MEDICAL STAFF BYLAWS, POLICIES, AND RULES AND REGULATIONS OF ELLIOT HOSPITAL

Credentials Policy of the Medical Staff Bylaws
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SECTION 1: CREDENTIALS COMMITTEE & NON-PHYSICIAN PROVIDER CREDENTIALS SUBCOMMITTEE

1.1. Credentials Committee:

1.1.1. Composition: Membership of the Credentials Committee shall consist of at least nine (9) members of the Active and Active-Ambulatory Medical Staff, and Senior Vice President of Medical Affairs (SVPMA). The President of the Medical Staff will appoint the Chair and other members. Members will be appointed for three (3) year terms with the initial terms staggered such that approximately one third of the members will be appointed each year. The Chair will be appointed for a two (2) year term. The Chair and members may be reappointed for additional terms without limit. Any member of the Credentials Committee, including the Chair, may be relieved of their committee membership by a two-thirds vote of the Medical Executive Committee (MEC). Service on this committee shall be considered as the primary Medical Staff obligation of each member of the committee and other Medical Staff duties shall not interfere.

1.1.2. Meetings: The committee shall meet at least 10 times per year, unless there is no business to be conducted.

1.1.3. Responsibilities: The responsibilities of the Credentials Committee are as follows:

1.1.3.1. To review and recommend action on all applications and reapplications for membership and status on the Elliot Hospital Medical and Allied Health Professional (AHP) Staff.

1.1.3.2. To review and recommend action on all requests for clinical privileges for practitioners.

1.1.3.3. To recommend criteria for the granting of Medical/AHP Staff membership and/or clinical privileges for Elliot Hospital.

1.1.3.4. To develop, recommend, and consistently implement contemporary policy and procedures for all credentialing and privileging activities at Elliot Hospital.

1.1.3.5. To review and recommend action on initial Focused Professional Practice Evaluations (FPPE) to determine if competency is demonstrated relative to the privilege in question or if an action plan for further education, monitoring of practice or changes in clinical privileges are necessary.

1.1.3.6. To oversee the Non-Physician Provider Credentials Subcommittee

1.1.4. Confidentiality: The committee shall function as a peer review committee consistent with federal and state law, including RSA 151:13a. All members of the Credentials Committee shall, consistent with the Medical Staff and hospital confidentiality policies, keep in strict confidence all papers, reports, and information obtained by virtue of membership on the committee. A separate credentials file for each applicant will be maintained in the Medical Staff Services Department (MSSD).

1.2. Non-Physician Provider Credentials Subcommittee:

1.2.1. Composition: Membership of the NPP Credentials Subcommittee shall consist of at least seven (7) members composed of the following: four (4) Non-Physician Provider members, one of whom is a member of the APRN Council; one (1) member of the Credentials Committee who shall be the chair; one (1) Active or Active-Ambulatory Medical Staff Member and the Chief Nursing Officer of the Elliot Hospital. The President of the Medical Staff shall appoint both the members representing the Credentials Committee and the Medical Staff, and the chair of this Subcommittee. The members will be appointed for three (3) year terms with the initial terms staggered such that approximately one third of the
members will be appointed each year. The Chair and members may be reappointed for additional terms without limit. Any member of the Non-Physician Provider Credentialing Subcommittee including the Chair, may be relieved of his or her committee membership by a two-thirds vote of the Medical Executive Committee.

1.2.2. Meetings: The subcommittee shall meet prior to the Credentials Committee meeting, unless there is no business to be conducted.

1.2.3. Responsibilities: The responsibilities of the Non-Physician Provider Credentials Subcommittee are as follows:

1.2.3.1. To review and recommend action on all applications and reapplications for membership in the appropriate category for Non-Physician Providers to the Credentials Committee Chair.

1.2.3.2. To review and recommend action on all requests for clinical privileges for Non-Physician Providers to the Credentialing Committee Chair.

1.2.3.3. To recommend criteria for granting Non-Physician Provider membership and clinical privileges for Elliot Hospital to the Credentialing Committee.

1.2.3.4. To develop and recommend policies and procedures for all credentialing and privileging activities relating to Non-Physician Providers.

SECTION 2: QUALIFICATIONS FOR MEMBERSHIP

2.1. Medical Staff Members:

The following qualifications must be met by all applicants for appointment to the Medical Staff before an application will be processed for recommendation of approval:

2.1.1. Demonstrate that he/she has successfully graduated from an approved school of medicine, osteopathy, dentistry, podiatry, or professional graduate school.

2.1.2. Have a current full and unrestricted State of New Hampshire license as a physician, dentist, APRN, physician’s assistant, or podiatrist required for the practice of their profession within the state of New Hampshire, and must meet any continuing education obligations required under applicable law.

2.1.3. Possess a current, valid unrestricted drug enforcement administration (DEA) number, if applicable.

2.1.4. Demonstrated ongoing clinical performance and competence with active clinical practice consistent with the privileges being requested.

2.1.5. Provide evidence of skills to provide a type of service that the BOT has determined to be appropriate for performance within the hospital and for which a need exists.

2.1.6. Provide evidence of Professional liability insurance to cover the privileges being requested and in an amount established by the BOT.

2.1.7. Have a record that is free from current Medicare/Medicaid/CHAMPUS sanctions or felony convictions, or occurrences that would raise questions of undesirable conduct.

2.1.8. Each applicant must submit the required immunization documentation and agree to the mandatory drug screening as noted in the application materials. Note: Drug screening requirement for Telemedicine providers is at the discretion of the BOT having received recommendation from MEC.

2.1.9. A physician applicant, MD or DO, must have successfully completed an allopathic or osteopathic residency program of at least three years, approved by the Accreditation Council for Graduate Medical Education (ACGME) or the American Osteopathic Association (AOA), and be board certified or board admissible by an approved board of the American Board of Medical Specialties or the American Osteopathic Association in the practicing specialty(ies).
A practitioner must receive board certification within five years of completion of residency or fellowship program in practicing specialty(ies) and subsequently maintain certification. Board certification must be in the same area in which the applicant is seeking clinical privileges.

A podiatric physician, DPM, must have successfully completed a two year residency program in surgical, orthopedic, or podiatric medicine approved by the Council on Podiatric Medical Education of the American Podiatric Medical Association (APMA), and be board certified or board admissible by the American Board of Podiatric Surgery within the same time frame as stated above.

2.1.10. Dentists must have graduated from an American Dental Association approved school of dentistry accredited by the Commission of Dental Accreditation.

Oral and maxillofacial surgeons must have graduated from an American Dental Association approved school of dentistry accredited by the Commission of Dental Accreditation and successfully completed an American Dental Association approved residency program and be board certified or board admissible by the American Board of Oral and Maxillofacial Surgery.

All Dentists and Oral Surgeons applying for membership to the Medical Staff will require certification within five (5) years of completion of training programs by the following agencies: Dental Specialist (any one):

- American Board of Dental Public Health
- American Board of Endodontics
- American Board of Oral and Maxillofacial Surgery
- American Board of Oral Pathology
- American Board of Orthodontics
- American Board of Pediatric Dentistry
- American Board of Periodontology
- American Board of Prosthodontics

General Dentist: Council of National Boards of Dental Examiners and/or Northeast Board of Dental Examiners.

2.1.11. Advanced Practice Registered Nurses (APRNs) and Physician Assistants (PAs) must have completed relevant education and training from an accredited program and be certified by the appropriate agency; i.e. American Nurses Credentialing Center (ANCC), The National Certification Corporation (NCC), National Commission on Certification of Physician Assistants (NCCPA), National Board of Certification & Recertification for Nurse Anesthetists (NBCRNA), etc.

2.1.11.1. APRNs applying for independent practice must, in addition to 2.1.11, have more than 2 years’ experience as an RN and more than one year working experience as an APRN, have work experience with a relevant patient population to their intended practice, provide a letter of recommendation from a physician colleague recommending them for independent practice, and apply for privileges that have been previously approved for independent APRN practice. If approved and pertinent privileges do not exist, the process for creation and approval of new privileges must be followed. Independent APRNs are not eligible for privileges to admit to the hospital.

2.1.12. Failure to achieve board certification within the time frames as noted under Sections 2.1.9, 2.1.10, and 2.1.11 or maintain board certification, if applicable, will be deemed a voluntary resignation as of board expiration date unless an extension of privileges is granted by the Board of Trustees upon recommendation of the Credentials Committee and MEC. The individual will not be entitled to the Hearing and Appeals Process.
2.1.12.1. Extension: An applicant who has not yet been board certified in their specialty but who meet the requirements as stated in the Medical Staff Bylaws for board certification, may request an extension.

2.1.12.2. Exceptions: All other exceptions to the above may be waived only by the BOT after a consultation with the MEC.

2.2. Elliot Hospital may grant Medical Staff membership and clinical privileges only to individuals who meet the following criteria:

2.2.1 Fulfill the qualifications as identified in Section 2.1

2.2.2 Demonstrate background, experience and training, current competence, knowledge judgment, ability to perform, and technique in the specialty for all privileges requested.

