

THE NEBRASKA MEDICAL CENTER

POLICY ON

ALLIED HEALTH PROFESSIONALS

June 20, 2011

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APPENDIX A

APPENDIX B

ARTICLE 1

SCOPE AND OVERVIEW OF POLICY

1.1 Scope of Policy:

- (a) This Policy addresses those Allied Health Professionals who are permitted to provide services within The Nebraska Medical Center. It sets forth the credentialing process and the general practice parameters for these individuals, as well as guidelines for determining the need for additional categories of Allied Health Professionals at the Hospital.
- (b) This Policy shall not apply to Allied Health Professionals who are employed by the Hospital (except to the extent set forth in Article 7).
- (c) "Hospital," as used in this Policy, shall mean The Nebraska Medical Center.
- (d) The terms used in this Policy are defined in the Medical Staff Bylaws of the Hospital except as otherwise noted herein.

1.2 Categories of Allied Health Professionals:

Only those specific categories of Allied Health Professionals that have been approved by the Board and granted privileges shall be permitted to practice at the Hospital. All such categories shall be classified as either "Licensed Independent Practitioners" or "Dependent Practitioners," each having a slightly different relationship to the Hospital.

1.3 Licensed Independent Practitioners:

- (a) "Licensed Independent Practitioners" shall include all those Allied Health Professionals, categorized as Professional Associates, who are licensed or certified under state law, authorized to function independently in the Hospital, and granted clinical privileges. These individuals generally require no formal or direct supervision by a physician.
- (b) A current listing of the specific categories of Allied Health Professionals functioning in the Hospital as Licensed Independent Practitioners is attached to this Policy as Appendix A. This Appendix may be modified or supplemented by action of the Board after receiving the recommendations of the Credentials and Medical Staff Executive Committees, without the necessity of further amendment of this Policy.

1.4 Dependent Practitioners:

- (a) "Dependent Practitioners" shall include all those Allied Health Professionals, categorized as Mid-Level Practitioners, who are permitted to practice in the Hospital only under the direct supervision of a physician(s) appointed to the Medical Staff and who are granted clinical privileges. The supervising physician(s) is responsible for the actions of the Dependent Practitioner in the Hospital.
- (b) A current listing of the specific categories of Allied Health Professionals functioning in the Hospital as Dependent Practitioners is attached to this Policy as Appendix B. This Appendix may be modified or supplemented by action of the Board, after receiving the recommendations of the Credentials and Medical Staff Executive Committees, without the necessity of further amendment of this Policy.

1.5 Additional Policies:

The Board shall adopt a separate policy for each category of Allied Health Professional that it approves to practice in the Hospital. These separate policies shall supplement this Policy and shall address the specific matters set forth in Section 2.2 of this Policy.

ARTICLE 2

GUIDELINES FOR DETERMINING THE NEED FOR NEW CATEGORIES OF ALLIED HEALTH PROFESSIONALS

2.1 Determination of Need:

Whenever an Allied Health Professional in a category that has not been approved by the Board requests permission to practice at the Hospital, the Board shall appoint an ad hoc committee to evaluate the need for that particular category of Allied Health Professional and to make a recommendation to the Board. As part of the process, the Allied Health Professional shall be invited to submit information about the nature of the proposed practice, why Hospital access is sought, and the potential benefits to the community by having such services available at the Hospital. The ad hoc committee may consider the following factors when making a recommendation to the Board as to the need for the services of this category of Allied Health Professionals:

- (a) the nature of the services that could be offered;
- (b) any state license or regulation which outlines the scope of practice for the Allied Health Professional;

- (c) any state "non-discrimination" or "any willing provider" laws that would apply to the Allied Health Professional;
- (d) the business and patient care objectives of the Hospital;
- (e) how well the community's needs are currently being met and whether they could be better met if the services offered by the Allied Health Professional were provided by the Hospital or as part of its facilities;
- (f) the type of training that is necessary to perform the services that could be offered and whether there are individuals with more training currently providing those services;
- (g) the availability of supplies, equipment, and other necessary Hospital resources;
- (h) the availability of trained staff;
- (i) patient convenience; and
- (j) the ability to appropriately supervise performance.

