

**UF HEALTH SHANDS HOSPITAL**  
**ALLIED HEALTH PROFESSIONALS**  
**POLICY ON CLINICAL PRIVILEGES**

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**ALLIED HEALTH PROFESSIONAL POLICY ON CLINICAL PRIVILEGES**

**TABLE OF CONTENTS**

<b>ARTICLE I – DEFINITIONS.....</b>	<b>5</b>
<b>ARTICLE II - TERM OF CLINICAL PRIVILEGES.....</b>	<b>5</b>
<b>ARTICLE III -CATEGORIES OF ALLIED HEALTH PROFESSIONALS .....</b>	<b>5</b>
Section 1. Board Approval of AHP Categories .....	5
Section 2. Privileged AHPs.....	5
<b>ARTICLE IV – QUALIFICATIONS FOR CLINICAL PRIVILEGES .....</b>	<b>5</b>
Section 1. Minimum Qualifications.....	5
Section 2. AHP Category-Specific Additional Requirements .....	6
Section 3. Waivers.....	8
<b>ARTICLE V - APPLICATION FOR CLINICAL PRIVILEGES .....</b>	<b>8</b>
Section 1. Pre-application Requirements .....	8
Section 2. Application.....	8
Section 3. Undertakings .....	10
Section 4. Burden of Providing Information.....	11
Section 5. Authorization to Obtain Information .....	12
<b>ARTICLE VI – PROCESSING APPLICATIONS .....</b>	<b>13</b>
Section 1. Department.....	13
Section 3. Credentials Committee .....	13
Section 4. Medical Executive Committee .....	13
Section 5. Deferral .....	14
Section 6. Board Approval.....	14
Section 7. Time for Final Action.....	15
<b>ARTICLE VII – TEMPORARY, EMERGENCY, DISASTER, AND INCREASED CLINICAL PRIVILEGES.....</b>	<b>15</b>
Section 1. Request for Temporary Clinical Privileges .....	15
Section 2. Term of Temporary Clinical Privileges.....	15
Section 3. Termination of Temporary Privileges .....	16
Section 4. Emergency & Disaster Privileges .....	16
Section 5. Application for Increased Clinical Privileges.....	17
<b>ARTICLE VIII – RENEWAL OF CLINICAL PRIVILEGES.....</b>	<b>17</b>
Section 1. Application.....	17
Section 2. Factors to be considered.....	17
Section 3. Renewal Procedure .....	18
<b>ARTICLE IX – STATUS CHANGES.....</b>	<b>18</b>
Section 1. Leave of Absence .....	18
Section 2. Change in Specialty Area .....	19
<b>ARTICLE X. HEALTH ASSISTANCE .....</b>	<b>19</b>
Section 1. General.....	19
Section 2. Referral.....	20
Section 3. Confidentiality .....	20
Section 4. Investigation of Complaints or Concerns .....	20

Section 5. Monitoring.....	21
Section 6. Relinquishment of Privileges.....	21
<b>ARTICLE XI – PROFESSIONAL CONDUCT.....</b>	<b>21</b>
Section 1. General.....	21
Section 2. Behaviors that Undermine a Culture of Safety.....	22
Section 3. Reporting Episodes of Behaviors that Undermine a Culture of Safety.....	23
Section 4. Processing Reported Episodes of Behavior that Undermines a Culture of Safety.....	23
<b>ARTICLE XII. FOCUSED PROFESSIONAL PRACTICE EVALUATION.....</b>	<b>24</b>
Section 1. Purpose.....	24
Section 2. Performance of the FPPE.....	25
Section 3. Requirements for new privileges.....	25
Section 4. Requirements for Quality Triggered FPPE.....	25
<b>ARTICLE XIII. ONGOING PROFESSIONAL PRACTICE EVALUATION.....</b>	<b>26</b>
Section 1. Purpose.....	26
Section 2. Performance of the OPPE.....	26
Section 3. Requirements.....	26
Section 4. Review.....	26
<b>ARTICLE XIV -- CORRECTIVE ACTIONS.....</b>	<b>26</b>
Section 1. Grounds for Initiating an Investigation.....	27
Section 2. Self-Referral.....	27
Section 3. Investigative Procedure.....	27
Section 4. Summary Suspensions.....	28
Section 5. Recommendations for Corrective Actions.....	29
Section 6. Automatic Suspension or Termination of Privileges.....	30
Section 7. Confidentiality and Reporting.....	31
<b>ARTICLE XV – HEARING AND APPEAL PROCESS.....</b>	<b>32</b>
Section 1. Preliminary Matters.....	32
Section 2. The Hearing.....	33
Section 3. Appeal.....	34
Section 4. Final Board Action.....	35
<b>ARTICLE XVI - AMENDMENTS.....</b>	<b>36</b>
Section 1. Initiation.....	36
Section 2. Medical Executive Committee Recommendation.....	36
Section 3. Adoption.....	36

## ARTICLE I – DEFINITIONS

The following definitions shall apply to terms in this Policy:

- 1 **Administrator:** the Chief Executive Officer of UF Health Shands Hospital
- 2 **Allied Health Professional or “AHP”:** a non-physician health practitioner who is granted clinical privileges in accordance with this Policy.
- 3 **“Board”:** the Board of Directors, or the appropriate Committee of the Board, of UF Health Shands
- 4 **“Chief Executive Officer” or “CEO”:** the Chief Executive Officer of UF Health Shands
- 5 **Credentials Committee:** the Credentials Committee of the Medical Staff.
- 6 **Credentials Advisory Subcommittee:** an advisory committee to the Credentials Committee, as described in this Policy
- 7 **License or licensed:** means license, certification or registration by the State of Florida, as appropriate to the Allied Health Professional category.
- 8 **“Medical Executive Committee” or “MEC”:** the Medical Executive Committee of the Medical Staff.
- 9 **“Medical Staff” or “Staff”:** medical and osteopathic physicians, dentists and podiatrists who have received an appointment by the Board in accordance with the Medical Staff Bylaws.
- 10 **“Notice”:** deemed given when a written communication is (a) hand delivered to the addressee’s business office, as indicated by signature of addressee or addressee’s office staff member, or (b) deposited with any type of delivery service offered by USPS, FED EX or other commercial express delivery service to be delivered to the addressee’s last known business or home address with proof of delivery, or (c) transmitted by facsimile or e-mail to the addressee’s last known business fax or email address.
- 11 **Practitioner:** unless otherwise indicated by context, a physician, dentist, podiatrist, or Allied Health Professional.
- 12 **Professional Review Body:** the Board, the Credentials Committee, the MEC, or any other committee or panel which has the authority to make an adverse recommendation or take an adverse action against an AHP in accordance with this Policy.
- 13 **Supervising Practitioner:** a member of the UF Health Shands Hospital Medical Staff who can attest to the competency of the AHP and supervises the AHP.

## **ARTICLE II - TERM OF CLINICAL PRIVILEGES**

Clinical privileges shall be granted by the Board for a period not to exceed two (2) years.

## **ARTICLE III -CATEGORIES OF ALLIED HEALTH PROFESSIONALS**

### **SECTION 1. BOARD APPROVAL OF AHP CATEGORIES**

Only qualified individuals in Allied Health Professional categories that are approved by the Board may be granted clinical privileges, in accordance with and subject to this policy.

### **SECTION 2. PRIVILEGED AHPs**

For the purposes of this Policy, AHPs are those individuals in the following categories:

- 1 Advanced Registered Nurse Practitioner
- 2 Anesthesiologist Assistant
- 3 Certified Nurse Midwife
- 4 Certified Registered Nurse Anesthetist
- 5 Certified Registered Nurse First Assistant
- 6 Expressive Therapist
- 7 Genetic Counselor
- 8 Licensed Mental Health Professional (Clinical Social Worker, Mental Health Counselor, Marriage & Family Therapist)
- 9 Optometrist
- 10 Physician Assistant
- 11 Psychologist
- 12 Radiologist Assistant

Clinical privileges of AHPs are coterminous with any employment or contractual relationship the AHP may have with UF Health Shands or her/his Supervising Practitioner(s); any termination of clinical privileges pursuant to this provision is not subject to the hearing and appeals rights or procedures provided in Article XV.

## **ARTICLE IV – QUALIFICATIONS FOR CLINICAL PRIVILEGES**

### **SECTION 1. MINIMUM QUALIFICATIONS**

Minimum Required Qualifications: Only Allied Health Professionals for whom the following minimum qualifications can be documented are eligible for clinical privileges.

- 1 Experience, education, training and judgment;
- 2 Current unrestricted License;
- 3 Current clinical competence;
- 4 Adherence to professional ethics and conduct in accordance with accepted professional standards;
- 5 Ability to care for patients safely and effectively;
- 6 Reasonable communication skills;
- 7 Ability to conduct oneself in a professional and cooperative manner, treating all persons with courtesy, respect and dignity in order to promote a culture within which patients can receive quality care and the Hospital and its Medical Staff will be able to operate in an orderly manner;
- 8 Status indicating that s/he is not temporarily or permanently suspended, excluded or debarred from Medicare or Medicaid;
- 9 Satisfaction of financial responsibility to pay claims and associated ancillary costs through professional liability insurance in the amount of \$250,000 per claim, \$750,000 in the aggregate, unless otherwise established by the Board;
- 10 Designation of a Supervising Practitioner where required by Florida Statute or UF Health Shands.