2.2.3 Provide evidence of both physical and mental health that does not impair the fulfillment of responsibilities, with or without a reasonable accommodation, of Medical Staff membership and the specific privileges requested by and granted to the applicant.

2.2.4 Have appropriate personal qualifications to include a record of applicant's observance of ethical standards including:

2.2.4.1 Abstinence from any participation in fee splitting or other illegal payment, receipt, or remuneration with respect to referral or patient service opportunities.

2.2.4.2 A record of working professionally with others within an institutional setting.

2.2.5 Have appropriate written and verbal communication skills.

2.2.6 Any member of the Active or Associate Medical Staff who have privileges to admit an inpatient must demonstrate the capability to provide continuous care. The applicant must provide evidence of acceptable patient coverage to the Medical Staff.

2.2.7 Members appointed to the Supervised Provider staff category must have a completed collaboration or delegation agreement signed by their supervisory physician. The supervisory physician must be an Elliot Hospital Medical Staff Member. The supervisory Physician Medical Staff Member must have the appropriate privileges to oversee the Supervised Provider. An APRN or PA cannot have privileges that exceed those of the Medical Staff Member with which they have the collaboration or delegation agreement.

SECTION 3: APPLICATION REQUEST PROCEDURE

3.1. All individuals wishing to obtain Medical Staff clinical privileges and/or membership must contact the Medical Staff Services Department at Elliot Hospital to request an application. Elliot Hospital requires the candidate to complete the Elliot application in its entirety.

3.2. If the applicant has not returned the completed application within 21 days from the date the application was provided, the application process may be inactivated and the application will be designated as “incomplete”. The applicant may not reapply to the Medical Staff for a minimum period of six (6) months.

3.3. A non-refundable $300 processing fee will be required of all new applicants. The application process may not begin without the fee being paid.
SECTION 4: INITIAL APPOINTMENT PROCEDURE

4.1. Upon receipt of a completed application, the initial credentialing process will be initiated as outlined in the Provider On-boarding Operating Manual.

4.2. The applicant must sign and date the application and in so doing:

4.2.1. Attests to the accuracy and completeness of all information on the application or/and accompanying documents and agrees that any inaccuracy, omission, or misrepresentation, whether intentional or not, may be grounds for termination of the application process. If the inaccuracy, omission or misstatement is discovered after an individual has been granted appointment, the discovery may be grounds for automatic relinquishment of appointment and clinical privileges. Neither the rejection of the application, nor the relinquishment of appointment and clinical privileges, shall entitle an individual to any hearing or appeals.

4.2.2. Signifies willingness to appear for any requested interviews in regard to the application.

4.2.3. Authorizes hospital representatives and Medical Staff representatives to consult with prior and current associates and others who may have information bearing on professional competence, character, ability to perform the privileges requested, ethical qualifications, ability to work cooperatively with others, and other qualifications for membership and the clinical privileges requested.

4.2.4. Consents to hospital representatives and Medical Staff representatives’ inspection of all records and documents that may be material to an evaluation of professional qualifications and competence to carry out the clinical privileges requested, physical and mental health status, and professional and ethical qualifications.

4.2.5. Releases from liability and grants immunity to the hospital representatives, its Medical Staff, and its representatives for acts performed and statements made in good faith and in connection with evaluation of the application and credentials and qualifications to the fullest extent permitted by law.

4.2.6. Releases from liability all individuals and organizations who provide information in good faith to the hospital or the Medical Staff, including otherwise privileged or confidential information to Elliot Hospital representatives concerning background, experience, competence, professional ethics, character, physical and mental health, emotional stability, utilization practice patterns, and other qualifications for staff appointment and clinical privileges.

4.2.7. Consents to authorized Elliot Hospital (EH) Medical Staff and administrative representatives providing other hospitals, managed care entities (health plans) 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 EH may have concerning the applicant and release EH representatives from liability for so doing. For the purposes of this provision, the term “EH representatives” includes the BOT, its directors and committees, the President of the Hospital or designee, registered nurses and other employees of EH, the Medical Staff organization, all Medical Staff appointees, clinical units, and committees which have responsibility for collecting and evaluating the applicant's credentials or acting on the application, and any authorized representative of any of the foregoing.

4.2.8. As soon as information is known, the applicant agrees to provide the MSSD with updated information requested on the original application and subsequent reapplication or privilege request forms to include at least the following:

4.2.8.1. Has your license, registration, or certification to practice in your profession ever been voluntarily or involuntarily relinquished, denied, suspended, revoked, restricted, or have you ever been subject to a fine, reprimand, consent order, probation, or any conditions or limitation by any state of professional licensing, registration, or certification board?

4.2.8.2. Has there been any challenge to your licensure, registration or certification?
4.2.8.3. Have your clinical privileges or medical staff membership at any hospital or healthcare institution, voluntarily or involuntarily, ever been denied, suspended, revoked, restricted, denied renewal or subject to probationary or to other disciplinary conditions (for reasons other than non-completion of medical record when quality of care was not adversely affected) or have proceedings toward any of those ends been instituted or recommended by any hospital or healthcare institution, medical staff or committee, or governing board?

4.2.8.4. Have you ever resigned from any hospital or healthcare institution to avoid an investigation?

4.2.8.5. Have any disciplinary actions been taken, or are any currently in the process of being taken, which resulted or may result in: revocation, censure, written reprimand, restriction, suspension, fine, reduction, limitation, placing on probation, required performance of public service, a course of education training, counseling or monitoring, resignation, leave of absence, withdrawal of an application, termination or non-renewal of a contract, voluntary/involuntary relinquishment or voluntary/involuntary non-renewal of any nature, which you have not disclosed elsewhere in this application?

4.2.8.6. Have you voluntarily or involuntarily surrendered, limited your privileges or not reapplied for privileges while under investigation?

4.2.8.7. Have you ever withdrawn your application for appointment, reappointment or clinical privileges or resigned voluntarily before a decision was made by the governing body of any healthcare facility or health plan?

4.2.8.8. Have you ever voluntarily or involuntarily withdrawn or not completed an application process for any training program, appointment, privileges, or employment?

4.2.8.9. Have you ever taken a leave of absence from any training, educational program, or healthcare facility?

4.2.8.10. Have you ever been terminated for cause or not renewed for cause from participation, or been subject to any disciplinary action, by any managed care organizations (including HMOs, PPOs, or provider organizations such as IPAs, PHOs)?

4.2.8.11. Were you ever placed on probation, disciplined, formally reprimanded, suspended or asked to resign during an internship, residency, fellowship, preceptorship or other clinical education program? If you are currently in a training program, have you been placed on probation, disciplined, formally reprimanded, suspended or asked to resign?

4.2.8.12. Have you ever, while under investigation or to avoid an investigation, voluntarily withdrawn or prematurely terminated your status as a student or employee in any internship, residency, fellowship, preceptorship, or other clinical education program?

4.2.8.13. Have any of your board certifications, professional certifications/registrations or eligibility ever been revoked?

4.2.8.14. Have any of your board certifications, professional certifications/registrations, or Medical Society memberships ever been relinquished, denied, restricted, limited, suspended, surrendered, revoked or not renewed or otherwise disciplined either voluntarily or involuntarily or is any action or challenge currently pending?

4.2.8.15. Have you ever chosen not to re-certify or voluntarily surrendered your board or professional certification(s) while under investigation?

4.2.8.16. Has your narcotics registration certificate(s) in any jurisdiction ever been challenged, denied, suspended, revoked, restricted, denied renewal, or voluntarily or involuntarily relinquished?
4.2.8.17. Have you ever been disciplined, excluded from, debarred, suspended, reprimanded, sanctioned, censured, disqualified or otherwise restricted in regard to participation in the Medicare or Medicaid program, or in regard to other federal or state governmental healthcare plans or programs?

4.2.8.18. Have you ever been denied membership or renewal thereof, including but not limited to having been the subject of disciplinary proceedings, reprimands or sanctions in any professional organization, or healthcare facility?

4.2.8.19. Have you ever been the subject of an inquiry or disciplinary action by any governmental or other regulatory agency? Is any such action pending? (Include all documentation relating to all inquiries whether action taken, dismissed or pending. Copy of complaint(s), response(s) to complaint(s) and any/all letters from the disciplining agency.)

4.2.8.20. Are you currently the subject of an investigation by any hospital, licensing authority, DEA or CDS authorizing entities, education or training program, Medicare or Medicaid program, or any other private, federal or state health program, or a defendant in any civil action that is reasonably related to your qualifications, competence, functions, or duties as a medical professional for alleged fraud, an act of violence, child abuse or a sexual offense or sexual misconduct?

4.2.8.21. Have you ever been the subject of an investigation by any hospital, licensing authority, DEA or CDS authorizing entities, education or training program, Medicare or Medicaid program, or any other private, federal or state health program or a defendant in any civil action that is reasonably related to your qualifications, competence, functions, or duties as a medical professional for alleged fraud, an act of violence, child abuse, a sexual offense or sexual misconduct, or drug diversion?

4.2.8.22. To your knowledge, has information pertaining to you ever been reported to the National Practitioner Data Bank or Healthcare Integrity and Protection Data Bank?

