Southern Maine Health Care

Medical Staff
Credentialing Manual

September 12, 2013

Approved by the Medical Executive Committee: 10/17/13
Approved by the Full Medical Staff: 12/19/14
Approved by the SMHC Board of Trustees: 12/9/14

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This manual contains Medical Staff policies considered associated details regarding credentialing and privileging. It supplements credentialing and privileging matters addressed in the Medical Staff Bylaws (including the Corrective Action and Fair Hearing Manual of those Bylaws).

PART I: MEDICAL STAFF MEMBERSHIP

1-1 ELIGIBILITY AND QUALIFICATIONS FOR MEMBERSHIP

The basic eligibility criteria and qualifications for membership on the Medical Staff of the SMHC (Hospital) are found in the Medical Staff Bylaws in Article II, Section 2-1. In addition, the Board, after requesting input from the Medical Executive Committee (MEC), may impose further requirements on specific practitioners where it believes these are warranted after a review of the practitioner's credentials file, peer review and performance data, or other relevant material.

1-2 CONDITIONS AND DURATION OF APPOINTMENT

1-2.1 Initial Appointment and Reappointment

A. Initial appointment and reappointment to the Medical Staff shall be made by the hospital Board. The Board shall act on appointments and reappointments only after there has been a recommendation, or an opportunity for a recommendation, from the Medical Executive Committee.
B. Appointment to the staff may be for up to 24 calendar months.
C. Appointment to the Medical Staff shall confer on the appointee only such clinical privileges as have been granted by the Board.

1-3 LEAVE OF ABSENCE (LOA)

1-3.1 Written Notice

A Medical Staff member who will be absent for longer than 90 days must request, in writing, a voluntary leave of absence from the Medical Staff. Such request shall be received in the Medical Staff Office a minimum of ninety (90) days prior to the requested leave date, unless a shorter period of time for notice is agreed to by the hospital it its discretion. Requests shall state the reason the Medical Staff member is seeking the leave of absence, and the anticipated period of leave time being sought, which may not exceed one year. Requests shall be submitted to the President of the Medical Staff, who shall review each request and, with the advice of the MEC, recommend approval or disapproval to the hospital Board. The hospital Board shall make the final decision whether to approve or disapprove such request. In the event that such request is approved, the staff member shall make necessary arrangement to provide alternate coverage for proper and necessary patient care during his or her absence and shall meet all obligations listed in Section 1-3.2, below. During the period of a leave, the staff member's membership status, privileges and prerogatives, duty to pay Medical Staff dues, if any, and any Medical

Staff attendance expectations shall be suspended. In the event that the Board disapproves a request, the affected staff member shall not be entitled to procedural rights as outlined in the Corrective Action and Fair Hearing Manual of the Medical Staff Bylaws.

1-3.2 Obligations

A request for leave of absence shall not be considered until all obligations to the hospital have been met, including completion of all medical records, payment of any outstanding dues, and fulfillment of any scheduled Emergency Department or other call obligations, unless the hospital clearly waives these requirements.

If the practitioner's current membership and/or privileges are due to expire during the leave of absence, the practitioner must apply for reappointment, or his/her appointment and/or clinical privileges shall lapse at the end of the appointment period.

1-3.3 Request to Return from LOA

Not less than 60 days prior to the termination of the leave, the Medical Staff member must request, in writing, reinstatement of his/her membership and/or clinical privileges and submit such request to the Medical Staff Office. In the event the LOA was for health reasons, the request for a return from LOA will include information from the practitioner's personal physician indicating whether or not a health condition continues to exist, and if the practitioner is capable of safely exercising the clinical privileges granted. The Medical Staff member must also submit a written summary of his/her relevant activities during the leave if so requested by the Credentials Committee or MEC. Reinstatement will be made by action of the Board following a recommendation from the MEC.

1-3.4 Failure to Return from LOA

The failure of a Medical staff member to request reinstatement from LOA shall be deemed a voluntary resignation. The affected practitioner shall not be entitled to procedural rights as outlined in the Corrective Action and Fair Hearing manual of these Bylaws.

1-4 PHYSICAL HEALTH STATUS

1-4.1 Health Requirements

Members of the Medical Staff and practitioners holding privileges must maintain the physical and mental ability to deliver patient care and exercise privileges safely and at an appropriate level of quality at all times.

1-4.2 Notification of Health Status

A staff member or practitioner holding privileges must immediately report, in writing, to the Chief Medical Officer when her or she has a mental or physical condition that has the potential or likelihood to impair judgment or affect functional capability to perform

granted privileges safely and at an appropriate level of quality at all times (as determined by the staff member, a treating or evaluating physician, or a health care facility). Failure to do so may result in corrective action.

1-4.3 Health Examination

At any time that the MEC or Board has any reason to question whether a Medical Staff member has the requisite physical and/or mental health required to care for patients safely and with an appropriate level of care and skill, it may require that member to undergo an appropriate health examination. The nature and scope of the exam and the examining clinician may be determined at the discretion of the MEC and/or Chief Medical Officer. Refusal of a Medical Staff member to comply with a request to undergo a requested health examination will be considered a voluntary resignation from the Medical Staff and voluntary relinquishment of privileges.

