Article 1 – Definitions:

1.1 **Board of Directors:** “Board” means the Board of Directors which, as established by State Law, is the governing authority of the West Virginia University Hospitals, Inc., and its Medical and Dental Staff.

1.2 **Quality and Patient Safety Committee:** “Quality and Patient Safety” means the committee of the Board that is responsible for the discussion of matters of medical and dental practice pertaining to efficient and effective patient care. It is the committee delegated authority by the governing body to render initial appointment, reappointment, and renewal or modification of clinical privileges.

1.3 **Dentist:** “Dentist” means a person with the academic degree of DDS and/or DMD and licensed to practice Dentistry in accordance with the laws of the State of West Virginia and the rules and regulations promulgated by the Board of Dentistry.

1.4 **Hospital:** “Hospital” shall mean any Hospital or entity subject to the authority of the Board of Directors of the West Virginia University Hospitals, Inc. (hereinafter WVUH”).

1.5 **President:** “President” means the duly appointed President of West Virginia University Hospitals, Inc., or his/her designee.

1.6 **Credentialing Policy:** “Credentialing Policy” means the procedures as approved by the Board relating to appointment and reappointment to the Medical Staff, granting clinical privileges, and hearing and appeals. WVUH does not delegate credentialing activities.

1.7 **Executive Committee:** “Executive Committee” means the Medical Executive Committee of the Medical Staff who has been delegated the primary authority over activities related to the functions of self-governance of the medical staff and over activities related to the functions of performance improvement of the professional services provided by individuals with clinical privileges including the Credentialing of medical staff and allied health professionals.

1.8 **Medical Staff:** “Medical Staff” means the physicians, dentists and podiatrists (“members” or “appointees”) who meet the standards and requirements set forth in these Bylaws and who have been appointed by the Board to WVUH’s Medical Staff. The Medical Staff is an operational extension of the Board.
1.9 **Physician:** “Physician” means a person with the academic degree of MD and/or DO and licensed to practice medicine in accordance with the laws of the State of West Virginia and the rules and regulations promulgated by the Board of Medicine.

1.10 **School of Medicine:** “School of Medicine” means West Virginia University School of Medicine.

1.11 **Allied Health Professional:** “Allied Health Professional” means person, other than a licensed physician, dentist or podiatrist whose professional activities in the Hospital require that his authority to care for patients in the Hospital be processed through Medical Staff channels, and who is qualified to render patient care either under the supervision of a physician, dentist or podiatrist on the Medical Staff or independently. Allied Health Professionals shall be granted Clinical Privileges either as independent Allied Health Professionals or as Clinical Assistants in accordance with the provisions of Article IV of the Medical Staff Bylaws. Additionally, all ANP’s, CRNA’s and CNM’s must have their privileges reviewed and approved by the Vice President of Nursing. Allied Health Professionals are entitled to the hearing and appeal procedures in Article V of this policy in the event of the adverse privileging recommendations.

1.12 **Privileges:** “Privileges” or “clinical privileges” means that permission granted by the Board to a physician, podiatrist, dentist or allied health professional to render specified health care services in the Hospital.

1.13 **Precautionary Suspension:** “Precautionary suspension” of clinical privileges, as used in this policy, means the suspension of certain or all clinical privileges during investigation. It will be taken when it has been deemed necessary to protect patients or prevent disruption of hospital operations. Precautionary suspensions are not reported to the Data Bank.

1.14 **Organizational Review:** “Organizational review” in this policy shall have the meaning ascribed to it as in the WV Code 30-3c-1.

1.15 **Days:** “Days” in this policy shall mean calendar days.

**WEST VIRGINIA UNIVERSITY HOSPITALS Credentialing Policy**

**Article II – Appointment to the Medical Staff and Clinical Privileges**

**Effective: 10/27/15**

2.1 **Qualifications for Appointment, Reappointment, and Clinical Privileges**

2.1.1 **Qualifications:** Only professionally competent individuals who continuously meet the qualifications, standards and requirements set forth in this policy, by Federal and State law and in such policies as are adopted from time to time by the Board, shall be appointed, reappointed to the Medical Staff or granted clinical privileges. All appointees of the Medical Staff shall be graduates of schools of medicine, podiatry, dentistry or osteopathy. All applicants for privileges must be
currently licensed to practice in the State of West Virginia, who by voluntary application and agreement to background research by WVUH can document:

1. Background, experience, training and demonstrated competence in the areas for which he/she is applying for clinical privileges, including medical/clinical knowledge, technical and clinical skills, clinical judgment and an understanding of the contexts and systems within which care is provided;
2. Board Certification or Board equivalent;
3. Compliance with the Code of Ethics adopted by the American Medical Association, American Dental Association or the American Osteopathic Association or other applicable ethical requirements; including a commitment to continuous professional development, an understanding of and sensitivity to diversity, and responsible attitude toward patients and their profession;
4. Good reputation and character, including mental and emotional stability;
5. Ability to work harmoniously with others sufficiently to persuade the Board that all patients treated by him/her in the Hospital will receive efficient and quality care and that the Hospital and its Medical Staff will be able to operate in an orderly manner, including, but not limited to, interpersonal and communication skills sufficient to enable them to maintain professional relationships with patients, families, and other members of the health care teams;
6. Willingness to participate in the discharge of Medical Staff obligations appropriate to his/her appointment category;
7. Absence, or adequate control of, any significant physical or behavioral impairment or difficulty in communicating clearly with patients and staff that adversely affects, or presents a substantial probability of adversely affecting, his/her skill, attitude and judgment;
8. That he/she resides close enough to provide timely care for their patients; and
9. Current and ongoing professional liability insurance coverage with limits as required by the Board.

2.1.2 Board Certification: Individuals who are making initial application to become a member of the WVUH Medical must provide documentation of board admissibility or current board certification from an American Board of Medical Specialties, American Board of Dentistry, or American Osteopathic Association approved Board or their equivalent. Equivalency will be determined by the Medical Executive Committee on an individual basis.

Initial applicants and current medical staff that are not board certified are expected to obtain board certification within six (6) years of appointment to the Medical and Dental Staff at WVUH in order to be eligible for consideration for reappointment to the Medical and Dental Staff at the sixth (6th) year.

It is the expectation that all Medical Staff members will maintain certification in their specialty or subspecialty whichever is related to their clinical practice, prior to the expiration of the time-limited board and in accordance with the policies of the respective board.

Clinical Department Chairs are appointed in accordance with the policies and guidelines of West Virginia University and the Bylaws of the West Virginia
University School of Medicine (WVUSOM). Board certification must be maintained as a condition of continued appointment in the position of Chair.

Special circumstances may allow for an “exception” to the board certification requirement and must be approved by the Medical Executive Committee prior to processing any request for appointment and reappointment. Exceptional circumstances include, but are not limited to:

A. The unavoidable failure to sit for initial or recertification boards secondary to illness or travel mishap, which must be satisfactorily documented.
B. The inability of a foreign medical trainee to become board eligible solely because of foreign schooling or training but whose training and credentials are otherwise consistent with clinical department peers.
C. Failure to pass or sit for a certification/recertification examination resulting in lapse of certification may result in a waiver period not to extend beyond two (2) years with potential to renew for one (1) more year.
D. If a practitioner has been certified by an alternate board other than those identified in this policy, MEC will determine whether this board is an acceptable certification.

If the Medical Staff member desires to apply for an exception, he/she must submit the proper documentation to the Medical Staff Office (MSO) for approval from the Medical Executive Committee, within a reasonable time frame and prior to being reappointed at the sixth (6th) year. The process includes:

1. The Medical or Dental Staff member submits a request for a waiver of the board certification requirement to the clinical department chairman with a copy to the Medical Staff Office.
2. The clinical department chairman reviews the request for a waiver and submits a recommendation to the Medical Staff Office.
3. The Medical Staff Office submits this information to the Medical Executive Committee at their next scheduled meeting. At that time, the committee will review the request for a waiver and the chairman’s recommendation, and submit its recommendation to the Quality and Patient Safety Committee of the Board of Directors.
4. The Quality and Patient Safety Committee of the Board of Directors renders the final decision.

2.1.3 Appointment to Faculty: Each appointee of the Medical Staff shall first have an appointment to the faculty of the West Virginia University School of Medicine.

2.1.4 No Entitlement: No individual shall be entitled to appointment to the medical Staff or to the exercise of particular clinical privileges in the Hospital merely by virtue of the fact that he/she:
1. Has an appointment to the faculty of the West Virginia University School of Medicine;
2. Is licensed to practice any profession in this or any other state;
3. Is a member of any particular professional organization; or
4. Has in the past, or currently has, Medical Staff appointment in this or any other hospital.

2.1.5 Non-Discrimination: Appointment to the Medical Staff shall not be denied or terminated based upon age, sex, race, religion, color, ethnic/national identity, sexual orientation, types of procedures or types of patients (i.e. Medicaid) in
which the practitioner specializes or any other criteria protected by law or lacking professional or business justification.

The non-discrimination statement above shall appear on all attendance sign-in forms of meetings of the Medical Executive Committee. Documents and/or information submitted to the Medical Executive Committee and/or the Board of Directors for approval, denial or termination shall not designate a practitioner’s age, sex, race, religion, color, ethnic/national identity, sexual orientation, types of procedures or types of patients.

Compliance with this policy shall be monitored by:
1. Tracking reasons for denial and/or termination of appointments;
2. Periodic audits of credentialing files; and
3. Periodic (at least annually) audits of practitioner credentialing complaints.

2.1.6 **Attend Patients:** Only duly appointed members of the Medical Staff shall be entitled to attend patients at the hospital.

2.1.7 **Termination:** Appointment on the Medical Staff shall automatically and immediately terminate in case of failure to be reappointed to the faculty of the School of Medicine or School of Dentistry or in case of resignation or termination from the facility.

2.1.8 **Hospital and Community Need:** In determining whether to appoint any particular individual to the Medical Staff, the Board shall consider the Hospital’s current and projected patient care, teaching and research needs and the needs of the community.

2.2 **Conditions of Appointment**

2.2.1 **Terms of Appointment and Provisional Appointments:**
1. The President of WVUH may grant an applicant Temporary Privileges. The Board of Directors shall approve all initial appointments and reappointments upon recommendation of the Medical Executive Committee of the Medical Staff.
2. Initial appointments, with the exception of honorary appointments, and all initial clinical privileges shall be granted for a period of twenty-four (24) months. Initial applicants will be evaluated by the Chair of the Department where he/she resides at six (6) and twelve (12) month intervals from time of initial appointment. At each interval, the evaluations will be reviewed at the Medical Executive Committee in the event of any adverse recommendations. Each new appointee shall be assigned to the Department which he/she has been granted clinical privileges, where performance and clinical competence shall be observed and evaluated by the Chairperson or delegated supervising physician and the relevant Committees of the Medical Staff and the Hospital as to the provisional appointee’s clinical competence, general behavior and conduct in the hospital.
3. If, at the six (6) and twelve (12) month evaluation intervals, his/her responsibilities of appointees to the Medical Staff as set forth in Article III and IV, as applicable, of the Bylaws, the Medical Executive Committee may request that he/she be monitored through an additional evaluation period for a time frame set forth by the Committee. Such recommendations shall be communicated by the Department of Medical
Staff Affairs to the Department Chairman and applicant at such time the recommendation is approved by the WVUH Board of Directors. If, at the end of the second evaluation period, the individual has not fulfilled the responsibilities of appointees to the Medical Staff as set forth in Article III and IV of the Bylaws (as applicable), his/her appointment and/or clinical privileges shall automatically terminate and the appointee shall be given written notice of such termination. Any continued appointment after the second evaluation period shall be conditioned on an evaluation of the factors to be considered for appointment and reappointment set forth in this manual. Any appointees may be placed on continued evaluation status at reappointment or at any other time that the Board determines it, after receipt of the recommendation of the Medical Executive Committee that the Appointee should be observed and evaluated for a period of up to one (1) year intervals.

4. All appointments, except temporary and privileges for non-applicants, shall be for a period of two (2) years, commencing from the date of approval by the Medical Executive Committee.

5. Appointment and reappointment shall be contingent upon adequate documentation of compliance with all relevant criteria including, but not limited to, training, experience, demonstrated competence, adherence to professional ethics, good reputation, physical health and mental stability. In addition, appointees shall demonstrate sufficient ability to work harmoniously with others in order to assure the Medical Executive Committee and the Board that all patients attended will receive high quality care in an orderly environment.

6. Appointments and reappointments are contingent upon, in addition to the other criteria set forth in this policy, attendance at relevant continuing education programs, outcomes of periodic performance evaluation, and compliance with Medical Staff Bylaws, policies and procedures.

7. Appointments and reappointments are contingent upon the ongoing maintenance of professional liability insurance coverage with limits as required by the Board.

### 2.2.2 Rights of Appointees:
Appointment to the Medical Staff shall confer only those specific clinical privileges granted by the Board in accordance with the Bylaws and this Credentialing Policy.

### 2.2.3 Responsibilities of Appointees:
Each Medical Staff appointee and applicant for staff appointment or reappointment and/or clinical privileges as a condition of consideration of such application and as a condition of continued Medical Staff appointment, if granted, shall:

1. Provide continuous care and supervision to all patients within the Hospital for whom the individual has responsibility.
2. Abide by the policies of the Hospital, including all Bylaws and Rules and Regulations of the Medical Staff as shall be in force from time to time during the appointment.
3. Accept committee assignments and such other reasonable duties and responsibilities as shall be assigned to him/her by the Board and Medical Staff.
4. Keep the Hospital supplied with current information regarding all questions on the application form any time new or updated information that is pertinent to any question on the application form becomes available to Appointee.
5. Acknowledge that he/she has had an opportunity to read a copy of the Medical Staff Bylaws, the Credentialing Policy and the Rules and Regulations of the Medical Staff, and that he/she has agreed to be bound by the terms thereof in all matters relating to consideration of his/her application without regard to whether or not he/she is granted appointment to the Medical Staff.