4.2.8.23. Have you ever received sanctions from or are you currently the subject of investigation by any regulatory agencies (e.g., CLIA, OSHA, etc.)?

4.2.8.24. Have you ever been convicted of, pled guilty to, pled nolo contendere to, sanctioned, reprimanded, restricted, disciplined or resigned in exchange for no investigation or adverse action within the last ten years for sexual harassment or other illegal misconduct?

4.2.8.25. Are you currently being investigated or have you ever been sanctioned, reprimanded, or cautioned by a military hospital, facility, or agency, or voluntarily terminated or resigned while under investigation or in exchange for no investigation or adverse action within the last ten years for sexual harassment or other illegal misconduct?

4.2.8.26. Has your professional liability coverage ever been cancelled, restricted, declined or not renewed by the carrier based on your individual liability history?

4.2.8.27. Have you ever been assessed a surcharge, or rated in a high-risk class for your specialty, by your professional liability insurance carrier, based on your individual liability history?

4.2.8.28. Have you ever had any professional liability actions (pending, settled, arbitrated, mediated or litigated) within the past 10 years?

4.2.8.29. Have you ever been convicted of, pled guilty to, or pled nolo contendere to any felony?

4.2.8.30. Do you have any felony, grand jury indictment, or other criminal charges pending?

4.2.8.31. Have you been convicted of a crime related to your clinical, medical, dental or professional practice?
4.2.8.32. In the past ten years have you been convicted of, pled guilty to, or pled nolo contendere to any misdemeanor (excluding minor traffic violations) or been found liable or responsible for any civil offense that is reasonably related to your qualifications, competence, functions, or duties as a medical professional, or for fraud, an act of violence, child abuse or a sexual offence or sexual misconduct?

4.2.8.33. Have you ever been convicted in a criminal action? (Do not include a first conviction for simple assault, speeding, minor traffic violations, affray, disturbance of the peace or any conviction of a misdemeanor more than 5 years prior to this application if there has been no criminal conviction of any offense within 5 years of this application.)

4.2.8.34. Have you ever been court-martialed for actions related to your duties as a medical professional?

4.2.8.35. Are you currently engaged in the illegal use of drugs? ("Currently" means sufficiently recent to justify a reasonable belief that the use of drugs may have an ongoing impact on one's ability to practice medicine. It is not limited to the day of, or within a matter of days or weeks before the date of application, rather that it has occurred recently enough to indicate the individual is actively engaged in such conduct. "Illegal use of drugs" refers to drugs whose possession or distribution is unlawful under the Controlled Substances Act, 21 U.S.C. § 812.22. It "does not include the use of a drug taken under supervision by a licensed health care professional, or other uses authorized by the Controlled Substances Act or other provision of Federal law." The term does include, however, the unlawful use of prescription controlled substances.)

4.2.8.36. Have you engaged in the illegal use of drugs within the past ten (10) years?

4.2.8.37. Do you use any chemical substances that would in any way impair or limit your ability to practice medicine and perform the functions of your job with reasonable skill and safety?

4.2.8.38. Do you have any reason to believe that you would pose a risk to the safety or well being of your patients?

4.2.8.39. Are you unable to perform the essential functions of a practitioner in your area of practice even with reasonable accommodation?

4.2.8.40. Are you currently using legal drugs in an illegal manner that may affect either your clinical judgment or motor skills, or would otherwise compromise your ability to perform the privileges you have requested?

4.2.8.41. Do you engage in alcohol consumption to the point where it may affect your ability to perform the clinical privileges you are requesting and essential functions of a practitioner in your area of practice, according to acceptable standards of professional performance, without posing a health or safety risk to your patients?

4.3. Procedure for processing applicants for initial staff appointment:

4.3.1. A "completed application" includes, a signed, dated application form and request for privileges (if applicable), copies of all documents and information necessary to confirm applicant meets criteria for membership and privileges, and references. Such application is hereby incorporated by reference. An application shall become incomplete if the need arises for new, additional, or clarifying information at any time. An incomplete application will not be processed.

4.3.2. The burden is on the applicant and it is the applicant's responsibility for ensuring that the MSSD receives supporting documents verifying information on the application. If all supporting documents required are not received within (28) twenty eight days of receipt of the application, this may be interpreted as a voluntary withdrawal of the application. An initial request, second reminder and final notice indicating missing information will be sent to the applicant after the receipt of the application.
4.3.3. Applicants will be provided regular updates on the status of their applications. Individuals seeking appointment have the burden of producing information deemed adequate by the hospital for a proper evaluation of current competence, character, ethics, and other qualifications, and of resolving any doubts.

4.3.4. Any application that is found to not meet the requirements for membership to the Medical Staff will not be considered for approval and will not be entitled to the Hearing and Appeals Process.

4.3.5. Verifications: Electronic queries and verifications, including faxes and emails, are accepted as originals. MSSD will maintain copies of all correspondence sent and will continue to monitor and follow-up with the status of the file approximately every two weeks.

Phone verifications are acceptable as long as they are made by an authorized member of the MSSD, Chair of the Credentials Committee, Senior Vice President of Medical Affairs or other person authorized for purposes of verifying credentials. The verification must be documented with complete information, including the date of the verification, the verifying person's name and title and the name of the person calling to verify the information.

Upon receipt of a completed application, the MSSD will verify its contents from primary sources whenever feasible. Designated equivalent sources may be used to verify certain documents in lieu of using primary source. The following information will be collected and considered as part of the credentialing process. Many sites now provide verifications through the internet and every attempt is made to ensure that the source being utilized is considered primary source information.

4.3.5.1. Licensure Verification: The MSSD verifies medical and professional licensure via the State Licensure Boards at the time of initial appointment, reappointment, change of privileges or status, and at the time of license expiration.

4.3.5.2. Certifying Board Verification: The MSSD verifies an individual's board status via primary source, either by contacting the individual board or through approved verification sources, i.e. the American Board of Medical Specialties, (ABMS), American Osteopathic Association (AOA); CertiFacts which is sponsored by the ABMS.

4.3.5.3. Education and Training Verification: Education and training is primary source verified directly through the appropriate facility; National Student Clearing House; American Medical Association (AMA); or American Osteopathic Association (AOA). The Educational Commission for Foreign Medical Graduates (ECFMG) is an acceptable equivalent for verification of a physician's graduation from a foreign medical school.

4.3.5.4. Hospital Appointment and Employment Verifications (Affiliations): Experience, ability and current competence in performing the requested privileges is verified by peers knowledgeable about the applicant's professional performance. This process may include an assessment for proficiency in the following six areas of “General Competencies” including: Patient Care, Medical/Clinical Knowledge, Practice-Based Learning and Improvement, Interpersonal and Communication Skills, Professionalism, Systems-Based Practice and based on a minimum of 5 years of clinical activity. The MSSD will verify all hospital appointments/employment for a minimum period of five (5) years from the date of application. The Credentials Chair or MSSD reserves the right to request as much verification as they feel necessary to evaluate the practitioner.

4.3.5.5. ECFMG Certification Verification: International medical graduates will be required to submit a copy of their certificate which will be verified with the Educational Commission for Foreign Medical Graduates.

4.3.5.6. Military Service Verification: A copy of the applicant’s DD-214 discharge papers is acceptable as verification of military service. As the National Military Personnel Records Center is inconsistent in responding to requests in a timely manner, application may not be held up for verification of individual military responses.
Military affiliation verifications may be substituted, as applicable.

4.3.5.7. **Peer Reference Verifications**: Two (2) current (within past two years) peer references not listed elsewhere in the application will be obtained. Peer recommendation includes documented information regarding the practitioner's current: 1) Medical/clinical knowledge; 2) Technical and clinical skills; 3) Clinical judgment; 4) Interpersonal skills; 5) Communication skills; and 6) Professionalism.

4.3.5.8. **Liability Insurance Coverage and Claims History**: Current malpractice insurance coverage in the minimum amount of $1,000,000.00 per incident/$3,000,000.00 aggregate is required. Verification of coverage, claims, suits, and settlements history is confirmed for all policies held within the past five (5) years. The Credentials Chair or MSSD reserves the right to request as much verification as they feel is necessary to evaluate the practitioner.

4.3.5.9. **National Practitioner Data Bank (NPDB)**: The practitioner is enrolled in the NPDB Continuous Query (CQ) during the initial credentialing process and re-enrolled as required to disclose any sanctions, settlements and judgments.

4.3.5.10. **Medicare and Medicaid Sanctions**: Both the AMA Profile and NPDB confirm any sanctions. The Office of Inspector General (OIG) and the System for Award Management (SAM) are queried at the time of initial appointment and reappointment. OIG is queried at the time of modification of privileges and change of status. In addition, a monthly OIG auditing report is run and reviewed for any changes.

4.3.5.11. **Controlled Substances Registration Certificate – Federal DEA**: Verifications are obtained by querying the DEA website. If we are not able to verify via the website, we may contact the Boston DEA office. The DEA registration address must be the NH office address where the practitioner will be administering and/or dispensing with the exception of low volume practitioners with a primary practice elsewhere in New Hampshire.