## **SECTION 2. AHP CATEGORY-SPECIFIC ADDITIONAL REQUIREMENTS**

- 1 **Advanced Registered Nurse Practitioner:** Must have and maintain continuous certification in the specialty area in which the Nurse Practitioner requests privileges unless such requirement is waived by the Board in consideration of the extraordinary competence and experience of a particular practitioner or an identified critical hospital patient care need. Applicants who are licensed and have been educated in the specialty area for which privileges are requested, but who are not yet certified in that specialty area must acquire certification in the specialty area in which the Nurse Practitioner has been granted privileges within one year of an initial grant of privileges. Practitioners granted clinical privileges prior to August 23, 2006 are exempt from the aforementioned requirement, except that any such exempted Nurse Practitioner thereafter applying for a change in specialty area of practice, must meet this requirement for the new specialty area, unless waived by the Board.
- 2 **Anesthesiologist Assistant:**
  - (1) Shall be currently licensed in the State of Florida as an Anesthesiologist Assistant
  - (2) Shall have a Supervising Practitioner as defined in Article I of this Policy
- 3 **Certified Nurse Midwife:** Must have and maintain continuous certification by the American College of Midwives, or be actively seeking certification and obtain the same within one year.
- 4 **Certified Registered Nurse Anesthetist:** Must have and maintain continuous certification by the Council on Certification of Nurse Anesthetists, or be actively seeking certification and obtain the same within one year.

- 5 **Certified Registered Nurse First Assistant:** Must be licensed as a registered Nurse. Current Certified Perioperative Nurse (CNOR). Certified completion of Association of perioperative Registered Nurses and Competency and Credentialing Institute (CCI) approved RNFA program CCI certification as CRNFA
- 6 **Expressive Therapist:** Completion of a Master's degree in an Expressive Therapy (such as Art Therapy, Music Therapy, Dance & Movement Therapy or other creative arts therapy)
- 7 **Genetic Counselor:** Shall have and maintain continuous certification as a genetic counselor by the American Board of Medical Genetics, or be actively seeking certification and obtain the same within three years of graduating from an American Board of Genetic Counseling accredited program. Must hold a Master's degree from a college or university medical genetics program accredited by the American Board of Genetic Counseling and be Board eligible or certified as a genetic counselor by the American Board of Medical Genetics or American Board of Genetic Counseling.
- 8 **Mental Health Professional:** Must be licensed as a clinical social worker, mental health counselor, or marriage and family therapist or hold a provisional license as a mental health counselor.
- 9 **Optometrist:** Shall be currently licensed in the State of Florida as an optometrist.
- 10 **Psychologist:** Shall be currently licensed in the State of Florida as a psychologist.
- 11 **Physician Assistant:** Must have and maintain continuous certification by the National Commission on Certification of Physician Assistants unless such requirement is waived by the Board in consideration of the extraordinary competence and experience of a particular practitioner or an identified critical hospital patient care need. Applicants who are licensed, but who are not yet certified must acquire certification within one year of an initial grant of privileges. Practitioners granted clinical privileges prior to March 25, 2009, are exempt from the aforementioned requirement. Physician Assistants seeking outpatient prescriptive privileges must be licensed with added qualifications as a prescribing physician assistant.
- 12 **Radiologist Assistant:** Graduation from an educational program recognized by the Certification Board of Radiology Practitioner Assistants (CBRPA). Licensed as a Radiology Technologist, as well as Certification by the American Registry of Radiologic Technologists as a Radiologist Assistant

### SECTION 3. WAIVERS

Only the Board may grant waivers to the qualifications described in sections 1 and 2 above.

## ARTICLE V - APPLICATION FOR CLINICAL PRIVILEGES

### SECTION 1. PRE-APPLICATION REQUIREMENTS

A pre-application may be used to ascertain whether an AHP appears to meet the minimum objective

criteria for privileges as set forth in this Policy.

## **SECTION 2. APPLICATION**

The application for clinical privileges shall be submitted electronically on the prescribed form and signed by the applicant. The application shall include a request for specific clinical privileges desired by the applicant and shall require detailed information concerning the applicant's professional qualifications, including, at a minimum:

- A. the names and current contact information of at least four (4) professionals who have knowledge of the applicant's current clinical competency. None of these references may be related to the applicant. In special circumstances where the AHP does not have any references with the same credentials who can attest to his/her competence, other professional references may be substituted at the discretion of the Credentials Committee;
- B. the names and complete address of any and all hospitals and other healthcare organizations at which the applicant has had privileges, trained, or worked in the profession in which he or she is requesting clinical privileges;
- C. information as to whether there have been any previously successful or currently pending challenges including investigations or inquiries, that have or may result in any of the following being either temporarily or permanently denied, voluntarily or involuntarily surrendered, suspended, reduced, revoked, relinquished, withdrawn, or not renewed, for any reason: membership status and/or clinical privileges at any hospital or healthcare institution; membership in a local, state, or national professional organization; professional certification; License(s) to practice any profession in any jurisdiction; or prescriber designation/authority;
- D. information as to whether the applicant has ever been subjected to any other corrective or quality-related action (whether disciplinary or not) by any of the institutions or agencies above, including, mandatory chart review, requirements for CME credits, proctoring or probation (subsequent to initial probation period upon first application), Focused Professional Practice Evaluation (FPPE) initiated other than for initial or additional privileges.
- E. information regarding the applicant's current professional liability insurance coverage, and the amounts and classifications of such coverage;
- F. information about whether the applicant has ever had any settlements paid by the applicant or on the applicant's behalf;
- G. information about whether any professional liability carriers have ever denied, cancelled, limited, or not renewed the applicant's liability coverage;
- H. information about whether any malpractice actions, arbitrations, or other judicial, quasi-judicial, or administrative proceedings based on the applicant's clinical practice have ever been instituted against the applicant;
- I. information about whether any Notices of Intent have ever been filed against the applicant;



- J. information about whether the applicant has any physical, medical (including substance abuse), mental or emotional condition that could affect the applicant's ability to exercise the clinical privileges requested safely and competently;
- K. information about whether the applicant has ever been denied enrollment, reprimanded, censured, excluded, suspended, had privileges suspended, or been disqualified by any private health insurance plan/program, or any federal or state program (in any state) or employed by a corporation, business or professional association that has been suspended or excluded from any such program in any state;
- L. information about whether the applicant has ever been convicted of or had adjudication withheld on a felony, pleaded guilty or nolo contendere to a felony, entered into a pretrial agreement for a felony, or is presently under indictment for a felony;
- M. information about whether the applicant has engaged in or been treated for the use or misuse of prescription drugs, use of illegal substance chemicals or any other substance that could impair the applicant's ability to perform his/her professional or clinical practice duties;
- N. information about whether the applicant has ever been the subject of any investigation by a state license board, Medicare, Medicaid, or any other federal or state program, hospital or other healthcare or managed care organization;
- O. information about whether the applicant has ever held or currently holds a contract with a healthcare professional recovery program (i.e. **Intervention Project for Nurses**,);
- P. information about whether the applicant has ever had any License subject to restriction, suspension, stipulation, limitation, reprimand, fine, letter of guidance, probation, revocation, or voluntary or involuntary surrender;
- Q. information about whether the applicant has ever had a confirmed/founded report of abuse or neglect of a patient;
- R. Copy of ARNP (including CNM and CRNA) or Anesthesiologist Assistant protocol submitted to the Florida licensing board for physician sponsorship;
- S. Copy of the Supervision Data Form for a physician assistant, or a current listing of all supervising physicians;
- T. A copy of the current certificate of professional liability coverage that denotes UF Health Shands as the Certificate Holder, provides the effective dates of the policy, identifies the applicant by name, coverage exclusions, if any, and provides for either claims made or occurrence based coverage of \$250,000 per claim, \$750,000 in the aggregate.
- U. A background screening performed by a contracted vendor, with results to be provided to UF Health Shands
- V. The applicant's dated signature on the prescribed Statement of Authorization and Release form;
- W. Such other information as the Credentials Advisory Subcommittee, Credentials Committee, MEC, or Board may require.

### SECTION 3. UNDERTAKINGS

Each applicant must specifically agree to the following undertakings as a condition of consideration of the application for clinical privileges and as a condition of continuation of clinical privileges:

- A. An agreement to be bound by the policies, procedures, bylaws and rules and regulations of the Medical Staff, Hospital and/or UF Health Shands;
- B. An acknowledgement that the applicant has the burden of producing adequate information for a proper evaluation of the applicant's competence, character, ethics, health status and other qualifications and for resolving any questions about such qualifications. Failure to do so may result in expiration of application;
- C. An agreement to appear for an interview, if requested;
- D. An acknowledgement that failure to produce requested information or appear for a requested interview will prevent the application from being evaluated and acted upon;
- E. An agreement to undergo a physical and/or mental health examination at any time, at the request of the Credentials Committee, MEC or Board. Such request must be supported by a statement of reasons;
- F. An attestation that the information in the application is true, complete and correct, and an agreement to notify the Hospital, in writing and within thirty days, of any changes or additions to the information provided by the applicant, including;
- G. Denial or voluntary surrender, suspension, reduction, revocation, relinquishment, withdrawal, or non-renewal, either temporarily or permanently, for any reason, of: (a) membership status and/or clinical privileges at any hospital or healthcare institution; (b) specialty board or professional certification; (c) Drug Enforcement Agency or prescriber registration; (d) License to practice any profession in any jurisdiction; or (e) professional liability coverage; including any changes in coverage, change in CMS eligibility status;
- H. Any malpractice actions, arbitrations, or other proceedings based on the Practitioner's practice, including any Notices of Intent;
- I. Any changes in physical or mental condition that could prevent the applicant, with or without reasonable accommodation, from performing professional or medical practice duties required for the privileges requested and/or granted; or
- J. Any convictions, indictments, pleadings of guilty or nolo contendere to any crimes (excluding minor/non-criminal traffic offenses);
- K. An acknowledgement that as a condition of making an application, any misrepresentation, misstatement, or omission, may constitute cause for automatic and immediate rejection of the application, and that, in the event that approval has been granted prior to the discovery of such misrepresentation, misstatement, or omission, such discovery may result in immediate termination of privileges;
- L. An agreement to provide continuous quality patient care for her/his patients if granted clinical privileges, which shall include an agreement to self-report any physical, medical, psychiatric, or emotional impairment which may result in an inability to perform her/his professional

responsibilities.