PART II: PROCEDURES FOR APPOINTMENT AND REAPPOINTMENT

2-1 GENERAL PROCEDURE

The Medical Staff, through its designated committees and officers, shall evaluate and consider each application for appointment or reappointment and/or clinical privileges, and each request for modification of staff membership or privileges, and shall adopt and transmit recommendations to the hospital Board.

2-2 APPLICATION FOR INITIAL APPOINTMENT

2-2.1 Application Form

Each application for appointment to the Medical Staff shall be in writing, submitted on the prescribed form issued by the hospital, and signed by the applicant. Any qualified practitioner who wishes to apply for membership on the Medical Staff shall contact the hospital, which shall forward to eligible practitioners an application form, copy of the Medical Staff Bylaws and associated manuals, selected associated policies and procedures of the Medical Staff, a delineation of privilege request form, and other specific hospital-required documents. The provision of these documents may be in electronic form.

The hospital may utilize a credentials verification organization (CVO) in the processing of new applications or reappointments. Any such CVO must be recommended by the MEC and approved by the Board of Directors.

2-2.2 Content of Application Form

The completed application for appointment shall be in a form determined by the hospital in consultation with the Medical Staff Credentials Committee and MEC. The completed application and its attachments shall include, but are not limited to, the following information:

A. Acknowledgement and Agreement: A statement signed by the applicant to the effect that he/she has read and agrees to be bound by the Bylaws and its associated manuals, and any Medical Staff rules, regulations, or policies that are provided or made accessible to the applicant as part of the application process. The applicant also agrees to be bound by these documents in all matters relating to consideration of his or her application whether or not he/she is granted membership and/or staff privileges. Furthermore, the applicant agrees that if he/she is granted Medical Staff membership and/or privileges, he/she agrees to follow and be bound by any and all Medical Staff and hospital policies, rules, or regulations and meet all the responsibilities of Medical Staff membership.

B. Qualifications: Detailed information concerning the applicant's qualifications, including information needed in order to satisfy the basic eligibility and qualifications of Medical Staff membership and to meet any additional qualifications necessary to be granted the privileges requested.

C. Requests: Specific requests stating the staff category and privileges for which the applicant wishes to be considered.

D. Peer References: The names of at least three (3) practitioners who are acceptable to the Credentials Committee and MEC and who have worked with the applicant and observed his/her professional performance and who can provide comment as to the applicant's current competence, professional ability and judgment, ethical character, and ability to work cooperatively with other practitioners and hospital personnel, such that patients treated by the applicant receive quality care delivered in a professional and timely manner. Where possible, information provided by the reference should address the applicant's abilities with regard to the general competencies adopted from time to time by the American College of Graduate Medical Education (ACGME). In general, peer references should be submitted on a peer reference form provided by the Medical Staff Office or its designee, and/or the reference should answer specific questions posed on this form.

E. Professional Sanctions: Information as to whether the applicant's membership status and/or medical staff privileges have ever been voluntarily or involuntarily revoked, suspended, reduced, subjected to restrictions or limitation not applicable to other practitioners in the same Medical Staff category, or not renewed at any other hospital,

health care institution, or health plan, including whether any of the following has ever been voluntarily or involuntarily suspended, revoked or denied:

1. Membership/fellowship in a local, state, or national professional organization;
2. Staff membership status or clinical privileges at any other hospital or health care institutions;
3. Specialty board certification;
4. Licensure to practice any profession in any jurisdiction;
5. Drug Enforcement (DEA) number or a state controlled substance license; and
6. Information as to any current or pending sanctions, affecting participation in any federal healthcare program or any actions which might cause the practitioner to become ineligible for such programs.

   If any such actions were ever taken, or if any such actions are currently pending, the particulars of these actions shall be included.

7. Criminal Proceedings: Information as to whether the applicant has ever been named as a defendant in any criminal proceedings, regardless of the outcome.
8. Felony Convictions: Information as to whether the applicant has ever been convicted of a felony or submitted a plea of guilty or no contest, if a felony prosecution is now pending against the applicant, and the particulars of any such conviction, settlement, or prosecution, if any.

F. History of Medical Staff Membership: A chronological history listing all of the applicant's prior hospital applications that were withdrawn, past medical staff memberships and associated privileges, including full addresses of the facilities at which such memberships or privileges were held.

G. Professional Employment History: A chronological history of the applicant's entire employment history as a healthcare professional.

H. Education and Training History: A chronological history of the applicant's undergraduate education, all graduate education in the healthcare field, and all post-graduate training (internships/residencies/fellowships) in any healthcare field.

I. Notification of Release and Immunity Statement: Such releases, waiver, and authorizations as are presented to the applicant by the hospital. These will include a statement signed by the applicant authorizing and consenting to allow Medical Staff and hospital representatives to provide other hospitals, medical associations, licensing boards, and other organizations concerned with provider performance and the quality and efficiency of patient care with any relevant information the hospital or Medical

Staff may have concerning the applicant. This statement will also release from liability the hospital, its Medical Staff, and their representatives for sharing with appropriate health care and licensing entities information concerns the professional competence, ethics, and other qualifications of the applicant for staff appointment and privileges, including information otherwise privileged or confidential, to the full extent permitted by Maine law.

