# CREDENTIALS MANUAL

*Medical Staff*
*Kettering Medical Center*
*Kettering, Ohio*

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# ARTICLE I: APPLICATION POLICY

1.1 As a general policy, this hospital permits application to the medical staff from licensed medical and osteopathic physicians, dentists, podiatrists and psychologists. Medical Staff categories include Active, Courtesy, Affiliate and Honorary. Active and Courtesy categories require a one year provisional period.

Other practitioners (specifically, employees of appointees to the medical staff) will be permitted to apply for specific clinical duties.

Exceptions to this policy may be made only by the Board of Directors.

1.2 It is currently the policy of the -Board of Directors that any physician meeting the basic criteria for the granting of an application may apply for privileges.

1.3 It is the policy of this hospital to process applications for membership appointment to the medical staff to individuals who are able to:

a) Demonstrate that they are a M.D., D.O., D.D.S, D.P.M., Ph.D., or Psy.D.;

b) Demonstrate that they will be accepted for professional liability insurance at the amounts specified by the Board;

c) Demonstrate that they have successfully completed a residency program approved by the ACGME, CPME, or the AOA, if applicable;

d) Possess or be in the process of obtaining a current license to practice their profession in Ohio;

e) Documentation that they have, within the last twenty-four months, been engaged in active clinical practice or demonstrate competency; and,

f) Explain in writing their plans for office location, their plans for utilizing this hospital and the mission, and plans for cross-coverage.

1.4 Decisions regarding appointment or reappointment to the medical staff and initial, renewed, or revised clinical privileges are rendered based on the merits of the applicant's credentials. The burden to provide the information necessary to make reasonable and informed decisions on an application is on the applicant. An application will remain incomplete until the applicant resolves all questions. Any intentional misrepresentation, misstatement or omission from an application shall constitute cause for an immediate cessation of the processing of the application. In the event that an appointment has been granted, prior to the discovery of such intentional misrepresentation or misstatement or omission, such discovery may be deemed to constitute automatic relinquishment of clinical privileges and medical staff appointment. Gender, race, creed, or national origin, are not used in making decisions regarding the granting or denying of medical staff membership or clinical privileges.

# ARTICLE II: APPLICATION

2.1 All requests for applications for appointment to the medical staff will be forwarded to Medical Staff Services. Upon receipt of a request for an application, Medical

Staff Services will provide the potential applicant with an application form if he/she appears to meet the eligibility requirements. For physicians, oral surgeons, and podiatrists graduating from medical school after January 1, 1996, board certification must be obtained within six (6) years after completing their residency program or being appointed to the medical staff of Kettering Medical Center, whichever comes first. Associate Medical Staff applicants are exempted. Only the Board for good reasons shown may make exceptions. The initial applicant must:

2.1-1 Have completed (or be in the last 12 months of) an approved residency program of at least three (3) years duration. Affiliate Medical Staff applicants are exempted.

2.1-2 Have actively practiced at least six of the last twenty-four months (residency or clinical practice) unless otherwise directed by the board. Affiliate Medical Staff applicants are exempted.

2.1-3 Have established or plan to establish an office and residence within one hour driving time of the hospital unless the applicant is joining a group and at least one-half of that group lives within the specified distance or provide other acceptable evidence of patient coverage. Clinical services may require a more stringent time period. Affiliate Medical Staff applicants are exempted.

2.1-4 Possess or be in the process of obtaining a licensed to practice in the State of Ohio; and

2.1-6 Maintain professional liability insurance in amount specified by the Board of Directors.

2.2 In the event the above requirements are not met and cannot be met by the requested date of admission to the medical staff, the potential applicant will be notified by letter and given an opportunity for an informal discussion with the President of the Medical Staff and/or the Hospital President. There is no right to request a hearing in the event an application is not provided.

2.3 The potential applicant will be provided an application packet, which includes the following:

2.3.1 Cover letter explaining the application process and conditions of application

2.3.2 Instructions for completing the application form and a request for all required documents, i.e., copy of license, DEA, malpractice certificate in the amount established by the board, copy of all diplomas and medical training certificates, board certifications and fellowships, ECFMG, and copies/originals of any other documents which may be requested by the medical staff or board.

2.3.3 Application form stamped with date of release.

2.3.4 Authorization for information and release from liability (both general and specific medical liability providers).

2.3.5 Alternate letter form

2.3.6 Medicare/Champus notice to physicians

2.3.7 Emergency Department preference form

2.3.8 Signature card for DEA

2.3.9 Physician Referral form (for Active Staff only)

2.3.10 Medical Staff Bylaws, Organization Manual, and Credentials Manual.

2.3.11 Clinical privilege delineation form(s), along with appropriate definitions and/or qualification criteria

2.3.12 and other promotional information as appropriate

2.4 If possible, the application packet will be hand delivered to the potential applicant by the Medical Staff Services staff member when the potential applicant visits the hospital. Alternately, the packet may be delivered to the potential applicant at his local office by a representative of the hospital if possible, otherwise by first class mail.

## ARTICLE III: INITIAL APPOINTMENT PROCESS

3.0 No Entitlement to Appointment:

No individual shall be entitled to appointment to the medical staff or to the exercise of particular clinical privileges in the hospital merely by virtue of the fact that (a) he/she is licensed to practice any profession in this or any other state, (b) he/she is a member of any particular professional organization, or (c) he/she had in the past, or currently has, medical staff appointment or privileges in this or another hospital.

3.1 Application for staff appointment is to be submitted by the applicant. The application must be typed or printed legibly and on such form as designated by the Credentials Committee and approved by the Board of Directors. Prior to the application being submitted, the applicant will be provided with a copy of the Medical Staff Bylaws, any accompanying manuals, including the Organization Manual and the Credentials Manual.

3.2 The applicant must sign the application for appointment and reappointment and in so doing:

3.2-1 Signifies his/her willingness to appear for interviews in regard to his/her application;

3.2-2 Authorizes hospital representatives to consult with others who have been associated with him/her and/or who have information bearing on his/her competence and qualifications;

3.2-3 Consents to hospital representatives' inspection of all records and documents that may be material to an evaluation of his/her professional qualifications and competence to carry out the clinical privileges(s) he/she requests, of his/her physical and mental health status and of his/her professional and ethical qualifications;

3.2-4 Releases from any civil liability all hospital representatives for their acts

performed in connection with evaluation of him/her or his/her credentials;

3.2-5 Releases from any civil liability all individuals and organizations who provide information, including otherwise privileged or confidential information to hospital representatives concerning his/her competence, professional ethics, character, physical and mental health, emotional stability, and other qualifications for staff appointment and clinical privileges;

3.2-6 Authorizes and consents to hospital representatives providing other hospitals, medical associations, licensing boards, and other organizations concerned with provider 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. For purposes of this provision, the term "hospital representatives" includes the Board of Directors, directors and committees; the Hospital President or his/her designee, registered nurses and other employees of the hospital; the medical staff organization and all medical staff appointees; clinical units and committees which have responsibility for collecting and evaluating the applicant's credentials or acting upon his/her application; and any authorized representative of any of the foregoing.

3.2-7 Signifies that (s)he has read the current Medical Staff Bylaws and associated manuals and agrees to abide by their provisions.

3.2-8 Signifies that (s)he is able to perform all the essential functions required by their privileges without posing a substantial risk of serious harm to him/herself, their patients or others. If continuing to perform the essential function of their privileges does pose a substantial risk of serious harm to him/herself, their patients or others, the privileged provider or member agrees to voluntarily cease these functions and report this change in status to the President of the Medical Staff. Where appropriate, the Credentials Committee may require an impartial physical or mental examination of the applicant at the applicant's expense and shall require that the results be made available for the Credentials Committee's consideration.

3.2-9 Agrees to provide and update, when changes occur, the information requested on the original application and subsequent reapplications or privilege request forms (specifically, hospital appointments, voluntary or involuntary relinquishment of medical staff membership or clinical privileges or licensure status, voluntary or involuntary limitation, reduction or loss of clinical privileges at another hospital, final judgments and/or settlements, or license/DEA restrictions including both current and pending investigations and challenges).

3.2-10 Pledges to provide for continuous care for his/her patients.

## 3.3 PROCEDURE FOR PROCESSING APPLICATIONS FOR STAFF APPOINTMENT

3.3-1 The following documentation is necessary to complete an application. It is

the applicant's responsibility to provide:

A. A legibly complete and signed application form and request for privileges;

B. A copy of current state license and DEA certificate as appropriate; (appointees without DEA certification can not prescribe controlled substances);

C. A copy of current professional liability insurance certificate;

D. Copies of certificates or letters confirming completion of an approved residency/training program or other educational curriculum;

E. Documentation supporting competence in the specific clinical privileges requested. Certificates of clinical skills courses taken and copies of procedure or operative notes may be required;

F. Three letters of recommendation forms must be sent directly to the Medical Staff Services from persons who have recently worked with the applicant and directly observed his/her professional performance over a reasonable period of time and who can and will provide reliable information regarding current clinical ability, ethical character and ability to work with others. References must be from individuals practicing in a field similar to the applicant;

G. Residents applying for clinical privileges must provide written documentation from the program director or designee that he/she approves that the resident be able to work outside the residency program;

H. Payment of the current non-refundable application fee as determined by the Medical Executive Committee.

3.3-2 If the applicant does not submit all information required above within *60* days of mailing of the application, it will be considered void and no further processing will take place.

3.3-3 The applicant's name and specialty will be placed on the medical staff bulletin board in order to permit members of the medical staff to provide additional written information regarding quality or professional concerns about the applicant to the clinical service chief and the President of the Medical Staff. (State and Federal Statutes provides: Protection for those providing information to professional review bodies. Notwithstanding any other provision of law, no person (whether as a witness or otherwise) providing information to a professional review body regarding the competence or professional conduct of a physician shall be held, by reason of having provided such information, to be liable in damages under any law of the United States or any State (or political subdivision thereof) unless such information is false and the person providing it knew that such information was false.)

3.3-4 Upon receipt of the application as defined above, the applicant will be sent a letter of acknowledgment by Medical Staff Services.

3.3-5 Upon receipt of the application, Medical Staff Services will verify its contents and collect additional information as follows:

A. Information from all current and, as needed, from prior insurance carriers concerning claims, suits and settlements (if any) during the past five (5) years;

B. Secure administrative and clinical reference questionnaires as needed from significant past practice settings for the previous five (5) years;

C. Documentation of the applicant's clinical competence during the past twelve (12) months;

D. Verification of medical school graduation and all postgraduate training;

E. Verification of licensure status in all current or past states of licensure (in states where a verification fee is charged, the AMA Physician Masterfile Profile and NPDB query will be used but the option for querying status of state licensure will be retained to do so if necessary);

F. Information from the AMA Physician Masterfile Profile (or its equivalent);

G. Information from the Office of the Inspector General (OIG);

H. Information from the National Practitioners' Data Bank established pursuant to the Healthcare Quality Improvement Act of 1986;

I. Information from CertiFacts for board certification status; and

J. ECFMG, if applicable.

NOTE: In the event there is undue delay in obtaining required information Medical Staff Services will (after consultation with a member of the Credentials Committee) request assistance from the applicant. During this time, the time periods for processing the application will be appropriately modified. Failure of an applicant to provide information to a request for assistance will, after thirty (30) days, result in termination of the application process.

3.3-6 When items 3.3-5 A through J above have been obtained, the file will then be summarized on an administrative review and presented to the appropriate clinical service chief and the Director of the Medical Staff Credentials Program.

3.3-7 The Director of the Medical Staff Credentials Program, member(s) of the Credentials Committee or any member of the Medical Executive Committee may, at their discretion, interview any applicant not currently known to the clinical service chief or a member of the Credentials

Committee, and document the results of the interview on the interview report. The interview may also be used to solicit information required to complete the credentials file or clarify information previously provided, e.g., past malpractice history, reasons for leaving past hospitals, or other matters bearing on the applicant's ability to render care at the generally recognized level for the community. It is the responsibility of the medical staff coordinator to contact the applicant to arrange the clinical interview. (S)He should be notified of the date, time and place of such interview in writing. No applicant will be granted temporary privileges or recommended to the Board of Directors without being known to the clinical service chief or a member of the Credentials Committee or first participating in a personal interview. A copy of any interview results will be placed in the applicant's file.

3.3-8 The chief of the clinical service in which the applicant seeks clinical privileges shall review the entire file and provide the Credentials Committee with written comments and advice for approving or disapproving the application and for delineating the applicant's clinical privileges. This opinion shall be made a part of the Credentials Committee's report. As part of the process of making this opinion, the clinical service chief has the right to meet with the applicant to discuss any aspect of his/her application, his/her qualifications and his/her requested clinical privileges. He/she will solicit review by another committee, if such an appropriate committee has been established, or may solicit input from individual members of his/her service with special skills relevant to the applicant's clinical procedures application. This report will be added to the applicant's credentials file.

3.3-9 The completed applicant's file will be reviewed by the Credentials Committee as soon as possible but no later than its next regularly scheduled meeting.

3.3-10 The signature of the Director of the Medical Staff Credentials Program on the applicable report will indicate the findings and recommendations of the Credentials Committee.

3.3-11 The Director of the Medical Staff Credentials Program will present to the Medical Executive Committee and the President of the Medical Staff will present to the Board a summary of the applicant's file, the Medical Executive Committee and Credentials Committee's findings and recommendations at the Board's next regularly scheduled meeting. If any recommendation is adverse as defined in the fair hearing plan, the provisions of the fair hearing plan will become effective.

3.3-12 The new appointee will be notified in writing by the Hospital President or designee of the action of the Board of Directors. The signature of the Hospital President will indicate approval by the Board of Directors provisionally appointing the applicant with specified privileges to the indicated category of the medical staff. Any pertinent information regarding appointment to the medical staff will be forwarded or made available to the appointee at this time.

3.3-13 The new appointee with clinical privileges who is approved by the Board of Directors, will be provided a hospital/medical staff orientation, if (s)he so desires.

## 3.4 EFFECT OF CLINICAL SERVICE CHIEF REPORT

3.4-1 Deferral: Service chiefs may not defer consideration of an application. A report must be forwarded to the Credentials Committee. In the event a chief is unable to formulate a report for any reason, the chief must so inform the Credentials Committee.

3.4-2 Favorable Findings: Service chiefs must document their findings pertaining to adequacy of education, training and experience for all privileges requested. Reference to any criteria for privileges review must be documented. Specific reference to the credentials file should be made in support of all findings.

3.4-3 Unfavorable Findings: Service chiefs must document the rationale for all unfavorable findings. Reference to any criteria for clinical privileges that is not met should be documented.

## 3.5 EFFECT OF CREDENTIALS COMMITTEE ACTION

3.5-1 Deferral: Action by the Credentials Committee to defer the application for further consideration must be followed at the next Credentials Committee meeting by subsequent recommendations as to approval or denial of, or any special limitations to, staff appointment, category of staff and prerogatives, clinical service affiliations, and scope of clinical privileges.

3.5-2 Favorable Recommendation: When the Credentials Committee's recommendation is favorable to the applicant in all respects, the Hospital President or designee shall promptly forward it, together with all supporting documentation, to the Medical Executive Committee who will make a final recommendation to the Board of Directors. All supporting documentation means the application form and its accompanying information, the reports and recommendations of the clinical service chief, Credentials Committee, comment by the Medical Executive Committee (if any) and all dissenting views.

3.5-3 Adverse Recommendation: When the Credentials Committee's adverse recommendation to the Medical Executive Committee is adopted by the Medical Executive Committee, the applicant will be entitled to the procedural rights as provided in the fair hearing plan as set forth in the bylaws. An adverse recommendation by the Credentials Committee, approved by the Medical Executive Committee, is defined as a recommendation to deny appointment, or to deny or restrict requested clinical privileges.

## 3.6 BOARD OF DIRECTORS ACTION

3.6-1 On a Favorable Recommendation: The Board of Directors may adopt or reject in whole or in part a favorable recommendation of the Medical Executive Committee or refer the recommendation back to the Medical

Executive Committee for further consideration stating the reasons for such referral back and setting a time limit within which a subsequent recommendation must be made.

Favorable action by the Board of Directors is effective as its final decision on adverse recommendations. If, after complying with the requirements, the Board of Directors' action is adverse to the applicant, a special notice will be sent to him and he shall then be entitled to the procedural rights provided in the fair hearing plan.

3.6-2 After Procedural Rights: In the case of an adverse Credentials Committee recommendation, the Board of Directors shall take final action in the matter as provided in the fair hearing plan.

3.6-3 Adverse Board of Directors Action Defined: Adverse action by the Board of Directors means action to deny appointment or to deny or restrict requested clinical privileges.

3.7 BASIS FOR RECOMMENDATIONS AND ACTION: The report of each individual or group, including the Board of Directors, required to act on an application must state the reasons for each recommendation or action taken, with specific reference to the completed application and all other documentation considered. Any dissenting views at any point in the process must also be documented, supported by reasons and references, and transmitted with the majority report.

3.8 CONFLICT RESOLUTION: Whenever the Board of Directors determines that it will decide a matter contrary to the Medical Executive Committee recommendations, the matter will be submitted to the Professional Practice Committee for review and recommendation before the Board of Directors makes its final decision.