- M. An agreement to submit to a background screening performed by a contracted vendor, with results to be provided to UF Health Shands.

#### **SECTION 4. BURDEN OF PROVIDING INFORMATION**

The AHP applicant shall have the burden of providing sufficient information for a proper evaluation of her/his competence, character, ethics, and other qualifications, and of resolving any questions about such qualifications. The applicant shall have the burden of providing evidence that all statements made and information given on the application are true, complete and correct. An application is not considered complete until all information requested by the Hospital has been received, including: an application form with all required responses provided; verification of all necessary information; adequate responses from references; and any other additional information deemed necessary for evaluation of the application or the applicant's qualifications. It is the responsibility of the applicant to ensure that the application is complete, including the direct payment of any unusual verification charges.

- A. An application that is not accompanied by the initial required supporting documents will be deemed expired if not complete within three months.
- B. An application will be deemed incomplete if at any time during the evaluation the need arises for new, additional, or clarifying information. Such application will not be further processed until all requested information is received. Applications which are not complete because of a failure of an applicant to provide requested additional information shall be deemed expired within two months of the request.
- C. Should information provided in the application for clinical privileges change during the period for which privileges have been granted, the AHP must provide written notice within 30 days of such change and sufficient information about such change for the credentials committees' review and evaluation.

#### **SECTION 5. AUTHORIZATION TO OBTAIN INFORMATION**

The following statements, which shall be included on the application form for clinical privileges, are applicable to any AHP applicant and any AHP granted privileges. By applying for initial or renewed clinical privileges, the applicant expressly accepts these conditions during the processing and consideration of his/her application, whether or not he/she is granted clinical privileges. This acceptance also applies once privileges are granted and for as long as privileges continue.

Authorization to Obtain Information: The applicant must authorize UF Health Shands to inspect all records and documents that may be material to evaluating the applicant's professional qualifications, competence, and ability to carry out the clinical privileges requested, as well as the applicant's ethical qualifications. The applicant must authorize UF Health Shands and its authorized representatives to consult with any individuals and/or entities who may have information, including otherwise privileged or confidential information, bearing on the professional qualifications, credentials, clinical competence, character, mental or emotional stability, criminal history, physical condition, ethics, behavior or any other matter bearing on the satisfaction of the criteria for granting of clinical privileges and on the applicant's ability to perform her/his professional responsibilities. The applicant must authorize said individuals

and/or entities, including, as applicable: (1) insurance companies; (2) the National Practitioner Data Bank; (3) The Federation of State Medical Boards (4) professional references; (5) specialty boards; (6) health care plans; (7) schools; (8) employers; (9) hospitals or facilities with which the applicant has been in association; (10) state licensing; (11) state or national certification agencies; (12) claims adjusters, attorneys and others who may have information regarding professional liability claims or lawsuits; (13) criminal background screening vendor; and (14) professional boards training programs, to release said information to UF Health Shands, upon request and receipt of a copy of the applicant's consent and release form.

1. Immunity: The applicant must agree to extend immunity to and release from any and all liability, to the fullest extent permitted by law, all individuals and organizations who provide information to UF Health Shands, including otherwise privileged and confidential information concerning the professional qualifications, credentials, clinical competence, character, mental or emotional stability, criminal history, physical condition, ethics, behavior or any other matter bearing on the satisfaction of the criteria for granting the clinical privileges requested.
2. Authorization to Release Information:
  1. For those applicants who will be credentialed for the UF Health Shands Network, the applicant must authorize UF Health Shands to release information to managed care organizations with which UF Health Shands is or may become affiliated, and release UF Health Shands from any and all liability for providing information concerning the applicant's professional qualifications, credentials, clinical competence, character, mental or emotional stability, physical condition, ethics, behavior or any other qualifications for clinical privileges, including otherwise privileged and confidential information, so long as such release of information is given without malice and in good faith.
  2. The applicant shall authorize UF Health Shands to disclose and make available to any UF Health Shands hospital/facility/program to which the applicant has made or makes application, any and all information contained in her/his application and/or obtained as a result thereof.

## **ARTICLE VI – PROCESSING APPLICATIONS**

### **SECTION 1. DEPARTMENT**

After receipt of references, verifications and all other information or materials deemed pertinent, the application and all supporting materials will be transmitted to the appropriate department chair ("Chair"). The Chair shall provide the Credentials SubCommittee with a recommendation regarding the privileges of the applicant, within ten (10) days of receipt of a complete application.

### **Section 2. Credentials Advisory SubCommittee**

- A. The MEC shall establish an AHP Credentials SubCommittee to review AHP applications for clinical privileges and make recommendations to the Credentials Committee. The AHP Credentials SubCommittee shall consist of, representatives from the relevant AHP categories, and any other professionals or Hospital representatives deemed appropriate to the process of determining an AHPs qualifications for clinical privileges. AHP Credentials SubCommittee members will be recommended to

the MEC by the Credentials Committee.

- B. The Credentials Advisory SubCommittee shall review the application, the supporting documentation, Chair recommendations, and any other information available that may be relevant to consideration of the applicant's qualifications for the clinical privileges requested. All recommendations to approve a grant of privileges must also recommend the specific clinical privileges to be granted. The Credentials Advisory SubCommittee shall then forward a report of its recommendations to the Credentials Committee for consideration.

Review and voting related to "clean" credentialing files and policies may be done without meeting, using secure email or other electronic transmissions in accordance with Article VI. A record of issues and concerns and voting will be maintained.

### **SECTION 3. CREDENTIALS COMMITTEE**

The Credentials Committee shall review the Credentials Advisory SubCommittee recommendations and shall forward a report of its recommendations to the MEC for review.

### **SECTION 4. MEDICAL EXECUTIVE COMMITTEE**

- A. After considering the recommendations from the Credentials Committee, the MEC shall recommend action upon each application for privileges. If a recommendation is favorable to the applicant, the recommendation shall be forwarded to the Board for final action.
- B. If an adverse recommendation is made with respect to clinical privileges, the recommendation, including a statement of the reason for such recommendation, supported by reference to the application and other documentation considered by the MEC, shall be forwarded to the Administrator or his/her designee. The Administrator or her/his designee shall promptly give Notice to the applicant of the adverse recommendation and of the applicant's right to a hearing in accordance with the Fair Hearing procedure set forth in Article XV of this Policy.
- C. If the applicant waives her/his right to a hearing, or does not have such right pursuant to Article XV, the Administrator or her/his designee shall forward the MEC recommendation with supporting documentation to the Board for final action. If the applicant exercises her/his right to a hearing, the MEC may reconsider its adverse recommendation after receiving the Hearing Panel report and recommendation, and forward its final recommendation to the Board.

### **SECTION 5. DEFERRAL**

When the recommendation of the credentials advisory subcommittee, the Credentials Committee or the MEC is to defer consideration of the application to obtain additional information; the Committee must make a subsequent recommendation within 60 days.

## **SECTION 6. BOARD APPROVAL**

- A. The Board of Directors has final responsibility for approval or disapproval of all AHP applications for initial or renewed clinical privileges.
- B. In accordance with the UF Health Shands Bylaws, the Professional Staff Credentials Committee of the Board (PSCC) is responsible for acting upon applications for initial or renewed privileges for all applications except that:
  - 1) Any application for which the MEC has made a final recommendation that is adverse shall be forwarded to the full board with the PSCC recommendation.
  - 2) The following applications must be evaluated by the PSCC for appropriateness of expedited review on a case-by-case basis and will usually result in ineligibility for expedited review :
    - a) There is a current challenge or a previously successful challenge to Licensure;
    - b) The applicant has received an involuntary termination of staff membership at another healthcare organization;
    - c) The applicant has received involuntary limitation, suspension, reduction, denial, or loss of clinical privileges; or,
    - d) There has been either an unusual pattern of, or an excessive number of, professional liability actions resulting in a final judgment against the applicant.
- C. Notice of the Board's decision shall be sent to the applicant within 30 days unless otherwise required in accordance with the hearing and appeals procedures of Article XV or delayed by the Board for good cause.

## **SECTION 7. TIME FOR FINAL ACTION**

Once received from the Chair an application must be acted upon by the Credentials Advisory SubCommittee, Credentials Committee and the MEC and presented to the Board within 90 days, unless the process has been delayed by a hearing or by the need to obtain further information, or unless an extension is approved by the Board upon a show of good cause.