J. Professional Liability Actions: All particulars regarding medical malpractice claims filed against the applicant, any adverse and/or pending malpractice decisions or settlements, and of any cancellation, non-renewal, or limitation of malpractice insurance coverage.

K. Miscellaneous Information: Such other information relating to evaluation of the applicant's professional qualification, ethical character and professional conduct, current competence, and prior professional experience, including utilization of hospital resources, as may be deemed relevant by the MEC and the hospital Board.

L. Minimum Basic Criteria: The following basic criteria must be appropriately documented and the information reasonably confirmed:

1. Evidence of current licensure: Unrestricted Maine State license, unrestricted federal DEA, as appropriate to specialty. Licensure is primary source verified.
2. Relevant training and/or experience: At the time of appointment and initial granting of clinical privileges, the hospital may require verification of relevant training or experience from the primary source(s), when feasible.
3. Current competence: Recent letters of verification from the applicant's residency program director or designee if residency training was within five years of initial application. Confirmation of board certification or qualification for certification from the appropriate specialty board(s). Written documentation from individuals personally acquainted first-hand with the applicant's recent professional and clinical performance including, if available and applicable, types of surgical procedures performed, outcomes for invasive procedures performed, and types of medical conditions managed as the responsible physician, clinical judgment and technical skills, and professional conduct. References should also provide, when available, information on the applicant's abilities regarding the six general competencies as described by the Accreditation Council for Graduate Medical Education (ACGME): Patient care, medical/clinical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice.

4. Ability to perform privileges requested (health status): A health status statement provided by the hospital and signed by the applicant indicating that no physical or mental health problems exist that prevent the applicant from performing the requested clinical privileges, with or without reasonable accommodation. This document may be confirmed by the director of the applicant's training program, a chief of service or chief of staff (or equivalent) at another hospital, or a qualified physician who has examined the applicant. The applicant must meet health screening requirements as determined by the MEC for membership and/or privileges.

2-3 APPLICATION FEE

If requested, a non-refundable application fee, in an amount established by the hospital Board after consultation with the MEC, shall be payable at the time of application for appointment of reappointment. Applications submitted without the accompanying fee, if one has been requested, will not be accepted for processing.

2-4 EFFECT OF APPLICATION

By applying for appointment to the Medical Staff, the applicant:

A. Agrees to provide, in a timely fashion, any additional information and to resolve any questions relating to his/her application that are requested or posed by the Medical Staff, hospital, or Board representatives.
B. Agrees to appear for interview(s) upon request.
C. Authorizes hospital representatives to consult with other hospitals and medical staffs who have been associated with the applicant and with anyone who may have information bearing on the applicant's clinical competence and qualifications for Medical Staff membership or privileges.
D. Consents to the inspection by hospital representatives of all records and documents that may be material to an evaluation of the applicant's professional and ethical qualifications for staff membership.
E. Agrees that, in the event of any adverse recommendations or decisions with respect to Medical Staff membership or privileges, as defined in these Bylaws, the applicant shall exhaust the administrative remedies afforded by these Bylaws before resorting to formal legal action.
F. Releases from liability all individuals and organizations that provide information, including otherwise legally privileged or confidential information, to hospital representatives concerning the applicant's competence, professional ethics, character, physical and mental health, professional conduct, and other qualifications for staff appointment and clinical privileges.

G. Signifies that the information submitted in her or her application is true to the best of his/her knowledge and belief, and that he/she understands that any significant misstatement(s) on, or omissions from, his/her application shall constitute grounds for rejection of the application. Where such omissions or misstatements are discovered after appointment to the staff, the hospital Board, at its sole discretion, and after consultation with the MEC, may terminate the applicant's membership and privileges, and the applicant will not be eligible for the due process described in the Medical Staff Corrective Action and Fair Hearing Manual.

2-5 PROCESSING OF INITIAL APPLICATIONS

2-5.1 Applicant's Burden

The applicant shall have the burden of producing adequate information for a proper evaluation of his or her experience, background, training, clinical competence, and ability to adequately perform the privileges requested, and for resolving any doubts about these or any of the qualifications specified in the Medical Staff Bylaws or in their associated manuals or policies. The applicant must be able to demonstrate, to the satisfaction of the MEC and Board, proficiency in the following six general competencies as described by the Accreditation Council for Graduate Medical Education (ACGME): patient care, medical/clinical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice. An application will not be processed by the Medical Staff until it is deemed complete by the hospital. If a Medical Staff committee or the Board request additional information from the applicant to evaluate an application, the application will be deemed incomplete until all requested information is provided. If the application remains incomplete for more than sixty days following the request for additional information by the hospital, it will be considered to have been voluntarily withdrawn by the practitioner who submitted the application.

2-5.2 Applicant Interview

All applicants for appointment to the Medical Staff and/or clinical privileges may be required to participate in an interview at the discretion of the Credentials Committee, MEC, or Board. The interview may take place in person or by telephone, video, or computer link, at the discretion of the party calling for the interview. The interview will be used to gather information about the applicant and to communicate information to the applicant concerning Medical Staff responsibilities and expectations.

