Virginia Mason Franciscan Health

FRANCISCAN MEDICAL STAFF CREDENTIALS MANUAL

St. Anne Hospital, St. Anthony Hospital,
St. Clare Hospital, St. Elizabeth Hospital,
St. Francis Hospital, St. Joseph Medical Center

Effective March 9, 2023

FRANCISCAN
CREDENTIALS MANUAL

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PURPOSE

The Credentials Manual outlines the uniform Credentialing process and the mechanism for granting appointment and reappointment to the Medical Staff as well as the process of evaluating and granting initial Clinical Privileges and renewal of Clinical Privileges for individual applicants. This Credentials Manual is incorporated into the Bylaws and is subject to the approval of the Medical Executive Committee and the Board.

DEFINITIONS

The definitions provided in the Medical Staff Bylaws shall apply to this Credentials Manual.

ARTICLE I. PROCEDURE FOR APPOINTMENT TO THE MEDICAL STAFF

SECTION 1. GENERAL

1.1. The Medical Staff Services Office collects and verifies data used in Credentialing and Privileging.

1.2. A separate credentials file is maintained for each individual requesting Medical Staff membership, Clinical Privileges and/or Scope of Practice.

1.3. Detailed Desktop Procedures are maintained in the MSSO and may be amended by the Regional Credentials Committee in order to meet regulatory requirements or other modifications deemed to be in the best interest of the Medical Staff, MSSO, and/or organization.

SECTION 2. INITIAL APPLICATION

2.1. The initial application for the Medical Staff Clinical Privileges and/or Scope of Practice shall be in writing or via electronic application, signed by the applicant, and submitted on a form specified by the Health System. The Health System may accept an Electronic Signature as defined in the Bylaws. The application form shall require detailed information concerning the applicant's Basic Qualifications, General Qualifications in accordance with Article I of the Bylaws and the Washington Practitioner Application, and any information necessary to support the request for Privileges or Scope of Practice.

2.2. The initial application shall include the following information:

2.2.1. Complete and current information regarding each element of the Basic Qualifications and General Qualifications as defined in the Bylaws, and any information necessary to support the request for Privileges or Scope of Practice, including without limitation, current unrestricted Washington State license, education, training, experience, current competence, board certification, health status, professional liability insurance coverage and claims experience, other hospital affiliation(s), previously successful and currently pending challenges to any licensure or registration (State or Drug Enforcement Administration), the voluntary or involuntary relinquishment of such licensure or registration.

2.2.2. A signed release and immunity from civil liability statement.

2.2.3. A signed release for the disclosure of information that consents to the inspection of records, and authorizes and requests that the MSSO at the Health System verify the applicant’s credentials.

2.2.4. A signed attestation that the applicant has read and agrees to comply with the Disruptive Behavior Policy.

2.2.5. A signed attestation that the applicant has read and agrees to comply with the Standards and Expectations for Medical Staff Communication Policy.

2.2.6. A signed attestation that the applicant has read and agrees to comply with the Medical Staff Compact.

2.2.7. Completion of a new privilege form with documentation supporting any request for new Privileges or Scope of Practice.

2.2.8. Statement regarding whether or not the applicant has been involved in disciplinary actions from any medical, dental or podiatric board or medical society.

2.2.9. Statement regarding whether or not the applicant has been charged in any criminal proceedings in accordance with the Washington Practitioner Application.

2.2.10. Statement as to whether or not the applicant's clinical privileging status, medical/dental/podiatric staff status, or appointment at any health care facility, has been revoked, denied, restricted reduced, suspended, terminated or granted with stated limitations or conditions.

2.2.11. Health statement indicating whether or not the applicant can safely perform the essential functions of the position for which the applicant is requesting Privileges with or without reasonable accommodation.

2.2.12. A minimum of two (2) references from professional peers who have personal knowledge of and are directly familiar with the applicant's professional competency.

2.2.13. Current contact information in accordance with Article I Section 3 below, including without limitation, physical address, email address, cell phone number, fax number (if applicable).

2.3. Initial applications for appointment to the Medical Staff, or for Privileges or Scope of Practice are reviewed by the Medical Staff leaders and Committees, and approved by the Board in accordance with the Bylaws.

2.4. The MSSO shall verify from primary sources the information provided by the applicant and collect additional information wherever necessary. Verifications will include but are not limited to:

2.4.1. Verification of all current and past ten (10) years' state medical or professional license(s) from primary sources. Washington State licenses shall also be verified at the time of expiration of the then current Washington State license.

2.4.2. Verification of a current Federal Drug Enforcement Agency (DEA) number with a Washington State address (if applicable) from primary sources. A current DEA number with a Washington State address will also be verified at the time of expiration of the then current DEA registration.

2.4.3. Information held by the Secretary of the Department of Health and Human Services or agency designated by the Secretary; pursuant to the Health Care Quality Improvement Act of 1986 including the National Practitioner Data Bank and Medicare/ Medicaid Sanctions.

2.4.4. Verification from primary sources of medical/professional education and training; internship; residency; fellowship; specialty board (where applicable); malpractice history, current and previous five (5) years' hospital affiliations, professional peer references, military experience, current and past employment (if relevant), and obtain the Washington State Patrol background check.

2.4.5. Information concerning the applicant's professional ethics, current competence, clinical judgment, clinical and technical skills, physical and mental health, and relationships with patient, peers, hospital and Medical Staff. A statement regarding whether or not the applicant has accepted voluntary or involuntary relinquishment of license, DEA registration, Medical Staff membership, voluntary or involuntary limitation, reduction, or loss of Clinical Privileges or Scope of Practice at any health care facility.

2.4.6. Any adverse or derogatory information that could adversely affect the harmonious relationship with the Medical Staff.

2.5. Upon completion of the application, verification of its contents and receipt of additional information, the credentials file with all related materials will be forwarded to the appropriate Department Head for evaluation.

2.5.1. A completed application is one where all of the information required under Article I Section 2.2 above is provided to the MSSO. The MSSO may consult with the Chief Medical Officer for any questions regarding a complete or incomplete application. If the required information is determined to be missing or incomplete by the MSSO, Department Head, or the Regional Credentials Committee, the application is considered incomplete. A completed application may become incomplete at any time if the need arises for new, additional, or clarifying information.

