relayed by the CNP in accordance with existing drug laws.
- 9.4 Quality of care is enhanced by the interdependent practice of the supervising physician and the CNP in the ambulatory care setting. This does not imply the physical presence

of the physician in the Clinic is always necessary when care is given by the CNP to ambulatory patients. However, ultimate responsibility for the patient's care lies with the supervising physician. In accordance with this, the physician must:

- Be available to provide consultation when requested, and to intervene when necessary;
- Countersign all orders on a weekly basis; and
- Perform random chart review every 6 months.

ARTICLE X. PHYSICIAN ASSISTANTS

10.1 Supervision Requirements

All Physician Assistants must be supervised by a member of the Medical Staff of Mount Carmel Health and be licensed by the State Medical Board of Ohio. All physicians supervising a Physician Assistant shall have obtained the State Medical Board's approval of a physician assistant utilization plan and approval of a supervision agreement entered into with the physician assistant prior to requesting an application for a Physician Assistant to provide patient care services at Mount Carmel East and Mount Carmel West. A copy of the current approved Utilization Plan and Supervision Agreement must be on file in the Medical Staff Office.

10.2 Orders

All orders written by a physician assistant must be signed, timed and dated. Orders will be executed in the best interest of the patient. The supervising physician named on the order shall review each order written by the physician assistant on a daily basis. After reviewing an order, the supervising physician shall countersign the order if the supervising physician determines that the order is appropriate.

10.3 Function and Scope of Practice

The physician assistant may perform any of the following functions only under the supervision of the employing physician or physicians and only while the employing physician or physicians are available for consultation; provided that the particular functions have been approved by the State Medical Board as set forth in the physician assistant's application for registration and approved by the Board of Trustees of Mount Carmel.

- Screen patients to aid the employing physician in determining need for further medical attention;
- Review patient records to aid in determining health status;
- Take patient histories; perform physical examinations; and identify normal and abnormal findings on histories, physical examinations, and commonly performed initial laboratory studies. Information collected is to be presented to the employing physician prior to treatment based upon such information;
- Perform developmental screening examination on children as relating to nervous, motor, and mental functions;
- Record pertinent patient data;

- Make decisions regarding data gathered on patients being seen for the initial evaluation of a problem or the follow-up evaluation of a previously diagnosed and stabilized condition. The physician's assistant will present the information collected to the employing physician prior to treatment based upon such data;
- Prepare patient summaries for employing physician's patients only, which must be reviewed and countersigned by the employing physician;
- Collect specimens for and perform commonly performed blood counts, urine analysis, stool analysis and cultures using office kits;
- Venipuncture
- Intradermal tests
- Electrocardiogram (not including interpretation)
- Care and suturing of minor lacerations
- Apply cast or splint under direction of the employing physician. Such application shall be made only after examination by the employing physician, and any necessary reduction by the employing physician
- Application of dressings and bandages
- Administration of medication and intravenous fluids upon order of the employing physician
- Removal of superficial foreign bodies after consultation with the employing physician and under his direction
- Cardio-pulmonary resuscitation
- Audiometry screening, to be presented to the employing physician
- Routine visual screening to be presented to the employing physician
- Carry out aseptic and isolation techniques
- Catheterization of the urinary bladder
- Provide patient education regarding common medical problems

All other functions approved under a standard or supplemental utilization plan must be requested individually and include supporting documentation, and require approval by the Board of Trustees of Mount Carmel Health.

10.4 Limitations

The physician's assistant shall not perform functions or acts including, but not limited to, the following:

- Make a diagnosis of a disease or ailment or the absence thereof independent of the employing physician;
- Prescribe any treatment or a regimen not previously set forth by the employing physician;
- Prescribe medication; sign or stamp prescriptions on behalf of the employing physician; have prescription blanks available that have been pre-signed or stamped by the physician; or dispense or order medication, although the employing physician's order for medication may be carried out or relayed by the physician's assistant in accordance with existing drug laws;
- Sign a physician's name for the purpose of authenticating any prescriptions, orders, recordings; or sign the physician's name in any situation where the physician's signature gives the appearance of physician's approval;
- Maintain an office within the hospital

- Delegate a function to be performed by him as assigned by the employing physician;
- Admit patient to or release patients from the hospital independent of the employing physician;
- Represent himself in any way as being able to perform beyond the specific functions set forth in the application of registration as approved by the State Medical Board and the Board of Trustees of Mount Carmel Health

Failure to practice in accordance with the Utilization Plan with the Medical Board or this policy will result in disciplinary action, which may include immediate termination of physician assistant function at Mount Carmel.