2-5.3 Verification of Information

The applicant shall deliver a completed application, including a current photo ID, to the hospital, which shall, in a timely fashion, seek to collect or verify the references, licensure, and other qualifications evidence submitted. The hospital shall promptly notify the applicant of any problems in obtaining the information required and it shall then be the

applicant's obligation to obtain the required information and provide it to the hospital in a timely manner. Once collection and verification is completed, the hospital shall make available the complete verified application and it's supporting materials to the Credentials Committee for evaluation.

2-5.4 Credentials Committee Action

Upon receipt of a completed application, the Credentials Committee shall review the application, its supporting documentation, and such other information available to it that may be relevant to consideration of the applicant's qualifications. The committee may also conduct a personal interview with the applicant. The Chair of the Credentials Committee may request evaluation of the application from anyone on the Medical Staff in order to obtain input from someone with needed subject matter expertise. Where necessary, the Chair may also seek such expertise from a specialist outside of the Medical Staff.

After its review of the applicant's credentials, the Credentials Committee shall submit a recommendation to the MEC. This recommendation shall address the applicant's Medical Staff membership and category, privileges, and any specific conditions relating to appointment and/or privileges. Minority views regarding any or all recommendations of the Credentials Committee may also be included.

2-5.5 Medical Executive Committee Action

At its next meeting after receipt of the report and recommendations of the Credentials Committee, the MEC shall review the applicant's request for membership and/or privileges. The MEC may utilize appropriate additional sources of information, including personal interviews with the applicant, as it deems necessary to complete its evaluation.

After completing its review of the applicant's qualifications, the MEC shall transmit to the hospital Board a report and recommendation regarding appointment and/or privileges for the applicant, indicating whether the applicant's requests should be accepted, accepted with modifications or qualification, or rejected. Where appointment is recommended, the MEC shall also recommend appointment to a staff category. Where the MEC recommends that the applicant's requests for membership and/or privileges be rejected, modified, qualified, or otherwise restricted, the report of the MEC shall set forth reasons for such recommendation(s). If a MEC recommendation is not unanimous, a minority report may be submitted to the Board.

2-5.6 Effect of Medical Executive Committee (MEC) Action

A. Favorable Recommendation: When the recommendation of the MEC is favorable to the applicant, the recommendation shall be forwarded to the hospital Board.

B. <u>Deferred:</u> Any action by the MEC to defer the application for further consideration must be followed up within ninety (90) days with a subsequent recommendation.

C. <u>Adverse Executive Committee Recommendation:</u> When the MEC recommends denial or a restriction of membership or a requested privilege, based on a determination of unprofessional conduct or inadequate clinical competence, the President of the Medical Staff shall inform the applicant by special notice within ten (10) days. The applicant shall be entitled to the procedural rights as provided in the Corrective Action and Fair Hearing Manual of the Medical Staff Bylaws. The Hospital CEO and hospital Board shall also be notified.

2-5.7 Action of the Hospital Board

At its next meeting after receipt of the reports and recommendations of the MEC regarding an application for membership and/or privileges, the hospital Board shall consider and act on such recommendations. If the hospital Board decides to defer action on the application pending further consideration by the MEC, or if the hospital Board does not accept the recommendation of the MEC, it shall refer the application back to the MEC for further consideration, subject to the requirement that a final recommendation be provided to the hospital Board by the MEC within ninety (90) days. At the next meeting following the receipt of the second report of the MEC, the hospital Board shall render its final decision regarding the application.

If the Board accepts a favorable MEC recommendation, it shall act to grant the requested membership and/or privileges.

If the recommendation of the MEC is adverse to the applicant, as defined under the Medical Staff Bylaws, the hospital Board shall postpone its final decision on the applicant, pending the applicant's decision to utilize or waive procedural rights. If the applicant waives his or her right to a fair hearing and appellate review, the Board will then determine its final decision on the request for membership and/or privileges. If the applicant requests a fair hearing, the Board will make a determination on the applicant's request following a final recommendation from the MEC, which takes into consideration the findings of the hearing panel. Where the applicant further requests an appellate review by the Board, its final determination will result from the decision made by the review panel.

When the hospital Board decided to appoint an applicant to the Medical Staff, its decision and the notice of appointment shall include:

A. Length of appointment (not to exceed 24 months);
B. Staff category to which the applicant is appointed;

C. Privileges the applicant may exercise; and
D. Special conditions attached to the appointment and/or exercise of privileges.

2-5.8 Conflict Resolution

Whenever the Board's proposed decision on an applicant for membership and/or privileges will be contrary to the MEC's recommendation, the Board shall submit the matter to a joint conference, as provided in Section 12-5 of the Medical Staff Bylaws. This joint conference will be held as soon as practicable and the Board will postpone any final determination on an applicant until such conference is held.

2-5.9 Notice of Final Decision

Notice of the final action of the hospital Board on an applicant shall be given to the hospital CEO and/or designee who will provide the applicant with a letter describing the Board's decision. The hospital Board shall give notice of its final decision through the hospital CEO to the President of the Medical Staff, and the MEC.