6. Agree that any misrepresentation or misstatement in, or omission from, the application whether intentional or not shall constitute cause for automatic and immediate rejection of the application resulting in denial of appointment and/or clinical privileges. In the event that appointment and/or clinical privileges have been granted prior to the discovery of such misrepresentation, misstatement or omission, such discovery may result in discipline, which may include dismissal from the Medical Staff and/or loss of privileges.

7. Execute a release authorizing Hospital access to any and all information pertinent to his/her application for, and maintenance of, privileges and Medical Staff appointment.

8. Not engage in fee splitting or other unlawful inducements relating to patient referral.

9. Not delegate responsibility for diagnosis and care of hospitalized patients to any individual who is not qualified to undertake such responsibility or who is not adequately supervised.

10. Not deceive patients as to the identity of an operating surgeon or any other individual providing treatment or services.

11. Seek consultation whenever appropriate.

12. Abide by generally accepted ethical principles applicable to his/her profession.

13. Diligently pursue the educational and charitable mission of the hospital through clinical teachings of students and residents and indigent care activities.

14. Provide testimony when requested by either party at hearings regarding Medical Staff privileges.

15. Comply with all Federal and State laws.


17. Maintain appropriate professional liability insurance coverage.

18. Pay all dues and assessments as determined by the Medical Staff and approved by the Board.

19. Cooperate with and permit unannounced screening of his blood and/or urine for controlled substances as directed by the Practitioner Health Committee; and


2.2.4 Medico-Administrative Appointees: Those appointed to administrative positions that also involve clinical responsibilities must achieve and maintain Medical Staff appointment through the same procedures provided for all Medical Staff appointees. Termination from a medico-administrative position shall not affect Medical Staff status. Medico-administrative appointees shall be entitled to all procedure and fair hearing provisions with respect to their Medical Staff status as provided for in this Credentialing Policy. However, termination from a medico-administrative position only shall not trigger any procedural or fair hearing provisions specified in this Credentialing Policy.

2.2.5 Clinical Information Systems Training: Clinical Informatics Systems training, applicable, for any individual applying for initial appointment, must be completed
and confirmed prior to granting of temporary privileges. Practitioner who are approved for initial appointment will not be granted security access until Clinical Informatics Systems training, as applicable, has been completed and confirmed.

Individuals with clinical privileges who have not completed Clinical Informatics Systems training, as applicable, will no longer be eligible to request a reappointment of clinical privileges. If any individual’s clinical privileges lapse, the provider will be required to reapply for privileges.

2.2.6 Self-Treatment and Treatment of Family Members: Objective decision-making is critical to medical care and business operations. Objectivity can be compromised if individuals are emotionally involved with the patient. WVUH has adopted this policy to alert health care providers and employees to avoid treating themselves, and further, to avoid providing services in situations where there is a family, personal or emotional relationship beyond that of the provider/employee/patient relationship.

POLICY: Except as provided below, providers and employees should not perform medical treatment or become involved in any aspect of health care operations in situations where the patient is a family member or where there is a close personal or emotional relationship with the patient. The reasons for this restriction are as follows:

1. There is a risk that the personal relationship will affect the provider’s or employee’s ability to provide good quality care or business operations;
2. It can be very difficult for a provider or employee to maintain clinical or operational objectivity when providing medical care for him/herself; and
3. It may prevent the patient from developing a good relationship with his/her own doctor or other staff members.

WVU Hospitals will permit health care providers to treat themselves or family members where care is limited or episodic for minor conditions, or in emergency situations where there is no one else qualified to provide care. Notwithstanding the restrictions on self-care and operations set forth in this policy, providers and employees may access their own medical records or the medical records of family members by following the procedures outlined in the MyWVUChart Activation Policy or Affiliate Link Policy.

Definitions:
1. Provider: Any member of the Medical Staff, a trainee or other independent provider, in each case credentialed by the Office of the Medical Director.
2. Employee: All non-provider staff of WVU Hospitals or UHA with access to Merlin.

PROCEDURE: The provider shall:
1. If it is essential to treat a family member in limited or episodic situations for minor conditions, or in emergency situations where there is no one else qualified to provide care, the provider must instruct the family member to advise his/her primary care provider of the treatment received and transfer care to another qualified health professional as soon as practical.
2. If it is essential to self-treat in limited or episodic situations for minor conditions, or in emergency situations where there is no one else qualified to provide care, the provider must notify his/her primary care provider of the treatment received and transfer care to another qualified health professional as soon as practical.
The Chief Medical Officer shall discuss the issue with the provider if a concern is raised that a Medical Staff member is managing care for a family member.

The Employee shall:
1. Request that a coworker or manager provide the services if a family member presents for services/business operations.
2. Request that a coworker or manager provide services or business operations for themselves.

The Privacy or Security Officer shall request that the employee’s Director or Manager discuss issues if a concern is raised regarding managing a family member’s health care or business operations.

2.2.7 Influenza Vaccination
1. All members of the Medical Staff (physicians, dentists and podiatrists), Allied Health Professionals with faculty appointments and residents are required to obtain the influenza vaccination annually. The deadline will be determined annually based on vaccination availability.
2. Exceptions will be made for medical and religious reasons.
   a) Physician documentation is required for medical exceptions and is reviewed by Employee Health’s medical director.
   b) Religious exceptions are reviewed by human resources.
3. If the influenza vaccination is obtained outside of WVUH's Employee Health, proof of immunization must be provided.
4. All initial applicants must either receive or provide proof of influenza vaccination before clinical privileges will be activated and direct patient care permitted.
5. Failure to obtain the influenza vaccination or to provide the required documentation will result in the suspension of the provider’s privileges until the vaccination or documentation is received or until the end of flu season.

WEST VIRGINIA UNIVERSITY HOSPITALS
Credentialing Policy

Article III – Procedure for Appointment and Reappointment

3.1 Appointment:

3.1.1 Application Information: All evidence of postgraduate training shall be in writing, and shall be submitted on forms approved by the Board. The application shall contain a request for specific clinical privileges desired by the applicant and shall require detailed information concerning the applicant’s professional qualifications. An applicant shall furnish all pertinent information as may be requested by the Hospital from time to time including, but not limited to, the following:
1. Information as to whether his/her license to practice in any jurisdiction or Drug Enforcement Administration (DEA) registration has ever been revoked, suspended, reduced, voluntarily relinquished, or not renewed
subject to any condition, limitation, reprimand, restriction or probation, 
whether or not any such action was stayed; or whether any application for 
such licensure or registration was voluntarily withdrawn; whether his/her 
appointment and/or clinical privileges on any Medical Staff have ever been 
revoked, reduced, voluntarily relinquished or not renewed, or subject to 
any conditions or limitations of any nature whatsoever; whether there are 
any past, current or pending malpractice actions or claims against him/her, 
together with all pertinent information regarding these actions or claims; 
and whether his/her membership in any professional organization has 
ever been suspended or revoked;

2. The names and complete addresses of at least three (3) physicians, 
dentists or other practitioners, as appropriate, who have had recent 
extensive experience in observing and working with the applicant and who 
can provide adequate information pertaining to the applicant’s present 
professional competence, both clinical and teaching, and character;

3. If the number of hospitals the applicant has worked in is substantial in 
number, the Medical Executive Committee and the Board may take into 
consideration the applicant’s good faith effort to produce this information;

4. Information as to whether the applicant has ever voluntarily or involuntarily 
withdrawn his/her application for appointment, reappointment and clinical 
privileges before final decision by a hospital’s or health care facility’s 
governing Board;

5. Copies of all the applicant’s current licenses to practice, including a 
current West Virginia license, as well as a copy of his/her Federal Drug 
Enforcement Administration (DEA) license that reflects West Virginia 
University (WVU) or West Virginia University Hospital (WVUH) as the 
practice location (for the purpose of locum tenens, the practice location is 
not required if the practitioner is practicing at the location for less than 
sixty (60) days). If the practitioner does not have a DEA reflecting the 
appropriate site address, the applicant is required to submit a copy of the 
confirmation page from the DEA acknowledging that a change of address 
request has been made if he/she remains at WVUH for a period longer 
than sixty (60) days. Furthermore, the Medical Staff Office (MSO) has a 
mechanism in place to grant the practitioner, through the pharmacy 
department, a temporary WVUH DEA to utilize while the practitioner 
applies for or updates the address, as required, to reflect the appropriate 
practice location on his/her DEA certificate, which is required of all 
applicants, when applicable, regardless of specialty, medical or dental 
school diploma; and certificates from all post-graduate training programs 
completed;

6. A signed agreement to be governed by the Bylaws, Credentialing Policy 
and Rules and Regulations, and any amendments thereto of which he/she 
is duly notified;

7. A signed authorization and release form authorizing the Hospital (or an 
entity selected by the Hospital) to conduct and receive the results of a 
background check;

8. A statement releasing the hospital, its representatives and any third party, 
including other appointees to the Medical Staff, from any and all civil 
liability which might arise from any acts, communications, reports, 
recommendations or disclosures involving the applicant or appointee’s 
professional qualifications, credentials, clinical competence, character, 
mental or emotional stability, physical condition, ethics, behavior or any 
other matter that might directly or indirectly have an effect on the 
individual’s competence, on patient care or on the orderly operation of the
Hospital or any other hospital or health care facility including, but not limited to, otherwise privileged or confidential information relating to:

a) Applications for appointment or clinical privileges, including temporary privileges;

b) Evaluations concerning reappointment or changes in clinical privileges;

c) Evaluations regarding teaching activities;

d) Proceedings for suspension or reduction of clinical privileges or for revocation of Medical Staff appointment, or any other disciplinary sanction;

e) Suspension of privileges;

f) Hearings and appellate reviews;

g) Medical care evaluations;

h) Utilization reviews;

i) Other activities relating to the quality of patient care or professional conduct;

j) Matters or inquiries concerning the individual's professional conduct;

k) Matters or inquiries concerning the individual’s professional qualifications, credentials, clinical competence, on patient care or on the orderly operation of this or any other Hospital or health care facility; and

l) Any other matter that might directly or indirectly have an effect on the individual’s competence, on patient care or on the orderly operation of this or any other Hospital or health care facility.*

*It is understood that the foregoing release from liability shall be limited to acts done or communications, reports, recommendations and disclosures made in good faith without malice and shall not be construed as depriving the applicant or appointee of any administrative or legal remedies which he/she may have for action taken with respect to him/her which are arbitrary or capricious.

Any act, communication, report, recommendation, or disclosure with respect to any such applicant or appointee, made in good faith and at the request of an authorized representative of this Hospital or any other hospital or health care facility, shall be privileged to the fullest extent permitted by law.

The Hospital and its representatives are specifically authorized by the applicant to consult with the appointees to the Medical Staffs of other hospitals or health care facilities or the management of such hospitals or facilities where the applicant is or has been associated and with any other third parties who may have information bearing on the applicant’s or appointee’s professional qualifications, credentials, clinical competence, character, mental or emotional stability, physical condition, ethics, behavior or any other matter as well as to inspect all records and documents that may be material to such questions.

The applicant or appointee grants immunity to any and all hospitals, health care facilities, individuals, institutions, organizations and their representatives who in good faith supply oral or written information, records or documents to the Hospital or its authorized agents.
As used in this section, the term “Hospital and its representatives” means this Hospital and its officers, employees and agents, the members of its Board, or the President, Chief of Staff, consultants to the Hospital, the Hospital’s attorneys, and all appointees to the Medical Staff who have any responsibility for obtaining or evaluating the applicant’s or appointee’s credentials and/or acting upon his/her application or conduct in the Hospital.

As used in this section, the term “third parties” means all individuals, including members of WVUHS’s Medical Staff and the Medical Staff of other Hospitals, government agencies, organizations, associations, partnerships and corporations, whether hospitals, health care facilities or not, from whom information has been requested by the Hospital or its authorized representatives or who have requested such information from the Hospital and its authorized representatives.

10. The Medical Staff Office may deem an application for appointment or reappointment complete for a practitioner whose application for a DEA certificate is pending approval. Upon notification by the applicant that his/her DEA is pending approval, the Medical Staff Office shall request that the WVUH Pharmacy Department issue a temporary DEA number, in order to allow the prescribing practitioner to continue through the application or reapplication process. The issuance of a temporary DEA number will allow the practitioner to write all prescriptions requiring a DEA number. This temporary DEA number will remain in effect until the practitioner has obtained a valid DEA certificate. At such time, the Medical Staff Office will notify the Pharmacy Department to deactivate the temporary number provided.

12. All applicants for Medical Staff appointment shall be required to present themselves for a preliminary interview with the Chairperson of the Department in which they request privileges.
13. Initial applicants and Medical Staff appointees shall submit to an impartial physical and/or mental examination at the request of the respective Clinical Chair, Chief of Staff or Chair of the Practitioner’s Health Committee.
14. Evidence of professional liability insurance coverage with limits as required by the Board.
15. The applicant at all times, including but not limited to, initial and reappointments on appeal and before a hearing panel, shall have the burden of producing such information for a proper evaluation of his competence, character, ethics, education, training and other qualifications as the Medical Executive Committee may from time to time require and for resolving any doubts about such qualifications. He/she shall have the burden of providing evidence that all the statements made and information given on the application is factual and true. Until the applicant has provided all information requested, the application will be deemed incomplete and will not be processed.
16. If any information obtained during the credentialing process is different from the information provided by the applicant, the Department of Medical Staff Affairs will notify the applicant. The applicant will have the
opportunity to clarify any discrepancies. All corrected information will be included with the application. Applicants have the right to review information obtained in support of their application. The Department of Medical Staff Affairs will notify the applicant of any information that is obtained from other sources that varies substantially from information provided on the application. The applicant has the right to correct erroneous information submitted by another party.