2.5.2. As a part of the process of evaluating an applicant, and in accordance with the Health System Well-Being Policy, the Regional Credentials Committee may require that an applicant undergo an examination or assessment by a program supervised by the WPHP or other health care professional(s) that is mutually acceptable to the Regional Credentials Committee and the applicant. If a mutually acceptable health care professional cannot be agreed upon within seven (7) days from receipt of the request from the Regional Credentials Committee, then the Regional Credentials Committee shall select a health care professional acceptable to the Regional Credentials Committee. The applicant will be required to execute a release allowing the Regional Credentials Committee to discuss with the health care professional(s) the reasons for the examination or assessment and allowing the health care professional to discuss and report the results of the examination or assessment to the Regional Credentials Committee. If the requested examination or assessment is not completed within thirty (30) days from receipt of the request from the Regional Credentials Committee, the application will be considered withdrawn, and the applicant will be so notified, provided however, the Regional Credentials Committee may extend the time frame for completion of the examination or assessment if the applicant has used best efforts to schedule the assessment or examination and the delay is solely the result of the availability of the selected health care provider.

2.6. Within fifteen (15) days of the final decision of the Board, the Chief Executive Officer, or a representative of the Board, shall inform the applicant in writing of the Board’s decision.

SECTION 3. CONTACT INFORMATION

3.1. To facilitate contact regarding patient care and correspondence related to the business of the organized Medical Staff, regardless of staff category, members of the Medical Staff and other Practitioners granted Privileges and Allied Health Professionals are required to provide the Health System with current and accurate:

3.1.1. Office mailing address (if applicable)

3.1.2. Office contact numbers (telephone, fax, and backline) (if applicable)

3.1.3. Cell phone and/or pager numbers

3.1.4. E-mail address

3.1.5. Home address and telephone number (for disaster plan)

3.1.6. Detailed information for after office hours contact preferences

3.2. This information is to be provided at appointment, reappointment and within 30 days of any changes to the MSSO and updated, as needed, thereafter with the MSSO.

3.3. The MSSO will maintain the contact information in the Medical Staff data base in a secure and confidential manner. It may only be made available to those individuals or entities with a bona fide need to access the information.

ARTICLE II. PROCEDURE FOR REAPPOINTMENT

SECTION 1. REAPPOINTMENT GENERALLY

1.1. The application for renewed Medical Staff membership, Clinical Privileges and/or Scope of Practice shall be in writing or via electronic application, signed by the applicant, and submitted on a form specified by the Health System. The Health System may accept an Electronic Signature as defined in the Bylaws. The application form shall require detailed information concerning the applicant's Basic Qualifications, General Qualifications in accordance with Article I of the Bylaws, and any information necessary to support the request for Privileges or Scope of Practice, in the same manner as Article I, Section A above, except for static information (e.g., education).

1.2. Applications for reappointment to the Medical Staff, and/or for renewed Privileges or Scope of Practice are reviewed by the Medical Staff leaders and Committees, and approved by the Board in accordance with the Bylaws.

1.3. By applying for reappointment to the Medical Staff, and/or for renewed Privileges or Scope of Practice, each applicant signs a release for information that consents to the inspection of records, authorizes and requests that the MSSO at the Health System verify the applicant’s credentials. The release for information is a part of a complete application.

1.4. The MSSO shall verify from primary sources the information provided by the applicant and collect additional information wherever necessary. Verifications for any change since the initial application will include but are not limited to the following information:

1.4.1. Verification of all current state medical or professional license(s) from primary sources. Washington State licenses shall also be verified at the time of expiration of the then current Washington State license.

1.4.2. Verification of current DEA number with Washington State address (if applicable) from primary sources. A current DEA number with a Washington State address will also be verified at the time of expiration of the then-current DEA registration.

1.4.3. Information held by the Secretary of the Department of Health and Human Services or agency designated by the Secretary; pursuant to the Health Care Quality Improvement Act of 1986 including the National Practitioner Data Bank and Medicare/ Medicaid Sanctions.

1.4.4. Verification from primary sources of information, including malpractice history, current and previous hospital affiliations, professional peer references, military experience, current and past employment (if relevant), and obtain the Washington State Patrol background check.

1.4.5. Information concerning the applicant's professional ethics, current competence, clinical judgment, clinical and technical skills, physical and mental health, and relationships with patient, peers, hospital and Medical Staff. A statement regarding whether or not the applicant has accepted voluntary or involuntary relinquishment of license, DEA registration, Medical Staff membership, voluntary or involuntary limitation, reduction, or loss of Clinical Privileges at any health care facility.

1.4.6. Any adverse or derogatory information that could adversely affect the harmonious relationship with the Medical Staff including without limitation peer review experience, FPPE, OPPE, and incident reports.

1.5. Upon completion of the application, verification of its contents and receipt of additional information, the credentials file with all related materials will be forwarded to the appropriate Division Chair or Department Head or designee for evaluation.

1.5.1. A completed application for reappointment is one where all of the information required under Article II Section 2.1 below is provided to the MSSO. The MSSO may consult with the Chief Medical Officer for any questions regarding a complete or incomplete application. If the information is determined to be missing or incomplete by the MSSO, the Department Head, or the Regional Credentials Committee, the application is considered incomplete. A completed application may become incomplete at any time if the need arises for new, additional, or clarifying information.

1.5.2. As a part of the process of evaluating an applicant, and in accordance with the Health System Well-Being Policy, the Regional Credentials Committee may require that an applicant undergo an examination or assessment by a program supervised by the WPHP or other health care professional(s) that is mutually acceptable to the Regional Credentials Committee and the applicant. If a mutually acceptable health care professional cannot be agreed upon within seven (7) days from receipt of the request from the Regional Credentials Committee, then the Regional Credentials Committee shall select a health care professional acceptable to the Regional Credentials Committee. The applicant will be required to execute a release allowing the Regional Credentials Committee to discuss with the health care professional(s) the reasons for the examination or assessment and allowing the health care professional to discuss and report the results of the examination or assessment to the Regional Credentials Committee. If the requested examination or assessment is not completed within thirty (30) days from receipt of the request from the Regional Credentials Committee, the application will be considered withdrawn, and the applicant will be so notified, provided however, the Regional Credentials Committee may extend the time frame for completion of the examination or assessment if the

applicant has used best efforts to schedule the assessment or examination and the delay is solely the result of the availability of the selected health care provider.