2-5.10 Time Periods for Processing

Applications for Medical Staff appointment and/or privileges shall be considered in a timely and good faith manner by all individuals and group required by the Medical Staff Bylaws or policies to act upon them, and shall be processed whenever possible within the time periods specified in this section. Any incomplete application after six (6) months shall be considered voluntarily withdrawn.

Within sixty (60) days after the receipt of a completed application for membership and/or privileges, the Credentials Committee or its Chair shall submit a written recommendation to the Medical Executive Committee.

Within sixty (60) days after receipt of recommendations from the Credentials Committee or its Chair, the MEC shall submit a recommendation regarding appointment and/or clinical privileges to the hospital Board.

The hospital Board will act upon recommendations from the MEC at its next regularly-scheduled meeting.

The time periods in this section are guidelines and deviations will not entitle the applicant to any procedures due process rights.

2-6 REAPPOINTMENT PROCESS

2-6.1 Application for Reappointment

Reappointment will be for a period of up to two (2) years. Approximately 180 days prior to the expiration date of his/her current appointment of membership and/or privileges, the hospital and/or its approved CVO shall provide each practitioner with an updated application form for reappointment and any required hospital-specific forms and documents for completion that must be received prior to the reappointment application being acted upon. Each practitioner who desires reappointment shall, at least 90 days prior to the expiration date of his/her current membership and/or privileges, complete such forms and return them to the hospital. Failure to return the completed form(s) at least 90 days prior to his/her expiration may, at the discretion of the hospital, be considered a voluntary resignation of membership and/or clinical privileges, effective at the end of the staff member's current term.

2-6.2 Content of Application

The application for reappointment shall be in a prescribed form determined by the hospital and setting forth, without limitation, requirements for the provision of the following information:

A. Specific request setting forth the category of staff membership to which the applicant seeks to be reappointed, and the privileges for which the applicant wishes to be considered.

B. Continuing training, education, and experience that qualify the staff member for the privileges sought on reappointment.

C. A statement that no health problems exist that could affect the applicant's ability to safely perform the privileges requested.

D. The name and address of any other health care organization or practice setting where the staff member provided professional services during the preceding appointment period.

E. Whether or not there are any restrictions upon the applicant's Maine license and/or drug enforcement (DEA) number, if applicable.

F. Information as to whether the applicant's membership status and/or Medical Staff privileges have ever been voluntarily or involuntarily revoked, suspended, reduced, subjected to restrictions or limitation if not applicable to all other practitioners in the same Medical Staff category, or not renewed at any other hospital or health care institution, and as to whether any of the following has ever been voluntarily or involuntarily suspended, revoked, or denied:

1. Staff membership status or clinical privileges at any other hospital or health care institutions;
2. Membership/fellowship in a local, station or national professional organization;
3. Specialty board certification;
4. Licensure to practice any profession in any jurisdiction; or
5. Drug enforcement (DEA) number.

If such actions were ever taken, or if any such actions are now pending, the particulars thereof shall be included.

6. Information as to whether the applicant has ever been prosecuted for, convicted of, or pled no contest to, a felony and, if so, the particulars of any such convictions.
7. Information as to whether the applicant has ever been named a defendant in any criminal proceedings, regardless of outcome.
8. Evidence of continuous malpractice insurance coverage, minimum of $1 million per occurrence/$3 million aggregate, or in an amount that may be determined from time to time by action of the Board.
9. A list of all practice complaints filed against the practitioner and the particulars regarding any adverse malpractice decisions or settlements.
10. Such specific information about the staff member's professional ethics, qualifications, and ability that may bear of his/her ability to provide medical or surgical care in the hospital.
11. Information regarding whether the applicant has been convicted of any type of insurance fraud, been found guilty under the False Claims Act, or is on the OIG excluded provider list for Medicare and/or Medicaid.

2-6.3 Completion and Verification of Information

The information provided on each application for reappointment and all other supporting materials and documentation, including information regarding the staff member's professional activities, performance and conduct in the hospital, and query reports from the National Practitioner Data Bank, as appropriate, shall be collected and verified. The applicant shall have the burden of producing adequate information for a proper evaluation of his/her qualification and of resolving any questions regarding such qualifications. When collection and verification has been completed, and the hospital has determined that the application is complete, it shall transmit the application and all supporting material to the Credentials Committee.

2-6.4 Credentials Committee Action

The Credentials Committee shall review each application, or a summary of the application, and all other relevant information available to it. The Credentials Committee may choose

to interview the applicant prior to rendering a formal recommendation to the Medical Executive Committee regarding its recommendations on the application for reappointment. The report of the Credentials Committee shall be accompanied by all relevant documentation.

2-6.5 Medical Executive Committee Action

The Medical Executive Committee shall review each application for reappointment, or a summary of the application, and all other relevant information available to it. The MEC may choose to interview the applicant prior to rendering a recommendation. The MEC shall make a report to the hospital Board regarding its recommendations on the application for reappointment of membership and/or privileges. The report of the MEC shall be accompanied by any relevant information and the report of the Credentials Committee.

2-6.6 Final Processing and Board Action

Following the report of the MEC to the hospital Board, the procedure provided in the Credentialing Manual relating to initial applications shall be followed, and the hospital Board shall render a decision prior to the expiration date of the applicant's appointment. Where the Board disagrees with the recommendation of the MEC, the matter will be brought to a joint conference as described in Section 2-5.8, above.