3.9 NOTICE OF FINAL DECISION

3.9-1 Notice of the Board of Directors' final decision shall be given through the Hospital President to the Medical Executive Committee and to the chief of each clinical service concerned. The applicant shall receive written notice of appointment and special notice of any adverse final decision. The President of the Medical Staff shall report Board actions back to the Medical Staff.

3.9-2 A decision and notice of appointment includes:

A. the staff category to which the applicant is appointed;

B. the clinical service to which (s)he is assigned;

C. the clinical privileges (s)he may exercise; and

D. any special conditions attached to the appointment.

3.9-3 TIME PERIODS FOR PROCESSING: All individuals and groups required to act on an application for staff appointment must do so in a timely and good faith manner and, except for good cause, each application should be processed within 120 days from receipt of a completed application with all requested documentation (3.3-1).

This time period is deemed a guideline and does not create any right to have an application processed within this precise period. If the provisions of the fair hearing plan are activated, the time requirements provided therein govern the continued processing of the application.

## ARTICLE IV: PROVISIONAL STATUS

4.1 PROVISIONAL PERIOD: All initial appointments and clinical privileges as well as any new clinical privileges granted to an existing medical staff appointee are provisional for a period of twelve months (12) during which time all individuals with provisional privileges may be subject to review of their clinical performance by the chief(s). Clinical service chiefs will conduct their reviews in accordance with procedures adopted by the Credentials Committee.

4.2 ACTION REQUIRED: The Credentials Committee considers the requests and statement(s) furnished to it and defers action for not more than thirty (30) days or prepares a written report with recommendations and supporting documentation for transmittal to the Board of Directors. For the purposes of this provision, an adverse recommendation from the Medical Executive Committee, which is adopted by the Medical Executive Committee or an adverse action by the Board of Directors as referred to in the appointment process means a recommendation or action to change, without the staff appointee's consent, his/her clinical service assignment; to reduce staff category without her/his consent; to deny or restrict requested clinical privileges. The "applicant" and "appointments" as used in these Sections shall be read, respectively, as "staff appointee" and "conclusion of the provisional status".

4.3 ADVERSE CONCLUSIONS - PROCEDURAL RIGHTS: Whenever a provisional period (including any period of extension) expires with an adverse recommendation for the practitioner or whenever extension is denied, the President of the Medical Staff will provide him/her with special notice of the adverse result and of his/her entitlement to procedural rights provided in the fair hearing plan.

## ARTICLE V: REAPPOINTMENT

ALL APPOINTMENTS (EXCEPT PROVISIONAL) ARE FOR A PERIOD NOT TO EXCEED TWO YEARS.

5.1 INFORMATION COLLECTION AND VERIFICATION

5.1-1 FROM STAFF APPOINTEES: On or before three months prior to the date of expiration of a medical staff appointment, the Medical Staff Services notifies the appointee of the date of expiration. At least sixty (60) days prior to this date, the appointee furnishes, in writing:

A. Complete information to update her/his file on items listed in his/her original application (See Section 3.2-8);

B. Continuing training and education during the preceding period;

C. Specific request for the clinical privileges sought on

reappointment, with any basis for changes;

D. Requests for changes in staff category or clinical service assignments;

E. Any changes, including but not limited to any change in professional liability coverage, the filing of a lawsuit against the practitioner and any changes in medical staff status at any other hospital;

F. Copy of board certifications if not already on file;

G. Copies of certificates regarding the following as appropriate: specialty society fellowships, honors or recognitions received since the last appointment;

H. The applicant for reappointment of clinical privileges is required to submit any reasonable evidence of current ability to perform privileges that may be requested;

I. Other documentation that may be required by other federal, state, or local government agencies;

J. Payment of a current non-refundable reappointment fee as determined by Medical Executive Committee.

Failure, without good cause, to provide this information is deemed a voluntary resignation from the staff and automatically results in expiration of appointment.

5.1-2 FROM INTERNAL AND/OR EXTERNAL SOURCES: Medical Staff Services collects from each staff appointee's credentials file and other relevant sources information regarding the individual's professional and collegial activities, performance and conduct in this hospital and/or other hospitals. Such information includes, without limitation:

A. level of patient care activity;

B. patterns of care as demonstrated in findings of performance improvement activities;

C. medical records/hospital reports;

D. Professional peer references as requested;

E. National Practitioner Data Bank inquiry;

F. Office of Inspector General inquiry;

G. CertiFacts inquiry;

H. continuing medical education (applicants must certify that they have completed the minimum specified hours of CME required for maintaining Ohio licensure. Verification may be requested);

I. service on appointed medical staff committees;

J. timely and accurate completion of medical records;

K. compliance with all applicable bylaws, policies, rules, regulations and procedures of the hospital and staff.

5.1-3 All returned documents shall be reviewed and verified as described in the APPOINTMENT PROCESS.

5.1-4 The manager, medical staff services or appropriate administrative representative will compile a summary of clinical activity for each appointee due for reappointment.

## 5.2 PROCEDURE FOR PROCESSING APPLICATIONS FOR STAFF REAPPOINTMENT

5.2-1 The manager, medical staff services or appropriate administrative representative shall review all pertinent medical staff committee minutes and available data and prepares a summary of findings for each appointee due for reappointment.

5.2-2 The completed file including all documentation mentioned above shall be sent to the chief of the clinical service for his/her review.

5.2-3 CLINICAL SERVICE ACTION: Each chief of a clinical service in which the staff appointee requests or has exercised privileges reviews the appointee's file as described above and forwards to the credentials committee a written report of the staff appointee's performance, including a statement as to whether or not (s)he knows of, or has observed or been informed of any conduct which indicates significant present or potential physical or behavioral problems affecting the practitioner's ability to perform professional and medical staff duties appropriately and with recommendations for reappointment, non-reappointment and for staff category, clinical service assignment and clinical privileges.

5.2-4 CREDENTIALS COMMITTEE ACTION: The Credentials Committee reviews the appointee's file, the clinical service reports and all relevant information available to it and forwards to the Medical Executive Committee and the Board of Directors a written report with recommendations for reappointment, or non-reappointment and for staff category, clinical service assignment and clinical privileges.

If the Medical Executive Committee's recommendation is deemed adverse under the terms of the fair hearing plan, the provisions of the fair hearing plan will become effective.

5.2-5 FINAL PROCESSING AND BOARD OF DIRECTORS ACTION: Final processing of requests for reappointment follows the procedure set forth earlier for initial appointment. For the purposes of reappointment an adverse action by the Board of Directors as used in these provisions means an action to deny reappointment, to deny a requested change in, or to change without the staff appointee's consent, his/her staff category or clinical service assignment; or to deny or restrict requested clinical privileges. The terms "applicant" and "appointment" as used in these Sections shall be read respectively, as "staff appointee" and

"reappointment."

5.2-6 REQUEST FOR MODIFICATION OF APPOINTMENT STATUS OR PRIVILEGES: A staff appointee, either in connection with reappointment or at any other time, may request modification of his/her staff category, clinical service assignment, or clinical privileges by submitting a written application to the Credentials Committee on the prescribed form. A modified application is processed in the same manner as a reappointment. All requests for increased privileges must be accompanied by information demonstrating current clinical competence in the specific privilege requested.

# ARTICLE VI: CLINICAL PRIVILEGES

6.1 EXERCISE OF PRIVILEGES: A practitioner providing clinical services at the hospital may exercise only those privileges granted to him/her by the Board of Directors or emergency privileges as described herein.

6.2 PRIVILEGES IN GENERAL: All individuals who are permitted by law and by the hospital to provide patient care services independently in the hospital have delineated clinical privileges, whether or not they are medical staff members.

6.2-1 REQUESTS: Each application for appointment or reappointment to the medical staff must contain a request for specific clinical privileges or class of privileges, defined by the clinical service and approved by the Medical Executive Committee, desired by the applicant. Specific requests must also be submitted for temporary privileges and for modification of privileges in the interim between reappraisals Granting of new temporary privileges to modify existing privileges will only be done under special circumstances.

6.2-2 BASIS FOR PRIVILEGES DETERMINATION: Requests for clinical privileges will be considered only when accompanied by evidence of education, training, experience and demonstrated competence as specified by the hospital. In the event a request is submitted for which no criteria have been created the request will be deferred until the Credentials Committee formulates the necessary criteria and the Credentials Committee, Medical Executive Committee and the Board through the Professional Practice Committee approve the criteria. The Credentials Committee will reference national guidelines and solicit input from the appropriate clinical service chief or committee.

Valid requests for clinical privileges will be evaluated on the basis of education, training, experience, demonstrated competence, ability and judgment. The basis for privileges determination to be made in connection with periodic reappointment or a requested change in privileges must include observed clinical performance with the individual's documented experience in categories of treatment or procedures, the results of treatment, and documented results and conclusions drawn from the staff's performance improvement program activities when available. Privileges determinations will also be based on pertinent information from other sources, especially other institutions and health care settings where

a professional exercises clinical privileges When privilege delineation is based primarily on experience, the individual's credentials record reflects the specific experience and successful results that form the basis for the granting of privileges. The information will be added to and maintained in the medical staff file established for the staff appointee.

6.2-3 The procedure by which requests for clinical privileges are processed and the specific qualifications for the exercise of privileges are found elsewhere in this Manual.

6.3 PROCTORING OF NEW CLINICAL PRIVILEGES: All newly granted clinical privileges may be subject to clinical proctoring for a specific period of time and/or number of cases. The Medical Executive Committee in concert with the clinical service chief and/or the Credentials Committee shall establish the need for proctoring and an individual plan for implementation of the proctoring detailing the proctor assigned, procedures to be proctored, number of procedures to be proctored, time period for proctoring, mechanism of proctoring, reporting of findings and expectations required to satisfy the proctoring requirements and to exercise the clinical privileges without direct proctoring observation.

6.4 SUPERVISION OF CLINICAL PRIVILEGES: The Medical Executive Committee as a function of peer review, usually subsequent to an adverse event(s), may impose required supervision such as mandatory concurring consultation, oversight or close monitoring of a physician who has privileges and whose clinical competence, cognitive skills, procedural skills, and/or outcomes have been questioned. The Medical Executive Committee in concert with the clinical service chief and/or the Credentials Committee shall establish the need for supervision and an individual plan for implementation of the supervision, detailing the supervisor assigned, procedures to be supervised, number of procedures to be supervised, time period for supervision, mechanism of supervision, reporting of findings and expectations required to satisfy the supervision requirements and to exercise the clinical privileges without supervised observation.

6.5 SPECIAL CONDITIONS FOR DENTAL PRIVILEGES: Requests for clinical privileges for dentists and reappointment are processed in the manner similar to other practitioners. Surgical procedures performed by dentists will be under the overall supervision of the chief of the surgery clinical service. All dental patients will receive a basic medical appraisal by a physician member of the medical staff. A physician member of the medical staff will also be responsible for the care of any medical condition that may be present on admission or that may arise during hospitalizations. This physician will have the responsibility for the overall medical care of the patient and any surgical procedure performed must be with his/her knowledge and concurrence. "Dental" as used herein does not necessarily include oral surgeons.

6.6 SPECIAL CONDITIONS FOR ALLIED HEALTH PROFESSIONALS:

Requests to perform specified patient care services from allied health professionals are processed in the manner specified herein. An allied health professional may, subject to any licensure requirements or other limitations, exercise independent judgment only within the areas of his/her professional competence and participate directly in the medical management of patients

under the supervision of a physician who has been accorded privileges to provide such care.

## 6.7 TEMPORARY PRIVILEGES

6.7-1 CONDITIONS: Temporary privileges may be granted only in the circumstances described below, only when verified information reasonably supports a favorable determination regarding the requesting practitioner's qualifications, ability and judgment to exercise the privileges requested, and only after the practitioner has satisfied the professional liability insurance requirement of the governing board. Temporary privileges may be granted only for specific patient care needs, documented by a letter to the President of the Medical Staff, from the applicant and/or clinical service chief. Special requirements of mandatory consultation, proctoring, and reporting may be imposed by the clinical service chief responsible for supervision. Except in unusual circumstances, temporary privileges will not be granted unless the practitioner has agreed in writing to abide by the bylaws, rules and regulations and policies of the medical staff and the hospital in all matters relating to his/her temporary privileges.

6.7-2 CIRCUMSTANCES: Upon written concurrence of the chief of the clinical service where the privileges will be exercised, the President of the Medical Staff and the Hospital President, except for emergency temporary privileges such as needed for organ donation surgical recovery teams which can be granted by the administrator on-call in concurrence with an officer of the medical staff, may grant temporary privileges in the following circumstances:

A. Pendency of Application: After receipt and verification of a completed application for staff appointment, including a request for specific temporary privileges for documented specific patient care needs, for an initial period of not more than one hundred twenty (120) days;

B. Pendency of Additional Privileges: Members of the medical staff requesting additional or new clinical privileges for documented specific patient care needs, after receipt and verification of any required supporting documentation may be granted temporary privileges for an initial period of not more than one hundred twenty (120) days;

C. Care of Specific Patients: Upon receipt of a request for specific patient care needs, documented by a letter to the President of the Medical Staff, from the applicant and/or a current medical staff member in good standing, who agrees to supervise the care provided by the temporary privileged practitioner, for specific temporary privileges for the care of one or more specific patients from a practitioner who is not an applicant for staff appointment. Such privileges shall be granted no more than three times in any twelve (12) month period;

D. Locum Tenens: Upon receipt of a written request for specific

temporary privileges, an appropriately licensed practitioner of documented competence who wishes to serve as locum tenens for a member of the medical staff may be granted temporary privileges for documented specific patient care needs, for a period not to exceed thirty days. The applicant must be approved by the clinical service chief, chair of credentials committee, president of the medical staff, and the hospital president (or their designees). Locum tenens practitioners will be assigned to provisional courtesy category on the medical staff. Locum tenens privileges may be renewed for two thirty day periods during a 12 month period. These privileges are limited to evaluation and treatment of the *primary or referred* patients of the staff appointee for whom this practitioner is serving as locum tenens and do not entitle him/her to admit her/his own patients to the hospital. Service on the emergency room specialty coverage program may be required. Once the medical staff member no longer requires the services of the locum tenens practitioner or the 12 month period expires (whichever comes sooner), the locum tenens practitioner will automatically lose membership and clinical privileges on the medical staff and be considered a voluntary resignation from the medical staff.

E. DISASTER PRIVILEGES: Disaster privileges may be granted when the emergency management plan has been activated. Disaster privileges may be granted, on a case-by-case basis and, by the hospital president or medical staff president [or their designee(s)], when the organization is unable to handle the immediate patient needs. The emergency management plan, describes a mechanism to manage individuals who receive disaster privileges and to allow staff to readily identify these individuals.

Disaster privileges will end when the emergency management plan is de-activated unless continuation of such privileges is requested for care of specific patient(s). Continuation of disaster privileges will be granted by the same or similar means as the initial disaster privileges.

Disaster privileges may be granted upon presentation of any of the following: 1) a current picture hospital ID card identifying the individual's credentials, 2) a current license to practice and a valid picture ID issued by a state, federal or regulatory agency, 3) identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT), 4) identification indicating that the individual has been granted authority to render patient care in disaster circumstances (such authority having been granted by a federal, state or municipal entity), or 5) presentation by current hospital or medical staff member(s) with personal knowledge regarding practitioner's identity.

Medical Staff Services begins the verification process of the

credentialing and privileging the individuals who receive disaster privileges as soon as the immediate situation is under control. This verification process will be identical to the process established for granting temporary privileges to meet an important patient care need.

F. EMERGENCY PRIVILEGES: In case of an emergency any medical staff member is authorized to do everything possible to save a patient's life or to save a patient from serious harm, to the degree permitted by the appointee's license, but regardless of clinical service affiliation, staff category, or level of privileges. A practitioner exercising emergency privileges is obligated to summon all consultative assistance deemed necessary and to arrange appropriate follow-up.

6.7-3 TERMINATION OF TEMPORARY PRIVILEGES: The President of the Medical Staff or the Hospital President, only after consultation with the appropriate clinical service chief, (or his/her designee) must on the discovery of any information or the occurrence of any event of a nature which raises questions about a practitioner's professional qualifications or ability to exercise any or all of the temporary privileges granted, terminate those privileges or and may at any other time terminate any or all of a practitioner's temporary privileges, provided that where the life or well being of a patient is determined to be endangered, the termination may be effected by any person entitled to impose summary suspension under the Medical Staff Bylaws. In the event of any such termination, the chief responsible for supervision will assign the practitioner's patients then in the hospital to another practitioner. The wishes of the patient shall be considered, when feasible, in choosing a substitute practitioner. Temporary privileges shall be automatically terminated at such time as the Credentials Committee recommends unfavorably with respect to the applicant's appointment to the medical staff or at the Credentials Committee's discretion shall be modified to conform to the recommendation of the Credentials Committee that the applicant be granted different permanent privileges from the temporary privileges.

6.7-4 RIGHTS OF THE PRACTITIONER WITH TEMPORARY PRIVILEGES: A practitioner is not entitled to the procedural rights afforded by the fair hearing plan because his/her request for temporary privileges is refused or because all or any part of his/her temporary privileges are terminated or suspended.