ARTICLE XI. LICENSED DEPENDENT PRACTITIONERS WITHOUT CLINICAL PRIVILEGES

11.1 Licensed Dependent Practitioners without clinical privileges are defined as:

- a. RN Clinical Coordinator/Assistant
- b. RN Private Scrub
- c. Licensed Practical Nurse

11.2 A non-licensed dependent practitioner is defined as:

- a. Scrub Assistants/surgical Technicians
- b. Ophthalmic Assistants
- c. Pathology Assistants
- d. Clinical Research Coordinators

11.3 Accountability

Persons authorized to perform services at Mount Carmel Health pursuant to an approved application shall represent, receive supervision from, report to, and be held accountable to the physician employer/contractor. All employees/contractees of physicians must wear identification while providing services in the hospital.

11.4 Limitations

Persons authorized will be required to adhere to all policies of Mount Carmel Health, and related regulatory requirements. Persons authorized may:

- provide specified services as approved for patient care upon direct order of the physician employer/contractor as outlined in the job description approved by the Medical Staff of Mount Carmel Health and the Board of Trustees;
- assist at any surgical, diagnostic, or therapeutic procedure for which the physician requires assistance and as approved by the Medical Staff of Mount Carmel Health;
- Registered nurses may write orders, verbal or otherwise. Orders must be countersigned by the responsible physician.

11.5 Termination

If approved duties are exceeded or abused, permission to provide services at Mount Carmel Health will be immediately revoked. No application will be accepted or processed if the physician's employee/contractee is also a physician. An LDP without clinical privileges is not entitled to an appeals process.

At no time will an application be processed if it will permit the physician's employee/contractee to perform billable procedures and/or services that are in themselves isolated from direct personal assistance to the physician; or which are available at Mount Carmel Health.

11.6 Regulatory Compliance

All physicians' employees/contractees will be required to comply with hospital, JCAHO, and other regulatory agency annual requirements (including, but not limited to, TB skin testing, safety education, age specific education, etc.). Failure to comply will be considered a voluntary withdrawal of his/her request.

11.7 Annual Reviews

Annual reviews of the physician's employee/contractee will be conducted. These evaluations will be facilitated by the Medical Staff Office with input from the physician employer.

Mount Carmel Health associates who are also employed/contracted by a physician and provide patient care services in the hospital under his/her supervision must also apply and be given permission to work in the hospital.

Applications for Physician's Employees will be processed by the Medical Staff Services office. Employees/contractees that work for more than one physician must have each physician sign the application. Licensure will be verified by the Medical Staff Offices, as applicable. Submission and/or approval of an application shall not imply or constitute any type or form of employment with Mount Carmel Health nor membership of said employee/contractee on the Medical Staff of Mount Carmel Health. Applications will be reviewed by the respective Department Chair and presented to the Central Credentials Committee for approval.

ARTICLE XII. NON-CLINICAL SUPPORT STAFF

12.1 The Mount Carmel medical staff will work to protect patient-identifiable information and to ensure strict patient confidentiality for all patients. Medical staff members are responsible for ensuring that his/her non-clinical office staff protects confidential information and/or materials. Confidential material may not be used for purposes other than patient care or other proper Hospital and Medical Staff functions. While information in a medical record belongs to the patient, the medical record belongs to the hospital.

12.2 Application Process

Medical staff members shall submit a written request to the Medical Staff Office to obtain permission for office staff to access hospital documentation and/or computer access.

- Each request shall outline the responsibilities of the employee within the hospital.
- All requests shall be accompanied by a Confidentiality/Security Agreement signed by the practitioner's employee. Further, each practitioner shall attest to protect patient confidentiality and security by countersigning the same agreement.

- Upon approval, the request shall be forwarded to the respective Department Chair for review and approval by the Central Credentials Committee, the Medical Executive Committee and the Board of Trustees.
- Each member of the medical staff is responsible for securing a signed Confidential/Security Agreement for every member of his/her office staff who will have access to patient-identifiable confidential material, for establishing office procedures and in-service training consistent with this policy, and for periodically having all office staff members re-sign a Confidentiality/Security Agreement.
- Requests, approvals, and confidentiality agreements shall be kept in the Medical Staff Office.
- Non-clinical personnel may not write on any patient chart in the hospital.
- Accessibility and approval will be automatically terminated when:
 - employment with the medical staff practitioner is terminated for any reason;
 - the practitioner's affiliation with the hospital is terminated for any reason.

ARTICLE XIII. NON-MOUNT CARMEL RESIDENTS

13.1 Purpose

The Mount Carmel Health Medical Staff will strive to promote patient safety, provide physicians with appropriate assistance, and to protect the integrity of the Graduate Medical Education program.