17. All information obtained during the credentialing process will be kept confidential and will only be reviewed by those individuals required in conjunction with the credentialing process.

18. In the event that the applicant is a foreign medical graduate, it is the responsibility of the applicant to ensure that all application information is submitted and verified in English.

3.1.2 Procedures for Initial Appointment and/or Clinical Privileges:

1. All applications shall be submitted to the WVUH Department of Medical Staff Affairs or their designee on a form approved by the Medical Executive Committee. All complete applications (See Appendix 1) will be acted upon (the credentialing decision will be made) within one-hundred-eighty (180) days of the applicant’s attestation.

2. The Department of Medical Staff Affairs or designee shall verify the qualifications and information reported by the applicant and collects references and obtains all other pertinent documents appropriate for a full and fair review. The applicant has the responsibility of ensuring that his/her application is complete and his/her references submit adequate responses prior to the submission of his application to the Department(s). No application will be considered for review by the Medical Executive Committee until the Department of Medical Staff Affairs has deemed it complete. The Department of Medical Staff Affairs shall then transmit pertinent application material to the Chairperson of the Medical Executive Committee in which the applicant is requesting privileges. An incomplete application will not be processed. Where the applicant seeks appointment and clinical privileges by a certain date, the Department of Medical Staff Affairs shall have authority to set reasonable time limits for the submission of his/her application in order to ensure adequate time for processing. The Chairperson has the right to review an applicant’s request, with respective to his/her Department, for Medical Staff membership and/or clinical privileges once application has been deemed complete and prior to review by the Medical Executive Committee.

3. The Medical Executive Committee may review the information reported by the applicant and verified by the Department of Medical Staff Affairs and shall consider the application and/or request for clinical privileges and then recommend to:
   a) Appoint for a twenty-four (24) month term;
   b) Reject the application and/or request for clinical privileges; or
   c) Defer the application and/or request for clinical privileges in order to obtain additional information necessary for proper evaluation.

   The Medical Executive Committee shall submit the recommendation in writing with all supporting documents to the Department of Medical Staff Affairs.

4. The Department of Medical Staff Affairs shall obtain primary source verification of data to include: NPDB/AMA Queries, License, Board
Certification, Medicare/Medicaid Sanctions, and other information as required by NCQA, JCAHO, and Medical Staff Bylaws.

5. The Department of Medical Staff Affairs shall transmit all supporting documents and application materials to the Medical Executive Committee, which shall review the applicant’s application. The Medical Executive Committee shall investigate and examine the evidence of the character, professional competence, qualifications, prior behavior and ethical standing of the applicant and shall determine through information contained in references given by the applicant and from other sources available to the Committee, including an appraisal from the Chairperson of each Clinical Department in which privileges are sought, whether the applicant has established and meets all of the necessary qualifications for the staff category and/or clinical privileges requested. As part of this process, the Medical Executive Committee may require a physical and mental examination of the applicant by a physician or physicians satisfactory to the Medical Executive Committee, and shall require that the results be made available for the Medical Executive Committee’s consideration. The Medical Executive Committee shall have the right to require the applicant to appear before the Medical Executive Committee to respond to questions about any aspect of his/her application, his/her qualifications and the clinical privileges he/she has requested. The Medical Executive Committee shall then submit to the Department of Medical Staff Affairs within thirty (30) days of receipt of the completed application and all supporting materials from the Department, including the Department’s recommendations and the conclusion of its investigations, a written report and recommendation to:

a) Recommend to the Board that it appoint. All recommendations to appoint shall also recommend the clinical privileges to be granted.

b) Recommend to the Board that it reject the application and/or request for clinical privileges.

c) Defer the application and/or clinical privileges for further consideration, or

d) Remand the application to the appropriate Committee or Chairperson for reconsideration or to consider or produce additional information.

6. When the recommendation of the Medical Executive Committee is to defer the application for further consideration, it should be followed at the next appropriate meeting of that Committee with either a recommendation for appointment with specified clinical privileges, or rejection of Medical Staff appointment and/or clinical privileges.

7. Recommendation for appointment to the Medical Staff by the Medical Executive Committee shall be forwarded by the Department of Medical Staff Affairs to the Board of Directors. This recommendation for appointment shall be accompanied by a recommendation of the delineation of clinical privileges to be granted.

8. When the recommendation made by the Medical Executive Committee of the Medical Staff is adverse to the applicant, the Department of Medical Staff Affairs shall forward the adverse recommendation to the President who shall promptly so notify the applicant in writing, by certified mail, return receipt requested, addressed to the applicant at his address shown on his application. The President shall then hold the application until after the applicant has exercised or has been deemed to have waived his/her right to a hearing as provided in Section 5.2.2 of the Credentialing Policy, after which the President shall forward the recommendation of the Medical
Executive Committee, together with the application and all supporting documentation to the Board for final action. When the Board’s decision is final, the President will notify the Chief of Staff and notify the applicant by certified mail, return receipt requested.

9. Medical Staff appointment or reappointment shall not confer any clinical privileges or right to practice in the Hospital. Each individual appointed to the Medical Staff shall be entitled to exercise only those clinical privileges specifically granted by the Board, except as stated in policies adopted by the Board. The clinical privileges recommended to the Board shall be based upon the applicant’s education, training, experience, demonstrated competence and judgment, references and other relevant information, including an appraisal by the Chief of the Clinical Department in which such privileges are sought. The applicant shall have the burden of establishing his/her qualification for and competence to exercise the clinical privileges he/she requests. Recommendations of the Clinical Department in which privileges are sought shall be forwarded to the Medical Executive Committee and thereafter processed as part of the application for Medical Staff appointment.

10. Residents in training in the Hospital shall not hold appointments to the Medical Staff and shall not be granted specific clinical privileges. Rather, they shall be permitted to exercise only those privileges set out in established training protocols. Resident practice shall be delineated by the policies and procedures of WVUH and the terms of agreements in effect between WVUH, the West Virginia University Board of Trustees, and the resident. The due process procedures set forth in this manual shall not apply to residents. This paragraph shall not be construed to prevent an individual otherwise qualified for Medical Staff appointment and clinical privileges from being granted such appointment and privileges simply by virtue of his/her participation in a post-graduate training program.

11. Where the applicant is to be Department Chairperson, the Chief of Staff, Vice Chief of Staff, and the Vice President of Medical Affairs shall select two Medical Staff members from the respective department who shall review the applicant’s qualifications. The Vice President for Medical Affairs shall then submit this panel’s recommendation in writing with all supporting documents to the Department of Medical Staff Affairs.

12. An applicant for initial appointment to the Staff of the Hospital agrees to submit a urine specimen to Employee Health or at a facility near the Applicant within thirty (30) days from the postmarked return of the offer letter. In the event that the Applicant submits the specimen at Employee Health, all procedures for confidentiality, specimen collection and laboratory testing shall follow the appropriate guidelines. If the Applicant chooses to utilize another facility, he or she must complete the appropriate release in order for the results to be transmitted to Medical Staff Affairs.

13. If the Applicant fails to comply with the request within thirty (30) days, notice shall be provided to the Department Chair of such failure and the Applicant shall not move forward in the Application process.

14. Any Applicant with confirmed positive results will be referred to the Medical Executive Committee and the appropriate Hospital leadership. In the event that the Applicant tests positive for prescription drugs, he or she shall have five (5) business days from the date of the testing to produce a valid current prescription.
3.1.2a Consent for Pre-Appointment Drug Test Screen and Release Covenant Not to Sue and Indemnity Agreement:

I hereby CONSENT to allow ______________________ to take a specimen of my urine and submit it for a pre-employment drug test screen. I FURTHER CONSENT to allow the laboratory testing service to make the results of such screen available to the Medical Staff Affairs Department of West Virginia University Hospitals, Inc. In consideration for such services being rendered on my behalf, I hereby RELEASE the laboratory testing service, its officers, agents, and employees from any and all claims which I might otherwise have due to such results being made so available. I hereby CONSENT NOT TO FILE ANY ACTION at law or in equity against West Virginia University Hospitals, Inc., the laboratory testing service, their respective officers, agents or employees in connection with the results of such screen being made so available, and I hereby agree to INDEMNIFY and HOLD HARMLESS West Virginia University Hospitals, Inc., the laboratory testing service, their respective officers, agents, and employees from all damages, expenses, reasonable attorney’s fees, and costs of court which they or any of them may suffer or incur, jointly or severally, due to the results of such screen being made so available.

SIGNED this _______________ day of _________________, 20___.

______________________________________________________
Signature

______________________________________________________
Notary

3.2 Reappointment

3.2.1 Board Reappoints: All reappointments shall occur every two (2) years, including appraisals of each appointee’s privileges, together with such changes in status as are appropriate, shall be made by the Board upon recommendation by the Medical Executive Committee of the Medical Staff.

3.2.2 Application: The reappointment process begins at least forty-five (45) days prior to expiration of the appointee’s appointment/reappointment. Each Medical Staff appointee shall receive an application for reappointment at least three (3) weeks prior to the expiration of the appointee’s reappointment and shall supply all information relative to his/her clinical privileges, including but not limited to:

1. any documented basis for change, including change in health status which might affect professional performance;
2. continuing education since his/her previous appointment/reappointment;
3. the status of his/her medical license; and
4. any other changes in his/her credentials.

Failure to submit a complete application for reappointment, including all associated paperwork, by the date specified by Medical Staff Affairs may result in the suspension of privileges at the discretion of the Vice President of Medical Staff Affairs. Furthermore, failure to submit a completed application, including all associated paperwork, by 12 noon the day prior to the expiration date of the provider’s current appointment (stated in the provider’s letter for application for reappointment) will result in automatic expiration of the provider’s appointment and clinical privileges.
Reappointment, if granted, shall be up to two (2) years. If an application for reappointment is duly filed and the Medical Executive Committee and the Board, through no fault of the applicant, has not acted on it prior to the expiration of the appointee’s current appointment and/or clinical privileges, the appointment and/or clinical privileges shall continue in effect until such time as the Board acts on the reappointment application, except as otherwise provided in these Bylaws.

In addition, an applicant for reappointment may be required to submit any reasonable evidence of current ability to perform the privileges applied for. The Department of Medical Staff Affairs shall obtain primary source verification of data to include: NPDB/AMA Queries, License, Board Certification, Medicare/Medicaid Sanctions, and other information as required by NCQA, TJC, and the Medical Staff Bylaws.

3.2.3 Department: The Department of Medical Staff Affairs shall permit the Chairperson of each appropriate Department to review his/her applicant’s request for appointment and/or clinical privileges prior to review by the Medical Executive Committee. The Chairperson of the Department shall transmit the recommendation regarding continuation, expansion or reduction of clinical privileges and appointment to the Department of Medical Staff Affairs. Factors to be considered shall include, but need not be limited to:

1. Ethical Behavior, clinical competence and clinical judgment in the treatment of patients;
2. Attendance at Medical Staff meetings and participation in staff duties;
3. Compliance with Hospital policies and with Medical Staff Bylaws and Rules and Regulations;
4. Behavior in the Hospital, his/her cooperation with Medical and Hospital personnel as it relates to patient care or the orderly operation of the Hospital and his/her general attitude toward the patients, the Hospital and its personnel (see Professional Conduct Policy in the Rules and Regulations);
5. Use of the Hospital’s facilities for his/her patients;
6. Physical and mental health;
7. Capacity to satisfactorily treat patients as indicated by the results of the Hospital’s quality assessment activities or other reasonable indicators of continuing qualifications;
8. Satisfactory completion of such continuing education requirements as may be imposed by law, the Hospital or applicable accreditation agencies;
9. Activities in furtherance of the Hospital’s mission to provide high quality clinical teaching opportunities to students and residents as evidenced by review of the appointee’s teaching efforts by Department Chairs, peers, residents, students and others;
10. Activities in furtherance of the Hospital’s mission to provide care to indigent patients;
11. Other relevant findings from the Hospital and the Medical Staff’s risk management and quality improvement activities;
12. Any previously successful or currently pending challenges to or voluntary relinquishment of license or registration;
13. Any voluntary or involuntary termination or changes of Medical Staff membership or privileges at another organization;
14. Medical malpractice claims, final judgments or settlements;
15. Compliance with all Federal and State laws;
16. Maintenance of adequate insurance; and
17. Where the applicant for reappointment is the Chairperson of the Department, the applicant’s qualifications shall be reviewed by two (2) Medical Staff members from the respective Department selected by the Chief of Staff and the Vice President for Medical Affairs of the Hospital. The Vice President for Medical Affairs shall then submit this panel’s recommendations in writing with all supporting documents to the Department of Medical Affairs.

Recommendations for increase or decrease of clinical privileges may be based upon, but need not be limited to, the following factors:

1. Relevant recent training;
2. Observation of patient care provided;
3. Review of the records of patients treated in this or other hospitals;
4. Review of the quality of the appointee’s clinical teaching efforts;
5. Results of the Hospital’s quality assessment activities; and
6. Other reasonable indicator of the individual’s continuing qualifications for the privileges in question.