2.2 Development of Policy:

If the ad hoc committee determines that there is a need for the particular category of Allied Health Professional at the Hospital, the committee shall recommend to the Board a separate policy for these practitioners that addresses: (1) any specific qualifications and/or training that they must possess beyond those set forth in this Policy; (2) a detailed description of their authorized clinical privileges; (3) any specific conditions that apply to their functioning within the Hospital; and (4) any supervision requirements, if applicable. In developing such policies, the ad hoc committee shall consult the appropriate service chief(s) and applicable state law and may contact applicable professional societies or associations. The ad hoc committee may also recommend to the Board the number of Allied Health Professionals that are needed in a particular category.

ARTICLE 3

QUALIFICATIONS, CONDITIONS, AND RESPONSIBILITIES

3.1 General Qualifications:

To be eligible to apply for initial and continued permission to practice at the Hospital, an Allied Health Professional must:

- (a) have a current unrestricted license to practice in this state and have never had a license to practice revoked or suspended by any state licensing agency;
- (b) where applicable to their practice, have a current, unrestricted DEA registration;
- (c) be located (office and residence) within the geographic service area of the Hospital, as defined by the Board, close enough to fulfill their responsibilities and to provide timely and continuous care for patients in the Hospital;
- (d) have current, valid professional liability insurance coverage in a form and in amounts satisfactory to the Hospital;
- (e) have never been convicted of Medicare, Medicaid, or other federal or state governmental or private third-party payer fraud or program abuse, nor have been required to pay civil penalties for the same;
- (f) have never been, and are not currently, excluded or precluded from participation in Medicare, Medicaid or other federal or state governmental health care program;
- (g) have never had clinical privileges or scope of practice denied, revoked, resigned, relinquished, or terminated by any health care facility or health plan for reasons related to clinical competence or professional conduct;
- (h) have never been convicted of, or entered a plea of guilty or no contest to, any felony, or any misdemeanor relating to controlled substances, illegal drugs, insurance or health care fraud or abuse or violence;
- (i) satisfy all additional eligibility qualifications relating to his or her specific area of practice that may be established by the Hospital;
- (j) if seeking to practice as a Dependent Practitioner, have a supervision agreement with a physician who is appointed to the Medical Staff and;

- (k) be able to document his or her:
 - (1) relevant training, experience, demonstrated current competence and judgment;
 - (2) adherence to the ethics of his or her profession;
 - (3) good reputation and character;
 - (4) ability to perform, safely and competently, the clinical privileges requested; and
 - (5) ability to work harmoniously with others sufficiently to convince the Hospital that all patients treated by them will receive quality care and that the Hospital and its Medical Staff will be able to operate in an orderly manner.

3.2 Waiver of Criteria:

- (a) Any individual who does not satisfy a criterion may request that it be waived. The individual requesting the waiver bears the burden of demonstrating that his or her qualifications are equivalent to, or exceed, the criterion in question.
- (b) The Board may grant waivers in exceptional cases after considering the findings of the Credentials and Medical Staff Executive Committees or other committee designated by the Board, the specific qualifications of the individual in question, and the best interests of the Hospital and the community it serves. The granting of a waiver in a particular case is not intended to set a precedent for any other individual or group of individuals.
- (c) No individual is entitled to a waiver or to a hearing if the Board determines not to grant a waiver.

3.3 No Entitlement to Medical Staff Appointment:

Allied Health Professionals shall not be appointed to the Medical Staff or entitled to the rights, privileges, and/or prerogatives of Medical Staff appointment.

3.4 Non-Discrimination Policy:

No individual shall be denied permission to practice at the Hospital on the basis of gender, race, creed, or national origin.

3.5 Assumption of Duties and Responsibilities:

As a condition of permission to practice at the Hospital, all Allied Health Professionals shall specifically agree to the following:

- (a) to provide continuous and timely care to all patients for whom the individual has responsibility;
- (b) to abide by all applicable bylaws, Policies, rules and regulations of the Medical Staff and Hospital;
- (c) to accept committee assignments and such other reasonable duties and responsibilities as may be assigned;
- (d) to provide, with or without request, new or updated information to the Chief Executive Officer, as it occurs, pertinent to any question on the application form;
- (e) to acknowledge that the individual has had an opportunity to read a copy of this Policy and any other applicable bylaws, Policies, rules and regulations and agrees to be bound by them;
- (f) to appear for personal interviews in regard to an application for permission to practice as may be requested;
- (g) to refrain from illegal fee splitting or other illegal inducements relating to patient referral;
- (h) to refrain from assuming responsibility for diagnosis or care of hospitalized patients for which he or she is not qualified or without adequate supervision;
- (i) to refrain from deceiving patients as to the individual's status as an Allied Health Professional;
- (j) to seek consultation when appropriate;
- (k) to participate in the monitoring and evaluation activities;
- (l) to complete, in a timely manner, all medical and other required records, containing all information required by the Hospital;
- (m) to perform all services and conduct himself/herself at all times in a cooperative and professional manner;
- (n) to satisfy applicable continuing education requirements;