SECTION 2. APPLICATION FOR REAPPOINTMENT

2.1. The reappointment application shall include the following information:

2.1.1. Complete and current information regarding each element of the Basic Qualifications and General Qualifications as defined in the Bylaws, including without limitation, current license, health status changes, professional liability insurance coverage and experience, other hospital affiliation(s), previously successful and currently pending challenges to any licensure or registration (State or Drug Enforcement Administration), the voluntary or involuntary relinquishment of such licensure or registration.

2.1.2. A signed release and immunity from civil liability statement.

2.1.3. A signed release for the disclosure of information that consents to the inspection of records, and authorizes and requests that the MSSO at the Health System verify the applicant's credentials.

2.1.4. Completion of a new privilege form with documentation supporting any request for new Privileges or Scope of Practice.

2.1.5. Statement regarding whether or not the applicant has been involved in disciplinary actions from any medical, dental or podiatric board or medical society.

2.1.6. Statement regarding whether or not the applicant has been charged in any criminal proceedings in accordance with the Washington Practitioner Application.

2.1.7. Statement as to whether or not the applicant's clinical privileging status, medical/dental/podiatric Staff status, or appointment at any health care facility, has been revoked, denied, restricted reduced, suspended, terminated or granted with stated limitations or conditions.

2.1.8. Health statement indicating whether or not the applicant can safely perform the essential functions of the position for which the applicant is requesting Privileges with or without reasonable accommodation.

2.1.9. A minimum of one (1) reference from a professional peer who has personal knowledge of and is directly familiar with the applicant's professional competency.

2.1.10. Current contact information in accordance with Article I Section 3 above, including without limitation, physical address, email address, cell phone number, fax number (if applicable).

2.2. By applying for reappointment to the Medical Staff, and renewal or revision of Clinical Privileges on the Medical Staff, each applicant agrees to the same conditions outlined in Article I Section 2 of this manual.

2.3. Upon completion of the verification process of the reappointment application, the following information will be considered for reappointment and renewal or revision of Clinical Privileges:

2.3.1. Professional ethics, competence, and clinical judgment in the treatment of patients.

2.3.2. Physical and mental health status.

2.3.3. Compliance with Hospital and Health System policies, and Medical Staff Bylaws, Rules and Regulations and the procedural policies and the Ethical and Religious Directives for Catholic Health Facilities.

2.3.4. Cooperation and relations with other Practitioners, and general attitude toward patients, the Hospital and the public.

2.3.5. Satisfactory completion of continuing education requirements as may be imposed by the law, this Health System or applicable accreditation agencies.

2.3.6. Individual's clinical and technical skills as indicated in part by the results of performance improvement or other monitoring functions.

2.3.7. Voluntary or involuntary termination of Medical Staff membership or voluntary or involuntary limitation, reduction, or loss of Clinical Privileges at this or another health care facility.

2.3.8. Other reasonable indicators of continuing qualifications including information found in the individual's credentials file.

2.3.9. Current professional liability insurance status, pending malpractice challenges, including claims, lawsuits, judgments and settlements.

2.3.10. Information from the National Practitioner Data Bank; Medical Board; Medicare or Medicaid sanctions or reports.

2.3.11. Ongoing Professional Practice Evaluation data.

2.3.12. Focused Professional Practice Evaluation data.

2.4. The MSSO will provide reappointment profile(s) reflecting statistical and clinical activity data, performance evaluation, improvement and peer review information to support the renewal of Clinical Privileges. The information will be considered at the time of reappointment. The information may include but is not limited to:

2.4.1. Outcomes of performance improvement activities.

2.4.2. Non-use of Privileges for high-risk procedure or treatment over a period of two (2) years.

2.4.3. Hospital utilization review data; infection control, drug usage review and blood usage review statistics.

2.4.4. Any unfavorable outcomes that have been attributed to the Practitioner's knowledge, skill, or judgment based on findings and conclusions of peer review actions.

2.4.5. Ongoing Professional Practice Evaluation data.

2.4.6. Focused Professional Practice Evaluation data.

SECTION 3. LEAVE OF ABSENCE (LOA)

3.1. A Medical Staff Member or Allied Health Professional may, for good cause, be granted a leave of absence by the Board for a definite stated period of time not to exceed one (1) year. An absence for longer than one (1) year will constitute an automatic resignation of Medical Staff appointment or Allied Health Professional status, as applicable, and termination of Clinical Privileges or Scope of Practice, unless an exception is made by the Board.

3.1.1. A request for a leave of absence, and the reason for the leave, including military duty, shall be made in writing to the President of the Medical Staff, the Chief Executive Officer of the Health System, or the Chief Medical Officer or their designee at least 30 days prior to the anticipated start of the leave unless the leave is precipitated by urgent circumstances.

3.1.2. Even if a Medical Staff Member or Allied Health Professional has been granted a Leave of Absence by their employer, it is still necessary to separately request a leave of absence from the Medical Staff.

3.1.3. The request shall state the beginning and ending dates, if known.

3.1.4. Concurrence of the Department Head is recommended.

3.1.5. A Medical Staff Member or Allied Health Professional must notify the MSSO in writing, but is not required to request a leave of absence if:

a. The Medical Staff Member or Allied Health Professional will be away from Medical Staff and/or patient care responsibilities for longer than 30 days and less than 120 calendar days. The Medical Staff Member or Allied Health Professional will be excused from Medical Staff and Allied Health Professional responsibilities (e.g. meeting attendance, committee service, and emergency service call obligations) during this period, but will not be subject to the reinstatement process set forth in Sections II and 3.1.14 below.

b. The Medical Staff Member or Allied Health Professional will be away from Medical Staff and/or patient care responsibilities for less than 30 calendar days and the reason for the leave of absence is related to physical or mental health, except for maternity leave related to an uncomplicated labor and delivery. The Medical Staff Member or Allied Health Professional must provide all health assessment documentation requested by the Campus Chief of Staff or the Medical Executive Committee.

3.1.6. A Medical Staff Member or Allied Health Professional must request a leave of absence in writing if:

a. The Medical Staff Member or Allied Health Professional will be away from Medical Staff and/or patient care responsibilities for longer than 120 calendar days.

b. The Medical Staff Member or Allied Health Professional will be away from Medical Staff and/or patient care responsibilities for longer than 30 calendar days and the reason for the leave of absence is related to physical or mental health, except for maternity leave related to an uncomplicated labor and delivery.