3.2.4 Medical Executive Committee: Upon the receipt of a complete reappointment application, the Department of Medical Staff Affairs shall transmit all supporting documents and reappointment application materials to the Medical Executive Committee, which shall review the appointee’s reappointment application. The Medical Executive Committee shall review all pertinent information available including all information provided from other Committees of the Medical Staff and from the Department of Medical Staff Affairs for the purpose of determining its recommendations for Medical Staff reappointment and for the granting of clinical privileges for the ensuing appointment period. WVUH does not delegate credentialing services.

The Medical Executive Committee may require that a person currently seeking reappointment procure a physical or a mental examination, or both, by a physician or physicians satisfactory to the Medical Executive Committee either as part of the reapplication process or during the appointment period to aid it in determining whether clinical privileges should be granted or continued and make results available for the Medical Executive Committee’s consideration. Failure of the person seeking reappointment to procure such an examination within a reasonable time after being requested to do so in writing by the Medical Executive Committee shall constitute a voluntary relinquishment of Medical Staff appointment and clinical privileges until such time as the Medical Executive Committee has received the examination results and has had a reasonable opportunity to evaluate them and make a recommendation thereon.

The Medical Executive Committee shall then submit to the Department of Medical Staff Affairs, within thirty (30) days of receipt, the completed application and all supporting materials from the Department along with the Department recommendation, a recommendation to:

1. Reappoint;
2. Reject in whole or in part the reappointment application and/or request for clinical privileges;
3. Defer the reappointment application and/or request for clinical privileges for further consideration; or
4. Remand the reappointment application to the Department Chair for reconsideration or the consideration or production of additional information.
When the recommendation of the Medical Executive Committee is to defer the reappointment application for further consideration, it should be followed at the next appropriate meeting of that Committee with either a recommendation for:

1. Reappointment or provisional reappointment with specified clinical privileges;
2. Rejection in whole or in part of the Medical Staff reappointment; or
3. Defer for no more than sixty (60) days pending receipt of additional information. If sufficient data is not received within such sixty (60) day period for the Committee to act upon an application, it must reject reappointment.

3.2.5 Recommendation to Reappoint: Recommendation for reappointment to the Medical Staff by the Medical Executive Committee shall be forwarded to the Board of Directors. This recommendation for reappointment shall be accompanied by a recommendation of the delineation of clinical privileges to be granted.

3.2.6 Burden of Providing Information:
1. Applicants for appointment, reappointment, and/or clinical privileges shall have the burden of producing information deemed adequate by the Hospital for a proper evaluation of competence, character, ethics, and other qualifications, and of resolving any doubts about such qualifications.
2. Applicants shall have the burden of providing evidence that all statements made and information given on their application are true and correct.
3. An application shall be deemed to be complete when all questions on the application form have been answered, all supporting documentation has been supplied, and all information verified. If at any time during the evaluation, the need arises for new, additional, or clarifying information, the application shall be considered incomplete. Any application that continues to be incomplete sixty (60) days after the applicant has been notified of the additional information required shall be deemed to be withdrawn.
4. It is the responsibility of the applicant to provide a complete application, including adequate responses from references. An incomplete application will not be processed.
5. Should information provided in an application for appointment or reappointment change during the course of an appointment year, the appointee has the burden to provide information about such change to the Medical Executive Committee sufficient for the Medical Executive Committee’s review and assessment.
6. Practitioners have the right, upon request, to be informed of the status of their credentialing or re-credentialing application.

3.2.7 Rights of Applicants and Re-applicants, and individuals with clinical privileges:
Applicants for appointment, reappointment, and/or clinical privileges shall have the right to:
1. Be informed, upon request, of the status of their applications;
2. Review the information submitted by applicant in their applications; and
3. Correct any erroneous information submitted. The Medical Staff Office will notify the practitioner, through the appropriate Department in the School of Medicine, of any variant information contained in the application within ten (10) business days of discovery via oral and/or written communication.
Changes to the application to resolve the variant information must be submitted, in writing, by the practitioner to the Medical Staff Office before the application will be considered complete, and presentation for review by the Medical Executive Committee can go forward. Any application that continues to remain incomplete sixty (60) days after the applicant has been notified to correct the variant information shall be deemed to be withdrawn.

3.2.8 Notification of Rights: All practitioners must be notified within sixty (60) calendar days of the committee’s credentialing or re-credentialing decisions. Applicants are provided with electronic access to the policies and procedures. Upon request, the Medical Staff Office will provide a hard copy of said policies and procedures. Once privileges are granted, electronic access is retained to the policies and procedures.

3.2.8a Collegial Intervention and Progressive Steps: See Section 4.1.

3.2.9 Core Privileging: Any changes to core privileges, approved by the Medical Executive Committee and the Governing Body, will be applicable to all practitioners who have or obtain the involved core privileges on or after the date of the change provided the practitioner meets the requirements for the core privileges in the applicable specialty/subspecialty.

3.3 Clinical Privileges

3.3.1 Privileges: Each member of the Medical Staff shall be entitled to exercise only those clinical privileges granted to him/her by the Board except as provided under Sections 3.4 and 3.5, Temporary and Emergency Privileges, of this Article.

3.3.2 Application: Every application for Medical Staff appointment or reappointment must contain a request for the specific clinical privileges desired by the applicant as approved within the Department. The evaluation of such requests shall be based upon the applicant’s education, training, experience, demonstrated current competence, references and other pertinent information. The applicant shall have the burden of establishing his/her qualifications and competency in the clinical privileges and their increase or curtailment shall be based on direct observation of care provided, review of the records of patients treated and review of the records of the Medical Staff which document evaluation of the appointee’s participation in the delivery of medical care.

3.3.3 Dentists: Privileges granted to dentists shall be based on the same factors as for physician members of the Medical Staff including, but not limited to, their training, experience, and demonstrated competence and judgment. The scope and extent of surgical procedures that each dentist may perform shall be specifically delineated and granted in the same manner as all other surgical privileges. Surgical procedures performed by dentists shall be under the overall supervision of the Chairperson of the Department of Surgery. All dental patients shall receive the same basic medical appraisal as patients admitted to other surgical services.

A physician member of the Medical Staff shall be responsible for the care of any medical problem which may be present at the time of admission or that may occur during hospitalization.
3.3.4 **Locum Tenens:** Privileges granted to locum tenens shall be based on the same factors as for physician members of the Medical Staff and allied health members of the Allied Health Staff including, but not limited to, their training, experience, and demonstrated competence and judgment. The scope and extent of medical or surgical procedures that each locum tenens may perform shall be specifically delineated and granted only after submission of requested supporting documentation, which shall be identified by the Vice President of Medical Affairs on an individual basis.

3.3.5 **Privileging of Fellows as Attending Physicians:**

**Policy:** It is the policy of WVUH that only professionally competent individuals who continuously meet the qualifications, standards, and requirements set forth under the credentialing policy, by Federal and State Law and in such policies as adopted by the Board shall be appointed, reappointed to the Medical Staff or granted clinical privileges.

**Definitions:**
1. **Medical Staff** means physicians and dentists (members or appointees) who meet the standards and requirements set forth in the Bylaws and approved by the Board.
2. **Physician** means a person with an academic degree of MD or DO and licensed to practice medicine in accordance with the laws of the State of West Virginia and the rules and regulations promulgated by the Board of Medicine.
3. **Fellow** means a physician enrolled in an ACGME accredited fellowship program regardless of whether federal funds are received by the sponsoring institution.

**Procedure:**
1. Medical and surgical services furnished by a physician within the scope of a training program are covered as provider services and paid by Medicare through direct GME and Indirect Medical Education (IME) payments, and the services of the trainee may not be billed or paid for using the Medicare Physician Fee Schedule (MPFS).
2. Medical and surgical services furnished by a trainee outside of their training program are covered as physician services under certain situations. When these criteria are met, the services are considered to have been furnished by the individuals in their capacity as an intern or resident.
3. The services must be identifiable physician services, the nature of which require performance by a physician in person and contribute to the diagnosis or treatment of a patient’s condition.
4. The trainee is fully licensed to practice medicine, osteopathy, dentistry or podiatry by the State.
5. The services furnished can be separately identified from those services that are required as part of the training program.

**Criteria for employment as a “Moonlighting” attending physician:**
1. The physician must have a current West Virginia license to practice medicine.
2. The physician must sign a part-time contract for professional services.
3. The physician must meet minimum qualifications as outlined in the Bylaws.
4. The physician must be credentialed.
5. The physician may bill only for those clinical services rendered to patients in the role of attending physician, not for services rendered as a Fellow.
6. The physician must log into Merlin using his/her attending name in order to complete documentation.
7. All other requirements of the Bylaws and other applicable policies of the Medical Staff apply.
8. Fellows holding a J1 Visa are excluded for moonlighting.
9. Fellowship training program must outline and grant permission for moonlighting; it is not assumed that all fellowship programs will allow moonlighting.
10. The physician will have completed a residency training program.

**Practice:**
The physician will be credentialed based on their completed training and physicians will be permitted to practice according to the privileges granted to them and outlined on their credentialing form. For example, a trainee enrolled in a Cardiology Fellowship may be credentialed and allowed to practice as an internal medicine provider.

### 3.4 Expedited Privileges for Practitioners

To expedite appointment, reappointment or renewal or modification of clinical privileges for practitioners, the Board has designated authority to Quality and Patient Safety Medical Staff Appointment Sub-Committee. The full Board will consider and, if appropriate, ratify all positive committee decisions at its next regularly scheduled meeting. If the Quality and Patient Safety Medical Staff Appointment Sub-Committee’s decision is adverse to an applicant, the matter is referred back to the Medical Executive Committee for further evaluation.

#### 3.4.1 Ineligibility for Expedited Privileges
An applicant will be ineligible for the expedited process if, at the time of appointment, or if since the time of reappointment, any of the following has occurred:

1. The applicant submits an incomplete application;
2. The Medical Executive Committee makes a final recommendation that is adverse or with limitation;
3. There is current challenge or a previously successful challenge to licensure or registration.
4. The applicant has received an involuntary termination of Medical Staff membership at another organization or has voluntarily relinquished Medical Staff membership after an investigation has been initiated;
5. The applicant has received involuntary limitation reduction, denial or loss of clinical privileges or has voluntarily limited, reduced or given up privileges after an investigation has been initiated; or
6. There has been either an unusual pattern of, or an excessive number of professional liability actions resulting in a final judgment against the applicant.

### 3.5 Temporary Privileges

#### 3.5.1 Temporary Privileges for Initial Applicants
The President or his/her designee, upon recommendation of the Department Chair or his/her designee, with the concurrence of the Chief of Staff, shall have the authority to grant temporary privileges when appropriate, for a period not to exceed one hundred twenty (120) days, to a physician, dentist, or allied health professional.
Temporary privileges shall be granted only after the submission by the applicant of a complete Medical Staff application (please refer to Appendix 1).

A request for temporary privileges must be submitted to Medical Staff Affairs by the Chair of the appropriate Department and include 1) the defined patient care need and 2) the competence, character, ethical standing, and other reasonable indicators of the individual’s qualifications. All information must, in the opinion of the Chief of Staff and President, reasonably support a favorable determination regarding the requesting practitioner’s qualifications, ability, and judgment to exercise the privileges requested.

In the absence of the Chief of Staff, the Vice Chief of Staff may grant temporary privileges following the above procedure. In the absence of both the Chief of Staff and the Vice Chief of Staff, the President may appoint an elected at-large physician from the Medical Executive Committee to grant temporary privileges following the above procedure.

3.5.2 Temporary Privileges for Supplementation of Privileges: Current Medical, Dental, and Allied Health staff members may be granted temporary privileges, not to exceed one hundred twenty (120) days, to supplement their current privileges to meet an important patient care need. The President or his/her designee upon recommendation of the Department Chair or his/her designee with the concurrence of the Chief of Staff, shall have the authority to grant temporary privileges when appropriate.

Temporary privileges shall be granted only after the submission by the applicant of a completed privilege specific application; verification of current licensure; completion of an NPDB query; and a letter from the Chairperson of the appropriate Department supporting the granting of additional privileges with reference to 1) the defined patient care need, and 2) the competence, character, ethical standing, and other reasonable indicators of the individual’s qualification for the additional privileges in question.

All information must, in the opinion of the Chief of Staff and President, reasonably support a favorable determination regarding the requesting practitioner’s qualifications, ability, and judgment to exercise the privileges requested. In the absence of the Chief of Staff, the Vice Chief of Staff may grant temporary privileges following the above procedure. In the absence of both the Chief of Staff and the Vice Chief of Staff, the President may appoint an elected at-large physician from the Medical Executive Committee to grant temporary privileges following the above procedure.

3.5.3 Temporary Clinical Privileges for Non-Applicants: Temporary Clinical Privileges for care of specific patients may be granted by the President with the concurrence of the Chief of Staff to a physician who is not an applicant for appointment to the Medical Staff, where the granting of such privileges is in the best interest of the patients. Temporary clinical privileges for the non-applicant shall be granted only after submission by the applicant of a completed Temporary Clinical Privileges for Non-Applicants form; a notarized copy of photo identification; current West Virginia medical license, unless practicing under an exemption as defined by the West Virginia Board of Medicine; proof of insurance; completion of the required primary source verification; a letter of support from the Chairperson of the appropriate Department or designee supporting temporary privileges with reference to the competence, character, ethical standing, and
other reasonable indicators of the individual’s qualification for the privileges in question, as well as confirmation that the practitioner will be under the direct supervision of the Chairperson or designee; and a signed acknowledgement that he/she agrees to be bound by the Medical Staff Bylaws and Rules and Regulations then in force in all matters relating to his/her temporary clinical privileges. All information must, in the opinion of the Chief of Staff and President, reasonably support a favorable determination regarding the requesting practitioner’s qualifications, ability, and judgment to exercise the privileges requested. Such privileges shall be restricted to specific patients for a defined period of time.