4.3.5.12. **Criminal Background Checks**: Criminal background checks will be performed by a contracted vendor as approved by the governing body and will include a national supplemental database search and sex offenders database to include all 50 states.

4.3.5.13. **Valid picture ID**: The hospital verifies that the practitioner requesting approval is the same practitioner identified in the credentialing documents by viewing one of the following: A current picture hospital ID card or a valid picture ID issued by a state or federal agency (e.g., driver's license or passport).

4.3.5.14. **Telemedicine Verification Services**: Physician privileging services for the Elliot Hospital may be delegated to a Joint Commission accredited distant site hospital or entity through a signed services agreement which meets or exceeds the credentialing and privileging policies as approved by the Elliot Hospital. The credentialing verifications will be delegated to the contracted entity with the exception of those services that cannot be delegated, as required by law, such as, but not limited to, National Practitioner Data Bank and criminal background checks. See Section on Telemedicine Privileges.

4.3.6. When the items identified in Section 4.3.5 above have been obtained satisfactorily, the file will then be reviewed by the MSSD with input from the SVPMA, as needed.

4.4. **Applicant interview**: Applicants may be required to participate in an interview at the discretion of the Credentials Committee. The interview may be conducted by Department Chair and one or more individuals selected by the Credentials Committee for this purpose. A permanent record of the interview will be documented. The interview may be used to solicit information required to complete the credentials file or clarify information previously provided, e.g., malpractice history, reasons for leaving past healthcare organizations, or other matters bearing on the applicant’s ability to render care at the generally recognized level for the community. Failure of the applicant to participate in the interview within 30 days of the request will be deemed a voluntary withdrawal.
4.5. Department Chair Recommendations:

4.5.1. All completed files are presented to the Department Chair for review and recommendation. The Department Chair reviews the application to ensure that it fulfills the established standards for membership and clinical privileges. The Department Chair will consult with or seek input from relevant Clinical Section Chiefs whenever necessary.

4.5.2. Department Chairs may not defer consideration of an application. The Chair will make a recommendation prior to Credentials Committee. In the event a recommendation cannot be met, the Chair must so inform the Credentials Committee.

4.5.3. The Department Chair must document the findings, including any adverse input, pertaining to education, training, and experience for all privileges requested. The application will be presented to the Credentials Committee with the Department Chair’s recommendation.

4.6. Credentials Committee action: The Credentials Committee Chair reviews the application to ensure that it fulfills the established standards for membership and clinical privileges. The application is presented to the Credentials Committee who reviews the application and votes for one of the following actions:

4.6.1. Deferral: Action by the Credentials Committee to defer the application for further consideration or gathering of information from the applicant or other sources must be followed within sixty (60) days by subsequent recommendations as to approval or denial of, or any special limitations to, staff appointment, category of staff and prerogatives, Department affiliations, and scope of clinical privileges. Additionally, the Credentials Committee can refer this to MEC for their recommendation prior to or after additional consideration has been completed if a Credentials recommendation is not determined.

4.6.2. Favorable recommendation: When the Credentials Committee’s recommendation is favorable to the applicant in all respects, the application shall be promptly forwarded, together with all supporting documentation, to the MEC. The Credentials Committee may recommend the imposition of specific conditions. These conditions may relate to behavior or to clinical issues. The Credentials Committee may also recommend that appointment be granted for a period of less than two years in order to permit closer monitoring of an individual’s compliance with any conditions.

4.6.3. Adverse recommendation: When the Credentials Committee’s recommendation is adverse to the applicant, the application shall be forwarded to the MEC.

4.7. Medical Executive Committee (MEC) Action - The application is presented to the MEC where the recommendation is reviewed to ensure that it fulfills the established standards for membership and clinical privileges. The MEC reviews the application and votes for one of the following actions:

4.7.1. Deferral: Action by the MEC to defer the application for further consideration must be followed within sixty (60) days by subsequent recommendations as to approval or denial of, or any special limitations to, staff appointment, category of staff and prerogatives, department affiliations, and clinical privileges. The President of the Medical Staff shall promptly notify the applicant by special, written notice of the action to defer.

4.7.2. Favorable recommendation: When the MEC’s recommendation is favorable to the applicant in all respects, the application shall be forwarded, together with all supporting documentation, to the BOT.

4.7.3. Adverse recommendation: When the MEC’s recommendation is adverse to the applicant, a special notice shall be sent to the applicant. No such adverse recommendation will be acted upon by the BOT until after the practitioner has exercised or has waived the right to a hearing as provided in the Hearing and Appeals Process. The practitioner has ten days to provide notification of their intent.

4.8. Board of Trustees Action - The application is presented to the Governing Board where the MEC recommendation is reviewed to ensure that it fulfills the established standards for membership and clinical privileges. The BOT reviews the MEC recommendation and votes for one of the following actions:
4.8.1. **Favorable recommendation:** The BOT may adopt or reject in whole or in part a favorable recommendation of the MEC or refer the recommendation back to the MEC for further consideration stating the reasons and setting a time limit within which a subsequent recommendation must be made. Favorable action by the BOT is effective as its final decision.

4.8.2. **Adverse recommendation:** If the BOT’s action is adverse, a special notice will be sent to the applicant. The applicant shall then be entitled to the procedural rights provided in the Hearing and Appeals Process.

4.8.3. **After procedural rights:** In the case of an adverse MEC recommendation, the BOT shall take final action in the matter as provided in the Hearing and Appeals Process.

4.8.4. All appointments to Medical Staff membership and the granting of privileges are for a period not to exceed 24 months.

4.9. **Basis for recommendation and action:** The report of each individual or group required to act on an application, including the BOT, must state in writing, the reasons for each recommendation or action taken with specific reference to the completed application and all other documentation considered.

4.10. **Conflict resolution:** Whenever the BOT determines that it will decide a matter contrary to the MEC’s recommendations, the matter will be submitted to a committee of equal members of the MEC and BOT for review and recommendation before the BOT makes its final decision. The committee will submit its recommendation within thirty (30) days of submission.

4.11. **Notice of final decision:** The applicant shall receive written notice of appointment and special notice of any adverse final decisions. A decision and notice of appointment includes the timeframe of the appointment, the staff category to which the applicant is appointed, the Department and Clinical Section to which the applicant is assigned, the clinical privileges approved (if applicable), and any special conditions attached to the appointment.

4.11.1. The applicant is notified by a letter signed by the President of Elliot Hospital (or designee) indicating the BOT’s decision for privileges and/or membership. The letter is accompanied by a copy of the Delineation of Clinical Privileges, as approved. A copy of the letter and the Delineation of Clinical Privileges are retained in the applicant’s credential file. All initial appointments shall be provisional for up to a period of up to two years in accordance with the initial Focus Professional Practice Evaluation (iFPPE).

4.11.2. In the event of an adverse recommendation, the “Hearing and Appeals Process” of the Medical Staff Bylaws is enacted.

4.12. The Medical Staff Members and Hospital staff are notified of those Medical Staff receiving clinical privileges and/or membership by way of a notification that is distributed to all Hospital department directors and managers, and a distribution made to relevant Department Chair and Clinical Section Chief via e-mail.

4.13. Each new member’s Delineation of Clinical Privileges is available for departmental access. A copy of the current Delineation of Privileges is stored on an external hard drive for emergency/downtime purposes.

4.14. All new members are required to attend a Practitioner Orientation program prior to clinical start date unless an exception is made by the President of the Medical Staff or the Senior Vice President of Medical Affairs. Newly approved practitioners attests by signing the new provider orientation checklist that they have been oriented to the current Medical Staff Bylaws and Rules and Regulations and agree to abide by their provisions. The practitioner acknowledges to have completed the New Provider Orientation which included presentations and/or copies or access to electronic versions of the items listed on the orientation checklist.

4.15. Locum Tenens privileges are used to provide temporary coverage for a period not to exceed one hundred (100) consecutive days. This allows only a short time to process the application and to verify information. Due to a considerable increase in staff time, processing costs and out of pocket charges, it is the policy of the MSSD to require a $500 fee prior to processing an application for a locum tenens privileges.
SECTION 5: INITIAL FOCUSED PROFESSIONAL PRACTICE EVALUATION (iFPPE)

5.1. All initially requested privileges shall undergo a period of FPPE. Routinely the section chief will provide a review appropriate to the providers experience and scope of practice. This review may be delegated to a supervisory provider for SP members or other relevant peers. Any iFPPE reviews with concerns will be further evaluated by the Department Chair. Such monitoring may utilize prospective, concurrent, or retrospective proctoring, including but not limited to: chart review, the tracking of performance monitors/indicators, external peer review, simulations, morbidity and mortality reviews, and discussion with other healthcare individuals involved in the care of each patient.

5.2. Monitoring of Initial Appointments: All initial appointments and clinical privileges, as well as any new clinical privileges granted to an existing Medical Staff appointee, are monitored to demonstrate clinical competency, during which time an individual's privileges shall be subject to review of their performance. The provisional review will be tracked as an initial FPPE and reviewed for relevant competency within eight months of initial appointment or sooner as indicated by BOT. If practice volume does not allow adequate review within eight months, this timeframe may be extended up to two years. The Credentials Committee or Department Chair may recommend an alternative timeframe or specific evaluation at the time of application review.