# ARTICLE VII: EXPEDITED CREDENTIALING AND PRIVILEGING PROCESS

7.1 CONDITIONS: An expedited process is available for initial appointments to membership and granting of clinical privileges, reappointment to membership, or renewal or modification of privileges when criteria for that process are met.

7.1.1 Expedited Credentialing and privileging process may be used only when an application is completed and all the necessary verified information is available and the verified information supports a favorable determination regarding the requesting practitioner's qualification, ability and judgment to exercise the rights of membership and privileges requested. Request for an expedited credentialing privileging process must be documented by an applicant's letter to the President of the medical Staff, as well as the non- refundable additional processing fee.

7.1.2 The following situations are evaluated on a case-by-case basis and may result in ineligibility for the expedited process:

A. There is a current challenge or a previously successful challenge to licensure or registration.

B. The applicant has received an involuntary termination of medical staff membership at another organization.

C. The applicant has received involuntary limitation, reduction, denial, or loss of clinical privileges.

D. The hospital determines that there has been either an unusual pattern of, or an excessive number of professional liability actions resulting in a final judgment against the applicant.

7.1.3 By delegated authority of the hospital Board of Directors and upon written concurrence of the chief of the clinical service where the privileges will be exercised, the Director of the Medical Staff Credentialing Program, the President of the Medical Staff, the Hospital President, and an additional member of the Board of Directors may grant expedited initial appointment to membership and clinical privileges, reappointment to membership, or renewal or modification of privileges through the expedited credentialing and privileging process.

7.1.4 Applicants that have been granted initial appointment to membership and clinical privileges, reappointment to membership, or renewal or modification of privileges through the expedited credentialing and privileging process will be presented to next meetings of the Medical Executive Committee and Board of Directors for information.

## ARTICLE VIII: LEAVE OF ABSENCE

A. Individuals appointed to the Medical Staff may, for good cause, be granted leave of absence by the Board of Directors for a definitely stated period of time not to exceed one (1) year. Absence for longer than one (1) year shall constitute voluntary resignation of medical staff appointment and clinical privileges unless the Board of Directors upon recommendation of the Medical Executive Committee makes an exception. During the period of time of the leave, the staff appointee's clinical privileges, prerogatives and responsibility are suspended.

B. Requests for leaves of absence shall be made to the VP of Medical Affairs, President of the Medical Staff, or chief of the clinical service in which the

individual applying for leave holds clinical privileges, and shall state the beginning and ending dates of the requested leave. The clinical service chief shall transmit the request together with a recommendation to the President of the Medical Staff. The President of the Medical Staff shall forward the request and all recommendations pertaining to said request to the Hospital President for action by the Board of Directors. The Credentials and Medical Executive Committees will be notified of all such requests.

C. Prior to the conclusion of the leave of absence, the individual must submit a formal request for return to the VP of Medical Affairs or the President of the Medical Staff summarizing the professional activities undertaken during the leave of absence. This request must be initiated with sufficient advance notice (usually at least one month) to allow for a reinstatement interview and the processing of the request by the credentials committee, medical executive committee and the board of directors. The individual shall also provide such other information as may be requested by the hospital at that time.

D. If the leave of absence was for medical reasons, the appointee must submit a report from his/her attending physician indicating that the appointee is physically and/or mentally capable of resuming a hospital practice and exercising the clinical privileges requested. The appointee shall also provide such other information as may be requested by the hospital at that time. All information shall then be forwarded to the Credentials Committee. After considering all relevant information, the Credentials Committee shall then make a recommendation regarding reinstatement to the Medical Executive Committee, which shall, thereafter, make a recommendation to the Board of Directors for final action.

E. In acting upon the request for reinstatement, the Board may approve reinstatement either to the same or a different staff category, and/or may limit or modify the clinical privileges to be extended to the individual upon reinstatement.

# ARTICLE IX: PRACTITIONER PROVIDING CONTRACTUAL SERVICES

9.1 EXCLUSIVITY POLICY: Whenever hospital policy specifies that certain hospital facilities or services may be used on an exclusive basis in accordance with contracts or letters of agreement between the hospital and qualified practitioners, then other staff appointees must, except in an emergency or life threatening situation, adhere to this exclusivity policy in arranging care for their patients. Application for initial appointment or for clinical privileges related to hospital facilities or services covered by exclusivity agreements will not be accepted or processed unless submitted in accordance with the existing contract or agreement with the hospital.

9.2 QUALIFICATIONS: A practitioner who is or will be providing specified professional services pursuant to a contract or a letter of agreement with the hospital must meet the same qualifications, must be processed in the same manner, and must fulfill all the obligations of his/her appointment category as any other applicant or staff appointee.

9.3 EFFECT OF STAFF APPOINTMENT TERMINATION: Because practice at the

hospital is always contingent upon continued staff appointment and is also constrained by the extent of clinical privileges enjoyed, a practitioner's right to use hospital facilities is automatically terminated when his/her staff appointment expires or is terminated. Similarly, the extent of his/her clinical privileges is automatically limited to the extent the pertinent clinical privileges are diminished.

9.4 EFFECT OF CONTRACT EXPIRATION OR TERMINATION: The effect of expiration or other termination of a contract upon a practitioner's staff appointment and clinical privileges will be governed solely by the terms of the practitioner's contract with the hospital. If the contract or the contract is silent on the matter, then contract expiration or other termination alone will not affect the practitioner's staff appointment status or clinical privileges.

# ARTICLE X: ALLIED HEALTH PROFESSIONALS

Effective June 1, 1998, all new Allied Health Professional applicants must be board certified or equivalent, if available, in their credentialing organization or if a recent graduate, must obtain board certification or equivalent, if available, in their credentialing organization within three (3) years after graduation from their training program. Such board certification or equivalent must be maintained at all times.

**10.1 General Scope and Authority of Article:**

This Allied Health Professionals Article X ("Article") addresses those Allied Health Professionals who are permitted to provide services at Kettering Medical Center ("KMC or "Hospital"). This Article sets forth the credentialing process and the general practice parameters for these individuals, as well as guidelines for determining the need for additional categories of Allied Health Professionals at KMC. Except as otherwise provided for herein, all policies and procedures affecting Allied Health Professionals, as they are defined in this Article, shall be established, maintained and enforced by the Medical Staff and the President of KMC who acts on behalf of the Hospital's Board of Directors.

Allied Health Professionals ("AHPs") are individuals privileged through the Medical Staff as authorized by the KMC Board of Directors (excluding medical students and KMC employees) who hold a valid license, certificate, or other legal credential as required by Ohio law that authorizes the provision of clinical services to patients, while working either independently or dependently under the direct or indirect supervision and/or collaboration of a credentialed member of the Medical Staff as is required for such professional by Ohio statute and Medical Staff policy, or such individual functions in a medical support role and under the supervision of such Medical Staff member in accordance with Medical Staff policy.

The term "supervision" has the meaning ascribed to it by applicable Ohio law in connection with an AHP's licensure as well as the undertakings of the supervising professional outlined in the Supervising Medical Staff Member Agreement, attached to the Credentials Manual as Appendix E. A physician shall supervise an unlicensed person only in the performance of delegated medical tasks that are within the authority of that physician and are within the physician's

training, expertise, or normal course of practice and hospital credentials. The supervisory physician retains responsibility for the manner in which the supervised AHP performs assigned duties while at the hospital.

AHP credentialing requirements under this Article adhere to the supervisory and collaborative standards of the Ohio Revised Code and Ohio Administrative Code that set forth specific requirements regarding supervision by, and collaboration with, a professional that is applicable to each category of licensed AHPs. The Hospital and its Medical Staff reserve the right to impose more stringent requirements regarding supervision and a more limited scope of practice for AHPs while practicing at the Hospital than is mandated by Ohio law with such being set forth at Exhibit D.

AHPs are not eligible for membership on the Medical Staff and shall not be entitled to any of the rights or privileges of appointment to the Medical Staff, and are not entitled vote on Medical Staff matters at any level. The granting of Allied Health Professional Staff membership and approval of practice duties shall not in and of itself carry the ability to use any particular Hospital facilities or equipment. No member of the Allied Health Professional Staff shall have admitting Privileges.

Nothing in this Policy prohibits KMC from hiring an Allied Health Professional as an employee and negotiating Supervision Agreements and/or Standard Care Arrangements as required by Ohio law and Medical Staff policy on behalf of the employee. A Supervising Medical Staff Member Agreement, including any required Standard Care Arrangement, between KMC's employee and the employee's supervising Medical Staff member is subject to approval by the Medical Staff and Board of Directors, or designee, prior to implementation of the agreement/arrangement at the Hospital. Grievance rights for AHPs who are Hospital employees are governed by the Hospital's Human Resources practices and policies as further described Section 10.8 hereunder.

Notwithstanding anything to the contrary contained in this Article, the Hospital is under no obligation to accept or favorably act upon a proposal or an application provided under the terms and conditions of this Article. The Hospital is not required to accept an application if it does not have, in its sole opinion, the financial resources, physical space, community need, or actual clinical need for that particular license or certification, or any other consideration that the Hospital, in its sole discretion, may factor into its decision.

### 10.2 Categories of Allied Health Professionals:

Only those specific categories of Allied Health Professionals that have been approved by the KMC Board shall be permitted to practice at KMC. All such categories shall be classified as either "Licensed Independent AHPs" or "Dependent AHPs," each having a different relationship with KMC. A statement of qualifications for every approved category of AHPs shall include: (1) the licensure and/or certificate or other credential as may be required by Ohio law

and Hospital policy; and (2) the required minimum of education and/or training. A written delineation of services/privileges for each category of AHPs shall include: (1) description of the services to be provided; (2) responsibility for documenting the services provided in the medical record, if applicable; and (3) the degree of supervision required. If the category of AHP requires supervision by a member of the Medical Staff for some or all of the services provided, a "Supervising Medical Staff Member Agreement" will be required and any requisite Standard Care Arrangement, as well as a written scope of practice applicable to the AHP's practice at KMC.

A current listing of the specific categories of AHPs functioning at KMC as Licensed Independent and Dependent AHPs is attached to this Credentialing Manual as Appendix D, and such Appendix may be modified or supplemented by action of the KMC Board after receiving the recommendations of the Credentials and Medical Executive Committees, without the necessity of further amendment of this Article.

**10.2-1 Licensed Independent Allied Health Professionals**

A "Licensed Independent AHP Practitioner" in addition is an individual who is permitted by law and by the Hospital to provide certain patient care services in collaboration with a member of the Hospital's medical staff (active or courtesy as determined by the Hospital) within the scope of such AHP's license and in accordance with the Hospital's individually granted privileges. Licensed Independent AHPs are not eligible for Medical Staff. Licensed Independent AHPs who are employees of KMC shall not be governed by this Article, except as expressly indicated in this Article.

**10.2-2 Dependent Allied Health Professionals**

A "Dependent AHP Practitioner" is an individual who is permitted by law and the Hospital to provide certain patient care services under the direction and supervision of an independent practitioner within the scope of the individual's license and in accordance with Hospital's individually approved scope of practice. Dependent AHPs are not eligible for Medical Staff membership and perform specified services to patients at KMC only under the responsibility and supervision of a Medical Staff member. In the absence of a more restrictive Hospital policy, the scope of practice of such AHP shall at all times adhere to the permissible scope of practice permitted by Ohio law. The supervising Medical Staff member is responsible for the actions of the Dependent Practitioner, unless otherwise stated herein, as further set forth in the Supervising Medical Staff Member Agreement at Appendix E of the Credentials Manual. Dependent AHPs who are employees of KMC shall not be governed by this Article, except as expressly indicated in this Article.

## 10.3 GUIDELINES FOR DETERMINING THE NEED FOR NEW CATEGORIES OF ALLIED HEALTH PROFESSIONALS

### 10.3.1 New Categories and Determination of Need:

Upon approval of the Board of Directors, the Medical Executive or Credentials Committees, in concurrence one with the other, may independently create new AHP categories following the criteria set forth in this Section 10.3 of Article X.

A. A supervising physician or licensed independent AHP practitioner who wishes to apply to a category which is not identified as being approved by the Board of Directors must submit a written request to the Medical Staff Office, requesting authorization to provide services at the hospital as an AHP and include with that request a written proposal stating:

1. Category. The category of AHP into which the individual is classified;

2. Licensure. The licensure or certificate status or other qualifications of the AHP to provide services;

3. Liability Insurance. The availability of professional liability insurance for this AHP category;

4. Scope of Practice. The proposed scope of practice;

5. Supervision. The level of supervision, if any, that will be provided, as well as the name of the appointed and credentialed member(s) of the Medical Staff who will provide supervision or act as the collaborating physician;

6. Reimbursement Status. The reimbursement status and method for the proposed AHP category;

7. Patient/Staff Relationship. The manner in which the individual proposes to relate to the patients and members of the Medical Staff within the Hospital as an AHP; and

8. Evaluation. The manner in which the individual proposes to be evaluated as an AHP.

B. Upon receipt of such request for new category, the Medical Staff Office will gather information as deemed necessary or appropriate which may include, but not be limited to: information from the appropriate specialty group or trade association; information from the supervising or collaborating member of the Medical Staff, and information from other hospitals, health care facilities, consultants and other appropriate sources. The Medical Staff Office will use

the individual's proposal, the above-listed gathered information and, with the assistance and input of the applicable Clinical Service Chief, will prepare the following:

(a) Statement of Qualifications. A Statement of Qualifications shall include a requirement that the AHP hold a current license or certificate and such other credential in good standing or list training and experience as may be required by Ohio law and Medical Staff credentialing requirements; the minimum level of education or training the AHP must have; and professional liability insurance requirements with the minimum limits.

(b) Delineation of Services/Privileges. A written delineation of services/privileges that may be provided by the category of AHP requested shall be developed and shall include the specification of the categories of patients to whom services may be provided; a description of the services to be provided; responsibility of the AHP for documenting the services provided in the medical record; a service designation; and the degree of supervision required for each specific service.

(c) Supervising Staff Member Agreement (with Standard Care Arrangement as applicable). If the category of AHP requires supervision by a member of the Medical Staff for some or all of the services to be provided, a "Supervising Medical Staff Member Agreement (with Standard Care Arrangement as applicable) shall be finalized which adheres substantially to the form agreement attached at Appendix E and otherwise the Standard Care Arrangement shall be provided.

C. The individual's proposal, along with the materials prepared by the Medical Staff Office shall be forwarded to the Credentials Committee, (Nursing Credentials Committee if applicable), and Clinical Service Chief for review and recommendation. The Credentials Committee recommendation shall be forwarded to the Medical Executive Committee for review with recommendations to the Professional Practice Committee of the Hospital's Board of Directors. Action by the Board of Directors, or its designee, shall be taken and shall be final and non-appealable.

D. When the Medical Executive Committee and the Board of Directors are requested to determine or approve whether a new category of AHP's is needed by the Hospital, the following factors should be considered:

(a) the nature of the services that could be offered;

(b) any Ohio state license or regulation that outlines the scope of practice or authorized clinical privileges for the Allied Health Professional;

(c) the patient care needs and strategic business objectives of KMC;

(d) how well the community's needs are currently being met and whether they could be better met if the services offered by the Allied Health Professional were provided by KMC;

(e) the clinical needs of the Hospital based on the type of training that is necessary to perform the services that could be offered and whether there are a sufficient number of individuals with other training currently providing those services;

(f) the availability of physical space, financial resources, support staff, supplies, equipment, and other necessary resources, as applicable;

(g) the availability of trained staff;

(h) patient convenience; and

(i) the ability for performance to be appropriately supervised, as applicable.

**10.3.2 Development of Category Requirements**:

The following responsibilities will be delegated to the Credentials Committee: (1) any specific qualifications and/or training that the AHP must possess beyond those set forth in this Article; (2) a detailed description of the authorized clinical practice privileges and scope of service; (3) any specific conditions that apply to the AHP's functioning within KMC; and (4) supervision requirements, or collaboration, as applicable. In developing such requirements, it shall consult the appropriate Clinical Service Chiefs, committees, applicable federal and state law, JCAHO accrediting standards, and may contact applicable professional societies or associations. Recommendations from the Credentials Committee will be presented to the Medical Executive Committee for review with recommendations to the Professional Practice Committee of the Board of Directors. Any changes in the credentials manual will be subject to approval as specified in the Medical Staff Bylaws and related manuals.