13.2 Processing and Approval Process

When an existing member of the Mount Carmel Health medical staff requests assistance from a non-Mount Carmel Health resident in training, the request shall be forwarded to the Office of Medical Education for processing. Processing shall be accomplished in accordance with regulatory requirements for Graduate Medical Education. The Chief Resident of the specialty involved shall have first opportunity to participate/assist in the case. In the event that the resident staff is not available or they do not yet possess the skills to perform the procedure, consideration will be given to non-Mount Carmel Health residents. The Medical Staff Office shall obtain final approval from the Program Director and/or Department Chairperson, as appropriate.

13.3 Limitations

This plan shall not supersede any contractual arrangements for graduate medical education between Mount Carmel Health System and any other entity for resident training.

ARTICLE XIV. TEMPORARY AND EMERGENCY/DISASTER PRIVILEGES

- 14.1 Temporary clinical privileges shall be granted in accordance with the Medical Staff Bylaws, Article VII. Temporary privileges may be considered for the following two reasons: Pendency of Application and Care of Specific Patients.

14.2 Pendency of Application

Requests for temporary privileges must be in writing to the President of the Medical Staff. Requests will be considered provided all required documentation has been received, all items requiring verification have been verified, the interview has been conducted, the Credentials Committee has reviewed the application and there are no significant questions concerning the applicant's qualifications for privileges.

- Once a positive recommendation is obtained from the Credentials Committee the Medical Staff President will be contacted for approval of the request for temporary privileges.
- If temporary privileges are requested for specific group coverage, a representative of the Credentials Committee will be contacted and asked to review the complete and verified application. Acting on behalf of the Credentials Committee, he/she can make a formal recommendation to the President of the Medical Staff or Acting President of the Medical Staff who may grant temporary privileges before the Credentials Committee convenes.

14.3 Care of Specific Patients

Upon receipt of a written request for specific temporary privileges, an appropriately licensed practitioner of documented competence, who is not an applicant for membership, may be granted temporary privileges for the care of one or more specific patients. Such privileges shall be restricted to the treatment of not more than two (2) patients in any one year by any practitioner, after which such practitioner shall be required to apply for membership on the medical staff before being allowed to attend additional patients.

Once a positive recommendation is obtained from the Chair of the Credentials Committee, or his/her designee, the Medical Staff President will be contacted for approval.

Once approval of temporary privileges has been obtained, the physician's relevant demographic information will be entered into the hospital's data base, including the effective date of the temporary privileges.

A memo will be sent, via e-mail, to appropriate hospital personnel notifying them of the physician's temporary status.

The Medical Staff Office credentialing computer system will be updated to reflect temporary status.

A letter granting temporary privileges will be sent to the physician, including the expiration date of the privileges. Privileges are granted for no more than 90 days.

14.4 Emergency/Disaster Privileges

In the event of a community, statewide, or national emergency or disaster, action shall be taken to protect all patients. Emergency privileges may be granted, on a case by case basis, when the emergency management plan has been activated and the organization is unable to handle the immediate patient needs or when specialty services are required to protect and serve patients due to the limitations or absence of a particular service line.

Whenever a specific specialty or service line is not available at the hospital, the President of the Medical Staff, President-Elect or the Chief Executive Officer may grant emergency privileges in order to serve patients presenting to the hospital. In this case, emergency privileges may be granted while an application for medical staff membership and privileges is being processed. Consideration of emergency privileges under these circumstances require submission of a valid, unrestricted Ohio medical license, evidence of adequate malpractice insurance, and a query of the National Practitioner Databank before clinical privileges can be granted.

The President of the Medical Staff, the President-elect or the Chief Executive Officer may grant, on a case-by-case basis, emergency privileges in the event of a community, statewide, or national emergency or disaster, upon presentation of the following:

- Unrestricted license to practice medicine in Ohio. Verified by Internet or phone sources (if accessible due to nature of disaster). Physicians who hold an unrestricted license in another state will be considered on a case-by-case basis.

AND, one of the following means of identification:

- A current picture hospital ID card
- A current photo ID issued by a state, federal or governmental agency.
- Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT);
- Identification indicating that the individual has been granted authority to render patient care in emergency circumstances. Such authority having been granted by a federal, state or municipal entity.
- Presentation by current hospital or medical staff member(s) with personal knowledge regarding practitioner's identity.

Physicians granted such emergency privileges will be under the direction of an existing medical staff member, and are obligated to summon all consultative assistance deemed necessary and shall be permitted to provide patient care to save the life of a patient or save a patient from serious harm. Such physicians will be issued special hospital identification to assist hospital and medical staff personnel to readily identify these individuals.

As soon as the immediate emergency situation is under control, the Medical Staff office will conduct verification of credentials and privileges of these practitioners pursuant to the Temporary Privileges policy of the Medical Staff. (See Medical Staff Policy, *Emergency or Disaster Privileges* for further details.)