# **ARTICLE VII – TEMPORARY, EMERGENCY, DISASTER, AND INCREASED CLINICAL PRIVILEGES**

## **SECTION 1. REQUEST FOR TEMPORARY CLINICAL PRIVILEGES**

- A. Upon the recommendation of a Chair, and the concurrence of the COS, the CEO or her/his designee, may, at her/his sole discretion, grant temporary privileges to an AHP for a specified period of time.
- B. An AHP may be granted temporary privileges in the following circumstances:
  - 1. **New Applicant Awaiting Board Approval:** When an applicant for initial grant of clinical privileges with a complete application that raises no significant quality or professionalism

concerns is awaiting review and approval by the Credentials Committee, MEC and/or Board, temporary privileges may be granted. A new applicant with a complete application awaiting review and approval is automatically ineligible for temporary privileges if the applicant has: a current or previously successful challenge to Licensure; or been subject to any involuntary limitations, suspension, reduction, denial, or loss of clinical privileges at another organization, experienced an excessive number of malpractice claims resulting in a judgment; or unable to demonstrate current (within past two years) clinical practice

- 2. Important Patient Care Need:** When there is an important patient care, treatment, and/or service need that requires urgent authorization to practice for a limited period of time to prevent a significant decrease in ability to provide services, as determined on a case-by-case basis by the COS and CEO, temporary privileges may be granted. In order to be granted privileges in this case, the following documentation shall have been acquired within the previous 90 days:
- a. a query of the National Practitioner Data Bank;
  - b. proof of current unrestricted Florida License;
  - c. evidence of professional liability coverage as set forth in Article V, Section 2;
  - d. current competence for the privileges requested; and
  - e. verification of relevant training or experience.

## **SECTION 2. TERM OF TEMPORARY CLINICAL PRIVILEGES**

- A. The term of temporary privileges to fulfill important patient care, treatment, and/or service needs will be set as appropriate for the circumstances. Each term requires a separate written request. The total period of temporary privileges shall not exceed 180 days in any rolling 365-day period; except that extensions may be granted by the CEO under extraordinary circumstances.
- B. Temporary privileges for new applicants shall not exceed 120 days.

## **SECTION 3. TERMINATION OF TEMPORARY PRIVILEGES**

- A. Temporary clinical privileges may be terminated by the Chair of the Board, the CEO, the Administrator, or the COS at any time with or without cause. Neither the granting, denial, nor the termination of such privileges shall entitle the individual concerned to any of the procedural rights provided in this Policy with respect to hearings or appeals.
- B. Temporary privileges shall be automatically terminated at such time as the Credentials Committee or MEC makes an adverse recommendation with respect to an applicant's request for clinical privileges.

## **SECTION 4. EMERGENCY PRIVILEGES**

- A. **Emergency Privileges for Live-Saving Measures:** In the case of an emergency, any AHP who has clinical privileges shall be permitted to provide any type of patient care necessary as a life-saving measure or to prevent serious harm, regardless of clinical privileges, provided that the care rendered is within the scope of the individual's License. For the purpose of this section, an "emergency" is defined as a condition which without immediate medical intervention could reasonably be expected to result in

placing the life of the patient in serious jeopardy or in serious or permanent harm to a patient.

#### B. Disaster Privileges

- 1) In disaster circumstances during which the emergency management plan has been activated, and the Hospital is unable to meet immediate patient needs, the CEO or his/her designee may approve the use of a modified credentialing and privileging process to grant temporary disaster privileges to AHPs to provide services during the disaster.
- 2) An individual requesting disaster privileges in these circumstances must produce his/her pocket License to practice (or a copy of the License); a valid photo ID issued by a state or federal agency, such as passport; membership in ESAR-VHP (Emergency System for Advance Registration of Volunteer Health Professionals, MRC (Medical Reserve Corps), DMAT (Disaster Management Assistance Team); the name of her/his malpractice insurance carrier, and the name and telephone number of a hospital where she/he currently has privileges or has recently practiced.
- 3) In granting disaster privileges in this circumstance, the Hospital shall make every effort to verify current Licensure directly with the appropriate agency within 72 hours from the time the volunteer presents to the Hospital. In addition, the Hospital shall attempt to contact the facility at which the applicant has recently practiced to verify that he/she is in good standing.
- 4) Once the emergency situation is under control, the Hospital shall verify all information in accordance with Article V.
- 5) Privileges granted in such situations are the core privileges in the volunteer's specialty.
- 6) All individuals granted disaster privileges under these circumstances must follow the Hospital's Disaster Plan procedures.
- 7) Any AHP in a category requiring a Supervising Practitioner who is granted disaster privileges must have oversight by a credentialed member of the Medical Staff; otherwise an AHP granted disaster privileges must have oversight by a an AHP with equivalent clinical privileges.
- 8) Within 72 hours of initial granting of privileges, a decision must be made regarding continuation of privileges, based on information acquired regarding the professional practice of the volunteer.
- 9) An individual's privileges, granted under this emergency situation, may be terminated at any time without any reason or cause. Neither the granting, denial, nor the termination of such privileges shall entitle the individual concerned to any of the procedural rights provided in this Policy with respect to hearings or appeals.

#### **SECTION 5. APPLICATION FOR INCREASED CLINICAL PRIVILEGES**

Whenever an individual desires additional clinical privileges, s/he shall make the request in writing, on the prescribed additional privilege forms. The applicant shall have the burden of providing sufficient information for a proper evaluation of his/her qualifications and for resolving any questions about such qualifications in accordance with Article V, Section 4 of this Policy. The request shall be processed in the same manner as an application for initial clinical privileges (see Article VI of this Policy).



## **ARTICLE VIII – RENEWAL OF CLINICAL PRIVILEGES**

### **SECTION 1. APPLICATION**

Each AHP who wishes to continue his or her clinical privileges shall be responsible for returning a completed electronic renewal application, accompanied by all required supporting documents, by the specified date. Applications received after the requested date are subject to a late fee as established by the UF Health Shands Hospital Medical Staff Administration Office and may result in expiration of clinical privileges if there is insufficient time to process the application before the current privileges expire. Failure to return the renewal application will result in expiration of the clinical privileges. In applying for renewal of clinical privileges, the AHP shall have the burden of producing adequate information to assure that the AHP continues to meet those criteria outlined in Article IV of this Policy. If granted by the Board, renewal shall be for a period not to exceed two years and may limit or modify the clinical privileges to be extended.

### **SECTION 2. FACTORS TO BE CONSIDERED**

Each recommendation regarding renewal of clinical privileges shall be based, at a minimum, upon the AHP's:

- A. current clinical competence, clinical judgment and quality of patient care, and clinical activity level at UF Health Shands;
- B. compliance with the Medical Staff and Hospital bylaws, policies and procedures and rules and regulations;
- C. ethical behavior and compliance with professional conduct expectations as reflected in Article XI of this Policy;
- D. ability to perform the clinical privileges requested;
- E. applicant's attestation regarding the completion of the appropriate State of Florida licensing board's mandated continuing education requirements for the individual's most recent license renewal period, if applicable, with an affirmation that a majority of the required hours were related to the individual's clinical privileges, specialty and/or subspecialty; and
- F. any other findings relevant to the AHP's competence and ability to perform her/his professional duties and responsibilities.

### **SECTION 3. RENEWAL PROCEDURE**

The completed application and supporting documents shall be forwarded to the Chair for evaluation of the AHP's demonstrated competence, professional performance, judgment, and clinical/technical skills, as indicated by Focused Professional Practice Evaluation, Ongoing Professional Practice Evaluation, and other quality monitoring and assessment activities. Peer recommendations may be considered by the Chair in recommending the AHP for continuation of specific clinical privileges. Upon completion of the evaluation, the procedure provided in Article VI, Processing Applications, shall be followed.

## **ARTICLE IX – STATUS CHANGES**

### **SECTION 1. LEAVE OF ABSENCE**

- A. Practitioners may be granted leaves of absence for up to one year upon approval.
- B. Prior to return from a leave of absence, the AHP may request reinstatement of clinical privileges by completing the prescribed return from leave of absence form. The completed form and any required supporting documentation will be processed in accordance with Article VI of this Policy.
- C. If a Practitioner engaged in clinical activity during the leave of absence, verification may be obtained from the practice site. A practitioner who was not engaged in clinical activity during a LOA, and who cannot demonstrate current clinical competence related to privileges requested will be required to have a re-entry plan developed by their Department/Supervising Practitioner prior to return to clinical activity.
- D. Practitioners who have been absent from clinical practice for more than 30 days due to a Medical LOA are required to provide a signed release from their medical provider prior to return to active practice.
- E. In acting upon the request for reinstatement, the Board may approve or disapprove reinstatement with the same clinical privileges, or may modify the clinical privileges to be extended and may take any other action deemed necessary to assure quality of care and patient safety.
- F. The clinical privileges for an AHP granted leave for a year who does not request a return to active practice will be automatically terminated unless a request for an extension is made and approved by the Board for extenuating circumstances.
- G. Upon return from LOA, the AHP must provide evidence that he/she meets the requirement for continuous satisfaction of financial responsibility to pay claims.
- H. See The Medical/Allied Health Staff Leave of Absence Policy for additional information.

### **SECTION 2. CHANGE IN SPECIALTY AREA**

Whenever an AHP desires to change her/his specialty area of practice, the request for change shall be in writing and shall include: 1) updated contact information; 2) a request for clinical privileges for the new specialty area; 3) updated physician sponsor information, as appropriate; and, 4) updated State of Florida practice protocol as required.

## **ARTICLE X. HEALTH ASSISTANCE**

### **SECTION 1. GENERAL**

In order to fulfill its obligation to protect patients, health care providers and other persons present in the Hospital from harm, the Medical Staff adopts the following process to identify and manage individual AHP

health matters that have the potential of adversely affecting patient care. This process is designed to focus on assisting the impaired AHP by facilitating confidential diagnosis, treatment, and rehabilitation of AHPs who suffer from a potentially impairing condition, in order to permit him/her to retain or regain optimal professional functioning, without recourse to the AHP disciplinary process. The process also aims to provide education about Practitioner health and address prevention of physical, psychiatric, or emotional illness.