## 10.4 QUALIFICATIONS, CONDITIONS, AND RESPONSIBILITIES of AHPs

**10.4.1 General Qualifications:**

To be eligible to apply for initial and continued privileges to practice at KMC, an Allied Health Professional must:

(a) possess and at all times maintain any and all current, valid unrestricted licenses, certificates, or other legal credentials or specific training statements by the supervising physician entitling practice of the profession or occupation in the State of Ohio, with a copy of each on file with the Medical Staff Office;

(b) when applicable to his or her practice, have a current, unrestricted DEA registration;

(c) be geographically located to be able to effectively meet the needs of Hospital patients and fulfill responsibilities to KMC patients;

(d) have and at all times maintain current, valid professional liability insurance coverage with a company and in a form and in amounts satisfactory to KMC;

(e) have never been, and are not currently, excluded or precluded from participation in Medicare, Medicaid, or other governmental payor programs;

(f) have never been convicted of Medicare, Medicaid, or other federal or state governmental or private third-party payor fraud or program abuse;

(g) have never had clinical privileges or a scope of practice denied, revoked, resigned, relinquished, or terminated by any health care facility or health plan for reasons related to clinical competence or professional conduct;

(h) have never been convicted of any felony; or of any misdemeanor relating to controlled substances, illegal drugs, insurance fraud or abuse, or violence; and pass any criminal background check;

(i) satisfy all additional eligibility qualifications relating to his or her specific area of practice that may be established from time to time by KMC and Ohio licensing boards and regulating bodies, inclusive of maintenance of relevant specialty certifications and recertifications, and adherence to continuing education requirements applicable to the specialty;

(j) provide care at KMC under the supervision of (or collaboration with, as applicable) an appointed and credentialed member of the Medical Staff, as evidenced by a Supervising Medical Staff Member Agreement (with Utilization Plan, as applicable) or Standard Care Arrangement which defines the scope of practice;

(k) possess the necessary physical and mental health status to perform AHP duties; and

(l) be able to continuously document his or her:

(1) background, education (graduate of an approved or recognized school or training program for the profession or occupation in question), relevant training, experience, and demonstrated current competence and clinical judgment as well as continuing medical education, licensure or certification, as applicable, and professional liability insurance coverage;

(2) adherence to the ethics of his or her profession;

(3) good reputation and character;

(4) ability to perform, competently and safely, the scope of practice or clinical privileges requested; and

(5) ability to work harmoniously with others so as not to disrupt the delivery of quality health care or the orderly operation of the Hospital.

**10.4.2 Allied Health Appointment**:

Allied Health Professionals are appointed to the Allied Health Professional Staff and are entitled to the rights, privileges, and/or prerogatives as outlined in this Article, and as may be referred to specifically in the Medical Staff Bylaws and related manuals. Each AHP shall be assigned to a Clinical Service appropriate to the practice or privileges sought in accordance with his/her occupational or professional training, and shall be subject to terms and conditions of the rules and regulations of the Clinical Service as such may be applicable to AHPs and appropriately tailored to the particular practice of the AHP. Unless otherwise stated in this Article, inclusive of Appendix D, each AHP shall be subject to the supervision or direction of an Active Medical Staff member in the appropriate specialty as required.

**10.4.3 Non-Discrimination Policy:**

No individual shall be denied permission to practice at KMC, or shall discriminate against others in practicing at KMC, on the basis of sex, race, creed, national origin or other discriminatory bases prohibited by applicable federal and state law.

**10.4.4 Assumption of Duties and Responsibilities:**

As a condition of permission to practice at KMC, all Allied Health Professionals shall specifically agree to the following:

(a) to provide continuous and timely care to all patients for whom the individual has responsibility, furnishing such services as are specifically granted to him/her to perform consistent with any limitations stated, and under the supervision or direction of or collaboration with a credentialed member of the Active Medical Staff, as required;

(b) to abide by all bylaws and policies of KMC, including all applicable bylaws, policies, rules and regulations of the Medical Staff in force during the time the individual is granted permission to practice;

(c) to accept committee assignments and such other reasonable duties and responsibilities as may be assigned;

(d) to provide to the Nursing Credential or Credentials Committee, as applicable, with or without request as it occurs, new or updated information that is pertinent to any question on the application form, including, but not limited to, any changes made or formal action initiated that could result in a change of license, participation in any program or plan of reimbursement, professional liability coverage, affiliation or employment status at other health care institutions and the initiation status and outcome of malpractice claims, professional disciplinary matters, or indictment or conviction of a felony;

(e) to appear for personal interviews in regard to an application for permission to practice as may be requested;

(f) to refrain from illegal fee splitting or other illegal inducements relating to patient referral;

(g) to refrain from assuming responsibility for diagnosis or care of hospitalized patients for which AHP is not qualified to provide, or to perform services without adequate supervision or collaboration, as applicable;

(h) to refrain from deceiving patients as to the individual's status as an AHP, and to make patients clearly aware that they are being cared for by an AHP;

(i) to seek consultation whenever necessary;

(j) to participate in the utilization, risk management, corporate compliance, performance improvement and quality monitoring activities of the Hospital;

(k) to complete in a timely manner the medical and other required records containing all information required by the Hospital;

(l) to write orders in the patient's medical record as authorized in accordance with his/her category of practice, licensure and AHP scope of services or practice privileges;

(m) to perform all services and conduct him/herself at all times in a cooperative, professional, civil and non-disruptive manner, refraining from any conduct or acts that are, or could be reasonably interpreted as being, unethical;

(n) to promptly pay any applicable dues, fines and assessments;

(o) to satisfy applicable continuing education requirements and continuously maintain personal professional liability insurance coverage (including gap coverage [tail insurance]) acceptable to the Hospital;

(p) to at all times respect the confidentiality of patient, Medical Staff and Hospital information obtained in the course of practice at the Hospital, including, at all times, being in compliance with the requirements of the Health Insurance Portability and Accountability Act of 1996, as may be amended from time to time, and all other current and future relevant federal and state statutes, rules, regulations and requirements regarding patient privacy, confidentiality and information security according to the applicable timetables.

(q) to exhaust all administrative remedies provided by this Article before initiating any legal proceeding in any state or federal court; and

(r) to agree that, if there is any misstatement in, or omission from, the application, KMC may stop processing the application (or, if permission to practice has been granted prior to the discovery of a misstatement or omission, the permission may be deemed to be automatically and voluntarily relinquished). In either event, there shall be no entitlement to the procedural rights provided in this Article.

(s) Approved Scope of Practice Services and Practice Privileges will be subject to biannual review by the Clinical Service and shall be limited to those approved at the time of appointment or reappointment by the Clinical Service.

**10.4.5 Burden of Providing Information**:

(a) Supervising and/or collaborating physicians and the Allied Health Professionals seeking permission to practice shall have the burden of producing information deemed adequate by KMC for a proper evaluation of current competence, character, training, experience, judgment, and other qualifications, and for resolving any doubts about such qualifications.

(b) Supervising and/or collaborating physicians and the Allied Health Professionals seeking permission to practice have the burden of providing evidence that all the statements made and information given on the application are accurate.

(c) An application shall be complete when all questions on the application form have been answered, all supporting documentation has been supplied, and all information verified from primary sources. An application shall become incomplete if the need arises for new, additional, or clarifying information at any time. Any application that continues to be

incomplete 30 days after the individual has been notified of the additional information required shall be deemed to be withdrawn.

(d) It is the responsibility of the supervising or collaborating physician and the individual seeking permission to practice to provide a complete application, including adequate responses from references. An incomplete application will not be processed.

**10.4.6 Application Form:**

(a) The application forms for both initial and reappointment to practice as an Allied Health Professional shall require detailed information concerning the applicant's professional qualifications. The Allied Health Professional applications existing now and as may be revised are incorporated by reference and made a part of this Article. In addition to other information, the applications shall seek the following:

(1) information as to whether the applicant's clinical privileges, scope of practice, permission to practice, and/or affiliation has ever been voluntarily or involuntarily relinquished, withdrawn, denied, revoked, suspended, subjected to probationary or other conditions, reduced, limited, terminated, or not renewed at any hospital or health care facility, or is currently being investigated or challenged;

(2) information as to whether the applicant's license or certification to practice any profession in any state, Drug Enforcement Administration registration, or any state controlled substance license (if applicable) is or has ever been voluntarily or involuntarily suspended, modified, terminated, restricted, relinquished, or is currently being investigated or challenged;

(3) information concerning the applicant's professional liability litigation experience during the past 10 years [or time frame as may be determined from time to time by the Board] , including past and pending claims, final judgments, or settlements; the substance of the allegations as well as the findings and the ultimate disposition; and any additional information concerning such proceedings or actions as the Nursing Credentials Committee or Credentials Committee (as applicable), the Medical Executive Committee, or the Board may request; and

(4) current information regarding the applicant's ability to safely and competently perform the scope of services or clinical privileges requested; and

(5) current information regarding the general qualifications set forth in this Section 10.4.6.

(b) The applicant shall sign the application and certify that he or she is able to perform the scope of services or clinical privileges requested and the responsibilities of Allied Health Professionals.

(c) Review regarding re-appointment of an AHP shall include appraisal, to the extent applicable, from the relevant Clinical Service; record completion history; reports from committees which review quality and utilization; reports from other institutions and entities regarding clinical practice and staff status; professional liability insurance coverage and history; and other relevant matters.

**10.4.7 Grant of Immunity and Authorization to Obtain/Release Information**:

By applying for permission to practice at KMC, Allied Health Professionals expressly accept the following conditions during the processing and consideration of the application, whether or not permission to practice is granted, and as a condition of continued permission to practice, if granted:

(a) Immunity:

To the fullest extent permitted by law, the Allied Health Professional releases from liability and agrees not to sue KMC, the KMC Medical Staff, their authorized representatives, and other third parties for acts performed and statements made in good faith and without malice in evaluating professional competence, ethics, character and other qualifications in any matter relating to such AHP's permission to practice, or clinical privileges at KMC. This includes any actions, recommendations, reports, statements, communications, or disclosures involving the individual, which are made, taken, or received by KMC, the KMC Medical Staff, their authorized agents, or other third parties. The covenants of this paragraph are irrevocable for as long as the AHP is an applicant for or has obtained permission to practice as an AHP at KMC or for subsequent verification in connection with the AHP's practice at KMC.

(b) Authorization to Obtain Information from Third Parties:

The Allied Health Professional specifically authorizes KMC, the KMC Medical Staff leaders, and their authorized representatives (1) to consult with any third party who may have information bearing on the Allied Health Professional's professional qualifications, credentials, clinical competence, character, ability to perform safely and competently, ethics, behavior, or any other matter reasonably having a bearing on the AHP's qualifications for permission to practice at KMC, and (2) to obtain any and all communications, reports, records, statements, documents, recommendations, or disclosures of third parties that may be relevant to such questions. The Allied Health Professional also specifically authorizes third parties to release this information to KMC, the KMC Medical Staff leaders, and their authorized representatives upon request and shall hold such third parties harmless for such release, granting to them the same immunity as stated in paragraph (a) above of this Section 10.4.7. The covenants of this paragraph are irrevocable for as long as the AHP is an applicant for or has obtained permission to practice as an AHP at KMC.

(c) Authorization to Release Information to Third Parties:

The Allied Health Professional also authorizes KMC representatives to release information to other hospitals, health care facilities, managed care organizations, educational/training facilities, and their agents when information is requested in order to evaluate his or her professional qualifications for appointment, privileges, permission to practice, scope of practice, and/or participation status at the requesting organization/facility.

(d) Authorization to Share Information Within the Hospital:

The individual AHP specifically authorizes KMC to share credentialing and peer review information pertaining to the individual's clinical competence and/or professional conduct within the Hospital departments and leadership. This information may be shared at initial appointment or reappointment and at any other time during the individual's appointment as an AHP on the Medical Staff. The covenants of this paragraph are irrevocable for as long as the AHP is an applicant for or has obtained permission to practice as an AHP at KMC.

(e) Procedural Rights:

The Allied Health Professional agrees that the procedural rights set forth in this Article shall be the sole and exclusive remedy of the AHP with respect to any professional review action taken by the Hospital.

(f) Reimbursement of Hospital for Legal Actions:

If, notwithstanding the provisions in this Section, an Allied Health Professional institutes legal action and does not prevail, he or she shall reimburse the hospital and any of its authorized representatives named in the action within 60 days of the final judgment or ruling concerning such legal action for any and all costs, fees, and expenses incurred in defending such legal action, including reasonable attorney's fees, expenses and costs. The covenants of this paragraph are irrevocable and survive the applicant's affiliation or appointment as an AHP on the Medical Staff.

## 10.5 CREDENTIALING PROCEDURE

### 10.5.1 Request for Application:

Any individual requesting an application to practice as a Licensed Independent Practitioner AHP or a Dependent AHP at KMC shall be sent a letter that outlines the eligibility criteria and an application form to complete and return. Individuals who fail to meet the criteria will not have their application processed, and such determination of ineligibility does not give rise to any hearing or other procedural rights set forth in this Article.

### 10.5.2 Initial Review of Application:

(a) A completed application, with copies of all required documents, must be submitted to the Medical Staff Office within 30 days after receipt of the application if the Allied Health Professional desires further consideration. The application must be accompanied by the application processing fee in effect at the time of submission.

(b) The application will be reviewed by the designated credentialing specialist to determine that all questions have been answered and that the individual satisfies all threshold criteria. Individuals who fail to return completed applications or fail to meet the eligibility criteria set forth in this Article will be notified that they are not eligible for permission to practice at KMC and that their application will not be processed. A determination of ineligibility does not entitle an Allied Health Professional to the procedural rights set forth in this Article.

(c) The Manager or other designated individual of Medical Staff Services shall oversee the process of gathering and verifying relevant information and confirming that all references and other information or materials deemed pertinent have been received.

### 10.5.3 Nursing Credentials Committee or Department Chair Procedure (Reviewer):

(a) The Medical Staff Office shall transmit the complete application and all supporting materials to either the Nursing Credentials Committee, the Clinical Services Chief or the individual to whom such Chief has assigned

this responsibility. All AHP personnel whose requested privileges require a nursing license shall be reviewed by the Nursing Credentials Committee. Each reviewer shall prepare a written report regarding whether the applicant has satisfied all of the qualifications for permission to practice and the clinical privileges or scope of practice requested. As part of the process of making this report, the reviewer has the right to meet with the applicant and the supervising or collaborating physician (as applicable) to discuss any aspect of the application, qualifications, and requested clinical privileges or scope of practice. The reviewer may also confer with experts within the department and outside of the department in preparing the report (e.g., other physicians, relevant hospital department heads, nurse managers). In the event that the reviewer is unavailable or unwilling to prepare a written report, each committee chair (Nursing Credentials Committee, Credentials Committee) or the President of the Medical Staff shall appoint an individual with equal qualifications to prepare the report.

(b) The reviewer may also recommend that an application, in which no concerns or quality issues have been raised, may be processed in an expedited manner.

(c) The reviewer shall be available to the Nursing Credentials Committee, Credentials Committee, Medical Executive Committee, or the Board to answer any questions that may be raised with respect to that reviewer's report and findings.

**10.5.4 Expedited Process**:

(a) If recommended by the reviewer, initial applications, only, to practice may be processed in an expedited manner as set forth in this Section so long as they meet the following conditions:

(1) all reference evaluations are completed and received within a reasonable time of the initial request;

(2) all references contain only favorable evaluations, including unqualified recommendations for the clinical privileges or scope of services requested;

(3) the applicant's professional liability claims activity (including past malpractice claims and settlements) is reasonable in light of his or her area of practice;

(4) there are no current pending investigations or previously successful challenges to licensure or registration;

(5) there has been no involuntary termination, limitation, restriction, reduction, denial or loss of permission to practice, clinical

privileges or scope of practice at any hospital or other health care entity; and

(6) there has been no investigation into and no disciplinary action taken relating to permission to practice, clinical privileges or scope of practice at any hospital or other health care entity or by any state licensing/credentialing authorities.

(b) The Chair of the Nursing Credentials Committee and the Chair of the Credentials Committee, acting on behalf of the Committee, shall review the report from the reviewer. The Chair of the Nursing Credentials Committee and the Credentials Committee shall examine evidence of the applicant's character, professional competence, qualifications, prior behavior, and ethical standing and shall determine whether the applicant has established and satisfied all of the necessary qualifications for permission to practice and the clinical privileges requested.

(c) The President of the Medical Staff shall review the report and recommendation made by the Chair of the Nursing Credentials Committee and the Chair of the Credentials Committee. If the President of the Medical Staff concurs with the recommendation, the recommendation shall be forwarded to the President of the Hospital.

(d) The President of the Hospital may grant the individual temporary clinical privileges, as applicable, for a period not to exceed 120 days.

(e) In the event the Chair of the Nursing Credentials Committee, the Chair of the Credentials Committee, the President of the Medical Staff, or the President of the Hospital has any questions about the applicant, the questions shall be noted and the matter shall be referred to the either the Nursing Credentials Committee or the Credentials Committee for further action, as appropriate.

(g) A report regarding all applicants granted temporary clinical privileges or approved scope of services through this process shall be forwarded to the Credentials Committee for its information, and the application and request for clinical privileges or scope of services shall be forwarded to the Medical Executive Committee for review and recommendation and to the Board or its designee for final action.

### 10.5.5 Nursing Credentials Committee Procedure

(a) For all other applications, the Nursing Credentials Committee shall review the report from the appropriate reviewer and the information contained in references given by the applicant and from other available sources. The Nursing Credentials Committee shall examine evidence of the applicant's character, professional competence, qualifications, prior behavior, and

ethical standing and shall determine whether the applicant has established and satisfied all of the necessary qualifications for the clinical privileges or scope of services requested.