5.3. Action required: Based upon a report concerning the applicant's performance at the end of the initial focused review period, the Department Chair makes a recommendation concerning continuing or terminating the relevant privileges granted. Any adverse recommendation will be further reviewed by the credentials committee.

5.3.1. If initial appointees are unable to obtain the number of cases required to demonstrate the ability to exercise a particular clinical privilege due to inadequate caseload then the applicant will be required to submit to the Credentials Committee a statement describing their caseload. A signature by the appropriate Department Chair with input from the Clinical Section Chief, if necessary, will be required. The Credentials Committee, upon review of the documentation, may extend the practitioner's initial focused review period for an additional one (1) year period.

5.4. Termination by practitioner: If the practitioner no longer wishes the privilege or privileges at issue and there are no quality concerns, then a request for the withdrawal of these privileges will not create an adverse action initiating the Hearing and Appeals Process.

5.5. Adverse conclusions: When an initial focused review, including any period of extension, expires with an adverse recommendation based on professional conduct, quality of care issues, or when an extension is denied, the President of the Hospital will notify the practitioner of the adverse result and the practitioner’s entitlement to procedural rights provided in the Hearing and Appeals Process.

SECTION 6: ONGOING PROFESSIONAL PRACTICE EVALUATION (OPPE)

6.1. The medical staff will also engage in OPPE to identify professional practice trends that affect quality of care and patient safety. Information from this evaluation process will be factored into the decision to maintain existing privileges, to revise existing privileges, or to revoke an existing privilege prior to or at the time of reappointment. OPPE shall be undertaken as part of the medical staff’s evaluation, measurement, and improvement of practitioner’s current clinical competency. In addition, each practitioner may be subject to FPPE when issues affecting the provision of safe, high quality patient care are identified through the OPPE process. Decisions to assign a period of performance monitoring or evaluation to further assess current competence must be based on the evaluation of an individual’s current clinical competence, practice behavior, and ability to perform a specific privilege.
SECTION 7: REAPPOINTMENT

7.1. Reappointments are for periods up to, but not exceeding, two years. Applicants are notified approximately six months prior to their expiration date. The Reappointment Packet includes, but not limited to, the following: Application, Authorization and Consent Form, Delineation of Clinical Privileges (if applicable), and a copy of previous Delineation of Privileges. The application process may not begin without the non-refundable $200 fee being paid or $500 fee for late submissions.

7.2. All terms and conditions described in the initial application section may also apply to any corresponding documents used in the reappointment process. Additional new privilege requests from existing Medical Staff members will follow the steps described in Section 4, Initial Appointment Procedure, and Section 5, initial Focused Professional Practice Evaluation.

7.2.1. Applications with all required documentation received at least 90 days from the reappointment end date will be processed in time to avoid lapse. Applications with all required documentation received less than 90 days prior to their reappointment end date will be designated as “late submission” and will be charged a $500 application fee. There is no guarantee “late submissions” will be processed in time to avoid a lapse in privileges. The applicant will then be required to submit an initial credentialing application to be processed as a new applicant as outlined in Section 4.

7.2.2. Upon receipt of the Reappointment Application Packet, the MSSD will review the documentation for completeness. If the requirements are not met, a letter describing the missing information is sent to the applicant.

7.2.3. The reappointment process will be followed as outlined in the Provider On-boarding Operating Manual.

7.3. Information collection from practitioner:

7.3.1. Attestation concerning continuing training and education internal and external to the hospital during the preceding period relating, at least in part, to their specialty. Additional documentation may be requested, as needed.

7.3.2. Specific request for the clinical privileges, staff category, or Department/Section assignment change(s) sought on reappointment with any basis for changes.

7.3.3. By signing the reapplication form, the appointee agrees to the same terms as identified in Section 4.2.

7.3.4. Each applicant agrees to provide to the MSSD updated information requested on the original reapplication request forms to include at least the requirements detailed in Section 4.2.8.

7.4. Verifications: From internal and/or external sources, MSSD collects information regarding each staff appointee’s professional and collegial activities since the appointment or last reappointment to include:

7.4.1. A summary of clinical activity at this hospital. External activity may be required for low or no volume practitioners.

7.4.2. Performance and conduct in this hospital and/or other healthcare organizations, as needed and without limitation, patterns of care as demonstrated in findings of quality assessment/performance improvement activities, clinical judgment and skills in the treatment of patients, and behavior and cooperation with hospital personnel, patients and visitors.

7.4.3. Timely and accurate completion of medical records. Restrictions and suspensions are tracked in the practitioner report card and included in the reappointment review.

7.4.4. Compliance with all applicable hospital and Medical Staff Bylaws, Rules & Regulations, and policies and procedures.

7.4.5. Any gaps in employment or practice since the previous appointment or reappointment.

7.5. Procedure for processing applications for staff reappointment: When the items identified above have been obtained, the file will then be reviewed by the MSSD with input from the Senior Vice President, Medical Affairs, as needed. The review and approval process will be the same as identified in an initial application delineated in Section 4.
7.6. Criteria for reappointment: It is the policy of Elliot Hospital to approve for reappointment only those individuals who meet the criteria for initial appointment as identified in Section 2 plus the following additional criteria:

7.6.1. Have an acceptable record of providing high quality and cost effective care that is consistent with Elliot Hospital’s standards of ongoing quality as determined by the Medical Staff and hospital quality improvement program.

SECTION 8: CLINICAL PRIVILEGES

8.1. Practitioners may exercise only those privileges granted by the BOT, emergency, temporary, or disaster privileges as described herein.

8.2. Each application for appointment or reappointment to the Medical Staff must contain a request for specific clinical privileges desired by the applicant with the exception of Emeritus Staff or Associate-Ambulatory (no privileges). Specific requests must also be submitted for additional or withdrawal of privileges between appointment.

8.3. Requests for clinical privileges will be considered only when accompanied by evidence of education, training, experience, and demonstrated current competence as specified by the hospital in its board approved criteria for clinical privileges.

8.4. Privileges for which no criteria have been established:

8.4.1. In the event a request for privileges is submitted for a procedure for which no criteria have been established, the request will be tabled for a reasonable period of time, usually not to exceed ninety (90) days. Once objective criteria have been established, upon recommendation from the Credentials Committee and appropriate subject matter specialists, will recommend to the MEC for approval.

8.4.2. Valid requests for establishing new clinical privileges will be evaluated on the basis of prior and continuing education, training, experience, utilization practice patterns, current ability to perform the privileges requested, and demonstrated current competence, ability, and judgment. Additional factors that may be used in determining privileges are patient care needs, the hospital’s capability to support the type of privileges being requested, and the availability of qualified coverage in the applicant’s absence.

8.4.3. Criteria to be established for the privilege(s) in question include education, training, board status or certification (if applicable), and experience. Proctoring requirements, if any, will be addressed including who may serve as proctor, how many proctored cases will be required, and deadline for completion of proctoring.

8.4.4. Once privilege criteria are developed, the clinical Section Chief and Department Chair will review and provide input working with MSSD staff. Criteria are then recommended to the Credentials Committee for approval and subsequently MEC.

8.4.5. If the privileges requested overlap two or more specialty disciplines, an ad hoc committee will be appointed by the Chair of the Credentials Committee to recommend criteria for the privilege(s) in question. This committee will consist of at least one, but not more than two, members from each involved discipline. The Chair of the ad hoc committee will be a member of the Credentials Committee who has no vested interest in the issue.

8.4.6. Hospital related issues such as equipment and management will be referred to the appropriate hospital Department Director.

8.4.7. The basis for privileges determination to be made in connection with periodic reappointment or a requested change in privileges must include observed clinical performance and documented results of the staff’s quality improvement program activities. 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.
8.5. **Special conditions for dental privileges:** Requests for clinical privileges for dentists are processed in the same manner as all other privilege requests. Privileges for surgical procedures performed by dentists and/or oral surgeons will require that all dental patients receive a basic medical evaluation (history and physical) by a member of the Medical Staff with privileges to perform such an evaluation, which will be recorded in the medical record. Oral surgeons may be granted the privilege of performing a history and physical on their own patients upon submission of documentation of completion of an accredited postgraduate residency in oral/maxillofacial surgery and demonstrated current competence.

8.6. **Special conditions for licensed independent practitioners not qualified for Medical Staff appointment or to practice without supervision:** Requests for privileges from Allied Health Professionals (AHP) are processed in the same manner as requests for clinical privileges by physicians, with the exception that AHPs are not granted membership on the Elliot Hospital Medical Staff and do not have the rights and privileges of such membership. Only those categories of AHPs approved by the BOT for patient care at Elliot Hospital are eligible to apply for a scope of practice. An AHP may, subject to any licensure requirements or other limitations, exercise independent judgment only within the areas of professional competence and participate directly in the medical management of patients under the supervision of a member of the Medical Staff who has been accorded privileges to provide such care. [See Policy for Allied Health Professionals.]