- A. The impaired Practitioner is one who is unable to perform her/his professional responsibilities with reasonable skill and safety or unable to work professionally and harmoniously with others within the Hospital, by reason of mental/emotional illness or deficiency, physical illness or condition, or use/abuse of drugs or alcohol.
- B. Upon a grant of clinical privileges, Allied Health Professionals shall receive information regarding illness and impairment recognition.

## **SECTION 2. REFERRAL**

- A. As part of her/his commitment to provide or arrange for the provision of continuous quality patient care for her/his patients each AHP has a responsibility to self-report any physical, psychiatric or emotional impairment which may compromise her/his ability to perform her/his professional responsibilities.
- B. Whenever an AHP has cause to question her/his own ability to perform her/his professional responsibilities due to physical, psychiatric or emotional illness or impairment, s/he should report confidentially to the COS. The COS, shall facilitate a referral to the appropriate internal or external resource(s) for diagnosis, treatment and/or rehabilitation and notify the Administrator of such referral.
- C. If the COS or the Administrator receives information from a Practitioner or a Hospital staff member indicating the possibility of impairment of an AHP, the COS/Administrator, or her/his designee, shall request a written report from the concerned Practitioner/Hospital staff member describing the specific incident(s)/circumstance(s) (including witnesses) which has led to the belief that the affected AHP is impaired.
- D. The COS/Administrator shall discuss the information with the affected AHP and, if appropriate, facilitate a referral to the appropriate internal or external resource(s) for evaluation and/or treatment.
- E. The affected AHP shall cooperate fully with the COS/Administrator to assure that patient care is not compromised, including the voluntary relinquishment of privileges if necessary.

## **SECTION 3. CONFIDENTIALITY**

The referral of any AHP for assistance pursuant to Section 2 of this Article shall be kept confidential, except as limited by law, ethical obligation, or as necessary to ensure patient safety. To the greatest extent possible and considering principles of fairness, the identity of the reporting Practitioner or Hospital staff member shall remain confidential.

#### **SECTION 4. INVESTIGATION OF COMPLAINTS OR CONCERNS**

- A. In the event that an AHP is not fully cooperative with the COS's referral for evaluation under Section 2, concerns regarding the AHP's physical, psychiatric or emotional illness or impairment shall be investigated in accordance with Article XIV.
- B. If the investigation indicates that the AHP may be affected by an illness or impairment that may compromise her/his ability to perform her/his professional responsibilities, a referral to the appropriate professional internal or external resource(s) for physical, psychiatric or emotional diagnostic and/or treatment or rehabilitative program shall be facilitated.
- C. If the affected AHP does not cooperate with the COS/Administrator regarding the referral after investigation, appropriate corrective action pursuant to Article XIV shall be taken in order to protect patients and maintain the orderly operation of the hospital.

#### **SECTION 5. MONITORING**

- A. Any recommendation for action shall provide for Hospital monitoring of the affected AHP to the extent necessary to assure patient safety. Such monitoring may include, but is not limited to the following: chart review; mandatory consultation; interviews with staff working with the affected AHP; and reports from a Practitioner recovery or other treatment/rehabilitation program.
- B. In order to facilitate appropriate monitoring, the affected AHP shall provide the COS/Administrator, either directly or through execution of the appropriate release form, with the terms of the contract and/or status reports from any Practitioner recovery or other treatment, rehabilitation or other monitoring program in which s/he is participating.
- C. Monitoring conditions agreed to pursuant to this Article are not subject to the hearing and appeals procedures under Article XV. Monitoring conditions imposed pursuant to an investigation under Article XIV may be subject to hearing and appeals as provided in Article XV.
- D. If the affected AHP's privileges have at any time during the process been limited, either voluntarily or involuntarily, or a leave of absence effected, reinstatement of privileges shall be made only at such time as the affected AHP can demonstrate that s/he can practice safely. A finding from the AHP's treatment/rehabilitative recovery program that s/he is able to practice without compromising patient safety shall be required. All other factors usually considered when an AHP requests reinstatement of privileges (such as proof of current competency) are also relevant.
- E. If the affected AHP disagrees with a decision regarding the reinstatement of her/his voluntarily restricted/relinquished privileges, s/he may request a fair hearing regarding that issue in accordance with Article XV.

#### **SECTION 6. RELINQUISHMENT OF PRIVILEGES**

If at any time during the referral, investigation or monitoring phase of the process under Sections 2, 4, or 5 above, it is determined that an AHP is unable to safely perform the privileges s/he has been granted, the affected AHP shall be granted the opportunity to voluntarily relinquish her/his privileges or take a leave of absence. If s/he does not voluntarily relinquish his/her privileges or take a leave of absence, the matter shall be referred for appropriate corrective action in accordance with Article XIV.

# ARTICLE XI – PROFESSIONAL CONDUCT

## SECTION 1. GENERAL

- A. The UF Health Shands has adopted the framework of a fair and just culture. In the Just Culture environment, the organization is accountable for safe system designs and for responding to staff behaviors in a fair and just manner. Likewise, staff is accountable for reporting errors and unsafe conditions, and for following all procedures and policies created to safeguard patients, within a learning environment focused on designing safer healthcare systems. The Just Culture framework provides a structured method to standardize the investigation of medical errors and management of staff behavioral choices in order to nurture and advance a culture of patient safety, and improve reliability and patient outcomes.
- B. Behaviors that undermine a culture of safety can foster medical errors, contribute to poor patient satisfaction and result in adverse outcomes. In addition, such behavior may increase the cost of care, and may cause qualified clinicians, administrators and managers to seek new positions in more professional environments. Safety and quality of patient care are dependent on teamwork, communication, and a collaborative work environment. To assure quality and to promote a culture of safety, the Medical Staff is committed to addressing the problem of behaviors that threaten the performance of the health care team. The Medical Staff shall work to ensure optimum patient care by fostering desirable behavior in order to promote a safe, cooperative and professional healthcare environment. Episodes of unprofessional behavior shall be addressed and appropriate action taken to eliminate the behavior.
- C. All individuals granted privileges in the hospital must conduct themselves in a professional and cooperative manner, treating all persons with courtesy, respect and dignity. Failure to do so may result in corrective action, up to and including suspension or termination of privileges in accordance with this Policy. Expected behaviors shall include:
1. timely communication, involving the appropriate person(s), in an appropriate setting;
  2. communications, including spoken remarks, body language, written documents, and emails that are honest, direct, professional, constructive, and respectful ;
  3. appropriate preparation for telephone conversations and meetings by gathering all necessary information, organizing questions or comments, and coordinating with others to effect efficient communication regarding all necessary issues;
  4. cooperation and availability when on call. When individuals are paged, they must respond promptly and appropriately to the issue(s) at hand.
  5. an understanding that a variety of experience levels exists, and tolerance for those who are learning.

## SECTION 2. BEHAVIORS THAT UNDERMINE A CULTURE OF SAFETY

- A. Defined as: conduct, whether verbal or physical, that negatively affects or may affect patient care, including behavior that:
1. disrupts the operation of the hospital;

2. affects the ability of others to perform their jobs;
  3. has the effect of being personally degrading to others in the workplace;
  4. creates a hostile work environment; or,
  5. interferes with an individual's ability to practice competently.
- B. Appropriate criticism offered in an appropriate place and manner, with the aim of improving patient care should not be construed as behaviors that undermine a culture of safety.
- C. Specific examples of behaviors that undermine a culture of safety include:
1. Attacks or outbursts – verbal or physical – leveled at anyone, including: shouting or yelling; use of profanity; and slamming or throwing objects in anger or disgust, whether or not directed at a specific individual;
  2. Comments (or illustrations) made in patient medical records or other official documents that are unnecessary for patient care, impugn the quality of care in the hospital, or attack particular individuals or hospital policies;
  3. Refusal to accept professional assignments or refusal to participate in committee or departmental affairs in a professional and appropriate manner;
  4. Hostile, condemning, or demeaning communications, including: 1) criticism of performance and/or competency that is delivered in an inappropriate location and not aimed at performance improvement; and, 2) criticism leveled at the recipient in such a way that it intimidates, undermines confidence, belittles, or implies stupidity or incompetence;
  5. Other behavior demonstrating disrespect or intimidation, or disrupting the delivery of patient care (e.g., reluctance or refusal to answer questions, return phone calls or pages; condescending language or voice intonation; and impatience with questions);
  6. Retaliation against any person who addresses or reports unacceptable behavior.

### **SECTION 3. REPORTING EPISODES OF BEHAVIORS THAT UNDERMINE A CULTURE OF SAFETY**

Any person may report perceived undermining conduct to a Hospital manager and/or COS, as appropriate, by providing the following information:

- A. Factual and objective description of the situation and the questionable behavior (including date and time);
- B. A statement regarding whether the behavior affected or involved a patient in any way; and, if so, information identifying the patient;
- C. Persons present during the incident; and;
- D. Any immediate response to the situation.

### **SECTION 4. PROCESSING REPORTED EPISODES OF BEHAVIOR THAT UNDERMINES A CULTURE OF SAFETY**

- A. Upon receipt of a report of undermining behavior, the Hospital manager and/or COS shall conduct an inquiry to confirm details of the incident with witness interviews as appropriate.