(b) The Nursing Credentials Committee may use the expertise of any individual on the Medical Staff or in the Hospital, or an outside consultant, if additional information is required regarding the applicant's qualifications. The Nursing Credentials Committee may also meet with the applicant and, when applicable, the supervising/collaborating physician.

**10.5.6 Credentials Committee Procedure:**

(a) At its next meeting, after receipt of the written findings and recommendation of the Nursing Credentials Committee, the Credentials Committee shall:

(1) adopt the findings and recommendations of the Nursing Credentials Committee as its own; or

(2) refer the matter back to the Nursing Credentials Committee for further consideration and responses to specific questions raised by the Credentials Committee; or

(3) set forth reasons in its report and recommendation, along with supporting information, for its disagreement with the Nursing Credentials Committee's recommendation.

(b) If the Credentials Committee's recommendation is favorable to the applicant, the Committee shall forward its recommendation to the Medical Executive Committee for review and for any recommendation it wishes to make, including the findings and recommendation of the reviewer and the Nursing Credentials Committee. The Credential's Committee recommendation must specifically address the clinical privileges or scope of practice requested by the applicant, which may be qualified by any probationary or other conditions or restrictions relating to such clinical privileges or scope of practice.

**10.5.7 Medical Executive Committee Procedure**:

(a) At its next meeting, after receipt of the written findings and recommendation of the Credentials Committee, the Medical Executive Committee shall:

(1) adopt the findings and recommendations of the Credentials Committee as its own; or

(2) refer the matter back to the Credentials Committee for further consideration and responses to specific questions raised by the Medical Executive Committee; or

(3) set forth reasons in its report and recommendation, along with supporting information, for its disagreement with the Credentials Committee's recommendation.

(b) If the Medical Executive Committee's recommendation is favorable to the applicant, the Committee shall forward its recommendation to the Board or its designee for review and for any recommendation it wishes to make, including the findings and recommendation of the reviewer, Nursing Credentials Committee and the Credentials Committee. The Medical Executive Committee's recommendation must specifically address the clinical privileges or scope of practice requested by the applicant, which may be qualified by any probationary or other conditions or restrictions relating to such clinical privileges or scope of practice.

(c) If the Medical Executive Committee's recommendation would entitle the applicant to the procedural rights set forth in this Article, the Medical Executive Committee shall forward its recommendation to the Vice President Medical Affairs [VPMA] who shall notify the applicant of the recommendation and his or her procedural rights. The VPMA shall then hold the Medical Executive Committee's recommendation until after the individual has completed or waived the procedural rights outlined in this Article.

**10.5.8 Board Action**:

(a) Upon receipt of a recommendation that the applicant be granted permission to practice and clinical privileges or scope of practice, the Board or its designee may:

(1) grant the applicant permission to practice and clinical privileges or scope of practice as recommended; or

(2) refer the matter back to the Nursing Credentials Committee, Credentials Committee or Medical Executive Committee or to another source inside or outside the hospital for additional research or information; or

(3) reject or modify the recommendation.

(b) If the Board or its designee determines to reject a favorable recommendation, it will first discuss the matter with the Chairs of the Nursing Credentials, Credentials and Medical Executive Committees. If the Board's determination remains unfavorable, the VPMA shall notify the applicant of its determination and the applicant's procedural rights as outlined in this Article.

**10.5.9 Reappointment Process**:

(a) Reappointment of an Allied Health Professional's clinical privileges or scope of practice shall be considered only upon submission of a completed application, that must be accompanied by the appropriate reappointment fee in affect at the time of submission. Four months prior to the date of expiration of an Allied Health Professional's clinical privileges or scope of practice, the Medical Staff Office shall give the individual notice of the date of expiration and an application form for renewed clinical privileges or scope of practice. If a complete application has not been returned to the Medical Staff Office within 30 days, a reminder notice shall be sent via certified mail.

(b) Failure to submit an application at least two months prior to the expiration of the individual's current term shall result in automatic expiration of appointment and clinical privileges or scope of practice at the end of the then current appointment term, and the individual may not practice until an application is processed.

(c) Reappointment, if granted, shall be for a period of not more than two years.

(d) Once an application for reappointment has been completed and submitted to the Medical Staff Office, it shall be evaluated in the same manner and follow the same procedures outlined in this Article for initial applicants. However, applications for reappointment are NOT eligible for the expedited review process and shall instead be processed through the full Nursing Credentials Committee and/or Credentials Committee and Medical Executive Committee.

(e) As part of the process for reappointment for Dependent Practitioners, the competency of the Dependent Practitioner shall be assessed by the supervising physician(s) and the applicable reviewer or designee on a biennial evaluation form. The evaluation form along with other reasonable indicators of continuing qualifications shall be factors for the renewal of the Dependent Practitioner's permission to practice.

(f) As part of the reappointment for Licensed Independent Practitioners, the following factors shall be considered:

(i) the competency of the Licensed Independent Practitioner as assessed by the appropriate reviewer, Clinical Service Chief(s) or designee and documented on a biennial evaluation form;

(ii) a recommendation from a peer;

(iii) use of KMCs facilities taking into consideration practitioner-specific information concerning other individuals in the same or similar specialty; and

(iv) input form the collaborating physician.

**10.5.10 Summary Suspension:**

(a) The President of the Medical Staff, the relevant Clinical Service Chief or the Chief Nursing Officer, the VPMA, and the President of the Hospital shall each have the authority to impose an summary suspension of all or any portion of the clinical privileges or scope of service of any Allied Health Professional whenever a concern has been raised about such individual's clinical practice or conduct.

(b) A summary suspension shall become effective immediately upon imposition, shall immediately be reported in writing to the President of the Hospital, the VPMA and/or Chief Nursing Officer, and the President of the Medical Staff, and shall remain in effect unless or until modified by the President of the Medical Staff, the relevant Clinical Service Chief or the Chief Nursing Officer, the VPMA, or the President of the Hospital, or Medical Executive Committee. In the event of disagreement in relation to the removal of a summary suspension, the Board or its designee would have final authority.

(c) Upon receipt of notice of the imposition of a summary suspension, the President of the Hospital, the VPMA and/or the Chief Nursing Officer, and the President of the Medical Staff shall forward the matter to the full Medical Executive Committee, which shall review and consider the question(s) raised and thereafter make an appropriate recommendation to the Board or its designee. If the Medical Executive Committee's recommendation is to restrict or terminate the Allied Health Professional's privileges to practice, the individual and, when applicable, the supervising physician and AHP shall be entitled to the procedural rights outlined in Section 10.7 of this Article before the Medical Executive Committee's recommendation is considered by the Board.

## 10.6 CONDITIONS OF PRACTICE APPLICABLE TO DEPENDENT PRACTITIONERS

**10.6.1 Supervision by Supervising Medical Staff Member**:

(a) Any activities permitted by the Board to be done at KMC by a Dependent AHP shall be done only under the supervision (and collaboration, as applicable) of an Active Medical Staff member. Except as provided by applicable federal and state law, accrediting standards, and rules and regulations or KMC policy, "supervision" shall not require the actual physical presence of the employing or supervising Medical Staff member.

(b) Dependent AHPs may function in the Hospital only so long as they (i) are under supervision (and collaboration, as applicable) with a currently appointed and credentialed Active Medical Staff Member, and (ii) have filed in the Medical Staff Office a current, written Supervising Medical

Staff Member Agreement in a form as set forth at Appendix E (with Standard Care Arrangement attached, as applicable) and a current written scope of practice that are in accordance with applicable law and Medical Staff credentialing requirements. In addition, should the supervising Medical Staff member's appointment or clinical privileges be suspended, revoked or terminated, the Dependent AHP's permission to practice at KMC and scope of service shall be deemed to be voluntarily and automatically relinquished or suspended (unless the individual will be supervised by another Medical Staff member) for at least the term of the suspension or revocation of the supervising physician's appointment and privileges.

(c) As a condition for appointment at KMC, each Dependent AHP and his/her supervising Medical Staff member must submit to the Medical Staff Office a copy of their written Supervising Medical Staff Member Agreement (attaching any Standard Care Arrangement as applicable) and written scope of practice. The Agreement and scope of practice must meet the requirements of all applicable federal and state statutes and regulations, as well as any additional requirements of the Hospital. It is also the responsibility of the Supervising Medical Staff Member and Dependent AHP to timely provide the Medical Staff Office any subsequent revisions made to such Agreement and scope of practice and to seek approval for any new duties.

(d) A dependent AHP may not: (i) provide a service which is not listed in the approved written scope of practice that is on file in the Medical Staff Office; (ii) prescribe drugs, medication, or devices not specifically authorized by the supervising physician and documented and approved in the scope of practice; or (iii) provide a medical service that exceeds the clinical privileges granted to the supervising physician.

**10.6.2 Questions Regarding Authority of a Dependent AHP**:

(a) Should any Medical Staff member or Hospital employee who is licensed or certified by the state have any question regarding the clinical competence or authority of a Dependent AHP either to act or to issue instructions outside the physical presence of their Supervising Medical Staff member, such individual shall have the right to require that the Dependent AHP's employer or Supervising Medical Staff Member to validate the act or instructions of the Dependent AHP. Any act or instruction of the Dependent AHP shall be delayed until such time as the action or instruction can be so verified as being within the scope of the Dependent AHP's scope of practice as permitted by the Board.

(b) Any question regarding the instructions or scope of practice or professional conduct of a Dependent AHP shall be reported to the President of the Medical Staff, the Chief of the relevant Clinical Service, the VPMA and/or the Chief Nursing Officer, or the President of the

Hospital, who shall undertake such action as may be appropriate under the circumstances.

**10.6.3 Responsibilities of Supervising Medical Staff Member**:

(a) The Supervising Medical Staff Member is ultimately responsible for coordinating and managing the health care of KMC patients, ensuring its quality; and shall be responsible for the actions of the Dependent AHP at KMC, unless and to the degree otherwise stated in this Article.

(b) The number of Dependent AHPs acting under the supervision of one Medical Staff member, as well as the scope of such AHP's authorized practice and acts they may undertake, shall be consistent with applicable state statutes and regulations, the rules and regulations of the Medical Staff, JCAHO accrediting standards, and the policies of the Board.

(c) The Supervising Medical Staff Member must be available for consultation with the Dependent AHP at all times, either in person or through telecommunication systems or other means as is consistent with Ohio law and Hospital requirements.

(d) The extent of the involvement by the AHP in the care of patients at KMC will depend on the complexity and acuity of the patient's condition and the training, experience, and preparation of the AHP, as adjudged by the supervising physician and in accordance with the Supervising Medical Staff Member Agreement.

(e) Patients should be made clearly aware at all times whether they are being cared for by a physician or an AHP.

(f) The supervising physician is responsible for clarifying and familiarizing the AHP with his/her supervising methods and style of delegating patient care.

(g) It shall be the responsibility of the Supervising Medical Staff member to provide, or to arrange for, and maintain professional liability insurance coverage for the Dependent AHP with such companies and in such amounts as may be required by the Board from time to time and that continuously covers any activities of the Dependent AHP at the Hospital. Evidence of such coverage shall be furnished to the Hospital prior to the AHP assuming any practice duties. If such insurance is "claims made", then in the event such insurance is terminated for any reason, the insured shall obtain gap coverage insurance in the form of a tail policy or an extended reporting endorsement corresponding to and with the same limits as the insurance carried during the time the AHP was practicing at the Hospital, to provide continuous coverage for the activities of the AHP while at KMC.

(h) It shall be the responsibility of the Supervising Medical Staff member to provide, or to arrange for the provision of a written scope of practice to be filed in the Medical Staff Office that describes all health care-related tasks that may be performed at KMC by the AHP. This document must be signed by the AHP, the supervising physician, and all alternate supervising physicians. Such scope of practice shall be submitted to the Credentials Committee and the Medical Executive Committee for approval before the AHP can provide services to KMC patients. Such scope of practice must include: (i) the name, license number and addresses of all supervising physicians; (ii )the name and practice address of the AHP; (iii) the dates the scope of practice was developed, reviewed, and/or amended; (iv) medical conditions for which therapies may be initiated, continued, or modified; (v) drug therapies, if any, that may be prescribed with drug-specific classifications; and (vi) situations that require direct evaluation by or immediate referral to the supervising physician.

(i) AHPs may enter progress notes and write orders within the scope of their written scope of practice which entries must be reviewed and countersigned by the supervising or alternate supervising physician within the time limits established by Medical Staff and Hospital policies.

(j) A supervising Medical Staff member who fails to fulfill the responsibilities defined in this Article and/or in the Supervising Medical Staff Member Agreement (and Standard Care Arrangement, as applicable) shall be subject to appropriate corrective action as provided in the Medical Staff Bylaws.

## 10.7 PROCEDURAL RIGHTS FOR ALLIED HEALTH PROFESSIONALS

### 10.7.1 General:

Allied Health Professionals shall not be entitled to the hearing and appeals procedures set forth in the Credentials Manual with respect to members of the Medical Staff. Any and all procedural rights to which AHPs are entitled are set forth in this Article. The procedural rights set forth in this Article are applicable to AHPs who are not Hospital employees.

### 10.7.2 Procedural Rights for Allied Health Professionals:

(a) In the event that a recommendation is made by the Medical Executive Committee that an AHP not be granted practice privileges or the scope of practice requested, or that the practice privileges or scope of practice previously granted be restricted or revoked, the practitioner shall be given written notice of such recommendation. The notice shall include the specific reasons for the recommendation and, unless such restriction or revocation was automatically imposed, shall advise the individual that he or she may request a hearing prior to the adverse recommendation being transmitted to the Board or its designee for final action.

(b) If the AHP desires to request a hearing, such request must be made in writing and directed to the VPMA within 30 days after receipt of the written notice of the adverse recommendation.

(c) If a request for a hearing is made in a timely manner, the VPMA, in conjunction with the President of the Medical Staff and/or Chief Nursing Officer, shall appoint an Ad Hoc Committee composed of up to three individuals (including, but not limited to, individuals appointed to the Medical Staff, Allied Health Professionals, KMC Leadership, individuals not connected to the KMC, or any combination of these individuals) and a Presiding Officer, who may be legal counsel to the Hospital. The Ad Hoc Committee shall not include anyone who previously participated in the recommendation, any relatives or practice partners of the Allied Health Professional, or any competitors of the affected individual.

(d) As an alternative to the Ad Hoc Committee described in paragraph (c) of this Section, the VPMA, in conjunction with the President of the Medical Staff and/or Chief Nursing Officer, may instead appoint a Hearing Officer to perform the functions that would otherwise be carried out by the Ad Hoc Committee. The Hearing Officer may be an attorney at law. The Hearing Officer may not be in direct economic competition with the individual requesting the hearing and shall not act as a prosecuting officer or as an advocate to either side at the hearing. If the Hearing Officer is an attorney, he or she shall not represent clients who are in direct economic competition with the affected individual. In the event a Hearing Officer is appointed instead of an Ad Hoc Committee, all references to the Ad Hoc Committee in this Section 10.7 shall be deemed to refer instead to the Hearing Officer, unless the context would clearly require otherwise.

(e) The hearing shall be convened as soon as is practical, but no sooner than 30 days after the notice of the hearing, unless an earlier hearing date has been specifically agreed to by the parties.

**10.7.3 Hearing Process for Allied Health Professionals:**

(a) At the hearing, a representative of the Medical Executive Committee shall first present the reasons for the recommendation. The AHP shall be invited to present information, both orally and in writing, to refute the reasons for the recommendation, subject to a determination by the Presiding Officer (or the Hearing Officer) that the information is relevant. The Presiding Officer (or the Hearing Officer) shall have the discretion to determine the amount of time allotted to the presentation by the representative of the Medical Executive Committee and the AHP.

(b) The AHP shall not have the right to present other witnesses unless he or she can demonstrate to the satisfaction of the Presiding Officer (or the Hearing Officer) that the failure to permit witnesses to appear would be fundamentally unfair. In the event witnesses are allowed, the Presiding

Officer (or the Hearing Officer) shall permit reasonable questioning of such witnesses.

(c) Neither the AHP nor the Medical Executive Committee shall be represented by counsel at this hearing.

(d) The affected AHP shall have the burden of demonstrating that the recommendation of the Medical Executive Committee was arbitrary, capricious, or not supported by substantial evidence. While the quality of care provided to patients and the smooth operation of the Hospital are paramount considerations, the Hospital may also consider other factors that the Hospital, in its sole discretion, deems relevant. Minutes of this proceeding shall be kept and shall be attached to the report and recommendation of the Ad Hoc Committee.

**10.7.4 Ad Hoc Committee or Hearing Officer Report**:

(a) The Ad Hoc Committee (or the Hearing Officer) shall prepare a written report and recommendation within 30 days after the conclusion of the proceeding, and shall forward it along with all supporting information to the VPMA. The VPMA shall send a copy of the written report and recommendation, via certified mail, return receipt requested, to the AHP. A copy shall also be provided to the Medical Executive Committee.

(b) Within ten days after receiving notice of the recommendation, either the AHP or the Medical Executive Committee may make a written request for an appeal. The request must be in writing and must include a statement of the reasons for appeal, including the specific facts, which justify further review. The request shall be delivered to the VPMA either in person or by certified mail or other commercially reasonable means of receipted delivery.