In the absence of the Chief of Staff, the Vice Chief of Staff may grant temporary privileges following the above procedure. In the absence of both the Chief of Staff and the Vice Chief of Staff, the President may appoint an elected at-large physician from the Medical Executive Committee to grant temporary privileges following the above procedure.

3.5.4 **No Entitlement:** Such an appointment does not imply the subsequent award of permanent privileges or the right to vote or hold office, and is intended only to address special situations and emergencies.

3.5.5 **Acknowledgement:** Before the granting of temporary privileges, the Chief of Staff shall first obtain the individual’s signed acknowledgment that he/she has read copies of these Medical Staff Bylaws and the Rules and Regulations then in force in all matters relating to his/her temporary privileges and agrees to be bound by the terms thereof in all matters relating to his temporary privileges.

3.5.6 **Right to Terminate:** The President may, at any time after asking for a recommendation from the Chairperson responsible for the individual’s supervision, terminate an individual’s temporary clinical privileges. Clinical privileges shall then be terminated when the physician’s inpatients are discharged from the Hospital. However, where it is determined that the care or safety of such patients would be endangered by continued treatment by the individual, a termination of temporary clinical privileges may be imposed by either the President or the Department Chair or Chief of Staff, and such termination shall be immediately effective in such a situation. The appropriate Department Chair or the Chief of Staff shall assign to a Medical Staff appointee responsibility for the care of such terminated individual’s patients until they are discharged from the Hospital, giving consideration wherever possible to the wishes of the patient in the selection of the substitute.

3.5.7 **Nature of Temporary Clinical Privileges:** The granting of any temporary clinical privileges is a courtesy on the part of the Hospital. The granting, denial, or termination of such privileges shall not entitle the individual concerned to any of the procedural rights provided in this manual with respect to hearings or appeals.

3.5.8 **Automatic Termination of Temporary Clinical Privileges:** Temporary privileges shall be automatically terminated at such time as the Medical Executive Committee recommends unfavorably with respect to the applicant’s appointment to the Medical Staff, or at the Medical Executive Committee’s discretion, shall be modified to conform to the recommendation of the Medical Executive Committee that the applicant can be granted permanent privileges different from the temporary privileges.
3.6 Emergency Privileges:

3.6.1 Emergency Defined: An “emergency” at WVUH also includes any condition where the patient is at increased risk for serious, permanent harm or in which the patient’s life is in immediate danger and any delay in administering treatment would add to the danger.

3.7 Clinical Privileges for New Procedures:

1. Any Medical Staff appointee who desires to perform a new procedure must contact the Medical Staff Office prior to performing the procedure. Any Medical Staff appointee who desires to use a new device with a procedure must contact the Medical Staff Office prior to the device being brought in or scheduled in the facility.

2. Any Medical Staff appointee who desires to utilize a piece of equipment that requires a vendor representative to be present during a procedure must notify the OR Scheduling office if the procedure occurs within the OR and the Medical Staff Office if the procedure occurs outside of the OR (i.e., Cancer Center, Eye Center, etc.) at a minimum of seven (7) days prior to the date of the procedure. Any instance where the OR scheduling office is not notified seven (7) days prior may result in the case being canceled and rescheduled.

3. Whenever a Medical Staff appointee requests clinical privileges to perform a significant procedure or service not currently being performed at the Hospital (or significant new technique to perform an existing procedure), the process outlined in this section shall be followed:
   a) The appointee shall first be informed by the President that his/her request will not be processed until (1) a determination has been made regarding whether the procedure or service will be offered by the Hospital, and (2) minimum threshold criteria to be eligible to request the clinical privileges in question have been established.
   b) Upon request by the President, the Medical Executive Committee shall make a preliminary recommendation as to whether the procedure or service (or technique) is one that should be offered to patients. One factor to be considered in reaching this recommendation is whether the Hospital has the capabilities, including support services, sufficient space, equipment, and financial resources, to perform the procedure or service in question.
   c) If the preliminary recommendation is favorable, the Medical Executive Committee shall then develop threshold-credentialing criteria to determine those individuals who are eligible to request the clinical privileges at the hospital. In developing the criteria, the Medical Executive Committee shall conduct research and, if it deems advisable, consult with experts – both those on the Hospital’s Medical Staff and those outside the Hospital. The Medical Executive Committee shall develop recommendations regarding (1) the minimum education, training, and experience necessary to perform the procedure or service, and (2) the extent of monitoring and supervision that should occur if the privileges are granted. The Medical Executive Committee may also, as it deems necessary or appropriate, develop criteria and/or indications for when the procedure or service is appropriate.
d) The governing body will approve all criteria established for new privileges.

e) In the event that a procedure needs performed prior to the next governing body meeting, the Medical Executive Committee may approve temporary privileging criteria to allow performance of the procedure until the governing body approves the final criteria.

3.8 Clinical Privileges that Cross Specialty Lines: Whenever a Medical Staff appointee requests clinical privileges that traditionally at WVUH have been exercised by individuals from another specialty, the process outlined below shall be followed:

1. The individual shall be first informed by the President that his/her request will not be processed until the steps outlined in this section have been completed and a determination has been made regarding the individual’s eligibility to request the clinical privileges in question.

2. The Medical Executive Committee shall then investigate the matter and prepare a report and recommendations for the Medical Executive Committee and the Board (or its designated committee). Specifically, the Medical Executive Committee shall conduct research and consult with experts, both those on the Hospital’s Medical Staff (i.e., appropriate department clinical chair, individuals on the Medical Staff with special interest and/or expertise in the privileges in question), and, if it deems appropriate, those outside the Hospital (i.e., other hospitals, residency training programs, specialty societies).

3. The Medical Executive Committee shall then develop recommendations regarding (1) the minimum education, training, and experience necessary to perform the clinical privileges in question, and (2) the extent of monitoring and supervision that should occur. These recommendations may or may not permit individuals from different specialties to request the privileges at issue.

4. The governing body will approve all criteria established for new privileges.

5. In the event that a procedure needs performed prior to the next governing body meeting, the Medical Executive Committee may approve temporary privileging criteria to allow performance of the procedure until the governing body approves the final criteria.

3.9 Temporary Post-Graduate Trainees: WVU Hospitals supports WVU’s mission to provide graduate, non-residency education and training to practitioners who are actively practicing medicine. These practitioners participate in a program specifically designed to meet their focused educational and training needs. Post-Graduate trainee status shall be granted only after approval by the Department Chairman; submission of a completed Temporary Post-Graduate Training Application; current West Virginia medical license, unless practitioner under an exemption as defined by the West Virginia Board of Medicine; proof of current professional liability insurance coverage of at least $1,000,000 per claim; completion of the required primary source verification; background check; completion of a HIPAA Confidentiality Agreement; and a signed acknowledgement that he/she agrees to be bound by the Medical Staff Bylaws and Rules and Regulations then in force in all matters relating to his/her temporary training status. The applicant will be practicing on his/her own professional license while undergoing the clinical training at WVUH. All information must, in the opinion of the Chief of Staff and President, reasonably support a favorable determination regarding the requesting practitioner’s qualifications, ability, and judgment to participate in their educational program.
Approved trainees will be accepted for a specified period of time and allowed supervised clinical patient interaction. Each trainee will be teamed with a WVU clinical educator from the WVU Medical Staff or other appropriate professionals.

All fees associated with processing of the application are the responsibility of the applicant, payable to the Medical Staff Affairs office of West Virginia University Hospitals, Inc.

3.10 Visiting Clinician:
1. WVU Hospitals supports visiting physicians, dentists and allied health professionals ("Visiting Clinicians") by way of providing the individual with the ability to shadow a physician, dentist, or allied health professional with privileges at WVU Hospitals. Visiting Clinician status shall be granted only after completion of the Visiting Clinician Application, completion of the WVU Hospitals Confidentiality and Security Agreement, approval from the Department Chair and obtaining a visitor pass from WVUH Human Resources. Upon departure, the visiting clinician must return the visitor pass to the respective Department or WVUH Human Resources to be discarded.

2. WVU Hospitals supports the WVU Residency Programs by way of providing applicants with the ability to tour West Virginia University Hospitals, Inc. Applicants must complete the Visiting Clinician Application, the WVU Hospitals Confidentiality and Security Agreement, be granted approval from the Department Chair, and obtain a visitor pass from WVUH Human Resources. Upon departure, the applicant must return the visitor pass to the respective Department or WVUH Human Resources to be discarded.

3. Approved visiting clinicians will be accepted for a specified period of time. Visiting Clinicians shall not and are not permitted to engage in the practice of medicine, dentistry, or the relevant allied health professional field. Visiting Clinicians may be permitted by a physician, dentist, or allied health professional with privileges at WVU Hospitals to speak with and/or interview a patient, be present for the examination of a patient, and be present in an operating/procedure room for a procedure on a patient. A Visiting Clinician may engage in the above activities only in the presence of a physician, dentist, or allied health professional with privileges at WVU Hospitals. The Visiting Clinician shall not at any time scrub for a surgical case or procedure in an operating/procedure room, participate in a surgical case or procedure while observing in an operating/procedure room, or write in, dictate in or otherwise cause an entry to be made in the patient’s chart. The Department Chairman shall assign a physician, dentist, or allied health professional with privileges at WVU Hospitals to accompany the Visiting Clinician.

3.11 Visiting Non-Clinician:
1. WVU Hospitals supports Visiting Non-Clinicians by way of providing the individual with the ability to shadow a physician, dentist, or allied health professional with privileges at WVU Hospitals. Visiting Non-Clinician status shall be granted only after completion of the Visiting Non-Clinician application, review of the “Information for Visiting Non-Clinicians” PowerPoint presentation, completion of the WVU Hospitals Confidentiality and Security Agreement, approval from the Department Chair and
obtaining a visitor pass from WVUH Human Resources. Upon departure, the Visiting Non-Clinician must return the visitor pass to the respective department or WVUH Human Resources to be discarded.

2. Approved Visiting Non-Clinicians will be accepted for a specified period of time. Visiting Non-Clinicians shall not and are not permitted to engage in the practice of medicine, dentistry, or the relevant allied health professional field. Visiting Non-Clinicians may be permitted by a physician, dentist, or allied health professional with privileges at WVU Hospitals to speak with and/or interview a patient, be present for the examination of a patient, and be present in an operating/procedure room for a procedure on a patient. A Visiting Non-Clinician may engage in the above activities only in the presence of a physician, dentist, or allied health professional with privileges at WVU Hospitals. The Visiting Non-Clinician shall not at any time scrub for a surgical case or procedure in an operating/procedure room, participate in a surgical case or procedure while observing in an operating/procedure room, or write in, dictate in or otherwise cause an entry to be made in the patient’s chart. The Department Chair shall assign a physician, dentist, or allied health professional with privileges at WVU Hospitals to accompany the Visiting Non-Clinician.
Health Policy) or Appendix I (Professional Conduct Policy) of the Rules and Regulations of the Medical Staff or another applicable Policy, or to direct it to the Medical Executive Committee for further determination.

7. Whenever there is an apparent or suspected deviation from standard clinical practice involving any individual, the Vice President of Medical Affairs may require the individual to attend a special conference with Medical Staff leaders and/or with an ad-hoc committee of the Medical Staff. The notice to the individual regarding this conference shall be given by written notice at least three days prior to the conference and shall inform the individual that attendance at the conference is mandatory. Failure of the individual to attend the conference shall be reported to the Medical Executive Committee. Unless excused by the Medical Executive Committee upon a showing of good cause, such failure shall result in automatic relinquishment of all or such portion of the individual’s clinical privileges as the Medical Executive Committee may direct. Such relinquishment shall remain in effect until the matter is resolved.

4.2 Ongoing Professional Practice Evaluation: A document summary of ongoing data collected for the purpose of assessing a practitioner’s clinical competence and professional behavior. The information gathered during this process is factored into decisions to maintain, revise, or revoke existing privilege(s) prior to, or at the end of, the two-year license and privilege renewal cycle. The Ongoing Professional Practice Evaluation process has been established to identify practitioner practice trends that may impact the quality of care and patient safety. Criteria have been developed for each Department as well as the mechanisms used to retrieve the data. The type of data to be collected is determined by individual Departments and approved by the Medical Executive Committee. These criteria are used by the Medical Executive Committee to recommend continuing, limiting or revoking any existing privileges. Additionally, through this process, practitioners receive feedback for personal improvement or confirmation of personal achievement related to the effectiveness of their professional practice as defined by the six Joint Commission/ACGME general competencies described below:

1. Patient Care: Practitioners are expected to provide patient care that is timely, compassionate, appropriate, and effective for the promotion of health, for the prevention of illness, for the treatment of disease, and at the end of life.
2. Medical/Clinical Knowledge: Practitioners are expected to demonstrate knowledge of established and evolving biomedical, clinical and social sciences, and the application of their knowledge to patient care and the education of others.
3. Practice-Based Learning and Improvement: Practitioners are expected to be able to use scientific evidence and methods to investigate, evaluate and improve patient care.
4. Interpersonal and Communication Skills: Practitioners are expected to demonstrate interpersonal and communication skills that enable them to establish and maintain professional relationships with patients, families, and other members of healthcare teams.
5. Professionalism: Practitioners are expected to demonstrate behaviors that reflect a commitment to continuous professional development, ethical practice, an understanding and sensitivity to diversity, and a responsible attitude toward their patients, their profession, and society.
6. System-Based Practice: Practitioners are expected to demonstrate both an understanding of the contexts and systems in which healthcare is
The Ongoing Professional Practice Evaluation (OPPE) Committee shall meet at least quarterly to review the data collected. A report identifying the results of these reviews will be shared with the Medical Executive Committee, the Chair and with the practitioners evaluated on a routine basis. Outliers identified during this committee review will follow the Focused Review Process outlined in Section 4.2.2 Focused Professional Practice Review. Each practitioner will be evaluated at least twice per year. The practitioner will be notified of the results of the review, committee findings and/or recommendations.