- B. Upon completion of the inquiry, the report and documentation of the inquiry shall be forwarded to the COS for her/his review.
- C. If it is determined that a violation of the policy has not occurred, the individual bringing the complaint shall be notified.
- D. If it is determined that there appears to have been an episode of undermining behavior, the COS shall request that the AHP provide him/her with a written response to the allegation and after review of such response may:
  - 1. meet with the AHP for discussion and collegial counseling (including identification of methods and resources for structuring professional and working relationships and resolving problems without undermining behavior) and document the discussion and any specific actions the individual has agreed to take, with a copy forwarded to the credentialing file; or,
  - 2. if the AHP has had previous occurrences, forward to the MEC for consideration of further action either under Article XIV of this Policy; or,
  - 3. all instances of egregious behavior that undermines a culture of safety shall automatically go to the MEC for consideration under Article XIV of this Policy.
- E. Whenever an episode of undermining behavior has been confirmed:
  - 1. A copy of this Article shall be provided to the offending individual.
  - 2. The offending individual shall also be informed that the Medical Staff and Board of Directors require compliance with this Article, and that attempts to confront, intimidate, or otherwise retaliate against the individual(s) who reported the behavior in question, by the involved AHP will be considered a violation of this Article and grounds for further disciplinary action.
  - 3. The approach during such an initial intervention should be collegial and helpful to the individual.
- F. A single egregious incident, such as sexual harassment (physical or verbal), assault, a fraudulent act, stealing, damaging Hospital property, or inappropriate physical behavior, may result in corrective action in accordance with Article XIV of this Policy up to and including suspension and/or termination of privileges.
- G. All documented episodes of undermining behavior shall be filed in the individual's credentialing file.

## **ARTICLE XII. FOCUSED PROFESSIONAL PRACTICE EVALUATION**

### **SECTION 1. PURPOSE**

The purpose of the Focused Professional Practice Evaluation (FPPE) is to establish:

- A. a systematic review and evaluation process for assuring that individuals who have been granted initial or additional privileges are performing those new privileges competently and;
- B. a deliberate and focused professional practice evaluation when indicated by Ongoing Professional Practice Evaluation (OPPE) mechanisms or by other Hospital or Medical Staff quality monitoring mechanisms.

## **SECTION 2. PERFORMANCE OF THE FPPE**

The FPPE will be performed:

- A. Upon the grant of initial privileges or additional privileges (new privileges); or,
- B. When indicated by OPPE thresholds, or other quality indicators or sources of information that raise questions regarding the AHP's ability to competently perform his/her privilege(s).

## **SECTION 3. REQUIREMENTS FOR NEW PRIVILEGES**

- A. Each Chair will review monitoring specifications to evaluate the privilege-specific competence of every AHP granted new privileges in his/her department. Such monitoring may include chart review, monitoring clinical practice patterns, simulation, proctoring, or discussions with other Practitioners involved in the care of each patient. The monitoring process shall include: a recommended minimum period of time and/or number of procedures for review; and identification of circumstances under which monitoring by an external source is required.
- B. The timeframe for completion of the FPPE shall be no greater than six months unless an extension is granted by the MEC. The overall initial privilege FPPE evaluation period cannot be extended beyond one year in total, except in extenuating circumstances approved by MEC, except in extenuating circumstances approved by MEC.
- C. At the conclusion of the monitoring period for new privileges, the Chair shall review the data and report to the MEC any AHP that has not adequately demonstrated his/her competence, with appropriate recommendations for further evaluation/action.

## **SECTION 4. REQUIREMENTS FOR QUALITY TRIGGERED FPPE**

- A. Where appropriate, each department may develop specific thresholds for OPPE indicators that will trigger an FPPE and/or a recommendation to the COS for a more comprehensive review of the AHP's competency, as appropriate. FPPE initiated through other Hospital or Medical Staff quality monitoring mechanisms will follow the process set forth in Article XIV of this policy.
- B. The FPPE indicators and thresholds must be consistently implemented and applied.
- C. The results of an FPPE under this section will be reviewed by the Chair, and/or the MEC as required or otherwise appropriate. If indicated, a specific performance improvement and/or corrective action plan shall be implemented to assure patient safety and quality care.



## **ARTICLE XIII. ONGOING PROFESSIONAL PRACTICE EVALUATION**

### **SECTION 1. PURPOSE**

The purpose of the OPPE is to establish a process for ongoing evaluation of each privileged AHP's professional practice to determine whether privileges continue to be performed competently.

### **SECTION 2. PERFORMANCE OF THE OPPE**

- A. An OPPE will be conducted on all individuals privileged through the Medical Staff process.
- B. An OPPE report will be generated for each privileged AHP at 9 month intervals.

### **SECTION 3. REQUIREMENTS**

- A. Each Chair must:
  - 1. identify the type of data to be collected for the specific category of AHP to support a specific plan for evaluating the competency of each privileged AHP that is a reliable indicator of her/his competency to maintain his/her privileges; or,
  - 2. perform a specified number of chart reviews to confirm the AHP's competency to maintain his/her privilege; and,
  - 3. establish thresholds (under a or b, as appropriate) that will result in a Chair review to determine the necessity for an FPPE or performance improvement intervention, as appropriate to ensure patient safety and quality care.
- B. OPPE parameters recommended by the department chairs shall become effective upon approval of the MEC. Every two years, each Chair shall review the type of data collected for his/her department and make recommendations for revisions to the MEC as indicated to assure that they continue to be reliable measures of competency.

### **SECTION 4. REVIEW**

- A. Each Chair shall timely review each OPPE report for his/her department and determine whether there is cause to initiate an FPPE.
- B. At the time of renewal of clinical privileges, the Chair shall consider the AHP's OPPEs in making his/her recommendation for continuation of specific privileges to the Credentials Committee.

## **ARTICLE XIV -- CORRECTIVE ACTIONS**

The Medical Staff is responsible not only for establishing, but for maintaining patient care standards and providing oversight of the quality of care rendered by Practitioners privileged through the Medical Staff process. The procedures set forth below provide guidelines for the Medical Staff to evaluate complaints or concerns regarding patient care, including the orderly functioning of the hospital, to formulate corrective action, and to monitor performance.

## **SECTION 1. GROUNDS FOR INITIATING AN INVESTIGATION**

- A. Whenever, on the basis of information and belief, the COS, the Chair, the chair or a majority of any Medical Staff committee, a Practitioner, the Chair of the Board, or the Administrator has cause to question:
1. the clinical competence or performance of any AHP;
  2. the care or treatment of a patient(s) or management of a case(s) by any AHP;
  3. the conduct of any AHP with regard to applicable ethical or professional standards, including expected behavior as set forth in this Policy and the bylaws, policies, procedures, rules or regulations of the Hospital, Board or Medical Staff, including, but not limited to the Hospital's quality improvement, risk management, and utilization review programs; a written request for an investigation of the matter shall be addressed to the COS, or if the COS is the requester, he/she shall address the request to the MEC, making specific reference to the incident(s), activity (ies) or conduct that constitutes the basis for the request. The COS shall promptly notify the Administrator of all such requests and proceed in accordance with the investigation procedures outlined in Section 3 of this Article.
- B. Nothing in this Article is meant to restrict the ability of any medical review or peer review committee to conduct a review or informal investigation of an AHP's practice in connection with such committee's quality improvement and/or assurance responsibilities.

## **SECTION 2. SELF-REFERRAL**

Whenever an AHP has cause to question his/her own ability to perform his/her professional responsibilities due to physical, psychiatric or emotional illness, the COS, shall assist in facilitating a referral to the appropriate agency in accordance with Article X of this Policy. The AHP shall cooperate with the COS, to assure that patient care is not compromised.

## **SECTION 3. INVESTIGATIVE PROCEDURE**

If, after receiving the request for investigation, the COS determines:

- A. the request contains sufficient information to support a recommendation, s/he shall make a recommendation for action to the MEC, with or without a personal interview with the AHP; or
- B. the request does not contain sufficient information to support a recommendation, the COS shall promptly appoint a SubCommittee of the MEC to investigate, appoint an ad hoc investigating committee, or present to the MEC for investigation as a committee.

An *ad hoc* Investigating Committee shall consist of at least three individuals, of which two (2) may be physicians, either of whom may or may not hold an appointment to the Medical Staff, and one (1) must be an AHP who has the same credentials as the individual who is the subject of the investigation. If possible, this committee should not include partners, associates, or relatives of the subject of the investigation, nor any individual in direct economic competition with the subject of the investigation.

The Investigating Committee shall have available to it the full resources of the Medical Staff and the Hospital to aid in its work, as well as the authority to use outside consultants as required.

The Investigating Committee may require a physical and/or mental examination of the AHP under review by a physician(s) satisfactory to the committee and the results of such examination must be made available for the committee's consideration. The subject of the investigation shall have an opportunity to meet with the Investigating Committee before it makes its report. At this meeting (but not, as a matter of right, in advance of it) the AHP will be informed of the general nature of the evidence supporting the investigation and will be invited to discuss, explain or refute it. This interview does not constitute a hearing, and none of the procedural rules provided in this Policy with respect to hearings, including the right to have legal counsel present, apply. A summary of such interview shall be made by the Investigating Committee and included with its report to the MEC. The Investigating Committee shall submit a report to the MEC that includes the evidence reviewed and its findings.

#### **SECTION 4. SUMMARY SUSPENSIONS**

##### **A. Prior to Investigation**

1. Upon a reasonable belief that failure to take such action may result in imminent danger to the health and/or safety of any individual, the COS, the chair of a department, the Administrator, or in her/his absence, her/his designee, or the Chair of the Board shall each have the authority to summarily suspend or restrict all or any portion of the clinical privileges of an AHP.
2. Upon a reasonable belief that failure to take such action may compromise the health, safety or welfare of trauma patients, the Medical Director of the Trauma Service shall have the authority to summarily suspend or restrict all or any portion of the clinical privileges of an AHP.
3. Prior to implementation of such summary suspension or restriction, the Administrator, her/his designee, the Chair of the Board or Trauma Medical Director, shall, whenever practicable, consult with the COS.
4. Any individual who exercises authority under Paragraph 1 or 2 to summarily suspend clinical privileges must assure that the Administrator and COS are both notified.
5. The COS shall initiate an investigation of the matter prompting the summary suspension in accordance with Section 3 of this Article.