(c) If a written request for appeal is not submitted within the ten (10) day time frame specified above, the recommendation and supporting information shall be forwarded by the VPMA to the Board or its designee for final action. If a timely request for appeal is submitted, the VPMA shall forward the report and recommendation, the supporting information, and the request for appeal to the Chairperson of the Board.

**10.7.5 Appeals Process for Allied Health Professionals:**

(a) The grounds for appeal shall be limited to the following assertions: (i) there was substantial failure to comply with this Section and/or other applicable bylaws or policies of the Hospital or the Medical Staff and/or (ii) the recommendation was arbitrary, capricious, or not supported by evidence.

(b) The Chairperson of the Board, or a committee of the Board appointed by the Chairperson or other Board designee, will consider the request for

appeal and the record upon which the adverse recommendation was made. This review shall be conducted within 30 days after receiving the request for appeal.

(c) The AHP and the Medical Executive Committee shall each have the right to present a written statement in support of its position on appeal.

(d) At the sole discretion of the Chairperson of the Board or the committee appointed by the Chairperson or other Board designee, the AHP and a representative of the Medical Executive Committee may also be permitted to appear personally to discuss their position.

(e) Upon completion of the review, the Chairperson of the Board or the committee appointed by the Chairperson or other Board designee shall provide a report and recommendation to the full Board for action. The Chairperson (or the committee) may also refer the matter to any committee or individual deemed appropriate for further review and recommendation to the full Board. The Board shall then make its final decision based upon the Board's ultimate legal responsibility to grant practice privileges and to authorize the performance of clinical activities at the Hospital.

**10.7.6 Exceptions to Procedural Rights**:

An Allied Health Professional's practice privileges or scope of practice shall voluntarily and automatically lapse and terminate and be automatically relinquished, without entitlement to the procedural rights outlined in this Section, in the following circumstances:

(a) the Medical Staff appointment or clinical privileges or scope of practice of the AHP's Supervising or collaborating Medical Staff member is suspended, revoked or terminated for any reason (unless the AHP will be supervised by or collaborates with another Medical Staff member acceptable to the Credentialing Committee);

(b) an AHP ceases to be supervised by or collaborates with a physician currently appointed to the Medical Staff for any reason (unless the AHP will be supervised by or collaborates with another Medical Staff member acceptable to the Credentialing Committee);

(c) an AHP's license or certification expires, is revoked, is revoked due to a lapse, or is suspended, and/or revocation of Certification of Authority by the Ohio Board of Nursing; or

(d) an AHP no longer satisfies all of the threshold eligibility criteria set forth in this Article or any additional threshold credentialing qualification set forth in Appendix D or other specific Department policies relating to their discipline.

#### 10.7.7 Reporting of Adverse Decisions

The Hospital acts in accordance with federal and state law regarding the reporting of certain final "adverse" actions taken by the Board which are related to the professional competence or conduct of a licensed AHP that could adversely affect the health or welfare of a patient.

### 10.8 KMC HOSPITAL EMPLOYEES

(a) Allied Health Professionals who are employees of KMC shall not be governed by this Article, except as expressly indicated in this Article. Rather, they shall be governed by such KMC employment policies, manuals, and descriptions as are appropriate and as may be established from time to time by Hospital management and/or Human Resources.

(b) Licensed Independent Practitioner AHPs who are employed by, or seeking employment with KMC shall be credentialed and re-credentialed using the same process set forth in this Article. In these situations, a report regarding their qualifications shall be made to the Nursing Credentials or Human Resources (as appropriate) to assist them in making credentialing or employment decisions. In addition, these employed Licensed Independent Practitioner AHPs shall be subject to the procedural rights set forth in Section 10.7 of this Article.

(c) Dependent Practitioner AHPs who are seeking employment with, or are employed by KMC may be approved for practice privileges using the same process set forth in this Article, or may be so approved through KMCs' Human Resources processes. In the event that they are approved through this Article, a report regarding their qualifications shall be made to the Nursing Credentials Committee or Human Resources (as appropriate) to assist them in making privileging and/or employment decisions. If these such AHPs are approved through the Human Resources processes, the Human Resources Department shall seek input from the appropriate Clinical Service Chief (or designee). In addition, all employed Dependent Practitioner AHPs shall be subject to the same supervision requirements set forth in this Article.

## ARTICLE XI: USE OF TERMS

When used herein the terms “clinical service”, “chief”, “director of medical staff credentials program", “Hospital President”, “President of the Medical Staff”, “medical staff coordinator” and “board of directors” are construed to include “designee”.

## ARTICLE XII: ANNUAL REVIEW, ADOPTION AND AMENDMENT

12.1 ANNUAL REVIEW: the Credentials Committee will review this policy manual on

an annual basis.

12.2 AMENDMENT: This Credentials Manual may be adopted, amended or repealed, in whole or in part, by the following mechanism: a resolution approved by 2/3 vote of the voting members present of the Medical Executive Committee, recommended to and adopted by the Board of Directors.

12.3.1 CORRECTIONS: The Credentials Committee and/or Medical Executive Committee may correct typographical, spellings or other obvious errors in this manual. The Credentials Committee may also make any changes specifically required by law, state regulation or JCAHO standards.

12.4 RESPONSIBILITIES AND AUTHORITY: The procedures outlined in the medical staff and hospital corporate bylaws regarding medical staff responsibility and authority to formulate, adopt and recommend medical staff bylaws and amendments thereto apply as well to the formulation, adoption and amendment of this Credentials Manual.

# APPENDIX A: CURRENT PROCEDURE PRIVILEGE CRITERIA

a. Criteria for Laparoscopy Privileges

(1) Qualified physician at Kettering Medical Center who has proper training documented, and

(2) Attended accredited course in use of laparoscope or completed a residency with proof of training in use of laparoscope.

b. Criteria for Gastrointestinal Endoscopy Privileges

(1) Privileges shall be granted for each major type of procedure (colonoscopy, esophagogastroduodenoscopies, endoscopic retrograde cholangiopancreatographies, flexible sigmoidoscopy, and percutaneous endoscopic gastrostomy individually.

(2) Members of the medical staff seeking endoscopic privileges will submit documentation of their ability to perform these procedures to the chair of the appropriate clinical service section of which they are a member.

(3) The clinical service chief will forward a copy of the request to the chair of the GI Endoscopy Committee , or its designee for comment.

(4) The recommendation of the clinical service chief along with the opinion from the chair of the GI Endoscopy Committee, or its designee, will be forwarded to the Credentials Committee for review. The Credentials Committee will make a recommendation to the Medical Executive Committee concerning the privileges requested.

(5) Criteria for granting privileges for GI endoscopy - one of the following mechanisms for each class of procedure for which privileges are requested will follow.

(a) Formal training.

(i) Training of adequate length in an ACGME or American Board of Osteopathic Medicine approved fellowship in gastroenterology, colon-rectal surgery or equivalent, consistent with the American Society of Gastrointestinal Endoscopy standards.

(ii) An adequate number of cases must have been performed under supervision.

(iii) The Program Director must certify as to the competence of the individual for each major type of procedure.

(b) Other acceptable training.

(i) Training must be equivalent to that of a formal program. The board certified or eligible surgeon does not need to have spent the full duration of a fellowship in obtaining this training, but must have obtained equivalent

technical training which is required by the American Society for Gastrointestinal Endoscopy.

(ii) Training must be provided in an ACGME approved program or by proctoring as defined in the ASGE guidelines.

(iii) Certified by the supervisor of training who has credentials acceptable to the committee for each procedure sought.

(c) Criteria for granting privileges for flexible sigmoidoscopy

Privileges for flexible sigmoidoscopy with 35-60 centimeter instrument may be granted to family practitioners, surgeons, internists, or emergency medicine physicians with the following requirements:

(i) Evidence of completion of a course of instruction during residency training or a post-residency course, and

(ii) Demonstration of proper technique to at least two physicians with current privileges in gastrointestinal endoscopy during their first five scheduled cases. Those physicians currently doing flexible sigmoidoscopy in the office setting may bypass requirement (a) but must fulfill (b).

(d). All individuals seeking new privileges in GI endoscopy shall demonstrate to the Clinical Director of the GI unit his/her familiarity with the particular instrument available and satisfactory knowledge of the proper use of the hospital facility and equipment.

c. Radium Insertion

Intracavitary Application of Radioactive Sources (Ex: 137Cs, Radium, Cobalt, Radon, etc.)

Deleted: ¶

(1) Adequately stored in Radiation Therapy and used under direct supervision and responsibility of an authorized and qualified Radiation Therapist, member of attending staff of Kettering Medical Center.

(2) Prior to scheduling patient for intracavitary application in surgery, proper Radiation Therapy consultation should be obtained. The Radiation Therapist will work with the referring physician at a mutually agreed upon time.

(3) The Radiation Safety Officer of Kettering Medical center has the responsibility to provide proper monitoring of said sources, to assure safe handling and maintain proper records as required by Federal Law.

(4) In compliance with rules and regulations issued by U.S. Nuclear Regulatory Commission, any physician using or handling radioactive

materials must submit suitable evidence of such experience, the clinical management of radioactive patients and be duly authorized by the Credentials Committee of the Medical Staff to perform such procedures. Such physicians shall also submit an application for by-product material license to the U.S. Nuclear Regulatory Commission and obtain said license for the human use of radioactive materials in Kettering Medical Center.

(5) Any questions or procedures not covered above shall be handled in accordance with existing Federal Law and regulations on file in the administrator's office of the institution.

d. Criteria for Telemedicine

(1) Telemedicine involves the use of electronic communication or other communication technologies to provide or support clinical care at a distance including diagnosis and treatment of a patient.

(2) The Medical Executive Committee, considering recommendation by the appropriate clinical service and the Credentials Committee, determines which clinical services may be appropriately delivered via telemedicine, according to commonly accepted quality standards.

(3) Practitioners who diagnose or treat patients via telemedicine link must be credentialed and privileges by Kettering Medical Center through the appropriate medical staff clinical service.

# APPENDIX B: ADMITTING AND OTHER PRIVILEGES FOR RADIOLOGISTS, ANESTHESIOLOGISTS, DENTISTS, PODIATRISTS AND PSYCHOLOGISTS

**1. Admitting Privileges for Radiologists**

a. Related to the admission of diagnostic and interventional radiology procedures and subsequent follow-up.

(1) Outpatient diagnostic radiology procedures which develop complications necessitating admission for observations and subsequent treatment. An admission greater than twenty-four (24) hours will require a consultation.

(2) Admission for elective interventional and diagnostic procedures requirement inpatient stay for extended monitoring and follow-up evaluation and treatment.

b. Guidelines

(1) Admission records shall include appropriate medical work-up, including history and physical and necessary consultations, along with appropriate testing results.

(2) Consultation, both medical and surgical, as necessary during hospitalization.

**2. Admitting Privileges for Anesthesiologists**

a. Restricted to diagnosis and treatment of chronic pain problems.

(1) Diagnostic testing requiring extended monitoring (i.e., apnea monitoring).

(2) Treatment requiring in-hospital stay for observations, repeat treatments, and treatment analysis.

(3) Hospitalization from complication of an otherwise routine outpatient procedure.

b. Guidelines

(1) Admission records shall include appropriate medical work-up, consultations, and testing results.

(2) Use as needed of additional medical and surgical consultation during hospitalization.

**3. Special Service: Dentistry**

a. Oral and maxillofacial dentists may admit, perform histories and physical examinations and order or perform diagnostic or therapeutic interventions for ASA Class I and II patients. A physician will perform a history and physical examination and co-admit if appropriate and confirm or endorse findings, conclusions and assessment of risk prior to major diagnostic or therapeutic interventions, on more ill patients as

described below (b through d). Dentists who do not have oral and maxillofacial privileges will provide care as outlined in b through d.

b. Dental patients, except as described above in a, shall be managed as the joint responsibility of a dentist and a physician.

c. Arrangements for admission shall be made by the dentist, and the patient shall be admitted under his name, together with the name of the physician responsible for the medical aspects of the case. Supervision of the physician will be the responsibility of the chief of his clinical service. Upon approval the dentist will be part of the Surgical Clinical Service.

d. The Dentist shall be responsible for:

(1) Provision, prior to surgery, of a detailed written history of the dental disease or condition justifying admission.

(2) Provision, prior to surgery, of a written report of his examination of the oral cavity.

(3) Recording of the preoperative diagnosis.

(4) When a hard copy of the operative report is not placed in the medical record immediately after surgery or the procedure, a progress note of the operation or procedure is entered immediately.

(5) Periodic progress notes as they relate to the dental management of the patient.

(6) Provision of a final dental diagnosis prior to the time of discharge.

(7) Completion of the clinical chart, including the narrative discharge summary.

e. The Physician shall be responsible for:

(1) Provision, prior to surgery, of an appropriate history and physical relating to the general health status of the patient, and a report of a physical examination.

(2) Management, as necessary, for intercurrent or concurrent medical conditions.

(3) Progress notes, as indicated, relative to the patient's medical status during the hospital stay.

(4) Addenda, if indicated, to the narrative discharge summary relative to concurrent or intercurrent medical conditions.

f. All teeth removed at surgery shall be sent to the hospital pathologist for verification and documentation.

## 4. Podiatry Privileges

a. Podiatrists who are appropriately licensed may be granted clinical privileges that are based on their documented training, experience, and current competence.

b. Podiatrists must comply with all applicable Medical Staff Bylaws, Organization Manual, Credentials Policy & Procedure Manual, including the procedures governing qualifications, method of selection, and the delineation of privileges.

c. Their request for privileges shall be processed through the normal Medical Staff mechanism to the Board of Directors, which shall have final approval. Upon approval the podiatrist will be part of the Surgical Clinical Service.

d. Podiatrists may admit, perform H & Ps, write orders and prescribe medications within the limits of their licensure and of the Medical Staff Bylaws, Organization Manual, and Credentials Manual. If treatment Is not within the scope of practice as determined by state law, at the time of admission or becomes necessary during the course of hospital treatment, such treatment shall be under the supervision of a doctor who is a member of the medical staff with privileges to treat the specified medical condition. It shall be the responsibility of the admitting podiatrist to make arrangements with a doctor who is a member of the medical staff to be responsible for the patient's treatment. Mandatory medical consults are required for admission greater than 24 hours.

e. Podiatrists who have not satisfied the Board Eligibility or Certification requirement at the time of application to hospitals may be granted privileges providing that they satisfy one of the following criteria:

(1) A grandfather clause exists for those already in practice as of 1/1/86 who have not had a podiatry residency. These applicants will also be required to document surgeries performed. However, they will also have to document a period of formal post-graduate training beyond podiatry school, internship, preceptorship or fellowship.

(2) Has successfully completed an approved post-graduate residency program by the Council on Podiatry Education or be Board Eligible/Qualified by the American Board of Podiatric Surgery or the American Board of Podiatric Orthopedics and Primary Podiatric Medicine

f. The podiatrist must have graduated from an accredited college of podiatric medicine and successfully completed an approved residency program. Residency programs are subject to approval by the Council on Podiatric Education of the American Podiatry Association. The resident receives additional training in podiatric medicine and surgery and serves on rotation in emergency services, anesthesiology, radiology, general medicine, pathology, as well as general and

podiatric surgery.

**5. Psychologists Privileges**

a. Psychologists who are appropriately licensed and trained may be granted clinical privileges that are based on their documented education, experience, and current competence.

b. Psychologists must comply with all applicable Medical Staff Bylaws, Organization Manual, Credentials Manual, including the procedures governing qualifications, method of selection and the delineation of privileges.

c. Psychologists' requests for privileges shall be processed through the normal Medical Staff mechanism to the Board of Directors, which shall have final approval. Upon approval the psychologist will be part of the Medicine Clinical Service.

d. Psychologists may write orders within the limits of their licensure and of the Medical Staff Bylaws, Organization Manual, and Credentials Manual and any other Kettering Medical Center Behavioral Health Policies.

e. Psychologists requesting privileges must have completed the following minimum requirements; 1) Completion of one year pre- or post-doctoral experience, 2) for those requesting inpatient setting privileges, confirmation of satisfactory completion of at least six months supervised inpatient experience, 3) for those requesting specialized evaluations, documentation of approved course training and/or supervised specialty training, 4) maintain a current, valid license to practice Psychology in Ohio.

f. Psychologists unable to provide documentation of sufficient experience with Inpatient Psychiatry and/or hospital procedures must be proctored for a period of time sufficient to meeting privileging guidelines.

g. Psychologists must abide by ethical guidelines promulgated by the American Psychological Association.

# APPENDIX C: OB-GYN PRIVILEGES FOR FAMILY PHYSICIANS

Family Practice will recommend and monitor the privileges, which are delineated below for members of the clinical service.

a. Level I Privileges

(1) Available to all members of the clinical service based on minimum criteria for membership in Family Practice. Privileges include diagnosis, evaluation, and non-surgical management of the female patient with common gynecologic and obstetrical problems, for example, abnormal uterine bleeding, infections of the GU tract, benign and malignant neoplasms, sexual assault, menopause and geriatric gynecology, medical diseases during pregnancy, such as hypertension, and ectopic pregnancy. Procedural skills necessary for such care include: gynecological examination, removal of vaginal foreign body, repair of minor vaginal trauma, culdocentesis, cervical biopsy, and polypectomy, IUD insertion and removal.