**Focused Professional Practice Evaluation (FPPE):** The FPPE process establishes current competency for new Medical Staff members, new privileges, and/or concerns from the OPPE Committee. These activities comprise what is typically called proctoring or focused review depending on the nature of the circumstances. (See Section 4.2.1 – Focused Professional Practice Evaluation)

**Peer Review Body:**

**Professional Practice Review Committee:** The peer review body designated to perform the Ongoing Professional Practice Evaluation (OPPE) of all credentialed providers is designated as the Ongoing Professional Practice Review (OPPE) Committee as described in the organizational policy unless otherwise designated for specific circumstances by the VPMA.

**Peer Review Committee:** The peer review body designated to review concerns is designated as the Peer Review Committee (PRC) as described in the organizational manual unless otherwise designated for specific circumstances by the VPMA. The issues that may be assigned to the PRC include, but are not limited to, any one or more of the following:

1. Issues identified by the OPPE Committee through the OPPE review of clinical competence of a provider(s);
2. Issues identified by the performance of a Root Cause Analysis;
3. Issues identified during a Sentinel Event; and/or
4. Issues identified through the Morbidity and Mortality (M&M) conferences which are performed by the West Virginia University School of Medicine individual Departments.

**Conflict of Interest:** A member of the Medical Staff requested to perform peer review may have a conflict of interest if they may not be able to render an unbiased opinion:

- An absolute conflict of interest would result if the physician is the provider under review.
- Relative conflicts of interest are either due to a provider’s involvement in the patient’s care not related to the issues under review or because of a relationship with the physician involved as a direct competitor, partner, or key referral source.

It is the obligation of the individual reviewer or committee member to disclose to the committee the potential conflict. It is the responsibility of the peer review body to determine on a case-by-case basis whether a relative conflict is substantial enough to prevent the individual from participating. When either an absolute or substantial relative conflict is determined to exist, the individual may not participate or be present during peer review body discussions or decisions.
other than to provide specific information requested by the MEC or OPPE Committee.

Policy:
1. All peer review information is privileged and confidential in accordance with Medical Staff and Hospital bylaws, state and federal laws, and regulations pertaining to confidentiality and non-discoverability.
2. The involved practitioner will receive provider-specific feedback on a routine basis.
3. The Medical Staff will use the provider-specific peer review results in making its recommendations to the Hospital regarding the credentialing and privileging process and, as appropriate, in its performance improvement activities.
4. The Hospital will keep provider-specific peer review and other quality information concerning a practitioner in a secure, locked file. Provider-specific peer review information consists of information related to:
   a) Performance data for all dimensions of performance measured for that individual physician;
   b) The individual physician’s role in sentinel events, significant incidents, or near misses; and
   c) Correspondence to the physician regarding commendations, comments regarding practice performance, or corrective action.
5. Only the final determinations of the Peer Review Committee and any subsequent actions are considered part of an individual provider’s quality file.
6. Peer review information in the individual provider’s quality file is available only to authorized individuals who have a legitimate need to know this information based upon their responsibilities as a Medical Staff leader or Hospital employee to the extent necessary to carry out their assigned responsibilities. This includes the following individuals who shall have access to provider-specific peer review information and only for purposes of quality improvement:
   a) The specific provider;
   b) The Vice President of Medical Affairs (VPMA) and the Chief of Staff for purposes of considering corrective action;
   c) Department Chairs (for members of their departments only) to complete appraisals for purposes of considering reappointment or corrective action;
   d) Medical Staff leaders and staff supporting the peer review process;
   e) Individuals surveying for accrediting bodies with appropriate jurisdiction;
   f) Individuals with a legitimate purpose for access as determined by the VPMA or Chief of Staff; and/or
   g) The Hospital CEO when information is needed for the CEO's involvement in the process of immediate formal corrective action as defined in the Medical Staff credentialing policy.
7. No copies of peer review documents will be created and distributed unless authorized by Medical Staff or Hospital policy.

Participants in the Review Process: Participants in the review process will be selected according to the Medical Staff Policies and Procedures. The work of all practitioners granted privileges will be reviewed through the peer review process. Clinical support staff will participate in the review process if deemed appropriate. The VPMA will consider the views of the person whose care is under review prior
to making a final determination regarding the care provided by that individual, as long as that individual responds in the timeframe outlined by the MEC or the VPMA.

In the event of a conflict of interest or circumstances that would suggest a biased review beyond that described above, the VPMA or the MEC will replace, appoint, or determine who will participate in the process so that bias does not interfere in the decision-making process.

**Thresholds for FPPE:** If the results of an OPPE indicate a potential issue with physician performance, the OPPE Committee may initiate a Focused Professional Practice Evaluation (FPPE) to determine whether there is a problem with current competency of the physician for either specific privileges or for more global dimensions of performance. If the results of the OPPE indicate a serious issue or concern, the OPPE Committee will refer the matter to the PRC for further review and action. These potential issues may be the result of individual case review or data from rule or rate indicators. (The thresholds for FPPE are described in the acceptable targets for the Medical Staff indicators, Section 4.2.1 – FPPE.)

**Oversight and Reporting:** Direct oversight of the ongoing review process is delegated by the MEC to the OPPE Committee. The responsibilities of the OPPE Committee as related to ongoing review are described in the Organizational Manual. The OPPE Committee will report to the MEC at least quarterly.

Direct oversight of the peer review process is delegated by the MEC to the PRC, and is described in the Organizational Manual. The PRC will report to the MEC at least quarterly.

**Statutory Authority:** This policy is based on the statutory authority of the Health Care Quality Improvement Act of 1986 U.S.C. 11101, et seq. and West Virginia Code §30-3C-1 et seq. All minutes, reports, recommendations, communications, and actions made or taken pursuant to this policy are deemed to be covered by such provisions of federal and state law providing protection to peer review related activities.

**4.2.1 Focused Professional Practice Evaluation:** The time limited evaluation of practitioner competence in performing a specific privilege. This process is implemented for all initially requested privileges and whenever a question arises regarding a practitioner’s ability to provide safe, high-quality patient care.

1. Whenever a serious question has been raised potentially affecting the provision of safe, high quality patient care or where collegial efforts have not resolved an issue regarding:
   a) The clinical competence or clinical practice of any individual with clinical privileges, including the care, treatment or management of a patient or patients;
   b) The known or suspected violation of applicable ethical standards or the Bylaws, Policies, Rules and Regulations of the Hospital or the Medical Staff; and/or
   c) Conduct that is considered lower than the standards of the Hospital or disruptive to the orderly operation of the Hospital or its Medical
Staff, including the inability of the individual to work harmoniously with others;

the matter shall be reviewed by the Vice President of Medical Affairs to determine if a Focused Professional Practice Evaluation is indicated. In making this determination, the Vice President of Medical Affairs shall consider circumstances approved by the Medical Executive Committee (MEC) and/or the following:

- Procedural complication rates higher than expected;
- Identification of unusual complications;
- When a practitioner’s Ongoing Professional Practice Evaluation (OPPE) report includes data that exceeds the defined thresholds, and review of the underlying cases that make up the data reflects a clinical pattern;
- Allegations of deviations of practice from the standard of care;
- Patient complaints;
- Behavioral complaints; and/or
- Incomplete medical records or delinquency.

2. The types of focused review utilized by the Peer Review Committee (PRC) and/or the Vice President of Medical Affairs shall include chart review, monitoring of clinical practice patterns, proctoring, internal peer review, external peer review, or discussion with any healthcare workers involved in the care of specific patients. The duration of Focused Professional Practice Evaluation can be limited based on either of the following:

- Specific time period; or
- Procedure/admission/activity threshold.

The review type can vary:

- Direct observation;
- Chart review;
- Simulation;
- Discussion with other individuals involved in the care of each patient, including consulting practitioners, surgical assistants, nurses, and administrative personnel.

The duration of FPPE may be tiered for different levels of documented training and experience:

- Practitioners coming directly from an outside residency program;
- Practitioners coming directly from the organization’s residency program;
- Practitioners coming with a documented record of performance of the privilege and its associated outcomes versus those with no record.

3. The plan may be continued for an assigned period after evaluation if the initial review is not conclusive regarding the provider’s clinical competence or practice behavior. Appropriate Medical Staff shall participate in the development of the plan at the request of the Vice President of Medical Affairs.

4. Should an issue be raised regarding a provider’s clinical practice and a FPPE be invoked outside of the normal parameters set forth in this policy under FPPE, reasonable efforts shall be made to complete internal FPPEs
within 30 to 60 days of assignment by the Peer Review Committee, including the Vice President of Medical Affairs. If it appears that the review will not be completed within this timeframe, the Vice President of Medical Affairs has the discretion to extend the timeframe as is reasonable under the circumstances.

5. Although the process may vary based on different levels of documented training and experience, no one can be excused from the process of initial evaluation. (See Section 2.2.1 – Terms of Appointment and Provisional Appointments) Focused Professional Practice Evaluation is consistently implemented in accordance with the criteria and requirements defined by the Medical Executive Committee. All practitioners are treated equitably. Criteria are applied as defined by the Medical Executive Committee. Specialty-specific data/indicators for the same privilege are managed the same way for all practitioners with that privilege.

6. The performance improvement plan must be documented and include the requirements, who is accountable, and how the improvement will be measured and documented. The performance improvement plan will include prospective and real-time evaluation to ensure safe, competent care. The performance improvement plan can include the following:
   - Necessary education;
   - Proctoring/assisting for defined privileges;
   - Counseling;
   - Physician/practitioner assistance programs;
   - Suspension of specific privileges;
   - Revocation of special privileges.

7. The measures employed to resolve performance issues are consistently applied to any practitioner undergoing FPPE for that privilege. The outcome of FPPE is documented as are decisions made to the further need for FPPE and/or the continuation or limiting of the privilege.

Circumstances That May Require Peer Review: Peer review is conducted on an ongoing basis by the OPPE Committee and reported to the PRC for review and action. The procedures for conducting peer review for an individual case and for aggregate performance measures are described in Section 4.2.2 and 4.2.3 of the Medical Staff Credentialing Policy.

Circumstances that May Require External Peer Review: An external peer review shall be initiated by the VPMA or the PRC when a possible quality concern cannot be effectively addressed through an internal process. No practitioner can require the Hospital to obtain external peer review if it is not deemed appropriate by the MEC. Circumstances that may require external peer review include the following:
   - Litigation: when dealing with the potential for a lawsuit.
   - Ambiguity: when dealing with vague or conflicting recommendations from internal reviewers or Medical Staff committees and conclusions from this review will directly affect a practitioner’s membership or privileges.
   - Lack of Internal Expertise: when no one on the Medical Staff has adequate expertise in the specialty under review, or when the only practitioners on the Medical Staff with that expertise are determined to have a conflict of interest regarding the practitioner under review as
described above. External peer review will take place if this potential for conflict of interest cannot be appropriately resolved by the Medical Executive Committee or governing board.

- Miscellaneous Issues: when the Medical Staff needs an expert witness for a fair hearing, for evaluation of a credentialing file, or for assistance in developing a benchmark for quality monitoring. In addition, the Medical Executive Committee or governing board may require external peer review in any circumstances deemed appropriate by either of these bodies.

No action taken pursuant to the Section shall constitute an investigation.

4.2.2 Initiation of Investigation:
1. When a question involving clinical competence or professional conduct is referred to, or raised by, the Medical Executive Committee, the Medical Executive Committee shall review the matter and determine whether to conduct an investigation or to direct the matter to be handled pursuant to Appendix J or K of the Rules and Regulations of the Medical Staff. In making this determination, the Medical Executive Committee may discuss the matter with the individual. An investigation shall begin only after a vote by the Medical Executive Committee to do so.
2. The Medical Executive Committee shall inform the individual that an investigation has begun. Notification may be delayed if, in the Medical Executive Committee’s judgment, informing the individual immediately would compromise the investigation or disrupt the operation of the Hospital or Medical Staff.
3. The Board may also determine to commence an investigation and may delegate the investigation to the Medical Executive Committee, a subcommittee of the Board, or an ad hoc committee.

4.2.3 Investigative Procedure:
1. Once a determination has been made to begin an investigation, the Medical Executive Committee shall either investigate the matter itself or appoint an individual or ad hoc committee to conduct the investigation. Whenever the questions raised concern the clinical competence of the individual under review, the ad hoc committee shall include a peer of the individual.
2. The individual or committee conducting the investigation (investigating committee) shall have the authority to review relevant documents and interview individuals. It shall also have available to it the full resources of the Medical Staff and the Vice President of Medical Affairs, as well as the authority to use outside consultants, if needed. An outside consultant or agency may be used whenever a determination is made by the Vice President of Medical Affairs and investigating committee that:
   a) The clinical expertise needed to conduct the review is not available on the Medical Staff; or
   b) The individuals with the necessary clinical expertise on the Medical Staff would not be able to conduct a review without risk of allegations of bias, even if such allegations are unfounded.
3. The investigating committee may require a physical and mental examination of the individual by health care professional(s) of its choice. The results of such examination shall be made available for consideration by the investigating committee.
4. The individual shall have an opportunity to meet with the investigating committee before it makes its report. Prior to this meeting, the individual
shall be informed of the general questions being investigated. At the meeting, the individual shall be invited to discuss, explain, or refute the questions that gave rise to the investigation. A summary of the interview shall be made by the investigating committee and included with its report. This meeting is not a hearing, and none of the procedural rules for hearings shall apply. The individual being investigated shall not be entitled to be represented by legal counsel at this meeting.