8.7. **Expedited Credentialing:** A Committee of at least two voting members of the Board may grant approval of medical staff membership and clinical privileges in accordance with the Expedited Credentialing Policy.

8.8. **Temporary Privileges:** The CEO, or designee, acting on behalf of the Board and based on the recommendation of the Chief of Staff or designee, may grant temporary privileges. Temporary privileges may be granted only to fulfill an important patient care need or proctoring.

8.8.1. **Important Patient Care Need:** Temporary privileges may be granted on a case by case basis when an important patient care need exists that mandates an immediate authorization to practice, for a limited period of time, not to exceed 100 calendar days. When granting such privileges the organized medical staff verifies current licensure, malpractice insurance, and current competence i.e. professional reference from Chair or Section Chief at the primary hospital where privileges are held, NPDB, and OIG.

8.8.2. **Locum Tenens:** Upon receipt of a written request for specific temporary privileges, an appropriately licensed practitioner of documented competence and verified credentials who is serving as a Locum Tenens Medical Staff may, without applying for appointment to the staff, be granted temporary privileges for a period of not more than one hundred (100) consecutive days.

8.8.3. **Visiting Proctor:** Upon receipt of a written request for specific temporary privileges, an appropriately licensed practitioner of documented competence and verified credentials who is serving as a proctor for an appointee of the Medical Staff may, without applying for appointment to the staff, be granted temporary privileges for a period of sixty (60) consecutive days. Proctoring privileges may be renewed for an additional sixty (60) consecutive day period. Visiting proctors are limited to proctoring/supervising the treatment of the patients of the staff member and are not entitled to admit their own patients to the hospital. Visiting proctors must possess a full unrestricted State of New Hampshire Medical License or a special visiting professor license through the State of New Hampshire Medical Licensure Board.

8.8.4. **Rights of the practitioner with temporary privileges:** A practitioner is not entitled to the procedural rights afforded in Part II of these bylaws (Investigation, Corrective Action, Hearing and Appeals Process) because the request for temporary privileges is refused or because all or any part of the temporary privileges are terminated or suspended unless the decision is based on clinical incompetence or unprofessional conduct.

8.8.5. **Termination of temporary privileges:** The President of the Hospital, or designee, acting on behalf of the Board of Trustees and after consultation with the President of the Medical Staff and Senior Vice President for Medical Affairs, may terminate any or all of the practitioner's privileges based upon 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, and may at any other time terminate any or all of a practitioner's temporary privileges. When the life or wellbeing of a patient is determined to be endangered, any person entitled to impose summary or precautionary suspension, under the Medical Staff Bylaws may affect the termination. In the event of any such termination, the practitioner's patients at Elliot Hospital will be assigned to another practitioner by the Senior Vice President of Medical Affairs or designee. The wishes of the patient shall be considered, when feasible, in choosing a substitute practitioner.

8.9. **Emergency privileges**: In case of an emergency, any Medical Staff member is authorized to do everything possible to save the patient's life or to save the patient from serious harm, to the degree permitted by the appointee's license, regardless of Department 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.

8.9.1. **Disaster Privileges**: In the case of an officially declared emergency, whether it is local, state or national, in collaboration with the hospital’s disaster plan, the Disaster Privileges policy will be followed for providing emergent, temporary privileges to practitioners who are not members of the Medical Staff and will assist in the immediate needs of patient care for the community. For the same reason, existing members of the medical staff may be granted additional privileges. The practitioners will supply specific information in order to meet the minimum qualifications as set forth in the policy and the MSSD will verify the information as soon as possible. The practitioner should be paired with a currently credentialed medical staff member privileged in the same specialty. Privileges will be granted by the appropriate Incident Commander (CEO, Hospital President, SVPMA, or designee) handling the situation and upon recommendation by the Medical Staff President or appointed Medical Staff Director as soon as possible. When the emergency situation no longer exists, these disaster privileges will terminate immediately.

8.10. **Telemedicine Privileges**: The Board shall determine the clinical services to be provided through telemedicine after considering the recommendations of the appropriate Department Chair, the Credentials Committee, and the MEC.

8.10.1. Individuals applying for telemedicine privileges shall meet the qualifications for Medical Staff appointment outlined in this Policy, except for those requirements relating to geographic residence, coverage arrangements, DEA registration, immunizations and emergency call responsibilities.

8.10.2. Qualified applicants may be granted telemedicine privileges but shall not be appointed membership to the Medical Staff. Telemedicine privileges granted in conjunction with a contractual agreement shall be incident to and coterminous with the agreement.

8.10.3. In order for a request for Telemedicine privileges to be processed, the practitioner must satisfy all eligibility requirements (Refer to Credentials Policy) with the exception noted under the “EXEMPTIONS” section (See below). All requests for privileges shall be processed in the same manner as all other requests for clinical privileges. Verifications from at least four (4) facilities must be documented, with at least two (2) of those attesting to competencies of the physician. A practitioner must have a current and unrestricted New Hampshire medical license and a current, unrestricted license where he/she resides and must be privileged at the distant site for those services to be provided at the Elliot Hospital. A practitioner requesting privileges will be required to be a legal resident and living in the United States. Any practitioner living outside of the United States will not be eligible.

8.10.4. Applications for telemedicine privileges shall be processed in accordance with the provisions of this Policy in the same manner as for any other applicant, except as set forth below:

8.10.4.1. When telemedicine services are furnished to the Hospital's patients through a written agreement with a distant-site entity, the Medical Staff may rely upon the credentialing and privileging information and decisions used by the distant-site hospital when making recommendations on privileges for the individual distant-site physicians and practitioners providing such services, if the agreement with the distant-site entity includes all of the following provisions:
8.10.4.1.1. The distant-site entity providing the telemedicine services is a Medicare-participating hospital accredited by The Joint Commission and the Telemedicine Entity shall provide the Elliot Hospital with a copy of its current Joint Commission certificate, credentialing and privileging policies and procedures upon request.

8.10.4.1.2. The distant-site entity’s medical staff credentialing and privileging process and standards at least meet the standards set forth at 42 CFR § 482.12(a)(1) through (a)(9) and 42 CFR § 482.22(a)(f) through (a)(4), and Joint Commission Standards MS.06.01.01 through MS.06.01.13;

8.10.4.1.3. The individual distant-site practitioner is privileged at the distant-site entity providing the telemedicine services, for those services to be provided by the distant-site practitioner at the originating site;

8.10.4.1.4. The distant-site entity provides to the originating site, a current list of the distant-site practitioner’s privileges at the distant-site hospital;

8.10.4.1.5. The individual distant-site practitioner holds a full unrestricted State of New Hampshire medical license and a full unrestricted medical license from the US state from which the practitioner is reading, i.e. originating site;

8.10.4.1.6. With respect to a distant-site practitioner who holds current privileges at the Hospital, the Hospital has evidence of an internal review of the distant-site practitioner’s performance of these privileges and sends the distant-site hospital such performance information for use in the periodic appraisal (OPPE) of the distant-site practitioner. At a minimum, this information must include all adverse events that result from the telemedicine services provided by the distant-site practitioner to the Hospital’s patients including but not limited to all outcomes related to sentinel events considered reviewable by The Joint Commission, and all complaints the Hospital has received about the distant site practitioner, including but not limited to those from patients, licensed independent practitioners or staff at the originating site;

8.10.4.1.7. With respect to a distant-site practitioner who holds current privileges at the Hospital, the distant-site entity has evidence of an internal review of the distant-site practitioner’s performance of these privileges and sends the Hospital such performance information for use in the OPPE of the distant-site practitioner. This information must include all adverse events that result from the telemedicine services provided by the distant-site practitioner to the distant-site hospital’s patients including but not limited to all outcomes related to sentinel events considered reviewable by The Joint Commission, and all complaints the hospital has received about the distant-site practitioner, including but not limited to those from patients, licensed independent practitioners or staff at the originating site. To maintain assurance of quality, the Telemedicine organization currently being utilized will forward quarterly quality reports for each Telemedicine practitioner who has current, unrestricted medical staff privileges at the Elliot Hospital, to the Hospital for inclusion in the OPPE Database as part of the collective information gathered for peer review.

8.10.5. When telemedicine services are furnished to the Hospital’s patients, the Medical Staff may rely upon the credentialing and privileging information obtained by the distant-site telemedicine entity as outlined in an agreed upon Delegation Contract and decisions used by the distant-site telemedicine entity when making recommendations on privileges for the individual distant-site practitioners providing such services, if the agreement with the distant-site telemedicine entity includes all of the provisions listed in Section 8.10.
8.10.6. Telemedicine privileges, if granted, shall be for a period of not more than two years. Individuals seeking reappointment of telemedicine privileges will be required to complete an application (excluding those who are included under a delegated credentialing agreement) and, upon request, provide the Hospital with evidence of current clinical competence. This information may include, but is not limited to, a quality profile from the applicant's primary practice affiliation and an evaluation form(s) from qualified supervisor(s). If all requested information is not received by dates established by the Hospital, the individual's telemedicine privileges will expire at the end of the current term. Once all information is received and verified, an application to renew telemedicine privileges will be processed as set forth above. Telemedicine practitioners who are part of a delegated credentialing agreement are exempt from completing the application for reappointment but are required to submit a Elliot Hospital privilege delineation form.