(2) Privileges for D & C for incomplete abortion and diagnostic D & C will be considered by special request based on documented training and/or experience and demonstrated competence.

b. Level II Privileges

(1) Available to members of the clinical service who have completed a three-year family practice residency with a minimum of three month obstetrical experience and/or have documented experience for and demonstrated competence in privileges listed. Privileges include all Level I privileges. In addition, care of the obstetrical patient including: evaluation of fetal maturity, feto-placental adequacy, normal cephalic delivery including outlet forceps, exploration of the vagina, cervix and uterus, manual removal of the placenta, episiotomy and repair including fourth degree perineal repair, pudendal and paracervical block anesthesia, fetal monitoring, diagnostic D & C, and D & C for incomplete AB. Selective induction of labor requires consultation.

(2) Application for Level II privileges must include a supporting letter for those privileges from the director of obstetrical training in the applicant's residency or from the chief of the obstetrical clinical service of the hospital where privileges were previously held.

c. Level III Privileges

(1) Available to those who have completed a three-year Family Practice residency with six months training or greater in OB and/or who have documented experience for an demonstrated competence in privileges listed. Privileges include Level I and II, and selective induction of labor. Augmentation of labor, pharmacologic inhibition of labor requires consultation. Multiple delivery and breech delivery must be requested and approved individually. Other more specialized privileges may be requested at this level and approved based on documented training,

experience and demonstrated competence.

(2) Applications must include a supporting letter for the privileges requested from the director of obstetrical training in the applicant's residency or from the chief of the obstetrical clinical service of the hospital where privileges were previously held.

Family physicians requesting Level II or III privileges should request and identify one or more obstetrician(s) on Active staff who agree to provide consultation.

Family physicians will be monitored according to standards currently established for members of the clinical section of Obstetrics-Gynecology. It will be the responsibility of Family Practice to evaluate its members according to these standards and alter or rescind privileges accordingly.

# APPENDIX D: ALLIED HEALTH STAFF PRIVILEGES

## I. DEPENDENT ALLIED HEALTH PROFESSIONALS

### A. Medical Assistants

(1) Each medical assistant must be an employee of and/or under the supervision of physician(s) who are presently appointed to the Active Medical Staff in accordance with the Allied Health Professional requirements of Article X of the Credentials Manual of the KMC Medical Staff. When a physician(s) employs a Medical Assistant, the privileges relating to the Medical Assistant can be granted only to the medical staff member(s). Any designated alternate must also agree to assume such responsibility for the Medical Assistant.

(2) When state, county, or city licensure has been established, each Medical Assistant must have such licensure as it applies to the area of activity.

(3) Each Medical Assistant must document satisfactory completion of education and/or training, inclusive of having been certified by the Certifying Board of the American Association of Medical Assistants. Experience may be substituted for a formal course in rare instances, but must be documented and acceptable to the clinical service, Credentials Committee, Executive Committee, and Board of Directors.

(4) Each supervising physician must develop and submit duties applicable to the Medical Assistant which shall be well-defined in a written scope of practice that is reviewed and approved by the applicable clinical service subject to final approval by the Credentials Committee, the Medical Executive Committee and the Board, in accordance with Article X of the Credentials Manual and reviewed bi-annually at the time of reappointment.

(a) Certified Medical Assistants:

**Qualifications:**

(1) Certified by the Certifying Board of the American Association of Medical Assistants.

(2) Fulfill the requirements and qualifications applicable to an AHP under Article X of the Credentials Manual.

**Duties:**

The supervising physician shall submit a written scope of practice and Supervising Medical Staff Member Agreement to the Medical Staff for approval in accordance with Article X of the Credentialing Manual.

(b) Physician Liaison RN/LPN Medical Assistants:

**Qualifications:**

(1) Possess a current and valid license under the State of Ohio to practice nursing as a RN or LPN.

(2) Fulfill the requirements and qualifications applicable to an AHP under Article X of the Credentials Manual.

(3) Employed by the supervising physician.

**Duties:**

The supervising physician shall submit a written scope of practice and Supervising Medical Staff Member Agreement to the Medical Staff for approval in accordance with Article X of the Credentialing Manual.

## B. Physician Assistants (PAs)

**Qualifications:**

(1) A physician assistant will be defined as an individual who has completed a course of study qualifying him/her to sit for the National Physician Assistant Certifying Examination. Such Certification should be obtained within three (3) years of completion of the individual's course of study. Failure to comply with this requirement will result in loss of AHP privileges for the physician assistant candidate.

(2) Application by a physician assistant may be made only by an employing physician(s) who will supervise and direct the PA. A Supervising Medical Staff Member Agreement and a utilization plan approved by the State Medical Board that contains a listing of proposed duties and responsibilities of the physician assistant must accompany the application as it applies to the employing physician's practice. The application and accompanying documents shall be reviewed by the clinical service in which the employing physician maintains privileges, reviewed by the Credentials Committee, and ultimately approved by the Medical Executive Committee and the Board of Directors. The supervising physician and physician assistant must have approval from the State Medical Board for the standard utilization plan and any supplemental plans of the physician assistant in his/her practice.

(3) No physician or group of physicians may employ more than the number of physician assistants that can be adequately supervised by such physician or group pursuant to the Ohio Revised Code.

(4) Following initial approval for a physician assistant, application for additional duties may be made and submitted to the clinical service in which the employing physician holds privileges subject to the PA utilization plan that has been approved for that physician by the State Medical Board, and must be subsequently approved by the Credentials Committee and the Medical Executive Committee.

(5) Supervision requirements for a PA shall at all times comply with Ohio law which currently requires continuous availability by the supervising physician either by being physically present on location or readily available through some means of telecommunication and in a physical proximity of not more than 60 minutes travel time away from where the PA is practicing.

**Duties:**

Subject to Ohio Medical Board Administrative Rules' Supervision Requirements, the general core duties for Physician Assistants pursuant to Hospital Board approval shall be limited to those set forth at OAC 4731-4-01(B) and shall include, but not be limited to the following in the discretion of the Hospital Board:

(1) Provide patient education to the employer's patients to include, but not be limited to, such things as pre-operative instructions,

instructions concerning the particular medical problem that the patient has, discharge instructions, and routine care instructions of any incisions or other physical ailments that the patient may have. The foregoing must be under the guidance of the employing physician.

(2) Physician assistants may make individual rounds and place progress notes in the medical record, which must be co-signed by the employing physician in accordance with law, accrediting standards and hospital policy.

(3) Physician assistants may write orders in the medical record in accordance with the utilization plan specifications, which orders have been directly given by the employing physician and which must be reviewed and countersigned by the employing physician in accordance with law, accrediting standards and hospital policy.

(4) Set up patients for monitoring.

(5) Perform histories and physicals and dictate these through the hospital medical records system. A history and physical must be reviewed and countersigned by the employing physician in accordance with law, accrediting standards and hospital policy. Patients new to a physician practice must be seen and personally evaluated by the employing physician prior to initiation of any treatment plan.

(6) Dictate operative notes and discharge summaries which will then be reviewed and countersigned by the employing physician within an appropriate time frame as indicated by Health Information Services.

(7) Participate in CPR after documented training.

(8) May have access to the Medical Library.

(9) May attend education conferences given by the hospital, and in so doing, at least partially satisfy their continuing education needs.

(10) First or second assist on surgeries and procedures under the supervision of the employing physician in accordance with applicable law.

(11) Perform clinical procedures considered routine in the practice, after appropriate instruction and demonstration of proficiency in accordance with Medical Staff and Hospital bylaws, policies and procedures, and under the direction and instruction of the employing physician.

(12) Physician assistants may perform specialized duties which typically require written informed consent, only if they work under the supervision of a physician who has been granted privileges to perform such duties and can supervise the physician assistant's performance and only when the participation of the PA is indicated on the informed consent form.

These procedures may be performed as approved in a supplemental utilization plan only after appropriate instruction and after demonstration of proficiency in accordance with Medical Staff and Hospital bylaws, policies and procedures, and under the direction of the employing supervising physician. A copy of the supplemental utilization plan shall be forwarded to the Medical Staff Office as an attachment to the application.

### C. Registered Nurse First Assistant (RNFA)

**Qualifications:**

The RNFA is defined by the Hospital Board to include as a minimum, the definition and qualifications in accordance with the Ohio Revised Code and Administrative Codes, and additional certification and supervision requirements as approved by the Hospital Board as follows:

(1) Current State of Ohio RN license;

(2) Minimum of 24 months of operating room nursing experience;

(3) Achievement of national Certification in Operating Room Nursing (CNOR) or CNRFA, which indicates

i) Satisfactory completion of two years peri-operative nursing

ii) Proficiency in the practice of caring for patients peri-operatively

iii) Documented validation of professional achievement of identified standards or practice as defined by the National Association of Operating Room Nurses (AORN) of a RNFA Program that meets AORN recommended education

standards for RNFA and is accepted by the Certification Board of Perioperative Nursing.

(4) Achieve and maintain certification as an RNFA;

(5) Current CPR certification.

**Duties:**

(1) The RNFA will function under the direct supervision and control of a physician or physicians present during surgery.

(2) The RNFA make entries in the medical record, including progress notes, immediately post-operative notes, and operative notes related to the operative procedure in which the RNFA participated. This is not to replace the doctor's daily visit. The RNFA may write orders in the medical record which have been given by the employing physician and which must be countersigned by the employing physician in accordance with law, accrediting standards and hospital policy.

(3) During surgery the RNFA collaborates with the surgeon and the healthcare team in performing a safe operation with optimal outcomes for the patient. The RNFA practices peri-operative nursing and must have acquired the necessary knowledge, skills, and judgment specific to clinical practice.

(4) Responsible preoperatively for:

(i) Interviewing the surgical patient for a comprehensive health history

(ii) Perform nursing physical assessments

(iii) Educating the patient and offering emotional support

(iv) Evaluating the needs of the patient and of the surgical team on a continuum, throughout the surgical encounter

(5) Responsible intra-operatively for:

(i) Collaborating with the surgeon and other health care professionals for an optimal surgical outcome

(ii) Assisting the anesthesiologist when applicable

(iii) Assisting with patient positioning, skin preparation, and draping

(iv) Providing wound exposure by suctioning, sponging, and retracting

(v) Handling tissue appropriately to reduce the potential for injury

(vi) Using and manipulating surgical instruments skillfully

(vii) Providing hemostasis by applying hemostatic clamps or clips, coagulating bleeding points, and ligating bleeding vessels

(viii) Suturing fascia, subcutaneous, and skin tissues

(ix) Saphenous vein harvesting if specially trained

(x) Closing

(6) Responsible postoperatively for:

a. Assisting in the safe delivery of the patient to the recovery room (PACU)
b. Communicating to the appropriate health care personnel and family members
c. Performing follow-up care to evaluate patient condition
d. Performing postoperative activities within the scope of their practice
e. Participating in discharge planning and providing discharge instructions

**D. Private Scrub, Registered Nurse or Technologist**

**Qualifications:**

(1) Licensed, registered Nurse with documented proof of three (3) months operating room experience, or verification of successful completion of an educational program in surgical technology. The three months operating room experience must be no less than 24 working days in the operating room.

(2) The Private Scrub is under the direct supervision of the physician present during surgery.

**Duties:**

(1) Private scrub personnel shall perform only duties that are delineated in the Hospital's job description for such position within the scope of their certification and licensure or

education. A copy of these delineated duties shall be provided to the Medical Staff Office by the supervising physician as an attachment to the application.

(2) Functions as the instrument nurse helping to collect and open supplies, maintaining a sterile field and passing instruments to the scrubbed surgical team.

**E. Surgical Assistant (not acting as a First Assistant)**

**Qualifications:**

(1) Licensed, registered Nurse in the State of Ohio, with operating room experience.

(2) Surgical Technician who is certified as such by a recognized certifying body.

(3) The Surgical Assistant is under the direct supervision of the physician present during surgery.

**Duties:**

(1) Help to collect and open supplies/instruments.

(2) Assist in transferring patient to and from operating room bed.

(3) Assist in positioning of patient.

(4) Assist with procedures by retracting tissue, keeping surgical site as dry as possible, and holding instruments as deemed necessary by the surgeon, and will work with the direct supervision of the physician who is immediately present.

(5) Assist with the transfer of the patient to PACU.

**F. Certified Surgical Technologist/First Assistant**

**Qualifications:**

(1) Certification as Surgical Technologist by a recognized certifying body.

(2) Qualification to sit for certification as a first assistant.

(3) Successful completion of examination for first assistant.

**Duties:**

The CST-CFA may perform and will work with the **direct** supervision of the physician present during surgery.

(1) Handling of tissue.

(2) Providing exposure.

(3) Using instruments.

(4) Suturing.

(5) Providing hemostasis.

(6) Closing of tissue and skin.

**G. Limited Specialty Scrub/Assist Personnel**

**Qualifications:**

(1) Will have documented proof of three (3) months experience in an operating room or an office/clinic setting for a particular surgical procedure, such as, ophthalmology, dental/oral, etc.

(2) Will have documented evidence of specialized training and/or appropriate certification in the requested specialty.

**Duties:**

(1) Provide visual access for the physician by retracting tissue, keeping the surgical site dry, and holding or passing the instruments as needed by the surgeon.

(2) Can only function in the approved specialty.

(3) Work under the direct supervision of the surgeon who is immediately present.

### H. Certified Registered Nurse Anesthetist (CRNA)

**Qualifications:**

(1) Current Ohio RN license.

(2) Certification by the American Association of Nurse Anesthetists.

**Duties:**

The CRNA practices at the hospital as a dependent practitioner with duties not to exceed those specified within the scope of practice under Ohio law, consistent with the CRNA's education and certification and limited to the following by the Hospital Board:

(1) Practice under the supervision and direction of an Active Medical Staff Member with privileges to perform the procedure; and, when administering anesthesia, the CRNA must be in the immediate presence of the supervising physician (immediate presence is defined by Ohio law to mean the physician being in the operating or labor room or in an adjoining room or in the operating or labor suite).

(2) The medical management of patients who are rendered unconscious and/or insensible to pain and emotional stress during surgical, obstetrical and certain other medical procedures (involves preoperative, intraoperative, and postoperative evaluation and treatment of these patients).

(3) The protection of life functions and vital organs (e.g., brain, heart, lungs, kidneys, liver) under the stress of anesthetic, surgical, and other medical procedures.

(4) The management of problems in pain relief.

(5) The management of cardiopulmonary resuscitation.

## I. Pump Perfusionists

**Qualifications:**

Have and maintain Board certification (or eligibility by the American Board of Cardio Vascular Perfusion with Board certification obtained within 2 years of eligibility)

**Duties:**

Under the direct supervision of a member of the medical staff with privileges to perform the underlying procedures.

(1) Maintenance extracorpeal circulation/cardiopulmonary support (including bypass, CPS, and ECMO),

(2) Operation of counterpulsation devices (including intra-aortic balloon pump),

(3) Operation of ventricular assistance devices (including LVAD, RVAD, BIVAD),

(4) Blood conservation techniques (autotransfusion utilizing the Cell saver),

(5) Administration of cardioplegic solution,

(6) Anticoagulation and hematologic monitoring/analysis,

(7) Physiologic monitoring,

(8) Blood gas/chemistry monitoring,

(9) Induction of hypothermia/hyperthermia, with reversal, including circulatory arrest,

(10) Hemodilution,

(11) Hemofiltration (ultrafiltration),

(12) Administration of medications, blood components, and anesthetic agents via the extracorporeal circuit,

(13) Chart review and consultation with the physician, documentation associated with described duties,

(14) Remain on hospital premises for follow-up care until released by treating physician,

(15) Standby for PTCA in house.

**J. Certified Nurse-Midwives (CNM)**

**Qualifications:**

(1) Successful completion of an approved training program for Midwifery acceptable to the State Board of Nursing.

(2) Certification by the American College of Nurse-Midwives.

(3) Current licensure as a certified nurse-midwife by the Ohio State Board of Nursing.

(4) The CNM's collaborating physician must be a member of the Active Staff of the Obstetrics-Gynecology Clinical Service.

(5) Evidence of continuing competence as required by the American College of Midwives.

(6) The CNM practices at the Hospital as a dependent practitioner only in accordance with a Standard Care Arrangement entered into with one or more collaborating physicians who are continuously available to communicate with the CNM either in person or by radio, telephone, or other form of telecommunication.

(7) The CNM's collaborating physician shall:

(i) Review the chart of each patient at least once during pregnancy care and as requested for Well Woman Care.

(ii) Be available for consultation and provision of direct care for the CNM 24 hours a day, seven days a week.

(iii) Be available within a maximum of 30 minutes for in-hospital care when the need arises.

**Duties:**

May provide the management of preventative services and those primary care services necessary to provide healthcare to women ante-partally, intra-partally, post-partally and gynecologically, consistent with the CNM's licensure education and certification, and in accordance with Ohio law, including the following:

(1) The CNM assumes responsibility for the management of the obstetric care of patients whose medical, surgical, or past obstetric history and present health status is uncomplicated and healthy.