3.1.7. During this leave, the Medical Staff Member or Allied Health Professional may not exercise any clinical Privileges or/Scope of Practice and will be excused from Medical Staff and Allied Health Professional responsibilities (e.g. meeting attendance, committee service, and emergency service call obligations) during this period.

3.1.8. Required expired items that come due during the leave of absence will not be required until reinstatement of Privileges or Scope of Practice (e.g. annual TB health testing, current malpractice certificate, alternate coverage arrangements).

3.1.9. If a Medical Staff Member or Allied Health Professional is incapacitated or unavailable to submit the leave of absence request, their designee may submit the leave of absence request on behalf of the Medical Staff Member or Allied Health Professional.

3.1.10. The Medical Executive Committee will consider the leave of absence request at its next regularly scheduled meeting and shall recommend approval or denial to the Board.

3.1.11. If a leave of absence request is submitted at any point during a potential corrective action or suspension, the corrective action or suspension may continue during the leave of absence.

3.1.12. In the event that a leave of absence request is denied, the Medical Staff Member or Allied Health Professional can either continue their Medical Staff appointment or Allied Health Professional status with Privileges, or resign Medical Staff membership or Allied Health Professional status.

3.1.13. Before a leave of absence is granted, the Medical Staff Member or Allied Health Professional must have completed all medical records and fulfilled any other Medical Staff/Allied Health Professional obligation required as a condition of membership on the Medical Staff or Allied Health Professional status, unless the Medical Staff Member or Allied Health Professional is incapacitated or unavailable to fulfill the obligations.

3.1.14. Prior to returning from leave, the Medical Staff Member or Allied Health Professional must submit a request for reinstatement with a written summary of professional activities during their leave. The Medical Staff Member or Allied Health Professional

must also provide current documentation of expired items along with any other information requested by the hospital.

3.1.15. At the conclusion of the leave of absence, the Medical Staff Member or Allied Health Professional may be reinstated, through the reappointment process. The Medical Staff Member or Allied Health Professional shall document professional activity during leave of absence period. Temporary Clinical Privileges are only granted as a courtesy and shall only be considered if the Medical Staff Member or Allied Health Professional meets any of the following circumstances:

a. To fulfill an important patient care need, or

b. When a Medical Staff Member or Allied Health Professional with a complete, clean application is awaiting review and approval of the Medical Executive Committee and the Board.

3.1.16. If the leave of absence was for health reasons, except for maternity leave related to an uncomplicated labor and delivery as attested to by the Member, the request for reinstatement must be accompanied by health assessment documentation from the provider's physician indicating the provider is physically and mentally capable of resuming a hospital practice, as applicable, and can safely exercise the clinical Privileges/Scope of Practice requested.

3.1.17. If the Medical Staff Member's or Allied Health Professional's then-current Medical Staff membership, Privileges, or Scope of Practice, as applicable, will expire during the requested leave of absence, the Medical Staff Member or Allied Health Professional may submit an early application for reappointment in advance of the start of the leave of absence.

3.1.18. The Medical Staff Member's or Allied Health Professional's failure to return a completed application for reappointment in accordance with this Credentials Manual and the Bylaws during a leave of absence will result in the Medical Staff Member or Allied Health Professional being deemed to have voluntarily resigned from the Medical Staff and to have relinquished the Medical Staff Member's or Allied Health Professional's Medical Staff membership, Privileges, and/or Scope of Practice, as applicable, on the date the applicant's then-current appointment and Privileges expire. The former Medical Staff Member's or Allied Health Professional may reapply for Medical Staff membership, Clinical Privileges and/or Scope of Practice, and the application will be processed as a new applicant without seniority.

ARTICLE III. CLINICAL PRIVILEGES OR SCOPE OF PRACTICE

SECTION 1. CLINICAL PRIVILEGES OR SCOPE OF PRACTICE

1.1. Every Practitioner or Allied Health Professional at the Health System by virtue of Medical Staff membership or otherwise, in connection with such practice, shall be entitled to exercise those Clinical Privileges or Scope of Practice specifically granted to the Practitioner or AHP by the Board.

1.2. Every application for initial appointment or reappointment must contain a request for Clinical Privileges or Scope of Practice (excluding the Affiliate or Honorary Category)

submitted on the appropriate delineation of Privilege form. The evaluation of such requests shall be based upon the applicant's current license, relevant education and training, evidence of ability to perform the requested Privileges, experience, demonstrated competence, peer and/or facility recommendations, data from professional practice review by an organization(s) that currently privileges the applicant, references and other relevant information. When renewing Privileges, review of the Practitioner's performance within the organization is performed. The applicant shall have the burden of establishing the applicant's qualifications and competency for the Clinical Privileges or Scope of Practice requested.

1.3. Periodic renewal or revision of Clinical Privileges or Scope of Practice, as applicable, and the increase or curtailment of same shall be based upon the direct observation of care provided, review of records of patients treated in the Health System Hospitals or other hospitals, and review of OPPE, FPPE, and the records of the Medical Staff that document the evaluation of the member's participation in the delivery of medical/surgical care and information gathered in the performance improvement process of the Hospital.

1.4. Exercise of Clinical Privileges or Scope of Practice will be restricted to those Practitioners or AHP's who have successfully completed training in the use of the electronic health record, imaging, and other clinical software as applicable to the Practitioner's or AHP's Clinical Privileges or Scope of Practice, and in accordance with the System's designated EHR, imaging, and clinical software training processes.

1.5. Professional Practice Evaluation consists of two phases:

1.5.1. Initial Focused Professional Practice Evaluation (FPPE)

a. Initial FPPE consists of an evaluation that will be conducted as set forth by the Medical Staff Professional Practice Evaluation Policy to confirm current competence for the following circumstances:

i. New Appointments: All Practitioners initially appointed to the Medical Staff and all new Independent Allied Health Professionals and Physician Assistants, as outlined in the Bylaws.

ii. New Privilege Requests: All Medical Staff Members and Allied Health Professionals requesting new Privileges not previously requested; when the new requested Privilege is significantly different from current practice.

b. Initial FPPE may include:

i. Monitoring and proctoring of performance as dictated by the Health System Regional Credentials Committee's review of the applicant's request for membership and Privileges. All proctoring must abide by the Health System Professional Proctoring Policy.

ii. Focused review of cases, by volume, outcome, complication rates, returns to the Hospital, post discharge surveillance data all compared to peer group comparisons, and adjusted where possible for acuity.