8.10.7. Individuals granted telemedicine privileges may be subject to the Hospital's performance improvement, ongoing and focused professional practice evaluations and peer review activities.

8.11. Administrative restriction or suspension of clinical privileges: The limit for a restriction or suspension is ninety (90) days. If no response or corrective action is made, it will result in an administrative resignation. An application fee of $1500 will apply for those who reapply for privileges within six (6) months of the administrative resignation.

SECTION 9: INVESTIGATION AND CORRECTIVE ACTION

9.1. Criteria For Initiation: Any person may provide information to the Medical Staff about the conduct, performance, or competence of its members. When reliable information indicates a member may have exhibited acts, demeanor, or conduct, reasonably likely to be (1) detrimental to patient safety or to the delivery of quality patient care within Elliot Hospital; (2) unethical; (3) contrary to the Medical Staff Bylaws and Rules and Regulations; or (4) below applicable professional standards, a request for an investigation or action against such member may be initiated by the President of the Medical Staff, Department Chair, Senior Vice President of Medical Affairs or the MEC.

9.2. Initiation: A request for an investigation must be in writing by one of the above parties, submitted to the MEC through the Medical Staff President, and supported by reference to specific activities or conduct alleged. If the MEC initiates the request, it shall make an appropriate record of the reasons.

9.3. Investigation: If the MEC concludes an investigation is warranted, it shall direct an investigation to be undertaken. The MEC may conduct the investigation itself, or may assign the task to an appropriate Medical Staff Officer, Medical Staff clinical department, or standing or ad hoc committee of the Medical Staff, or the Senior Vice President of Medical Affairs. If the investigation is delegated to an officer or committee other than the MEC, such officer or committee shall proceed with the investigation in a prompt manner and shall forward a written report of the investigation to the MEC as soon as practicable. The report may include recommendations for appropriate corrective action. The member shall be notified that the investigation is being conducted and shall be given an opportunity to provide information in a manner upon such terms as the investigating body deems appropriate. The individual or body investigating the matter may, but is not obligated to, conduct interviews with persons involved. However, such investigations shall not constitute a "hearing" as that term is used in the Hearing and Appeals Process, nor shall the procedural rules with respect to hearings or appeals apply. Despite the status of any investigation, at all times the MEC shall retain authority and discretion to take whatever action may be warranted by the circumstances including precautionary suspension, termination of the investigative process; or other action.

9.4. Medical Executive Committee Action: As soon as practicable after the conclusion of the investigation the MEC shall take action that may include, without limitation:

9.4.1. Determining no corrective action be taken, and if the MEC determines there was not credible evidence for the complaint in the first instance, shall remove any adverse information from the member's file.

9.4.2. Deferring action for a reasonable time where circumstances warrant.
9.4.3. Issuing letters of admonition, censure, reprimand, or warning, although nothing herein shall be deemed to preclude Department Chairpersons from issuing informal written or oral warnings outside of the mechanism for corrective action. In the event such letters are issued, the affected member may make a written response which shall be placed in the member's file.

9.4.4. Recommending the imposition of terms of probation or special limitation upon continued Medical Staff membership or exercise of clinical privileges, including, without limitation, requirements for co-admissions, mandatory consultation, or monitoring.

9.4.5. Recommending reduction, modification, suspension or revocation of clinical privileges.

9.4.6. Recommending reductions of membership status or limitation of any prerogatives directly related to the member's delivery of patient care.

9.4.7. Recommending suspension, revocation, or probation of Medical Staff membership.

9.4.8. Other actions deemed appropriate under the circumstances.

9.5. **Subsequent Action:**

9.5.1. If the MEC recommends corrective action as set forth in the Hearing and Appeals Process, that recommendation shall be transmitted to the Board. The recommendation of the MEC shall become final action unless the member requests a hearing, in which case the final decision shall be determined as set forth in the Hearing and Appeals Process.

9.5.2. **Precautionary Restriction Or Suspension of Membership and/or Clinical Privileges:** The limit for a restriction or suspension is ninety (90) days.

9.5.3. **Criteria For Initiation:** Whenever a member's conduct appears to require that immediate action be taken to protect the life or well-being of patient(s) or to reduce a substantial and imminent likelihood of significant impairment of the life, health, safety of any patient, prospective patient, or other person, the President of the Hospital, the President of the Medical Staff, the MEC, or the Senior Vice President of Medical Affairs may restrict or suspend the Medical Staff membership or clinical privileges of such member as a precaution. Unless otherwise stated, such precautionary restriction or suspension shall become effective immediately upon imposition. The person or body responsible shall promptly give written notice to the member, the MEC, the SVPMA, the President of the Hospital and the Board. The restriction or suspension may be limited in duration and shall remain in effect for the period stated or, if none, until resolved as set forth herein. Unless otherwise indicated by the terms of the precautionary restriction or suspension, the member's patients shall be promptly assigned to another member by the Department Chairperson or by the President of the Hospital, considering where feasible, the wishes of the patient in the choice of a substitute member.

9.5.4. **Medical Executive Committee Action:** As soon as practicable after such precautionary restriction or suspension has been imposed, a meeting of the MEC shall be convened to review and consider the action and, if necessary, begin the investigation process as noted in Section 9.3. Upon request, the member may attend at the discretion of the MEC and make a statement concerning the issues under investigation, on such terms and conditions as the MEC may impose, although in no event shall any meeting of the MEC, with or without the member, constitute a "hearing" within the meaning defined in the Hearing and Appeals Process, nor shall any procedural rules with respect to hearing and appeal apply. The MEC may modify, continue, or terminate the precautionary restriction or suspension, but in any event it shall furnish the member with notice of its decision Hearing rights must be applied if a precautionary (summary) suspension lasts longer than fourteen (14) days.

9.5.5. **Procedural Rights:** Unless the MEC promptly terminates the summary restriction or suspension prior to or immediately after reviewing the results of the investigation described in Section 9.3, the member shall be entitled to the procedural rights afforded by the Hearing and Appeals Process.

9.5.6. **Automatic Suspension Or Limitation:** In the following instances, the member's privileges or membership may be suspended or limited as described, which action shall be final without a
right to a hearing or further review, except where a bona fide dispute exists as to whether the circumstances have occurred.

9.5.6.1. **Licensure**: Whenever a member's license or other legal credential authorizing practice in this or other state is revoked, limited, suspended or temporarily suspended, the Medical Staff membership for clinical privileges shall be automatically revoked, limited, suspended or temporarily suspended as of the date such action becomes effective and throughout its term.

9.5.6.1.1. **Restriction**: Whenever a member's license or other legal credential authorizing practice in this or other state is limited or restricted by the applicable licensing or certifying authority, any clinical privileges which the member has been granted at Elliot Hospital which are within the scope of said limitation or restriction shall be automatically limited or restricted in a similar manner, as of the date such action becomes effective and throughout its term.

9.5.6.1.2. **Probation**: Whenever a member is placed on probation by the applicable licensing or certifying authority, their membership status and clinical privileges shall automatically become subject to the same terms and conditions of the probation as of the date such action becomes effective and throughout its term.

9.5.6.2. **Controlled Substances**: Whenever a member's DEA certificate is revoked, limited, or suspended, the member shall automatically and correspondingly be divested of the right to prescribe medications covered by the certificate, as of the date such action becomes effective and throughout its term.

9.5.6.2.1. **Probation**: Whenever a member's DEA certificate is subject to probation, the member's right to prescribe such medications shall automatically become subject to the same terms of the probation, as of the date such action becomes effective and throughout its term.

9.6. **Medical Executive Committee Deliberation**: As soon as practicable after action is taken or warranted as described in Section 9.4, the MEC shall convene to review and consider the facts, and may recommend such further corrective action as it may deem appropriate following the procedure generally set forth in the Section 9.5.

9.7. **Medical Records**: Members of the Medical Staff are required to complete medical records within such reasonable time as may be prescribed by the MEC as delineated in the Rules and Regulations policy. The SVPMA or Medical Staff President shall impose a limited restriction in the form of withdrawal of privileges until medical records are completed following notice of delinquency for failure to complete medical records within such period. Bona fide vacation or illness may constitute an excuse subject to approval by the MEC. Members whose privileges have been restricted for delinquent records may provide care to patients only in emergency situations. The restriction shall be automatically lifted upon completion of all such delinquent records. If within ninety (90) days after written warnings of the delinquency, the member does not complete all medical records, the practitioner’s membership and clinical privileges shall be automatically terminated.

When an administrative suspension is issued due to a medical record delinquency, the matter will be referred to the Department Chair and Section Chief for immediate review and determination as to whether the delinquency relates to professional competence or conduct that adversely affects, or could adversely affect, the health or welfare of a patient. If such a determination is made by the MEC, the suspension shall be considered a suspension of clinical privileges within the meaning of section e of the "Initiation of Hearing" section of the Hearing and Appeals Process, and all rights and processes set forth therein shall apply.