2-6.7 Basis for Recommendation

Each recommendation concerning the reappointment of a practitioner's membership and/or privileges shall be based on review not only of those matters set forth in the Medical Staff Bylaws and policies pertaining to such practitioner, but also on any other information bearing on the ability and willingness of the practitioner to contribute to the rendering of quality health care within the hospital and to contribute to the mission of the hospital.

2-7 REQUESTS FOR MODIFICATION OF MEMBERSHIP STATUS AND/OR PRIVILEGES

A medical staff member may, either in connection with reappointment or at any other time, request modification of staff category or clinical privileges by submitting a written application to the hospital in such form as may be prescribed by the MEC and the hospital Board. Such staff member shall have the burden of justifying such modification(s). Such appointments shall be processed in substantially the same manner as applications for reappointment or membership and/or privileges.

2-8 EFFECTIVE DATE OF REAPPOINTMENT/MODIFICATIONS OF APPOINTMENTS AND/OR STAFF PRIVILEGES

Reappointments approved by the hospital Board, including privileges awarded in connection with such reappointments, modifications or categories of staff membership, and/or privileges, shall take effect on a date determined by the hospital Board.

PART III: DETERMINATION OF PRIVILEGES

3-1 EXERCISE OF PRIVILEGES

Practitioners providing clinical services at the hospital shall be entitled to exercise only those privileges specifically granted to them by the hospital Board, or emergency or disaster privileges as described in this manual.

3-2 DELINEATION OF PRIVILEGES IN GENERAL

3-2.1 Requests

Each application for appointment and reappointment to the Medical Staff must contain a request for the specific clinical privileges desired by the applicant. Practitioners who are ineligible for Medical Staff membership may, nevertheless, apply for privileges by requesting a privilege application form from the hospital. A request by a practitioner for privileges or the modification of privileges must be supported by all requested documentation regarding appropriate licensure, education, training, and evidence of current competence. Privilege requests will not be process where the applicant does not meet the eligibility requirements to be granted the privilege at SMHC.

3-2.2 Basis for Determinations of Privileges

Privileges shall be determined on the basis of the practitioner's prior and continuing education, training, experience, utilization patterns and demonstrated current competence, including observed professional performance and documented results of practitioner-specific performance improvement/peer review activities. Information concerning professional performance obtained from other sources will be considered when available, especially from other institutions or health care settings where a practitioner exercised privileges. It is the burden of the practitioner applying for privileges to provide all information requested by the Medical Staff and Board as they determine necessary to evaluate the request.

Residents or fellows in training in an ACGME-approved program, and acting under the auspices of that program, will not be required to request specific privileges. They must carry out any clinical care in accordance with the written educations protocols developed by the hospital CMO and their training program. These protocols must delineate the roles, responsibilities, and scope of the clinical activities applicable to such trainees. They must also describe the requirements for oversight of trainees, the types of orders they

may write, and when such orders must be countersigned and by whom. The protocols will describe how this information will be transmitted to staff and personnel working in the hospital. These protocols must be periodically reviewed and approved by the MEC. In addition, training programs will periodically communicate with the MEC regarding the performance of their trainees and alert it to any performance concerns or matters that may threaten patient safety. Each training program must work with the MEC to assure that all supervising practitioners hold privileges commensurate with their oversight activities.

3-2.3 Procedure

All requests for clinical privileges shall be processed pursuant to the procedures outlined in Article II. Requests for privileges will not be processed where the Board has made a determination that the hospital will not support or authorize the exercise of a particular privilege for any practitioner at the hospital, where the privilege requested is covered by an exclusive contract granted by the hospital Board and the requesting practitioner is not a party to the contract or a provider under the contract, or where the requesting practitioner does not meet the eligibility requirements to request or exercise a privilege as described in the hospital's delineation or privileges documents.

In the even a practitioner requests a privilege for which the hospital has not adopted eligibility criteria (e.g., for a new technology or procedure), the request may be tabled for a reasonable period of time, usually not in excess of 90 calendar days. During this time, the MEC and Board will review the community, patient, and hospital need for the privilege and determine if the institution can make available the necessary resources to adequately support the exercise of that privilege. The MEC will research appropriate eligibility criteria for the safe and effective exercise of the requested privilege and establish, with the approval of the Board, the necessary education, training, experience, and evidence of current competence that will be required to request the granted privilege. Once these steps are taken, a request for the privilege will be evaluated.

3-3 EMERGENCY PRIVILEGES

3-3.1 Authority

If the institution's emergency management plan has been activated, and the immediate needs of patients cannot be met, the CEO and other designated individuals identified in the plan may grant selected practitioners emergency/disaster privileges to provide patient care, in accordance with statute and regulation, as described in the relevant Human Resources policy. One of the following individuals may grant disaster privileges once appropriate identification is obtained from a physician who has offered to volunteer during a disaster:

A. CEO or designee
B. President or any elected officer of the Medical Staff
C. Credentials Committee Chair

3-3.2 Eligible Physicians

Disaster privileges may be granted only to physicians who hold a valid medical license in the State of Maine to practice medicine or as otherwise permitted by law, and who volunteer their services but do not possess Medical Staff privileges at SMHC.