1.5.2. Ongoing Professional Practice Evaluation (OPPE) shall be carried out as set forth by the Medical Staff Professional Practice Evaluation Policy and may consist of:

a. Ongoing review of cases, by volume, outcome, complication rates, returns to the Hospital, average length of stay, average cost by case, post discharge surveillance data- all compared to peer group comparisons, and adjusted where possible for acuity

b. Review of participants peer review experience, grievances, incident reports, litigation/claims, patient satisfaction data, and CMS Core Measures report cards.

c. OPPE may be performed concurrent with the reappointment cycle but must meet the timelines as set forth by the Medical Staff OPPE Policy and Procedure. The data used is presented to the Department Head, the Chief Medical Officer (or designee), and available to the Regional Credentials Committee.

1.5.3. For Cause FPPE, if appropriate, will be conducted in accordance with Article VII Section 6.4.8 of the Bylaws and the Medical Staff Professional Practice Evaluation Policy.

SECTION 2. REQUEST FOR ADDITIONAL CLINICAL PRIVILEGES OR SCOPE OF PRACTICE

2.1. Requests for additional Privileges or Scope of Practice may be made at any time. The request shall be made in writing on the appropriate Privilege form. The request shall state in detail the specific additional Clinical Privileges or Scope of Practice desired and the appointee's relevant recent training and experience which justify increased Privileges or Scope of Practice. The request for additional Privileges or Scope of Practice will be processed in the same manner as an initial application. Each applicant agrees to the same conditions outlined in Article I, Section 2 of this Manual.

2.2. The Regional Credentials Committee will require Initial FPPE for any Additional Clinical Privileges or Scope of Practice granted.

2.3. The Regional Credentials Committee may require proctoring as part of Initial FPPE for any additional Privilege or Scope of Practice. This requirement will be based upon the complexity of the subject procedure, risks involved, and similarity or dissimilarity to procedures for which the Practitioner or Allied Health Professional is currently Privileged. At the completion of each proctored case, the proctoring provider will be required to complete and submit a proctor report regarding the competence of the proctored Medical Staff Member or Allied Health Professional in the subject procedure.

2.4. The Health System will verify current state medical or professional license(s) from primary sources and will query the National Practitioner Data Bank for requests for additional Privileges or Scope of Practice.

2.5. Recommendation for additional Clinical Privileges or Scope of Practice made to the MEC and the Board shall be based upon the same criteria as for initial Clinical Privileges, including:

2.5.1. Relevant recent training and/or education for the additional Clinical Privileges or Scope of Practice;

2.5.2. The Practitioner's OPPE and any FPPE results for current Clinical Privileges or Scope of Practice; and

2.5.3. Any other reasonable indicators of the Medical Staff Member's or Allied Health Professional's continuing qualifications for the additional Clinical Privileges or Scope of Practice requested.

SECTION 3. PROCTOR QUALIFICATIONS

3.1. Proctoring is defined in the Health System Professional Practice Evaluation Policy.

3.2. A proctor must be a Practitioner, ARNP, or PA subject to appropriate physician supervision who has recognized proficiency or documented expertise in the specialty area being proctored. In order to be eligible to be a proctor at the Health System, Practitioners, ARNPs, or PAs must meet one of the following criteria:

3.2.1. Be a member of the Active or Associate Medical Staff, or an ARNP or PA with appropriate skills and training, in Good Standing with Clinical Privileges for the Privileges being proctored.

3.2.2. Apply for and be granted Temporary Privileges for the Privileges being proctored, and hold privileges for the Privilege they will proctor at an accredited health care facility.

3.2.3. Proctoring may be performed outside of the Health System facilities under circumstances where it is not practical to perform within the Health System facilities. The outside facility and proctor must be approved in advance by the Department Head. Proposed proctors must hold the privilege for the Privileges they will proctor at their own health care facility, and must possess a current unrestricted medical or professional license in the state of Washington or in the state in which the proctoring will take place.

3.3. The subject Practitioner, Independent AHP, or Physician Assistant is solely responsible for all arrangements for the Proctor.

SECTION 4. WAIVED/NON-WAIVED TESTING

By virtue of their medical training, the Medical Staff providers may perform waived testing that falls within the provider's specialty and does not involve an instrument. Medical Staff providers may perform additional waived and non-waived testing based on their medical specialty training if the additional testing Privileges are documented.

ARTICLE IV. ALLIED HEALTH PROFESSIONALS

SECTION 1. ALLIED HEALTH PROFESSIONALS - GENERAL

1.1. Allied Health Professionals are not members of the Medical Staff, and accordingly, have none of the rights of Medical Staff members, except as specified in the Bylaws. The two

categories of Allied Health Professionals are Independent Allied Health Professionals and Dependent Allied Health Professionals, as defined in the Bylaws.

1.1.1. The categories of Independent Allied Health Professionals are defined in the Bylaws.

1.1.2. The categories of Dependent Allied Health Professionals as recommended by the MEC and approved by the Board are defined in Addendum A.

1.1.3. Independent AHPs and Physician Assistants must meet the same Basic Qualifications and General Qualifications for Medical Staff membership set forth in Article 1 Sections 2 and 3 of the Bylaws, as modified to reflect the more limited practice, license and certification, and Privileges of the Independent AHP or Physician Assistant.

1.1.4. Dependent AHPs, except Physician Assistants, must meet the basic qualifications for Dependent AHPs set forth below, and the same General Qualifications for Medical Staff membership set forth in Article 1, Section 3 of the Bylaws.

1.2. Following recommendations by the Regional Credentials Committees and the Professional Practice Committee, the MEC will recommend Privileges descriptions, including any supervision requirements, for each category of Independent Allied Health Professional and for Physician Assistants, subject to approval by the Board.

1.3. Following recommendations by the Regional Credentials Committees and the Professional Practice Committee, the MEC will recommend Scope of Practice descriptions, including any supervision requirements, for each category of Dependent Allied Health Professional (except Physician Assistants), subject to approval by the Board.