9.8. **Professional Liability Insurance**: Failure to maintain professional liability insurance in the amount of $1,000,000.00 and $3,000,000.00 aggregate sufficient to cover for the clinical privileges granted shall be grounds for automatic suspension of a members’ clinical privileges. If within ninety (90) days after written warnings of the delinquency, the member does not provide evidence of required professional liability insurance, the member's membership shall be automatically terminated.
SECTION 10: PRECEPTORSHIP FOR PRACTITIONERS RE-ENTERING INPATIENT CARE

10.1. At the discretion of the Chair of the Credentialing Committee, a practitioner who has not provided acute inpatient care for the past twelve (12) months or more who requests clinical privileges at the hospital, may be required to arrange for a preceptorship with a current member in good standing of the Medical Staff who practices in the same specialty during a specified portion of the initial appointment period. The Elliot Hospital Policy on Proctoring must be followed.

SECTION 11: REAPPLICATION AND MODIFICATIONS OF MEMBERSHIP STATUS OR PRIVILEGES AND EXHAUSTION OF REMEDIES

11.1. Reapplication after adverse credentials decision: Any such application is processed in accordance with the procedures set forth in Section 4 of this manual. As part of the reapplication, the practitioner must submit such additional information as the Medical Staff and/or BOT requires demonstrating that the basis of the earlier adverse action no longer exists. If such information is not provided, the reapplication will be considered incomplete and voluntarily withdrawn and will not be processed any further.

11.2. Reapplication after administrative revocation: A practitioner who has had their appointment or clinical privileges administratively revoked for failure to maintain current professional liability insurance in the specified amount, failure to maintain relevant licensing and DEA certification, or failure to maintain and complete medical records, will be reinstated for appointment and appropriate privileges upon submission of documentation that he/she has resolved the reason for the revocation.

11.3. 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 staff category, Department assignment, or clinical privileges by submitting a written request to the MSSD. A modification request must contain all pertinent information supportive of the request. If applicable, all requests for additional clinical privileges must be accompanied by information demonstrating additional education, training, and current clinical competence in the specific privileges requested. A modified application is processed in the same manner as a reappointment, which is outlined in Section 7 of this manual. A practitioner who determines that he/she no longer exercises, or wishes to restrict or limit the exercise of, particular privileges that he/she has been granted shall send written notice, through the MSSD, to the Credentials Committee, MEC, and BOT. A copy of this notice shall be included in the practitioner’s credentials file.

11.4. Resignation of staff appointment: A practitioner may resign their staff appointment and/or clinical privileges by providing written notice to the MSSD who notifies via electronic communication the Department Chair, Section Chief, President of the Medical Staff and Senior Vice President of Medical Affairs and any and all appropriate departments and individuals. The resignation shall specify the the effective date or the MSSD will designate the date of notice as the effective date. A practitioner who resigns their staff appointment and/or clinical privileges is obligated to fully and accurately complete all portions of all medical records prior to the effective date of resignation. Failure to do so shall result in an entry in the practitioner’s credentials file acknowledging the resignation and indicating that it became effective under unfavorable circumstances and shall be considered a matter of professional conduct that could adversely affect the health or welfare of a patient and so is reportable to the National Practitioner Data Bank pursuant to the Health Care Quality Improvement Act of 1986. A letter acknowledging receipt of request for resignation and reminding practitioner of responsibilities will be sent via electronic communication.

11.5. Exhaustion of administrative remedies: Every practitioner agrees that when an investigation is initiated or taken according to the Hearing and Appeals Process, or when an adverse action or recommended action as defined in the Hearing and Appeals Process is proposed or made, all of the administrative remedies afforded in the various sections of this manual, the Bylaws and the Hearing and Appeals Process will be exhausted.

11.6. Reporting requirements: The President of the Hospital or designee shall be responsible for assuring
that the hospital satisfies its obligations under the Health Care Quality Improvement Act of 1986 and its successor statutes.

SECTION 12: LEAVE OF ABSENCE

12.1. **Request for Leave:** A member of the Medical Staff may obtain a voluntary leave of absence from the Medical Staff by submitting a written request specifying the reason for the leave to the Medical Staff President, through the MSSD stating the exact period of the time of leave. The MSSD will immediately notify the Department Chair, Section Chief, President of the Medical Staff and Sr. Vice President of Medical Affairs. The application will be forwarded to the Credentials Committee, the MEC and BOT for review and approval. If the leave is granted, all of the staff member’s clinical privileges, membership prerogatives and membership obligations shall not be exercisable for the duration of the leave. The practitioner is obligated to complete the reappointment application in accordance with their reappointment date.

12.2. **Duration of Leave:** A Leave of Absence may be granted for a maximum of twenty-four (24) months.

12.3. **Return from Leave:** Prior to the termination of the leave, the practitioner must notify the Hospital of the practitioner’s intent to resume his or her privileges by submitting a request in writing to the Medical Staff President, through the MSSD. The Credentials Committee, through the MSSD, will query the practitioner in writing as to the practitioner’s intentions at least sixty (60) days prior to the termination of the leave. The practitioner must present a current New Hampshire license in the practitioner’s field of practice and malpractice insurance in the required amount.

12.3.1. Failure to respond to the Credentials Committee’s query will result in termination of staff membership and/or clinical privileges.

12.3.2. If, during any leave of absence, there is no practice by the practitioner for a period of twelve (12) consecutive months or more, the Department’s Chair or the Credentials Committee may require proof of competency by either further education, clinical training, appropriate monitoring for a period of time, or other such matters that may be judged necessary to ensure competence.

SECTION 13: PRACTITIONER PROVIDING CONTRACTUAL SERVICES

13.1. **Exclusivity policy:** Whenever hospital policy specifies that certain hospital facilities or services may be provided on an exclusive basis in accordance with contracts or letters of agreement between Elliot 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 Elliot Hospital facilities or services covered by exclusive agreements will not be accepted or processed unless submitted in accordance with the existing contract or agreement with the hospital.

13.2. **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 their appointment category as any other applicant or staff appointee.

13.3. **Effect of staff appointment termination:** Because practice at the hospital is always contingent upon continued staff appointment and also constrained by the extent of clinical privileges enjoyed, a practitioner's right to use hospital facilities is automatically terminated when the staff appointment expires or is terminated. The extent of their clinical privileges is automatically limited to the extent that the pertinent clinical privileges are diminished, restricted or revoked. The effect of an adverse change in clinical privileges on continuation of a contract or employment is governed solely by the terms of the contract or employment arrangement. If the contract or employment agreement is silent on the matter, the Board will determine it after soliciting and considering the recommendations of relevant components and officials of the Medical Staff.
13.4. A Medical Staff member providing professional services under a contract shall not have their clinical privileges terminated for reasons pertaining to quality of care or professional conduct issues without the same rights to the Hearing and Appeals Process identified in the Medical Staff Bylaws as available to all members of the Medical Staff.

13.5. **Effect of contract or employment 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 Elliot Hospital. If the contract or the employment agreement is silent on the matter, then contract expiration or other termination alone will not affect the practitioner's staff appointment status or clinical privileges.

**SECTION 14: MEDICAL ADMINISTRATIVE OFFICERS**

14.1. A medical administrative officer is a practitioner engaged by the hospital either full or part time in an administratively responsible capacity, whose activities may also include clinical responsibilities such as direct patient care, teaching, or supervision of the patient care activities of other practitioners under the officer's direction.

14.2. Each medical administrative officer must achieve and maintain Medical Staff appointment and clinical privileges appropriate to their clinical responsibilities and discharge staff obligations appropriate to their staff category in the same manner applicable to all other staff members.

14.3. **Effect of removal from office or adverse change in appointment status or clinical privileges:**

14.3.1. Where a contract exists between the officer and the hospital, its terms govern the effect of removal from the medical administrative office on the officer’s staff appointment and privileges and the effect of an adverse change in the officer’s staff appointment or clinical privileges on his remaining in office.

14.3.2. In the absence of a contract or where the contract is silent on the matter, removal from office has no effect on appointment status or clinical privileges. The effect of an adverse change in appointment status or clinical privileges on continuance in office will be as determined by the board after requesting and considering the recommendations of relevant components and officials of the staff.

14.3.3. A medical administrative officer has the same procedural rights as all other staff members in the event of an adverse change in appointment status or clinical privileges unless the change is, by contract a consequence of removal from office.

**SECTION 15: AMENDMENT**

15.1. This Policy is part of the Medical Staff Bylaws and is subject to the amendment provisions set forth therein as they may be amended from time to time.

**SECTION 16: USE OF TERMS**

16.1. When used herein the terms “Senior Vice President of Medical Affairs”, “Credentials Committee Chairperson,” “President,” “Director of Provider On-Boarding”, “President of the Hospital/Administrator,” and “BOT” are construed to include “designee.”

16.2. "Subject matter expert" is an individual chosen by the Credentials Committee, President or MEC to assist and advise them in evaluation of recommendations for clinical privileges for their peers.

16.3. Days shall mean calendar days unless otherwise specified.