Before a volunteer practitioner is considered eligible to function as a volunteer licensed independent practitioner, the hospital will obtain valid government-issued photo identification (for example, a drivers' license or passport) and at least one of the following:

A. A current picture identification card form a health care organization that clearly identifies professional designation;

B. A current license to practice;

C. Primary source verification of licensure;

D. Identification indicated that the individual is a member of a Disaster Medical Assistance Team (DMAT), the Medical Reserves Corps (MRC), the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP), or other recognized state or federal response organization or group;

E. Identification indicating that the individual has been granted authority by a government entity to provide patient care, treatment, or services in disaster circumstances;

F. Confirmation by a licensed independent practitioner currently privileges by the hospital or by a staff member with personal knowledge of the volunteer practitioner's ability to act as a licensed independent practitioner during a disaster;

G. The physician is responsible to the appropriate Clinical Section Leader who will assign the practitioner to patient care responsibilities.

Primary source verification of licensure will begin as soon as the immediate situation is under control, and completed within 72 hours from the time the volunteer physician presents to the hospital. Primary source verification applies only to volunteer physicians who actually provide care, treatment and services while under disaster privileges. In

extraordinary circumstance, in which primary source verification cannot be completed within 72 hours, it will be completed as soon as possible and reasons for the delay documented.

3-3.3 Scope of Privileges

Volunteering physicians granted disaster privileges shall wear an approved ID at all times while volunteering at the hospital. Scope of privileges for the volunteering physician shall be consistent with minimum core privileges for the practitioner's specialty and as determined by the onsite supervising physician.

Within 72 hours of disaster privileges being granted, the Medical Staff leadership will make a determination of the professional practice of the volunteer physicians utilizing direct observation, mentoring or record review and the need for continuation of the disaster privileges granted.

3-3.4 Termination of Privileges

Disaster privileges will be for the duration of the emergency situation. Privileges will automatically be canceled when it is determined by the hospital that an emergency situation no longer exists. In the event that any information received through the verification process or the professional practice review indicates adverse information suggesting the person is not capable of rendering services in an emergency, such privileges shall be immediately terminated. Practitioners granted disaster privileges will not be eligible for the due process rights afforded under the Medical Staff Bylaws, and the exercise of disaster privileges will be considered a waiver by the practitioner to any and all rights to contest or appeal the restriction or termination of such privileges.

3-4 TELEMEDICINE PRIVILEGES

3-4.1 Definitions

A. Telemedicine: The use of electronic or other communication technology to provide or support clinical care from a distance.
B. Originating Site: The patient location site.
C. Distant Site: The telemedicine provider location.

3-4.2 Telemedicine Providers

Telemedicine will be provided by licensed independent and dependent practitioners who provide medical information exchanged from a distant site to SMHC via electronic communications for the health and education of the patient or health care provider, and for the purpose of improving patient care, treatment, and services. These services shall be defined in a contract with the Distant Site hospital that describes the services to be

provided. These practitioners shall be privileged relying on the credentialing and privileging decision of distant site if the distant site is a Medicare participating organization, as described in Section 3-6.6 (below).

Telemedicine practitioners shall not be eligible to vote or to hold office in the Medical Staff organization; they shall not be members of the Medical Staff. Any licensed practitioner appointed as a member of the Telemedicine Section of the Medical Staff shall be under the medical and administrative supervision of the Active Medical Staff.

If, at any time, the contract is canceled, or if the practitioner leaves the employ of the contracted organization, or membership and privileges of the telemedicine practitioner lapse at the distant hospital, the telemedicine practitioner shall be considered to have had a voluntarily relinquishment of all clinical privileges related to telemedicine, and in the case of practitioners with privileges solely related to telemedicine, considered a voluntary relinquishment of membership and privileges. The provider will not be entitled to the procedural rights provided in these Bylaws or the Fair Hearing Plan.

3-4.3 Qualifications

To be a member of the Telemedicine Staff, a practitioner must:

A. Be a party to a contract for provision of telemedicine services
B. Be legally licensed to practice medicine in the State of Maine
C. Have satisfactorily completed the credentialing and privileging process at the Medicare participating hospital sponsoring the telemedicine service

3-4.4 Prerogatives

The prerogatives of a Telemedicine Staff member shall be to exercise such clinical privileges as are granted pursuant to the telemedicine contract;

3-4.5 Obligations

Each practitioner on the Telemedicine Staff shall:

A. Pay dues and assessments as determined by the Medical Staff
B. Provide care for his or her patients at the generally recognized professional level of quality and efficiency;
C. Abide by the Medical Staff and hospital's established Bylaws, protocols, standards, policies and rules in effect at the time privileges are granted and as they may be revised from time to time.

3-4.6 Telemedicine privileging by proxy

In the presence of a contract with a Medicare-participating hospital for the provision of telemedicine services, the Medical Staff and Board have agreed to waive the initial and reappointment process as described in the Medical Staff Bylaws and Credentialing policies. Instead, privileges limited to the scope of service delineated in the telemedicine agreement, will be granted in reliance on the successful completion of a credentialing and privileging process at the distant hospital. If a telemedicine provider wishes to exercise additional privileges at SMHC, the usual appointment and reappointment procedures shall be followed.