##### **B. During an Investigation**

At any time during an investigation, the COS, the Administrator, or the Chair of the Board may suspend all or any part of the clinical privileges of the AHP being investigated upon a reasonable belief that failure to take such action may result in an imminent danger to the health and/or safety of any individual.

##### **C. General Requirements for Summary Suspensions**

1. A summary suspension shall become effective immediately upon imposition and remain in effect unless or until modified by the Administrator or the Board.
2. An investigation must be completed within 14 days of the suspension or reasons for the delay must be transmitted to the Administrator so that he/she may consider, as soon as practicable, whether the suspension should be lifted prior to its completion.
3. Immediately upon the imposition of a summary suspension, the COS shall notify the AHP's Supervising Practitioner or Chair as appropriate to assure continuity of patient care.

4. It is the duty of the COS and the Chair to cooperate with the Administrator in enforcing all suspensions.
5. Summary suspension under this section shall be deemed an interim precautionary step in the professional review activity and shall not imply a final finding of responsibility for the situation that prompted the suspension.

## **SECTION 5. RECOMMENDATIONS FOR CORRECTIVE ACTIONS**

- A. After review of the Investigating Committee report, the MEC may recommend any appropriate action in furtherance of safe, quality care and performance improvement, including but not limited to:
  1. no action;
  2. further evaluation;
  3. a written warning;
  4. a letter of reprimand;
  5. proctoring;
  6. a requirement for consultation;
  7. reduction or revocation of clinical privileges;
  8. remedial education;
  9. referral to the appropriate professional internal or external resource, including physical, psychiatric or emotional diagnostic and/or rehabilitative programs;
- B. A recommendation for action will provide for monitoring of the affected AHP to the extent necessary to assure patient safety.
- C. If the recommendation of the MEC would entitle the affected AHP to a hearing in accordance with Article XV of this Policy, the recommendation shall be forwarded to the Administrator, who shall promptly give Notice to the affected AHP. The Administrator shall then hold the recommendation until after the AHP has exercised or waived her/his right to a hearing and appeal as provided in Article XV. At that time, the Administrator shall forward the MEC's recommendation, together with all supporting documentation, to the Board. The COS or her/his designee shall be available to the Board to answer any questions that may be raised with respect to the recommendation.
- D. If the recommendation of the MEC includes a recommendation for the imposition of an immediate suspension or restriction of clinical privileges based on the reasonable belief that failure to take such action may result in imminent danger to the health and/or safety of any individual, the recommendation will take effect immediately and remain in effect until modified by the Administrator or Board. The COS must promptly give Notice to the affected member of the recommended suspension/restriction and its immediate effect.
- E. If the recommendation of the MEC would not entitle the individual to a hearing, in accordance with Article XV, the action will take effect immediately. A report of the action taken and reasons therefore will be made to the Board through the Administrator and the action shall stand unless modified by the Board.
- F. In the event the Board considers modification of an MEC action given immediate effect pursuant to subsection E, and such modification would entitle the individual to a hearing, the affected AHP will be given Notice by the Administrator, and no final action thereon shall be taken by the Board until the

individual has exercised or waived her/his right to a hearing and appeal.

## **SECTION 6. AUTOMATIC SUSPENSION OR TERMINATION OF PRIVILEGES**

A. Suspension/termination of all clinical privileges shall occur automatically as indicated upon the occurrence of any of the following events:

Termination of all clinical privileges shall occur, as provided in Article III, Section 2, upon termination of any employment or contractual relationship the AHP may have with the UF Health Shands Hospital or the AHP's supervising Medical Staff member. Upon termination of such employment or contractual relationship, AHPs shall have no rights under Article XV.

1. Revocation or restriction of License to practice shall result in automatic termination of clinical privileges.
2. Suspension of License to practice shall result in automatic summary suspension of all clinical privileges and prompt investigation in accordance with this Article. A summary suspension based on suspension of License to practice will be in effect, at a minimum, for a period concomitant with State action.
3. Failure to take appropriate steps to cause License renewal, thereby rendering the License inactive, shall result in automatic suspension of all clinical privileges. Privileges will be terminated if license is not renewed within 30 days of expiration. Failure to report to the Hospital within 7 days any license action that limits the practitioner's ability to practice in the State of Florida.
4. Failure to appear at a Medical Staff or Hospital committee meeting to which the AHP has been invited, and at which a discussion of the AHP's clinical or professional practice is scheduled, unless excused by the MEC upon a showing of good cause, shall result in automatic suspension of privileges. Such suspension will be automatically rescinded upon the AHP's participation in a rescheduled conference; provided that the AHP makes a request within 14 days of the original conference date to reschedule. Upon failure to request the rescheduling within 14 days, the AHP's clinical privileges will be automatically terminated.
5. Failure to undergo a medical, psychological and/or psychiatric examination/evaluation at the request of the Credentials Committee, MEC or Board shall result in automatic suspension of privileges. Such suspension will be automatically rescinded upon the AHP's agreement to comply with the request; provided that the AHP commits to undergo such evaluation within 14 days of the suspension. Upon failure to agree to comply with the request within 14 days, the AHP's privileges will be automatically terminated.
6. Failure to complete medical records in a timely fashion, in accordance with the requirements of the Medical Staff Bylaws, Chapter 3 and Hospital Policy, shall result in automatic suspension of all clinical privileges until such time as completion has occurred.
7. Failure to maintain the minimum professional liability insurance coverage as provided in Article V, Section 2 shall result in automatic suspension of clinical privileges, unless the AHP has requested a waiver of such requirement from the Board and is awaiting final action on such request.
8. Temporary or permanent exclusion or suspension from participation in any federal program shall result in automatic termination of privileges.

9. Lack of patient care activity during the previous two OPPE evaluations shall result in automatic termination of privileges.
  10. Failure to acquire certification, within the timeframe established in this Policy shall result in automatic termination of privileges unless the AHP has requested waiver of such requirement from the Board and is awaiting final action on such request.
  11. Failure to maintain a Supervising Practitioner shall result in automatic termination of privileges.
  12. Failure to request a return to active practice after a one-year Leave of Absence, in accordance with Article IX, Section 1, of this Policy will result in automatic termination of privileges.
- B. Upon the occurrence of any of the foregoing events, the Administrator, or her/his designee, shall promptly give Notice of the automatic termination or suspension to the affected AHP, and the specific grounds for the termination/suspension. Within ten (10) days of receipt of such Notice, the affected AHP may present written evidence to the Administrator that negates the grounds for the automatic suspension or termination. If the Administrator determines, in his/her sole discretion, that the written evidence is sufficient to negate the grounds for the automatic suspension or termination, s/he shall give Notice to the affected AHP and the automatic suspension or termination shall be considered void from the beginning. Unless otherwise provided in this section, any automatic suspension that is not corrected within thirty days shall result in automatic termination, without further notice. Automatic terminations not immediately effected due to a pending request for a Board waiver will take effect immediately upon denial of the request.
- C. Practitioners terminated due to lack of clinical activity or failure to return application and materials will not be able to reapply to UF Health Shands for a period of one year.
- D. It is the responsibility of the COS and the Administrator to enforce all automatic suspensions and terminations.

## **SECTION 7. CONFIDENTIALITY AND REPORTING**

All minutes, reports, recommendations, communications, and actions made or taken pursuant to this Policy are deemed confidential and/or privileged pursuant to federal and/or state statutes providing protection to peer review or other patient safety related activities and to such policies regarding confidentiality as may be adopted by the Hospital. Furthermore, the committees and/or panels charged with making reports, findings, recommendations or investigations pursuant to this Policy shall be considered to be acting on behalf of the Hospital and its Board when engaged in such professional review activities and thus shall be deemed the "professional review bodies" as that term is defined in the Health Care Quality Improvement Act of 1986.

Reports of actions taken pursuant to this Policy shall be made by the Administrator to such governmental agencies as may be required by law.

## ARTICLE XV – HEARING AND APPEAL PROCESS

### SECTION 1. PRELIMINARY MATTERS

- A. There shall be no right of review with regard to elimination or change in privileges resulting from a determination by the Hospital regarding allocation or elimination of clinical services or approved AHP categories.
- B. If an AHP is the subject of any of the following recommended actions by the MEC, the AHP shall have the right for a review of such recommended action under the Hearing and Appeal process before the recommended action goes to the Board for its consideration:
  - 1. Denial of requested clinical privileges;
  - 2. Decrease or termination of clinical privileges;
  - 3. Suspension of clinical privileges for thirty (30) days or more; or
  - 4. Mandatory concurring consultation except where such consult is with the Supervising Practitioner.
- C. Recommendations for, or imposition of, any of the following actions by the MEC or the Board do not constitute grounds for a hearing:
  - 1. Denial of all clinical privileges based on an inability to meet any one of the minimum objective criteria for clinical privileges set forth in Article IV;
  - 2. Automatic suspension or termination of privileges pursuant to Article XIV, Section 6;
  - 3. Summary suspension pursuant to Article XIV;
  - 4. Denial or termination of temporary privileges under Article VII;
  - 5. Requirement for supervision or observation of an AHP that does not restrict the clinical privileges of the AHP;
  - 6. A general consultation or corrective counseling requirement;
  - 7. Issuance of a letter of warning, admonition or reprimand;
  - 8. Denial of a request for clinical privileges on the basis that approval would contravene the terms of an exclusive agreement between the Hospital and any other party; and
  - 9. Denial of a request to be granted privileges to perform a procedure or service not currently provided at the Hospital.
- D. The Administrator shall promptly give Notice to the subject AHP in the event any recommendation is made that gives rise to the Hearing and Appeal Process. This Notice shall specify the recommendation made and the general reasons for the recommendation and provide the AHP with a copy of the Hearing and Appeal Process.
- E. The affected AHP shall have thirty (30) calendar days from receipt of the Notice to request a hearing in writing delivered to the Administrator.
- F. Failure to request a hearing in the time and manner specified herein shall be deemed a waiver of the affected AHP's right to a hearing on the recommendation and shall be considered an acceptance of the recommendation, which recommendation shall go to the Board and any action taken by the Board shall be deemed final.