- (o) to promptly pay any applicable dues and assessments;
- (p) that, if there is any misstatement in, or omission from, the application, the Hospital may stop processing the application (or, if permission to practice has been granted prior to the discovery of a misstatement or omission, the permission may be deemed to be automatically relinquished). In either situation, there shall be no entitlement to the procedural rights provided in this Policy; and
- (q) effective as of the date of appointment, to become a participant in an Organized Health Care Arrangement with the Hospital and as part of the Organized Health Care Arrangement, each Allied Health Professional and any other individual exercising clinical privileges in the Hospital will provide patients with a Notice of Organized Health Care Arrangement as a supplement to their own Notice of Privacy Practices and to comply with any federal or state laws or Hospital policies related to the use or disclosure of individually identifiable health information, including but not limited to the HIPAA Privacy Regulations at 45 C.F.R. Parts 160 and 164.

3.6 Burden of Providing Information:

- (a) Allied Health Professionals seeking permission to practice shall have the burden of producing information deemed adequate by the Hospital for a proper evaluation of current competence, character, ethics, and other qualifications, and for resolving any doubts about such qualifications.
- (b) Allied Health Professionals seeking appointment have the burden of providing evidence that all the statements made and information given on the application are accurate.
- (c) An application shall be complete when all questions on the application form have been answered, all supporting documentation has been supplied, and all information verified from primary sources. An application shall become incomplete if the need arises for new, additional, or clarifying information at any time. Any application that continues to be incomplete 30 days after the individual has been notified of the additional information required shall be deemed to be withdrawn.
- (d) It is the responsibility of the individual seeking permission to practice to provide a complete application, including adequate responses from references. An incomplete application will not be processed.

3.7 Application Form:

- (a) The application forms for both initial and renewed permission to practice as an Allied Health Professional shall require detailed information concerning the applicant's professional qualifications. The Allied Health Professional applications existing now and as may be revised are incorporated by reference and made a part of this Policy. In addition to other information, the applications shall seek the following:
- (1) information as to whether the applicant's clinical privileges, scope of practice, permission to practice, and/or affiliation has ever been voluntarily or involuntarily relinquished, withdrawn, denied, revoked, suspended, reduced, subjected to probationary or other conditions, limited, terminated, or not renewed at any hospital or health care facility, or is currently being investigated or challenged;
 - (2) information as to whether the applicant's license or certification to practice any profession in any state or Drug Enforcement Administration registration is or has ever been voluntarily or involuntarily relinquished, suspended, modified, terminated, restricted, or is currently being investigated or challenged;
 - (3) information concerning the applicant's professional liability litigation experience and/or any professional misconduct proceedings involving the applicant, in this state or any other state, whether such proceedings are closed or still pending, including the substance of the allegations of such proceedings or actions, the substance of the findings of such proceedings or actions, the ultimate disposition of any such proceedings or actions that have been closed, and any additional information concerning such proceedings or actions as the Credentials Committee, Medical Staff Executive Committee or Board may deem appropriate; and
 - (4) current information regarding the applicant's ability to perform, safely and competently, the clinical privileges requested and the duties of Allied Health Professionals.
- (b) The applicant shall sign the application and certify that he or she is able to perform the clinical privileges requested and the responsibilities of Allied Health Professionals.

3.8 Grant of Immunity and Authorization to Obtain/Release Information:

By applying for permission to practice at the Hospital, Allied Health Professionals expressly accept the following conditions during the processing and consideration of the application, whether or not permission to practice is granted, and as a condition of continued permission to practice, if granted:

(a) Immunity:

To the fullest extent permitted by law, the Allied Health Professional releases from any and all liability, extends absolute immunity to, and agrees not to sue the Hospital, the Medical Staff, their authorized representatives, and appropriate third parties for any matter relating to permission to practice, clinical privileges, at the Hospital, or the individual's qualifications for the same. This includes any actions, recommendations, reports, statements, communications, or disclosures involving the individual which are made, taken, or received by the Hospital, its authorized agents, or appropriate third parties.