5. The investigating committee shall make a reasonable effort to complete the investigation and issue its report within 30 days of the commencement of the investigation, provided that an outside review is not necessary. When an outside review is necessary, the investigating committee shall make a reasonable effort to complete the investigation and issue its report within 30 days of receiving the results of the outside review, and within a total of 90 – 120 days of the commencement of the investigation. These time frames are intended to serve as guidelines and, as such, shall not be deemed to create any right for an individual to have an investigation completed within such time periods. In the event the investigating committee is unable to complete the investigation and issue its report within these time frames, it shall inform the individual of the reasons for the delay and the approximate date on which it expects to complete the investigation.

6. At the conclusion of the investigation, the investigating committee shall prepare a report with its findings, conclusions and recommendations.

4.2.4 Recommendation:

1. The Medical Executive Committee may accept, modify, or reject any recommendation it receives from an investigating committee. Specifically, the Medical Executive Committee may:
   a) Determine that no action is justified;
   b) Issue a letter of guidance, warning, or reprimand;
   c) Impose conditions for continued appointment;
   d) Impose a requirement for monitoring or consultation;
   e) Recommend additional training or education;
   f) Recommend reduction of clinical privileges;
   g) Recommend suspension of clinical privileges for a term;
   h) Recommend revocation of appointment and/or clinical privileges; or
   i) Make any other recommendation that it deems necessary or appropriate.

2. A recommendation by the Medical Executive Committee that would entitle the individual to request a hearing shall be forwarded to the Vice President of Medical Affairs, who shall promptly inform the individual by written notice. The Vice President of Medical Affairs shall hold the recommendation until after the individual has completed or waived a hearing and appeal.

3. If the Medical Executive Committee makes a recommendation that does not entitle the individual to request a hearing, it shall take effect immediately and shall remain in effect unless modified by the Quality and Patient Safety Committee or the Board, as applicable.

4. In the event the Quality and Patient Safety Committee or the Board considers a modification to the recommendation of the Medical Executive Committee that would entitle the individual to request a hearing, the President shall inform the individual by written notice. No final Board action shall occur until the individual has completed or waived a hearing and appeal.
5. When applicable, any recommendations or actions that are the result of an investigation or hearing and appeal shall be monitored by Medical Staff leaders on an ongoing basis through the Hospital's performance improvement activities or pursuant to the applicable policies regarding conduct, as appropriate.

4.3 Precautionary Suspension or Restriction of Clinical Privileges:

4.3.1 Grounds for Precautionary Suspension or Restriction:
1. The Quality and Patient Safety Committee, or any two of the following: the Chief of Staff, the President, the Vice President of Medical Affairs or the Chairperson of the Board, shall each have the authority to suspend or restrict all or any portion of an individual’s clinical privileges whenever, in their opinion, failure to take such action may result in imminent danger to the health and/or safety of any individual or may interfere with the orderly operation of the Hospital. The individual may be given an opportunity to refrain voluntarily from exercising privileges pending an investigation.

2. In the event a Medical Staff appointee or House Staff violates Medical Staff or Hospital policy that adversely affects patient safety or Hospital accreditation, or violates the professional conduct policy, any two of the following, the Vice President of Medical Affairs, the Chief of Staff, the President, or the Chairperson of the Board shall have the authority to precautionary suspend or restrict any portion of the individual’s privileges for no more than five days. All precautionary suspensions of this type will be reported to the Medical Executive Committee at the next regularly scheduled meeting. A copy of the letter of suspension will be included in the individual’s quality file and the individual will have an opportunity to respond in writing. The response shall be maintained in that individual’s file along with the original documentation.

3. Precautionary suspension or restriction is an interim step in the professional review activity, but it is not a complete professional review action in and of itself. It shall not imply any final finding of responsibility for the situation that caused the suspension or restriction.

4. A precautionary suspension or restriction shall become effective immediately upon imposition, shall immediately be reported in writing to the applicable Department Chair, the President and the Chief of Staff, and shall remain in effect unless it is modified by the President or Medical Executive Committee.

4.3.2 Medical Executive Committee Procedure:
1. The Medical Executive Committee shall review the matter resulting in a precautionary suspension or restriction within a reasonable time under the circumstances, not to exceed 14 days. The individual may propose to the Vice President of Medical Affairs ways other than precautionary suspension or restriction to protect patients, employees and/or the smooth operation of the Hospital, depending on the circumstances.

2. After considering the matters resulting in the suspension or restriction and the individual’s response, if any, the Medical Executive Committee shall determine whether there is sufficient information to warrant a final recommendation, or whether it is necessary to commence an investigation. The Medical Executive Committee shall also determine whether the precautionary suspension or restriction should be continued, modified, or terminated pending the completion of the investigation (and hearing, if applicable).
3. There is no right to a hearing based on the imposition or continuation of a precautionary suspension or restriction.

4.3.3 Care of Patients:
1. Immediately upon the imposition of a precautionary suspension or restriction, the Department Chair shall assign to another individual with appropriate clinical privileges responsibility for care of the suspended individual’s hospitalized patients, or to aid in implementing the precautionary restriction, as appropriate. The assignment shall be effective until the patients are discharged.
2. All Medical Staff appointees and others with clinical privileges have a duty to cooperate with the Chief of Staff, the Vice President of Medical Affairs, the Department Chair, the Medical Executive Committee, and the President in enforcing precautionary suspensions or restrictions.

4.4 Automatic Relinquishment:

4.4.1 Failure to Complete Medical Records:
1. The elective and emergency clinical privileges of any individual shall be voluntarily relinquished for failure to timely complete medical records as defined in the Rules and Regulations.
2. Failure to complete the medical records that caused relinquishment of the clinical privileges within two (2) months from the relinquishment of privileges shall constitute a voluntary relinquishment of all clinical privileges and resignation from the Medical Staff.

4.4.2 Action by Government Agency or Insurer:
1. Any action taken by any licensing board, professional liability insurance company, court, or government agency regarding any of the matters set forth below must be promptly reported to the Vice President of Medical Affairs.
2. An individual’s appointment and clinical privileges shall be automatically relinquished if any of the following occur:
   a) Licensure: Revocation, suspension, or the placement of conditions or restrictions on an individual’s license.
   b) Controlled Substance Authorization: Revocation or suspension of an individual’s DEA controlled substance authorization.
   c) Insurance Coverage: Termination or lapse of an individual’s professional liability insurance coverage or other action causing the coverage to fall below the minimum required by the Hospital or cease to be in effect, in whole or in part.
   d) Medicare and Medicaid Participation: Termination, exclusion, or preclusion by government action from participation in the Medicare/Medicaid or other federal or state health care programs.
   e) Criminal Activity: Conviction or a plea of guilty or no contest pertaining to any felony.
3. Automatic relinquishment shall take effect immediately and continue until the matter is resolved, if applicable, and a request for reinstatement of appointment and privileges has been acted upon by the Medical Executive Committee, the Quality and Patient Safety Committee and the Board.

4.4.3 Failure to Provide Requested Information: Failure to provide information pertaining to an individual’s qualifications for appointment or clinical privileges, in response to a written request from the Medical Executive Committee, the Vice
President of Medical Affairs, or any other committee authorized to request such information, shall result in automatic relinquishment of all clinical privileges until the information is provided.

4.5 Leaves of Absence

4.5.1 Availability of Leave: Persons appointed to the Medical Staff may, for good cause, be granted leaves of absence by the Vice President of Medical Affairs for a definitely stated period of time, not to exceed ten (10) months. Absence for longer than ten (10) months shall constitute resignation of Medical Staff appointment and clinical privileges unless an exception is made by the Board.

4.5.2 Requests for Leave: Requests for leaves of absence shall be made to the Chair of the Department in which the individual applying for leave has his/her primary clinical privileges, and shall state the beginning and ending dates of the requested leave. The Department Chair shall notify the Department of Medical Staff Affairs. Requests for medical leaves of absence for health reasons shall be referred to the Practitioner Health Committee.

4.5.3 Reinstatement After Leave: Prior to the conclusion of the leave of absence, whether medical or personal, the individual may be reinstated, upon notifying the Department of Medical Staff Affairs. The President (or his or her designee) and/or the Chief of Staff may require the individual to provide a summary of his/her professional activities and all information regarding the obtained leave of absence. If the leave of absence was for health reasons, the request for reinstatement must be accompanied by a report from the individual's physician indicating that the individual is physically and/or mentally capable of resuming a Hospital practice and safely exercising the clinical privileges requested. In acting upon the request for reinstatement after a medical or personal leave of absence, the President (or his or her designee) and the Chief of Staff may reinstate the applicant or if deemed necessary refer the individual to the Practitioner Health Committee for further evaluation and recommendations before reinstatement. To the extent applicable, the Practitioner Health Policy, Appendix J of the Rules and Regulations of the Medical and Dental Staff, is incorporated herein by reference.

5.1 Initiation of Hearing

5.1.1 Grounds for Hearing:
1. An individual is entitled to request a hearing whenever the Medical Executive Committee makes one of the following recommendations:
   a) Denial of initial appointment to the Medical Staff;
   b) Denial of reappointment to the Medical Staff;
   c) Revocation of appointment to the Medical Staff;
   d) Reduction of clinical privileges;
   e) Denial of requested clinical privileges;
   f) Revocation of clinical privileges;
g) Suspension of clinical privileges for more than 30 days (other than precautionary); or
h) Mandatory concurring consultation requirement (i.e., the consultant must approve the course of treatment in advance).

2. No other recommendations shall entitle the individual to a hearing.
3. The hearing shall be conducted in as informal a manner as possible.
4. The individual may request a hearing before the Board or the Quality and Patient Safety Committee, as applicable, takes final action if the Board makes any of these recommendations without a prior Medical Executive Committee recommendation. In this instance, all references in this Article to the Medical Executive Committee shall mean the Board, or the Quality and Patient Safety Committee, as applicable.

5.1.2 Actions Not Grounds for Hearing: None of the following actions shall constitute grounds for a hearing, and they shall take effect without hearing or appeal, provided that the individual shall be entitled to submit a written explanation to be placed into his or her file:
   - Issuance of a letter of guidance, warning, or reprimand;
   1. Imposition of conditions, monitoring, or a general consultation requirement (i.e., the individual must obtain a consult but need not get prior approval for the treatment);
   2. Termination of temporary privileges;
   3. Automatic relinquishment of appointment or privileges;
   4. Imposition of a requirement for additional training or continuing education;
   5. Precautionary suspension;
   6. Determination that an application is incomplete;
   7. Determination that an application will not be processed due to a misstatement or omission; or
   8. Determination of ineligibility based on a failure to meet threshold criteria or a lack of need or resources.

5.2 The Hearing

5.2.1 Notice of Recommendation: The President shall, within 14 days of the recommendation, give written notice of the recommendation which entitles an individual to request a hearing. This notice shall contain:
   1. A statement of the recommendation and the general reasons for it;
   2. A statement that the individual has the right to request a hearing on the recommendation within 30 days of receipt of this notice; and
   3. A copy of this Article.

5.2.2 Request for Hearing: An individual has 30 days following receipt of the notice to request a hearing. The request shall be in writing to the President and shall include the name, address and telephone number of the individual’s counsel, if any. Failure to request a hearing shall constitute waiver of the right to a hearing, and the recommendation shall be transmitted to the Board for final action.

5.2.3 Notice of Hearing and Statement of Reasons:
   1. The President shall schedule the hearing and provide, by written notice, the following:
a) The time, place and date of the hearing;
b) A proposed list of witnesses who will give testimony at the hearing and a brief summary of the anticipated testimony;
c) The names of the Hearing Panel members and Presiding Officer (or Hearing Officer) if known; and
d) A statement of the specific reasons for the recommendation, including a list of patient records (if applicable) and information supporting the recommendation. This statement may be revised or amended at any time, even during the hearing, so long as the additional material is relevant to the recommendation or the individual’s qualifications and the individual has had a sufficient opportunity, up to 30 days, to review and rebut the additional information.

2. The hearing shall begin as soon as practicable, but no sooner than 30 days after the notice of the hearing, unless an earlier hearing date has been specifically agreed to in writing by the parties.

5.2.4 Witness List:
1. At least 15 days before the pre-hearing conference, the individual requesting the hearing shall provide a written list of the names of witnesses expected to offer testimony on his or her behalf.
2. The witness list shall include a brief summary of the anticipated testimony.
3. The witness list of either party may, in the discretion of the Presiding Officer, be amended at any time during the course of the hearing, provided that notice of the change is given to the other party.