1.4. The MEC may recommend additions or deletions to the categories Dependent Allied Health Professionals (except Physician Assistants), with any new categories accompanied by recommendations for Scope of Practice descriptions, which shall be final upon approval by the Board.

SECTION 2. BASIC QUALIFICATIONS OF DEPENDENT ALLIED HEALTH PROFESSIONALS

2.1. A Dependent AHP, except Physician Assistants, must demonstrate continuous compliance with each of the basic qualifications set forth in this section in order to have an application for Scope of Practice accepted for review, and to maintain Scope of Practice. The Dependent AHP, except Physician Assistants, must continuously:

2.1.1. Possess a current and unrestricted Washington State license, certification, or other qualification as required by the applicable Scope of Practice.

2.1.2. Demonstrate education and training required for the applicable Scope of Practice.

2.1.3. Have and continuously maintain professional liability insurance coverage, either independently or through the Dependent AHPs medical group coverage, including prior acts coverage for claims made policies that meet the criteria specified by the Board. Minimum professional liability insurance coverage requirements are one

million ($1,000,000) per occurrence, and three million ($3,000,000) annual aggregate for each Dependent AHP.

2.1.4. Not have been convicted of, or entered a plea of guilty or no contest to any felony within the past ten (10) years.

2.1.5. Not have been convicted of, or entered a plea of guilty or no contest to any misdemeanor involving (a) insurance or health care fraud or abuse, (b) violence, physical abuse or exploitation directed at a person, or (c) violation of law pertaining to controlled substances or illegal drugs, unless the Applicant is enrolled and satisfactorily participating in, or has successfully completed, a program supervised by the Washington Physician Health Program (WPHP), or other program approved by the Medical Executive Committee, within the past ten (10) years.

2.1.6. Attest to reading and agrees to comply with the Disruptive Behavior Policy.

2.1.7. Attest to reading and agrees to comply with the Standards and Expectations for Medical Staff Communication Policy.

2.1.8. Be an employee, or subcontractor of the group or person that holds an exclusive or semi-exclusive contract or participates in a closed panel, if requesting Scope of Practice in a Department or service line operated under an exclusive or semi-exclusive contract or a closed panel approved by the Board.

2.1.9. Not be currently excluded or suspended from participation in any federal health care program, including the Medicare, Medicaid, and Tricare programs.

2.1.10. Participate in any vaccination, screening, or personal protective equipment requirements in accordance with Hospital licensure requirements, CMS requirements, accreditation standards, and Health System policy based on the above requirements or standards approved by the Board, unless the Dependent AHP limits their practice to Virtual Health Services and does not furnish services on-site at the Campuses.

2.1.11. Not have been involuntarily dismissed, terminated or summarily suspended from any hospital or had Scope of Practice involuntarily terminated, restricted or summarily suspended by any health facility (including any Health System Campus) for reasons of clinical competence or professional conduct, which action was upheld following waiver or exhaustion of any procedural remedies.

2.1.12. Not have voluntarily resigned or surrendered hospital affiliation, Scope of Practice, or failed to renew Scope of Practice while under investigation or to avoid investigation or other peer review activity by any health facility (including any Health System Campus).

2.1.13. Provide and maintain a valid physical address, email address, and phone number that will be used as the primary methods of communication.

2.1.14. Have an Active or Associate Medical Staff Member to serve as Sponsor or supervising/collaborating Practitioner, as required by the Scope of Practice.

2.2. A Dependent AHP, except a Physician Assistant, who does not meet the basic qualifications above is ineligible to apply for Scope of Practice, and the application shall not be accepted for review. If it is determined during the processing that an applicant does not meet all of the basic qualifications, the review of the application shall be discontinued. An applicant who does not meet the basic qualifications above is not entitled to the procedural rights set forth in this Credentials Manual.

2.3. The Board has discretion to deem a Dependent AHP, except a Physician Assistant, to have satisfied a basic qualification above only in the following situations.

2.3.1. The Dependent AHP has the burden and has demonstrated by clear and convincing evidence that the Dependent AHP has substantially comparable qualifications;

2.3.2. Waiving the qualification is not inconsistent with applicable laws and accreditation standards;

2.3.3. Waiving the qualification is necessary to serve the best interests of the patients and the System; and

2.3.4. Waiving the qualification fulfills an important patient care need, treatment, or service.

2.4. There is no obligation to grant any such waiver, and Dependent AHPs have no right to have a waiver considered or granted. A Dependent AHP who is denied a waiver or consideration of a waiver shall not be entitled to any grievance process under Article IV Section 3 below. The waiver, if granted, may set a waiver period and/or any additional conditions associated with such waiver. If the waiver is granted and the Dependent AHP does not meet any of the conditions associated with the waiver by any time period/deadline, then the Dependent AHPs Scope of Practice shall be automatically suspended as of the date the Dependent AHP fails to meet such condition(s)

SECTION 3. RIGHTS, PREROGATIVES, AND RESPONSIBILITIES

3.1. The rights, prerogatives and responsibilities of Independent Allied Health Professionals and Dependent Allied Health Professionals are set forth in the Bylaws.

3.2. The clinical practices of the Allied Health Professionals are set forth in the Privilege forms and Scope of Practice forms, as applicable.

3.3. Dependent Allied Health Professionals, except for Physician Assistants, do not have the same rights and prerogatives as Medical Staff Members, Independent Allied Health Professionals, or Physician Assistants, as set forth in the Bylaws. Dependent AHPs, except for Physician Assistants, are not entitled to a Hearing under Article VII of the Bylaws. In lieu of a Hearing, Dependent AHPs, except for Physician Assistants, are entitled to the following process:

3.3.1. Within fifteen (15) days of receiving Notice of an action that would otherwise constitute grounds for a hearing under Article VIII of these Bylaws, Dependent AHPs have the right to have any such action reviewed by filing a written Notice of grievance with the Campus Chief of Staff. The written Notice of grievance will state a summary of the basis the grievance.

3.3.2. Upon receipt of such a Notice of grievance, the Campus Chief of Staff with assistance of the Chief Medical Officer will appoint an ad hoc grievance committee.

3.3.3. The ad hoc grievance committee will conduct a review of the matter, and will afford the Dependent AHP an opportunity for an interview concerning the matter.

a. The interview will not constitute a "hearing" as that term is used in the Bylaws, nor will the hearing and appeal procedures apply, and the Dependent AHP is not entitled to have an attorney participate in the interview.

b. Before the interview, the Dependent AHP will be informed of the general nature and circumstances giving rise to the action, and the Dependent AHP may present information relevant thereto at the interview.

c. A summary of the interview will be made.