3-4.7 Initial Appointment

A list of providers to be privileged will be provided by the telemedicine program. Additionally, the distant hospital will provide the medical staff with the following:

A. Physician-specific information including home and business address(es), education and training, social security number, date of birth, hospital affiliations, board certification (if applicable), current hospital status, date of initial appointment, next reappointment and last reappointment (if applicable) and statement of good standing;
B. A copy of current delineation of privileges;
C. Copies of license, DEA (if applicable) and current insurance certificate.

The Medical Executive committee shall, at its next regular meeting after receiving the provider information, recommend to the Board of Trustees the granting of privileges as delineated in the telemedicine agreement. The Board will then grant clinical privileges restricted to, and consistent with, the scope of service outlined in the telemedicine agreement.

3-4.8 Reappointment

At the time of reappointment of the telemedicine provider to the staff of the distant hospital, the distant hospital shall provide complete information to bring the file current on items including current license and, if applicable, DEA registration, professional liability insurance coverage and experience, other institutional affiliations, specialty Board certification status, a statement of good standing and a copy of current delineation of privileges. In making its reappointment decision, the distant hospital will consider information related to telemedicine provider's performance at SMHC.

The Medical Executive committee shall, at its next regular meeting after receiving the provider information, recommend to the Governing body the granting of privileges as delineated in the telemedicine agreement. The Board will then grant clinical privileges restricted to, and consistent with, the scope of service outlined in the telemedicine agreement.

3.4-9 Relinquishment of Telemedicine Privileges

If, at any time, the contract is canceled, or if the practitioner leaves the employ of the contracting organization, or membership and privileges of the telemedicine practitioner lapse at the distant hospital, the telemedicine practitioner shall be considered to have voluntarily relinquished all clinical privileges related to telemedicine, and in the case of practitioners with privileges solely related to telemedicine, considered a voluntary relinquishment of membership. The provider will not be entitled to the procedural rights provided in the Fair Hearing Plan.

A. There is a written agreement between the originating site and the distant site that specifies that the governing body of the distant site is responsible for ensuring that the telemedicine services provided by its Telemedicine Professionals meet the requirements of the Medicare Conditions of Participation and the obligations of both parties.

B. SMHC must set up a process to monitor ongoing telemedicine provider performance and report annually to distant site. This information must include, at a minimum, all adverse events at the originating hospital that resulted from telemedicine services provided by the telemedicine practitioner and all complaints the hospital has received about the telemedicine practitioner. It may also include satisfaction data from physician and other staff who interact with the telemedicine provider on such issues as: communication is courteous, clear and appropriate; provides rationale for recommendations/actions; respect demonstrated and returned; patient outcomes.

3-5 FOCUSED PROFESSIONAL PRACTICE EVALUATION (FPPE)

The Medical staff will confirm the competence of all practitioners newly granted privileges at SMHC. This will occur following the practitioner's initial appointment of privileges and subsequently at any time a new privilege is requested for addition to the practitioners then current privileges. This activity will occur in conformance with the policy on focused professional practice evaluation adopted by the MEC. This policy will determine the manner and duration of evaluation of the practitioner's exercise of privileges and the available monitoring modalities that may be used. As a result of this initial FPPE, the

Credentials Committee may recommend to the MEC and Board modifications in the privileges granted upon initial appointment.

3-6 PRACTITIONERS PROVIDING CONTRACTED SERVICES

3-6.1 Medical Administrative Officers

A medical administrative officer is a practitioner engaged by the hospital in a management capacity which may also include clinical responsibilities such as direct patient care, clinical supervision of residents or fellows, or the proctoring of privileged practitioners. Medical administrative officers must hold Medical Staff appointment and clinical privileges appropriate to their clinical activities and discharge Medical Staff obligations appropriate to their staff category. The terms of the officer's contract with the hospital will govern the effect of that contract's termination on the appointment and privileges of the officer. The officer will not be entitled to the procedural due process rights in the Corrective Action and Fair Hearing Manual of these Bylaws where membership and privileges are terminated as a matter of contract. The officer will be entitled to the same procedural rights as other staff members in the event of an adverse change in appointment or privileges is the result of a determination of demonstrated incompetence or unprofessional conduct.

3-6.2 Exclusive Contracts

Whenever the hospital Board determines that certain hospital facilities or services will be staffed on an exclusive basis, it will do so under contracts (or letters of agreement) that identify which practitioners may work pursuant to the contract. Except in emergency or disaster situations, only practitioners authorized under the exclusive contract may hold privileges for the clinical services covered by the contract. Requests for such privileges from practitioners not so authorized will not be processed by the Medical Staff or Board. Practitioners not authorized under the contract who were granted privileges prior to the contract will not be allowed to exercise those privileges once an exclusive agreement is signed by the hospital. Ineligibility to exercise or request privileges covered by an exclusive contract will not entitle a practitioner to the procedural due process rights described in the Corrective Action and Fair Hearing Manual of these Bylaws.

Revised MEC: 6/20/14
Revised BOT: 7/7/14

Revised MEC: 9/18/14
Revised BOT: 10/6/14