5.2.5 Hearing Panel, Presiding Officer, and Hearing Officer:
1. Hearing Panel:
   a) The President, after consulting with the Chief of Staff, shall appoint a Hearing Panel composed of not less than three members, one of whom shall be designated as chairperson. The Hearing Panel shall be composed of Medical Staff appointees experienced in Medical Staff leadership and peer review, or laypersons, who did not actively participate in the matter at any previous level, or a combination thereof. Knowledge of the matter involved shall not preclude any individual from serving as a member of the Hearing Panel. Employment by, or a contract with, the Hospital or an affiliate shall not preclude any individual from serving on the Hearing Panel.
   b) The Hearing Panel shall not include anyone who is in direct economic competition with the individual requesting the hearing, unless such individual consents, in writing, to the participation of that member of the Hearing Panel. University Health Associate individuals shall not be deemed to be in direct economic competition with each other.
2. Presiding Officer:
   a) In lieu of a Hearing Panel Chairperson, the President may appoint a Presiding Officer who may be an attorney. The Presiding Officer shall not act as an advocate for either side at the hearing.
   b) If no Presiding Officer has been appointed, the Chairperson of the Hearing Panel shall serve as the Presiding Officer and shall be entitled to one vote.
   c) The Presiding Officer shall:
i. Allow the participants in the hearing to have a reasonable opportunity to be heard and to present evidence, subject to reasonable limits on the number of witnesses and duration of direct and cross-examination;

ii. Prohibit conduct or presentation of evidence that is cumulative, excessive, irrelevant or abusive or that causes undue delay;

iii. Maintain decorum throughout the hearing;

iv. Determine the order of procedure;

v. Rule on all matters of procedure and the admissibility of evidence; and

vi. Conduct argument by counsel on procedural points outside the presence of the Hearing Panel unless the Panel wishes to be present.

d) The Presiding Officer may participate in the private deliberations of the Hearing Panel and be a legal advisor to it, but shall not be entitled to vote on its recommendations unless he or she is the Chairperson.

3. Hearing Officer:
   a) As an alternative to a Hearing Panel, the President, after consulting with the Chief of Staff, may appoint a Hearing Officer, preferably an attorney, to perform the functions of a Hearing Panel. The Hearing Officer may not be, or represent clients, in direct economic competition with the individual requesting the hearing.

   b) If a Hearing Officer is appointed instead of a Hearing Panel, all references in this Article to the “Hearing Panel” or “Presiding Officer” shall be deemed to refer to the Hearing Officer.

4. Objections:
   a) Any objection to any member of the Hearing Panel, or the Hearing Officer or Presiding Officer, shall be made in writing within 10 days of receipt of notice to the President, who shall, in his discretion, resolve the objection.

5.3 Pre-Hearing and Hearing Procedure

5.3.1 Provision of Relevant Information:

1. The individual requesting the hearing is entitled to the following, subject to the condition that all documents and information be maintained as confidential and not disclosed or used for any purpose outside the hearing:

   a) Copies of, or reasonable access to, all patient medical records referred to in the statement of reasons, at the individual’s expense;

   b) Reports of experts relied upon by the Medical Executive Committee;

   c) Copies of relevant minutes (with portions regarding other physicians and unrelated matters deleted); and

   d) Copies of any other documents relied upon by the Medical Executive Committee.

   The provision of this information is not intended to waive any privilege under the state peer review protection statute.

2. The individual shall have no right to discovery beyond the above information. No information shall be provided regarding other practitioners.
3. Prior to the hearing, on dates set by the Presiding Officer or agreed upon by both sides, each party shall provide the other party with its proposed exhibits. All objections to documents or witnesses, to the extent then reasonably known, shall be submitted in writing in advance of the pre-hearing conference. The Presiding Officer shall not entertain subsequent objections unless the party offering the objection demonstrates good cause.

4. Evidence unrelated to the reasons for the recommendation or to the individual’s qualifications for appointment or the relevant clinical privileges shall be excluded.

5. Neither the individual, nor his or her attorney, nor any other person acting on behalf of the individual shall contact Hospital employees appearing on the Medical Executive Committee’s witness list concerning the subject matter of the hearing, unless specifically agreed upon by counsel.

5.3.2 Pre-Hearing Conference: The Presiding Officer shall require the individual and/or a representative (who may be counsel) for the individual and for the Medical Executive Committee to participate in a pre-hearing conference. At the pre-hearing conference, the Presiding Officer shall resolve all procedural questions, including any objections to exhibits or witnesses, and the time to be allotted to each witness’s testimony and cross-examination.

5.3.3 Failure to Appear: Failure, without good cause, to appear and proceed at the hearing shall constitute a waiver of the right to a hearing and the matter shall be transmitted to the Board for final action. “Failure without good cause” shall be determined by the President at his/her discretion.

5.3.4 Record of Hearing: A stenographic reporter shall be present to make a record of the hearing. The cost of the reporter shall be borne by the Hospital. Copies of the transcript shall be available at the individual's expense. Oral evidence shall be taken only on oath or affirmation administered by any person entitled to notarize documents in this state.

5.3.5 Rights of Both Sides and the Hearing Panel at the Hearing:

1. At a hearing, both sides shall have the following rights, subject to reasonable limits determined by the Presiding Officer:
   a) To call and examine witnesses, to the extent they are available and willing to testify;
   b) To introduce exhibits’
   c) To cross-examine any witness on any matter relevant to the issues;
   d) To have representation by counsel who may call, examine, and cross-examine witnesses and present the case; and
   e) To submit a written statement at the close of the hearing.

2. If the individual who requested the hearing does not testify, he or she may be called and questioned.

3. The Hearing Panel may question witnesses, request the presence of additional witnesses, and/or request documentary evidence.

5.3.6 Admissibility of Evidence: The hearing shall not be conducted according to rules of evidence. Evidence shall not be excluded merely because it is hearsay. Any relevant evidence shall be admitted if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law. The guiding principle shall be that the record contains information sufficient to allow the Board
to decide whether the individual is qualified for appointment and clinical privileges.

5.3.7 **Post Hearing Statement:** Each party shall have the right to submit a written statement, and the Hearing Panel may request that statements be filed within seven days following the close of the hearing unless otherwise agreed by the parties.

5.3.8 **Persons to be Present:** The hearing shall be restricted to those individuals involved in the proceeding. Administrative personnel may be present as requested by the President or Chief of Staff.

5.3.9 **Postponements and Extensions:** Postponements and extensions of time may be requested by anyone, but shall be permitted only by the Presiding Officer or the President on a showing of good cause.

5.3.10 **Presence of Hearing Panel Members:** A majority of the Hearing Panel shall be present throughout the hearing. In unusual circumstances when a Hearing Panel member must be absent from any part of the hearing, he or she shall read the entire transcript of the portion of the hearing from which he or she was absent.

5.4 **Hearing Conclusion, Deliberations, and Recommendations**

5.4.1 **Order of Presentation:** The Medical Executive Committee’s designee shall first present evidence in support of its recommendation. Thereafter, the burden shall shift to the individual who requested the hearing to present evidence.

5.4.2 **Basis of Hearing Panel Recommendation:** Consistent with the burden on the individual to demonstrate that he or she satisfies, on a continuing basis, all criteria for initial appointment, reappointment and clinical privileges, the Hearing Panel shall recommend in favor of the Medical Executive Committee unless it finds that the individual who requested the hearing has proved, by a preponderance of the evidence, that the recommendation that prompted the hearing was arbitrary, capricious, or not supported by credible evidence. If the Hearing Panel fails to recommend in favor of the Medical Executive Committee, the Hearing Panel shall delineate in its report the basis for its finding that the individual who requested the hearing has proved, by a preponderance of the evidence, that the recommendation that prompted the hearing was arbitrary, capricious, or not supported by credible evidence.

5.4.3 **Deliberations and Recommendation of the Hearing Panel:** Within 20 days after final adjournment of the hearing (which may be designated as the time the Hearing Panel receives the hearing transcript or any post-hearing statements, whichever is later), the Hearing Panel shall conduct its deliberations outside the presence of any other person except the Presiding Officer. The Hearing Panel shall render a recommendation, accompanied by a report, which shall contain a concise statement of the reasons and basis for its recommendation.

5.4.4 **Disposition of Hearing Panel Report:** The Hearing Panel shall deliver its report to the President. The President shall send by written notice a copy of the report to the individual who requested the hearing. The President shall also provide a copy of the report to the Medical Executive Committee.

5.5 **Appeal Procedure**
5.5.1 **Time for Appeal:** Within fourteen (14) calendar days after notice of the Hearing Panel's recommendation, either party may request an appeal. The request shall be in writing, delivered to the President either in person or by certified mail, return receipt requested, and shall include a statement of the reasons for appeal and the specific facts or circumstances which justify further review. If an appeal is not requested within 14 calendar days, an appeal is deemed to be waived and the Hearing Panel’s report and recommendation shall be forwarded to the Quality and Patient Safety Committee for its consideration and its recommendation to the Board for final action.

5.5.2 **Grounds for Appeal:** The grounds for appeal shall be limited to the following:
   1. There was substantial failure to comply with this Policy and/or the Bylaws of the Hospital or Medical Staff during or prior to the hearing, so as to deny a fair hearing; and/or
   2. The recommendations of the Hearing Panel were made arbitrarily or capriciously and/or were not supported by credible evidence.

5.5.3 **Time, Place and Notice:** Whenever an appeal is requested as set forth in the preceding Sections, the President shall schedule and arrange for an appeal. The individual shall be given written notice of the time, place and date of the appeal. The appeal shall be held as soon as arrangements can reasonably be made, taking into account the schedules of all the individuals involved.

5.5.4 **Nature of Appellate Review:**
   1. The Chairperson of the Board shall appoint a Review Panel composed of not less than three persons, either members of the Board or others including, but not limited to, reputable persons outside the Hospital to consider the record upon which the recommendation before it was made, or the Board or the Quality and Patient Safety Committee may consider the appeal as a whole body.
   2. Each party shall have the right to present a written statement in support of its position on appeal. The party requesting the appeal shall submit a statement first and the other party shall then have fourteen (14) days to respond. In its sole discretion, the Review Panel (or the Quality and Patient Safety Committee, as appropriate) may allow each party or its representative to appear personally and make oral argument not to exceed thirty (30) minutes.

5.5.5 **Final Decision of the Board:** Within sixty (60) days after receipt of the Quality and Patient Safety Committee’s recommendation, the Board shall render a final decision in writing, including specific reasons, and shall send written notice thereof to the individual. The Board may affirm, modify, or reverse the recommendation of the Review Panel or, in its discretion, refer the matter for further review and recommendation, or make its own decision based upon the Board’s ultimate legal responsibility to grant appointment and clinical privileges. A copy shall also be provided to the Medical Executive Committee for its information. Additionally, the Board retains absolute discretion to take action it deems to be in the best interest of the corporation and the discretion of the Board shall be final.

5.5.6 **Further Review:** Except where the matter is referred for further action and recommendation, the final decision of the Board following the appeal shall be effective immediately and shall not be subject to further review. If the matter is
referred for further action and recommendation, such recommendation shall be promptly made to the Board in accordance with the instructions given by the Board.

5.5.7 **Right to One Hearing and One Appeal Only:** No applicant or Medical Staff appointee shall be entitled to more than one hearing and one appellate review on any matter. If the Board denies initial appointment to the Medical Staff or reappointment or revokes the appointment and/or clinical privileges of a current Medical Staff appointee, that individual may not apply for staff appointment or for those clinical privileges for a period of five years unless the Board provides otherwise.

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**WEST VIRGINIA UNIVERSITY HOSPITALS**

**Credentialing Policy**

**Article VI – Confidentiality and Peer Review Protection**

6.1 **Confidentiality:** Actions taken and recommendations made pursuant to this Policy shall be strictly confidential and privileged. Individuals participating in peer review activities shall make no disclosures of any such information (discussions or documentations) outside of the peer review committee meetings, except:

1. When the disclosures are to another authorized appointee to the Medical Staff or authorized Hospital employee and are for the purpose of conducting legitimate peer review activities; or
2. When the disclosures are authorized, in writing, by the President or by legal counsel to the Hospital.

Any breach of confidentiality may result in a professional review action and/or appropriate legal action.

6.2 **Peer Review Committees:**

1. All peer review activities pursuant to this Policy and related Medical Staff documents shall be performed by peer review committees in attendance with applicable state law. Peer review committees include, but are not limited to:
   a) All Medical Staff committees;
   b) All Medical Staff departments;
   c) The Board and its pertinent committees;
   d) The Quality and Patient Safety Committee; and
   e) Any individual acting for or on behalf of any such entity including, but not limited to, department chairs, committee chairs and members, officers of the Medical Staff, the Vice President of Medical Affairs and experts or consultants retained to assist in peer review activities.

All reports, recommendations, actions and minutes made or taken by peer review committees are confidential, privileged and covered by the provisions of applicable state law.
2. All peer review committees shall also be deemed to be “professional review bodies” as that term is defined in the Health Care Quality Improvement Act of 1986, 42 U.S.C. ‘11101 et seq.

WEST VIRGINIA UNIVERSITY HOSPITALS
Credentialing Policy

Appendix 1 – Completed Application for West Virginia University Hospitals:

Evidence of faculty appointment with WVU School of Medicine (if applicable)
Applicant consent and release
Completed WV state credentialing application
Completed Department Chair/applicant signature page and Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) statement
Completed privilege forms
West Virginia state medical license (copy of wallet license and primary source verification)
Notarized copy of photo identification
Federal DEA certificate (if applicable)
Evidence of highest level of education completed, education verification forms completed, copy of certificates/diplomas
Proof of Continuing Medical Education (CME)
Evidence of board certification and primary source verification (if applicable)
Completed internship, residency, and fellowship verification forms (if applicable)
Copy of collaborative agreement (applicable for Advanced Practice Registered Nurses – APRN)
Copy of PA-C practice agreement (if applicable)
Copy of allied health certification certificates (if applicable)
Three professional references
Completed hospital staff appointment evaluations
Curriculum Vitae with a complete work history
Evidence of malpractice insurance
Legal documentation (if applicable)
Background Check
American Medical Association (AMA) check
National Practitioner Data Bank (NPDB) check
PA Medicaid, Ohio Medicaid, West Virginia “Opt-Out” list and federal sanctions checked
System for Award Management (SAM) sanctions check
Social Security Death Master File check
Completed practitioner health test
Completed pain management test
Proof of completion of employee health requirements
All appropriate dates and signatures

The Credentialing Policy was approved by members of the WVUH Medical Staff on 10/27/15.