## SECTION 2. THE HEARING

- A. Within fifteen (15) days of the Administrator's receipt of a timely request for a hearing, the Administrator shall:
1. Appoint a Hearing Officer, who may or may not hold clinical privileges at the Hospital, so long as the Hearing Officer is not in direct economic competition with the AHP or his/her Supervising Practitioner; and
  2. Schedule the hearing and give Notice to the AHP of the hearing time, place, and date. The Notice shall also inform the AHP of the general nature of the support for the recommendation and a list of expected witnesses. The hearing shall begin as soon as practicable but no sooner than thirty (30) days from the date of Notice of the hearing, unless an earlier hearing date has been mutually agreed to in writing.
- B. Within fifteen (15) days of the Notice of the hearing, the affected AHP or applicant shall provide a written list of names of the persons expected to give testimony or present evidence at the hearing on the AHP or applicant's behalf. The witness list of either party may be supplemented or amended at any time prior to the hearing, so long as there is adequate notice to the other party.
- C. Postponement of the hearing beyond the time originally noticed may be mutually agreed to by both parties, or if an agreement cannot be reached, upon written request to the Hearing Officer who may grant at his/her sole discretion.
- D. The personal presence of the affected AHP at the hearing shall be required. Failure of the affected AHP to appear and remain present for the hearing, without good cause as determined by the Hearing Officer shall be deemed to constitute acceptance of the subject recommendation.
- E. The hearing shall be conducted as informally as possible. Each party has the right to representation at the hearing by an attorney or any other person.
- F. At the hearing, a representative of the MEC shall first present the basis for the recommendation and the information relied upon to support it. The MEC may call witnesses and submit information relevant to its recommendation. The AHP may call witnesses and submit any information relevant to the recommendation. The Hearing Officer shall admit any evidence that it determines to be relevant, which is commonly relied upon by reasonably prudent persons in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law. At the conclusion of the hearing, the Hearing Officer, in his/her sole discretion, may request the submission of written statements from both parties.
- G. The Hearing Officer shall:
1. Act to ensure that the AHP has a reasonable opportunity to be heard and to present relevant witnesses and/or documentary evidence and that decorum is maintained throughout the hearing;
  2. Conduct the hearing according to the general order set forth herein;
  3. Have the authority and discretion to make rulings, consistent with this Policy, on all questions and issues of procedure, relevancy, and admissibility of evidence including subject matter and length of time for questioning witnesses; and
  4. Have the authority to remove any person who is disruptive to the orderly and professional conduct of the hearing.
  5. The Hearing Officer may be advised on procedural matters and compliance with this Policy and



other applicable documents by legal counsel to the Hospital.

- H. An audio tape or minutes of the hearing, as determined by the Administrator, shall be kept.
- I. Within twenty (20) days after conclusion of the hearing, the Hearing Officer shall render a report to the Administrator containing a written recommendation with a concise summary of the reasons for his/her recommendations.
- J. The affected practitioner has the burden of proving that the recommendation that prompted the hearing was unreasonable, not sustained by the evidence, or otherwise unfounded. Unless s/he so proves, the Hearing Officer shall recommend in favor of the MEC.
- K. The Administrator shall forward the Hearing Officer's report to the Board for final action after the AHP exercises or waives his/her right to an appeal pursuant to Section 3 herein. The Administrator shall send Notice of the recommendation and copy of report to the affected AHP, and his/her Supervising Practitioner, if applicable and the MEC.

An AHP shall not be entitled to more than one hearing with respect to the subject matter of any proposed adverse recommendation or action giving rise to a hearing right. A hearing right provided as to an initial or proposed adverse recommendation or action satisfies the requirements for a hearing right as to the final recommendation or action which is based on the same subject matter.

### **SECTION 3. APPEAL**

- A. Within ten (10) days of receipt of the Notice of an adverse recommendation from the Hearing Officer, the affected AHP may request an appeal of the Hearing Officer's recommendation. The request shall be in the form of a written submission to the Administrator, which submission shall identify the grounds for appeal and detailed, factual support for the grounds alleged. The AHP shall have the burden of demonstrating with clear factual support in the submission that the grounds for appeal are met. The submission shall be delivered to the Administrator via hand-delivery or first class US mail. If an appeal is not timely requested and with the sufficiency and in the manner herein specified, as determined by the Administrator, the affected AHP shall be deemed to have waived his/her right to an appeal and to have accepted the adverse recommendation of the Hearing Officer.
- B. The grounds for an appeal are that the recommendations of the Hearing Officer were:
  - 1. Arbitrary or capricious; or
  - 2. Not supported by the evidence presented at the hearing.
- C. Within fourteen (14) days of receipt of a sufficient request for an appeal, the Administrator shall schedule and arrange for an appellate review. The date of appellate review shall not be less than twenty (20) days, or more than thirty (30) days, from the date of receipt of the request. The Administrator shall give the affected AHP Notice of the time, place, and date of the appellate review. The time and date for appellate review may be extended for good cause as determined by the Administrator.
- D. The Administrator shall appoint a Review Panel composed of not less than three (3) persons without any prior involvement in the subject matter of the appeal and may include reputable persons outside the Hospital to consider the appeal.

- E. The Administrator shall designate a Chairman of the Review Panel. The majority of the members of the Review Panel must be present when the Panel meets. The Chairman of the Review Panel may, without special notice, adjourn and reconvene meeting(s) of the Review Panel at the convenience of the participants.
- F. The purpose of the appeal and the task of the Review Panel are to ascertain whether the recommendation of the Hearing Officer is supported by evidence submitted at the hearing. The Review Panel shall review the Hearing Officer's recommendation, the hearing minutes, and all evidence submitted at the hearing prior to making its determinations and recommendations to the Board. The Review Panel shall not accept additional evidence. The Review Panel may, in its sole discretion, invite the affected AHP to appear and make a brief statement.
- G. The Review Panel shall uphold the recommendation of the Hearing Officer, unless it finds that the Hearing Officer's recommendation was not supported by evidence presented at the hearing or was arbitrary or capricious. It shall not be the role of the Review Panel to substitute its judgment for that of the Hearing Officer but to determine whether or not the Hearing Officer's recommendation is supported by evidence presented to it at the hearing.
- H. Within twenty-one (21) days of the date of the Review Panel's last meeting, the Review Panel shall forward its written recommendation and reasons for its recommendation to the Administrator. Agreement by a majority of all the members of the Review Panel shall be required for the issuance by the Panel of any recommendation.
- I. Upon its receipt, the Administrator shall forward the Review Panel's recommendation to the Hearing Officer, the MEC, the affected AHP, and the Supervising Practitioner, if applicable. The Board shall consider the Review Panel's recommendation at its next regular meeting.

#### **SECTION 4. FINAL BOARD ACTION**

- A. The Board may affirm, modify, or reverse the recommendation presented to it for final action, after exhaustion or waiver of hearing and appeal rights.
- B. Final Board action shall be taken at the meeting following the exhaustion or waiver of hearing and appeal rights. The Administrator shall provide Notice of the final Board action to the affected AHP, the Supervising Practitioner, if applicable, the panel providing the recommendation, and the MEC.
- C. The decision of the Board with regard to any recommendation is final, shall be effective immediately, and shall not be subject to further review.
- D. In the event that the Board revokes or terminates the AHP's clinical privileges, that AHP may not again apply for clinical privileges at this Hospital for a period of five (5) years, unless the Board provides otherwise in its written final decision.

## **ARTICLE XVI – AMENDMENTS**

### **SECTION 1. INITIATION**

The Board, the MEC or Credentials Committee may initiate amendments to this policy. If initiated by the Board or MEC, proposed amendments must be provided to the Credentials Advisory SubCommittee and Credentials Committee for comments prior to the Medical Executive Committee's vote on the proposed amendment. Except that, the following types of amendments may be initiated by the Board or MEC and adopted without prior notice to or comment from the Credentials Advisory SubCommittee or Credentials Committee:

- A. Amendments that are technical or legal clarifications;
- B. Amendments that are required in order to comply with any federal, state, or local law or regulation, or with The Joint Commission or other accrediting agency standards, as appropriate;
- C. Amendments made to conform to approved Medical Staff Bylaws; or
- D. Amendments that are merely for the purpose of reorganization, renumbering, or correcting references, or to correct punctuation, spelling, or other errors of grammar or expression.

### **SECTION 2. MEDICAL EXECUTIVE COMMITTEE RECOMMENDATION**

Amendments may be recommended to the Board upon a majority vote of the members of the Medical Executive Committee present and voting at any meeting of that committee where a quorum exists.

### **SECTION 3. ADOPTION**

An amendment shall be effective upon adoption by the Board.