3.3.4. The ad hoc grievance committee will make a recommendation to the Professional Performance Committee based on the interview and all other information available to it.

3.3.5. The Professional Performance Committee will consider the recommendation of the ad hoc grievance committee, and may request any additional information to assist in its deliberations. The Professional Performance Committee will make a recommendation to the MEC based on its review and all other information available to it.

3.3.6. The MEC will consider the recommendation of the Professional Performance Committee and will make a recommendation to the Board.

3.3.7. The Board will make a final decision in accordance with this Section 3.3 within sixty (60) days of receipt of the MEC's recommendation. The Board may adopt, reject, or modify the recommendation of the MEC. Notice of the Board's decision and a summary for the basis of the decision will be promptly provided to the Dependent AHP.

SECTION 4. DEPENDENT ALLIED HEALTH PROFESSIONAL EVALUATIONS

4.1. Evaluation of Performance:

4.1.1. This Section 4 applies to the evaluation of Dependent AHPs, except Physician Assistants.

4.1.2. The performance of Dependent AHPs will be evaluated as part of the Medical Staff's routine performance improvement processes consistent with the Bylaws and the Professional Performance Evaluation Policy.

4.1.3. Any concerns regarding the professional conduct, or quality or appropriateness of care provided by a Dependent AHP, identified during such a review process will be referred to the appropriate Division Chair, Campus Chief of Staff, or Department Head for review in accordance with Section 4.2 below.

4.1.4. Any concerns regarding the supervision of the Dependent AHP by the Supervising Practitioner arising out of the Medical Staff's routine evaluation will be referred to the Professional Performance Committee in accordance with Article VII Section 6 of the Bylaws.

4.1.5. Any professional performance evaluations, including FPPE, will be included in the Sponsor's quality file for the purposes of aggregating data and tracking and trending performance of the Dependent AHP.

4.2. Initial Inquiry

4.2.1. Any concerns relating to a Dependent AHP's qualifications, competence, judgment, clinical practice, professional conduct, or wellness must be referred to a Medical Staff Officer, the Division Chair, the Campus Chief of Staff, the Department Head, the Chief Medical Officer, the chair of any standing committee, the Chief Executive Officer, or the Board Chair, regarding any of the following:

a. The clinical competence or clinical practice of a Dependent AHP including patient care, treatment or management, and failure to follow adopted protocols and guidelines;

b. The known or suspected violation by a Dependent AHP of applicable internal and external ethical standards, or the Bylaws, the Policies and Manuals, and other adopted standards of the Health System or Medical Staff, or any applicable laws or regulations;

c. Professional conduct that is considered lower than the established standards of the Health System, or is considered to be disruptive to the operations of the Health Systems or its Medical Staff, such that the quality or efficiency of patient care is or may be affected;

d. The ability of the Dependent AHP to perform, with or without reasonable accommodation, the essential functions of the granted Scope of Practice; or

e. The Dependent AHP's failure to satisfy the basic qualifications of Dependent Allied Health Professionals as set forth in Article IV Section 2 of the Credentials Manual.

4.2.2. The person or committee to whom the concern is referred will make a sufficient initial inquiry to determine whether the concern is credible and, if so, will forward it to the Department Head with a copy to the Dependent AHP's Sponsor.

4.2.3. No inquiry or other action taken pursuant to this Section 4.2 will constitute an "Investigation" as that term is used in the Bylaws, nor will the procedural rights, including hearing and appeal procedures, under the Bylaws apply, and the Dependent AHP is not entitled to have an attorney participate with the Medical Staff leaders in any inquiry or other action taken pursuant to this Section 4.2.

4.3. Initiation of Evaluation of Dependent AHP

4.3.1. The Department Head will review the matter in question, may discuss the matter with the Dependent AHP, and will determine whether to approve an evaluation or

direct that the matter be handled pursuant to another process. The review and discussion with the Dependent AHP shall not constitute a "hearing" as that term is used in the Bylaws, nor shall the hearing and appeal procedures apply, and the Dependent AHP is not entitled to have an attorney participate in the discussion with the Department Head.

4.3.2. The Department Head will promptly inform the Dependent AHP and the Sponsor that an evaluation has begun. In rare instances, notification of the Dependent AHP and the Sponsor may be delayed if, in the judgment of the Department Head, informing the Dependent AHP or Sponsor might compromise the integrity of the evaluation or disrupt the operation of the Health System, Hospital, or Medical Staff.

4.4. Evaluation Procedure

4.4.1. Once a decision has been taken to initiate an evaluation of the Dependent AHP, the Department Head will evaluate the matter itself, or will delegate the evaluation to an ad hoc committee or individual to serve as the evaluating committee.

4.4.2. Whenever the matter raised regarding concerns the clinical competence of the Dependent AHP being evaluated, the evaluating committee may, but is not required, to include or consult with another Practitioner or AHP in the same specialty as the Dependent AHP being evaluated.

4.4.3. The evaluating committee may:

a. Review relevant documents, which may include patient records, incident reports and relevant literature or guidelines;

b. Conduct interviews;

c. Use outside consultants, as needed; or

d. Require an examination or assessment by a health care professional(s) acceptable to the evaluating committee. The Dependent AHP being evaluated will execute a release allowing the evaluating committee to discuss with the health care professional(s) the reasons for the examination or assessment and allowing the health care professional to discuss and report the results of the examination or assessment to the evaluating committee.

4.4.4. The evaluating committee will make a reasonable effort to complete the evaluation and issue its report within thirty (30) days of initiation of the evaluation provided that an outside review is not necessary. When an outside review is used, the evaluating committee will make a reasonable effort to complete the evaluation and issue its report within thirty (30) days of receiving the results of the outside review. These time periods are guidelines and are not directives that create any right for a Dependent AHP to have an evaluation completed within such time periods.

4.4.5. At the conclusion of the evaluation, the evaluating committee will submit a written report to the Department Head with the evaluating committee's findings, conclusions, and recommendations. The Department Head will consider the recommendation of the evaluating committee, may request any additional

information to assist in its deliberations, and will make a recommendation to the applicable Division Chair. If the Department Head evaluated the matter itself, the Department Head will submit a written report directly to the applicable Division Chair with the Department Head's findings, conclusions, and recommendations.