(2) During the course of care, the CNM consults the collaborating physician when deviations from normal arise and/or a course of action is not already specified in medically approved policies.

(3) The CNM may implement accepted emergency procedures for a patient requiring immediate care. Emergency management is implemented until such time as the collaborating physician arrives to assume management of care.

(4) Nurse-Midwifery care must be low risk patients who anticipate and desire a normal spontaneous delivery and who have no adverse factors of a substantial magnitude.

(5) Notification of the collaborating physician of patient's admission and status as applicable in accordance with Ohio law.

(6) The admission, physical examination and evaluation of maternal and fetal vital signs.

(7) Evaluation of maternal and fetal well-being and the progress of labor.

(8) Evaluation of need for analgesia/anesthesia.

(9) Amniotomy, as indicated.

(10) Administration of local or pudendal anesthesia.

(11) Midline episiotomy, as indicated.

(12) Spontaneous delivery of the infant.

(13) Delivery and/or manual removal of the placenta as indicated.

(14) Collection of cord blood.

(15) Evaluation of the placenta, cervix, vagina and perineum.

(16) Repair of episiotomy and first and second degree perinatal and vaginal lacerations.

(17) Evaluation of the newborn and initiation of resuscitation measures, as necessary.

(18) Assessing the stability of the mother's physical condition in the immediate postpartum until discharge period.

(19) Participating in the decision to keep the infant in the LDR area during recovery or to transport to the appropriate nursery.

(20) Completion of appropriate progress notes, admission notes, orders and permanent records.

(21) Must follow all Women and Children Services Policies, Procedures, and Practice Guidelines.

(22) Other duties requested must be forwarded to the Medical Staff Office as an attachment to the application.

(23) Consultation must occur with collaborating physician:

(i) Any condition of mother and baby about which the Nurse-Midwife is concerned including but not limited to proeclampsia, gestational diabetes, and hypertension.
(ii) Suspected or confirmed multiple gestation.
(iii) A non-vertex or unstable presentation.
(iv) Fetal distress, any indicator.
(v) A placenta retained more than 30 minutes after delivery of infant.
(vi) Excessive bleeding (intrapartum/postpartum).
(vii) Onset of labor at less than 37 completed weeks.
(viii) Failure to progress in labor.

(ix) Patient with previous C-sections undergoing a trial of labor.

## II. LICENSED INDEPENDENT PRACTITIONER ALLIED HEALTH PROFESSIONALS

### D. Clinical Nurse Specialists

Clinical Nurse Specialists are nurses authorized by Ohio law and the Hospital board to practice as licensed independent practitioners in collaboration with one or more physicians under a Standard Care Arrangement who may provide and manage the care of individuals and groups with complex health problems and provide health care services that promote, improve, and manage health care within the CNS's nursing specialty, consistent with the CNS's education and in accordance with Ohio law.

**Qualifications:**

(1) Licensed, registered Nurse in the State of Ohio, with a Master's Degree in the specialty and hold an Ohio certificate of authority to practice as a clinical nurse specialist.

(2) For prescriptive privileges a Certificate to Prescribe is required, and must act at all times in accordance with Ohio law.

(3) Practices only in accordance with a Standard Care Arrangement entered into with one or more collaborating physicians who are continuously available to communicate with the CNS either in person or by radio, telephone, or other form of telecommunication. It is the responsibility of the CNS and collaborating physician to provide Medical Staff Services with a copy of the original and any revisions to the Standard Care Arrangement.

**Duties:**

As defined by Ohio law and approved by the Hospital Board including, but not limited to the following:

(1) Provide patient assessment.

(2) Provide patient education to employer's patients regarding common medical problems.

(3) Assist in clinical studies.

(4) Document in progress notes.

(5) Provide routine instructions to patients at discharge.

(6) Make individual rounds in accordance with his/her scope of practice as defined by Ohio law and approved by the Hospital Board.

(7) Set up patients for monitoring within the limitations of his/her scope of practice.

(8) Write orders in accordance with applicable Ohio law and regulations regarding prescriptive authority.

(9) In no instance shall the scope of duties granted by the Hospital exceed those granted under the Ohio Board of Nursing's regulations regarding the Clinical Nurse Specialist's Scope of Practice.

(10) Any other duties requested must be forwarded to the Medical Staff Office as an attachment to the application.

## MONITORING OF QUALITY OF CARE

The collaborating physician shall review the CNS's performance as identified in the Standard Care Arrangement in compliance with the State's requirements for an approved quality assurance program. The CNS is responsible for maintaining records for ongoing continuing education and annually reporting these to the collaborating physician at the time when the Standard Care Arrangement is reviewed in compliance with the clinical service, Hospital and State requirements. It is the responsibility of the collaborating physician to ensure compliance with these requirements.

### E. Clinical Nurse Specialists – Mental Health or Psychiatric Mental Health

The Clinical Nurse Specialist in Behavioral Health has a nursing specialty in mental health or psychiatric mental health as determined

by the Ohio Board of Nursing, and practices as a licensed independent practitioner, providing assessment of seclusion and restraints, and discharging other duties in conformance with applicable Ohio law and regulations, and as approved by the Hospital Board.

**Qualifications:**

(1) See above qualifications under Clinical Nurse Specialist.

(2) National Certification from the American Nurses Credentialing Center.

(3) If the Behavioral Health CNS does not hold a certificate to prescribe, the CNS is not required to enter into a Standard Care Arrangement, but shall practice in collaboration with one or more physicians and shall submit a Supervising Medical Staff Member Agreement and written scope of practice.

**Duties:**

In addition to the duties listed above under CNS Duties, the responsibilities of the Behavioral Health CNS may also include:

(1) Perform patient assessment with DSM IV-R diagnosis and document findings in the medical record.

(2) Assessment of Seclusion and Restraint.

(3) Prescribe medication in harmony within scope of defined Certificate to Prescribe (also requires a standard care arrangement).

(4) Assessment and treatment of chemical dependency.

(5) Psychotherapy.

1 **MONITORING OF QUALITY OF CARE**

2 The collaborating physician shall review the CNS's performance as
3 identified in the Standard Care Arrangement in compliance with the
4 State's requirements for an approved quality assurance program. The
5 CNS is responsible for maintaining records for ongoing continuing
6 education and annually reporting these to the collaborating physician
7 at the time when the Standard Care Arrangement is reviewed in
8 compliance with the clinical service, Hospital and State requirements.
9 It is the responsibility of the collaborating physician to ensure
10 compliance with these requirements.

## C. Certified Nurse-Practitioner (CNP)

**Qualifications:**

The CNP practices at the Hospital as a licensed independent practitioner AHP in accordance with Ohio law and as authorized by the Hospital Board.

(1) Licensed registered nurse in the State of Ohio, with a Master's Degree in the specialty and holds an Ohio certificate of authority to practice as a CNP.

(2) For prescriptive privileges, a Certificate to Prescribe is required.

(3) Practices only in accordance with a Standard Care Arrangement entered into with one or more collaborating physicians who are continuously available to communicate with the CNP either in person or by radio, telephone, or other form of telecommunication. It is the responsibility of the CNP and collaborating physician to provide Medical Staff Services with a copy of the original and any revisions to the Standard Care Arrangement.

(4) Successfully passed the certification exam of the American Nurses Credentialing Center, or other certifying organizations approved by the Ohio Board of Nursing relative to the CNP.

**Duties:**

(1) A CNP may provide preventative and primary care services and evaluate and promote patient wellness within the CNP's nursing specialty, consistent with licensure education, certification and Ohio law, as approved by the Hospital Board.

(2) A CNP who holds a certificate to prescribe may, in collaboration with a physician, prescribe drugs and therapeutic devices in accordance with Ohio law.

(3) Conducting comprehensive health assessments.

(4) Order and interpret diagnostic tests.

(5) Appraise health risks and behaviors.

1 (6) Provide admission and discharge orders.

2 (7) Diagnose and manage commonly occurring health and disease
3 related symptoms.

4 (8) Planning intervention with patients.

5 (9) Intervening to assist clients in healthcare activities.

6 (10) Perform consultation.

7 (11) Prescribe, evaluate and adjust medication regimens and other
8 treatments as allowed by Ohio law and Ohio Board of Nursing.

9 (12) Coordinate care during transition periods in the hospital.

10 (13) Provide patient/family education concerning diagnosis,
11 treatment and clinical course.

12 (14) Dictate H/P's.

13 (15) Provide timely and accurate progress note documentation.

14 (16) Work independently and collaboratively with other health care
15 providers to enhance quality care for patients and their families.

16 (17) Achieve a cost-effective, comprehensive, outcome-oriented
17 practice.

18 (18) Perform advanced procedures: airway management and
19 endotracheal intubation central venous catheter insertion
20 (external jugular, subclavian, and femoral veins) chest tube
21 insertion and care; aspiration of cerebrospinal fluid; and
22 suturing as needed.

23 (19) Advanced monitoring of acutely ill patients.

24 (20) Provide acute-life threatening care based on current ACLS
25 protocols, including conducting code situations and
26 defibrillation.

(21) Prescribe drugs in accordance with a modified exclusionary formulary with prescribing parameters determined by the ACNP and the Collaborating Physician.

(22) Prescribe off-label drugs in accordance with Ohio law, with oversight by the Collaborating Physician.

(23) Other duties requested must be forwarded to the Medical Staff Office as an attachment to the application.

## D. Neonatal Certified Nurse Practitioner (NCNP)

**Qualifications:**

The NCNP practices as authorized by Ohio law and the Hospital Board as a licensed independent practitioner.

(1) Licensed, registered nurse in the State of Ohio who has satisfactory completed an accredited Neonatal Nurse Practitioner (NNP) program and is eligible for or is certified by a national organization.

(2) The NCNP shall have satisfactorily completed a recognized Nurse Practitioner program accredited by the National League of Nursing and recognized by the Ohio Board of Nursing.

(3) The NCNP must have successfully passed a National Certification examination for Nurse Practitioners given by a National Certifying agency approved by the Ohio Board of Nursing.

(4) The NCNP must continuously maintain a current Ohio Board of Nursing License and must have obtained a Certification of Authority from the Ohio Board of Nursing to practice as a certified nurse practitioner.

(5) Practices only in accordance with a Standard Care Arrangement entered into with one or more collaborating physicians who are continuously available to communicate with the NCNP either in person or by radio, telephone, or other form of telecommunication. It is the responsibility of the NCNP to provide Medical Staff Services with a copy of the original and any revisions to the Standard Care Arrangement.

(6) For prescriptive privileges, must hold a Certificate to Prescribe and act in accordance with Ohio law.

**Duties:**

The responsibilities of the NCNP include but are not limited to the following:

(1) Eliciting, recording, and interpreting the obstetrical, past medical, family and psycho-social history of the neonate's parents, noting risk factors and their implications for problems in the immediate newborn period, as well as the potential impact on the neonate's future growth and development. They may record findings, opinions and activities in the progress notes.

(2) Performing the standard newborn physical examination using the techniques of observation, inspection, auscultation, palpation and percussion.

(3) Performing clinical assessment of gestational age and relates this data to fetal growth measurements for determination of size/date discrepancies.

(4) Discriminating between normal and abnormal findings on the physical examination, recording these findings, and discussing findings with attending physician.

(5) Developing and implementing an initial plan for differential diagnosis and management of presenting problems in accordance with Ohio law.

(6) Performing necessary diagnostic and therapeutic procedures based on demonstrated skills, as indicated for identification and management of problems in accordance with Ohio law including:

a. Suprapubic aspiration
b. Tracheal aspiration and intubation
c. Umbilical vessel catheterization
d. Lumbar punctures
e. Peripheral percutaneous arterial line placement
f. Percutaneous central line placement
g. Chest tube placement
h. Partial/complete exchange transfusion
i. Needle aspiration of the chest

(7) Writing and effectively communicating orders in accordance with Ohio law, Hospital Board approval, and the accepted scope of the practitioner's practice.

(8) Performing a daily reassessment of all problems, patient progress, and implications for revision of management.

(9) Communicating information about the neonate's diagnosis, plan of management, and prognosis with the referring physician, parents and other members of the health care team.

(10) Collaborating with other health team members, referring physician and family in planning and coordinating appropriate follow up prior to discharge.

(11) Collaborating with members of the high-risk obstetrical team:

j. Communicates frequently with members of the high-risk obstetrical team regarding high-risk obstetrical team regarding high-risk or potentially high-risk mothers, to remain current with medical and gestational problems affecting the neonatal outcomes.
k. Participates in association with attending physician in counseling and supporting parents likely to deliver a high-risk infant.
l. Provides immediate supportive care for the high-risk neonate, performing the initial assessment and resuscitation, when necessary.

(12) Contributing to educational efforts:

m. Contribute to the education programs in the nurseries.
n. Participates in community and professional organizations concerned with improving the quality of care available and acceptable to the high-risk mother and newborn.
o. Attends all appropriate medical education presentations.
p. Participates in research projects as assigned.

(13) Any other duties requested must be forwarded to the Medical Staff Office as an attachment to the application.

**MONITORING OF QUALITY OF CARE**

The collaborating physician shall audit the NCNP's performance as identified in the Standard of Care Arrangement in compliance with the state's requirements for an approved quality assurance program. The NCNP is responsible for maintaining records for ongoing continuing education and annually reporting

1 these to the collaborating physician at the time when the Standard of Care
2 Arrangement is reviewed, in compliance with the clinical service, Hospital and
3 State requirements. It is the responsibility of the collaborating physician to ensure
4 compliance with these requirements.

# APPENDIX E: Supervising Medical Staff Member Agreement – Allied Health Professional

(To be included with application from the affected Allied Health Professional and signed by principal physician supervisor and all designated alternates where applicable.)

In supervising ______________________________ (Name of Allied Health Professional) while providing services on Kettering Medical Center premises, I agree:

- To accept full legal and ethical responsibility for the Allied Health Professional's ("AHP") performance of the duties and acts authorized for him/her while under my supervision;

- To accept full responsibility for the proper conduct of the AHP within the Hospital, for the AHP's observance of all bylaws, policies and rules of this Hospital and Medical Staff, and for the correction and resolution of any problems that may arise;

- To abide by all bylaws, policies and rules governing the use of AHPs in this Hospital, including refraining from requesting that the AHP provide services beyond, or that might reasonably be construed as being beyond, his/her authorized scope of practice in the Hospital;

- To immediately notify the Medical Staff Office in the event any of the following occur:

  (a) My approval to supervise the AHP is revoked, limited, or otherwise altered by action of the Ohio State Medical Board and applicable Certification Programs;

  (b) Notification is given to me of investigation of my supervision of the AHP by the Ohio State Medical Board of applicable Certification Program;

  (c) The employment status of the AHP changes;

  (d) The AHP's authorized scope of practice changes, or the AHP is under investigation by the Ohio State Medical Board or applicable Certification Program;

  (e) My professional liability insurance coverage is changed insofar as coverage of the acts of the AHP are concerned;

- To comply with all regulations of the Ohio State Medical Board and Certification Program with respect to my supervision of the AHP specifically including (but not limited to) such regulations as have been (or may from time to time, be) adopted by said Board with respect to (1) billing for the services of such AHP, and (2) requirements for supervision of said AHP with respect to the type and

scope of services such AHP is approved to perform by the Board. In the event the AHP's license or certification requires that a standard care arrangement be entered into between the AHP and a collaborating physician, I represent that I meet the qualifications to collaborate with the above-named AHP and that I am not, at the same time, collaborating with more than that number of AHPs as is authorized by Ohio law. I further represent that any standard care arrangement as may be required by Ohio law conforms to the minimum requirements of Section 4723.431 of the Ohio Revised Code in that it contains all of the following as applicable to this AHP:

(1) Criteria for referral of a patient by the AHP (clinical nurse specialist, certified nurse-midwife, or certified nurse practitioner) to me as a collaborating physician or podiatrist;

(2) A process for the AHP to obtain a consultation with me;

(3) A plan for coverage in instances of emergency or planned absences of either myself or the AHP that provides the means whereby I am available for emergency care;

(4) The process for resolution of disagreements regarding matters of patient management between myself and the AHP;

(5) A procedure for a regular review of the referrals by the AHP to other health care professionals and the care outcomes for a random sample of all patients seen by the AHP;

(6) If the AHP regularly provides services to infants, a policy for care of infants up to age one and recommendations for my visits for children from birth to age three;

(7) Any other criteria as may be required by law from time to time.

I am attaching a copy of the Standard Care Arrangement between myself and the AHP who is the subject of this Agreement.

I (we) agree that the above provisions fully represent my (our) capacity as Supervising Medical Staff Member(s):

Date: ____________ Principal Supervisor: ______________________________________

Date: ____________ Alternate Supervisor: ______________________________________

## CERTIFICATION OF ADOPTION AND APPROVAL

Adopted by the Medical Executive Committee on
November 15, 2005

______________________________________
Rakesh Gupta, M.D.
Medical Staff President

Approved by the Board of Directors on
November 29, 2005 after receipt of a recommendation by the Medical Executive Committee

______________________________________
Fred Manchur
Secretary