4.4.6. The Department Head may, subject to approval of the Division Chair, initiate informal collegial Peer Review efforts with the Dependent AHP. There is no obligation to initiate collegial intervention efforts, and the Dependent AHP has no right to have collegial intervention considered or granted.

a. The goal of collegial intervention efforts is to arrive at voluntary, responsive actions by the Dependent AHP to resolve the issue that has been raised.

b. Collegial intervention efforts and voluntary progressive steps may include, but are not limited to, the following:

i. Sharing and discussing applicable policies, such as policies regarding appropriate professional conduct, and the timely and adequate completion of medical records;

ii. Counseling, mentoring, monitoring, observational proctoring, consultation, and education, including formal retraining programs;

iii. Sharing the results of FPPE, comparative quality, utilization, and other relevant information, including any variations from clinical protocols or guidelines, in order to assist an individual to conform the Dependent AHP's practice to appropriate norms;

iv. Communicating expectations for professionalism and behaviors that promote a culture of safety;

v. Informational letters of guidance, education, or counseling; and

vi. Performance improvement plans that do not restrict or limit the Dependent AHP's Scope of Practice.

c. The Department Head will document the collegial intervention efforts and the outcome in writing, and will be included in the Sponsor's quality file.

4.4.7. If the collegial intervention efforts do not resolve the concern, the Department Head will forward the matter to the Division Chair, and the Division Chair may proceed with further Peer Review efforts as set forth in Section 4.5 below.

4.5. The Division Chair Recommendation

4.5.1. The Division Chair will consider the report and recommendations of the evaluating committee, and may take any action or make any recommendation deemed appropriate, including without limitation any of the following:

a. Determine that no Corrective Action is justified;

b. Issue a letter of guidance, counsel, warning, or reprimand;

c. Require a FPPE;

d. Enter into a voluntary remediation agreement;

e. Impose conditions for continued Scope of Practice;

f. Require additional training or education;

g. Recommend revocation, reduction, or restriction of some or all of the Dependent AHP's Scope of Practice;

h. Recommend suspension or restriction of some or all the Dependent AHP's Scope of Practice for a period of time;

i. Initiate or continue a summary suspension or restriction of the Dependent AHP's Scope of Practice; or

j. Make any other recommendation that the Division Chair deems necessary or appropriate.

4.5.2. The recommendation of the Division Chair will take effect immediately, unless the recommendation is an action that would constitute grounds for a grievance in accordance with Article IV Section 3.3 of the Credentials Manual.

4.5.3. If a recommendation of the Division Chair is an action that would constitute grounds for a grievance process in accordance with Article IV Section 3.3 of the Credentials Manual, the Division Chair will promptly notify the Dependent AHP by Special Notice of the decision and the reasons for the recommendation, and inform the Dependent AHP of their right to a grievance process under Article IV Section 3.3 of the Credentials Manual. No final action against the Dependent AHP will occur until the Dependent AHP has exhausted or waived the Dependent AHP's procedural rights under Article IV Section 3.3 of the Credentials Manual.

4.5.4. If a recommendation of the Division Chair includes collegial intervention with the Supervising Practitioner, the matter will be forwarded to the appropriate Medical Staff Officer, Division Chair, Department Head, or Chief Medical Officer for review in accordance with Article XI Section 7 of the Bylaws.

4.5.5. If a recommendation of the Division Chair includes a Formal Investigation of the Supervising Practitioner, the matter will be referred to the MEC for review in accordance with the Bylaws.

SECTION 5. OTHER HEALTH PROFESSIONALS

The qualifications of Health System employed or contracted health professionals who are not Practitioners, Independent Allied Health Professionals or Dependent Allied Health Professionals are evaluated processed, supervised and evaluated through the Human Resources mechanisms. Health professionals who are not Practitioners, Independent Allied Health Professionals, or Dependent Allied Health Professionals, and who are not employed by the Health System must be contracted with the Health System or supervised by a Practitioner who will have primary clinical and administrative oversight for the health professional. This category includes, but is not limited to, surgical technicians, vascular technicians, EEG technicians, dental assistants, chemical

dependency professionals, clinical research coordinators, medical scribes, physical therapists, Prosthetists, Orthotists, and Registered Nurses.

ARTICLE V. REGIONS OF THE MEDICAL STAFF

The Medical Staff shall be organized in the following Regions, with the associated Campuses:

1. Pierce County Region (St. Clare Hospital, St. Joseph Medical Center, and St. Anthony Hospital); and

2. King County Region (St. Francis Hospital, St. Elizabeth Hospital, and St. Anne Hospital).

ARTICLE VI. CONFIDENTIALITY OF MEDICAL STAFF CREDENTIALS FILES AND QUALITY FILES

It is the policy of the Health System to protect the confidentiality of credentials files and quality files in accordance with all applicable legal requirements, the Bylaws, and Health System policies on confidentiality.

ARTICLE VII. AMENDMENTS

An amendment to this Credentials Manual may be made in accordance with Article XV of the Bylaws.

ARTICLE VIII. ADOPTION

This Credentials Manual will replace any previous version and will become effective when adopted by the Medical Executive Committee and approved by the Board.

ADOPTED by the Medical Executive Committee on October 13, 2022.

APPROVED by the Board on November 30, 2022.

ADDENDUM A
CATEGORIES OF DEPENDENT ALLIED HEALTH PROFESSIONALS

SECTION 1. CATEGORIES OF DEPENDENT ALLIED HEALTH PROFESSIONALS

1.1. The categories of Dependent Allied Health Professionals as recommended by the Medical Executive Committee and approved by the Board are detailed in the following table:

CATEGORY OF DEPENDENT AHP	ST. ANNE HOSPITAL	ST. ANTHONY HOSPITAL	ST. CLARE HOSPITAL	ST. ELIZABETH HOSPITAL	ST. FRANCIS HOSPITAL	ST. JOSEPH MEDICAL CENTER
Physician Assistants	X	X	X	X	X	X
Registered Nurse First Assist	X	X	X	X	X	X
Registered Radiology Assistant	X	X	X	X	X	X
Social Worker	X	X	X	X	X	X
Optician	X	X	X	X	X	X