(b) Authorization to Obtain Information from Third Parties:

The Allied Health Professional specifically authorizes the Hospital, Medical Staff leaders, and their authorized representatives (1) to consult with any third party who may have information bearing on the Allied Health Professional's professional qualifications, credentials, clinical competence, character, ability to perform safely and competently, ethics, behavior, or any other matter reasonably having a bearing on his or her qualifications for permission to practice at the Hospital, and (2) to obtain any and all communications, reports, records, statements, documents, recommendations, or disclosures of third parties that may be relevant to such questions. The Allied Health Professional also specifically authorizes third parties to release this information to the Hospital and its authorized representatives upon request.

(c) Authorization to Release Information to Third Parties:

The Allied Health Professional also authorizes Hospital representatives to release information to other hospitals, health care facilities, managed care organizations, and their agents when information is requested in order to evaluate his or her professional qualifications for appointment, privileges, permission to practice, scope of practice, and/or participation status at the requesting organization/facility.

(d) Procedural Rights:

The Allied Health Professional agrees that the procedural rights set forth in this Policy shall be the sole and exclusive remedy with respect to any professional review action taken by the Hospital.

(e) Legal Actions:

If, notwithstanding the provisions in this Section, an Allied Health Professional institutes legal action and does not prevail, he or she shall reimburse the Hospital and any of its authorized representatives named in the action for all costs incurred in defending such legal action, including reasonable attorney's fees.

(f) Authorization to Share Information Among Affiliates of the Hospital:

The individual specifically authorizes the Hospital and its Affiliates to share credentialing and peer review information among them pertaining to the individual's clinical competence and/or professional conduct. This information may be shared at initial appointment or reappointment and at any other time during the individual's appointment. For purposes of this Section 3.1(f), an Affiliate shall be deemed to include but not be limited to Medical Staff Appointees, and their employers, employees and agents and shall specifically include the University of Nebraska College of Medicine, University Medical Associates and Private Practice Associates, LLC.

ARTICLE 4

CREDENTIALING PROCEDURE

4.1 Request for Application:

- (a) Applications for permission to practice at the Hospital shall be in writing and shall be on forms approved by the Board upon recommendation by the Medical Staff Executive Committee and Credentials Committee.
- (b) Any individual requesting an application for permission to practice at the Hospital shall be sent a letter that outlines the eligibility criteria for permission to practice, as well as any eligibility requirements that relate to the Allied Health Professional's specific area of practice, and the application form.
- (c) Allied Health Professionals who are in a category of practitioners that has not been approved by the Board for access to the Hospital shall be ineligible to receive an application. A determination of ineligibility does not entitle an Allied Health Professional to the procedural rights outlined in Article 6 of this Policy.

4.2 Initial Review of Application:

- (a) A completed application, with copies of all required documents, must be submitted to the Medical Staff Office within 30 days after receipt of the application if the Allied Health Professional desires further consideration. The application must be accompanied by the application processing fee, if one is required.
- (b) Individuals who fail to return completed applications or fail to meet the eligibility criteria set forth in Section 3.1(a-j) of this Policy will be notified that they are not eligible for permission to practice at the Hospital and that their application will not be processed. A determination of ineligibility does not entitle an Allied Health Professional to the procedural rights outlined in Article 6 of this Policy.
- (c) The Chief Medical Officer or designee shall oversee the process of gathering and verifying relevant information and confirming that all references and other information or materials deemed pertinent have been received.

4.3 Service Chief Procedure:

- (a) The Hospital's office of Medical Staff Services shall transmit the complete application and all supporting materials to the appropriate Service chief or the individual to whom the Service chief has assigned this responsibility. Each chief shall prepare a written report regarding whether the applicant has satisfied all of the qualifications for permission to practice and the clinical privileges requested. As part of the process of making this report, the Service chief has the right to meet with the applicant and the supervising physician (if applicable) to discuss any aspect of the application, qualifications, and requested clinical privileges. The Service chief may also confer with experts within the clinical Service and outside of the Service in preparing the report (e.g., other physicians, relevant Hospital clinical service heads, nurse managers). In the event that the Service chief or the individual to whom the Service chief has assigned the responsibility is unavailable or unwilling to prepare a written report, the Chair of the Credentials Committee or the Chief of Staff shall appoint an individual to prepare the report.
- (b) The service chief shall be available to the Credentials Committee, Medical Staff Executive Committee, or the Board to answer any questions that may be raised with respect to that chief's report and findings.

4.4 Credentials Committee Procedure:

- (a) The Credentials Committee shall review the report from the appropriate Service chief and the information contained in references given by the applicant and from other available sources. The Credentials Committee shall examine evidence of

the applicant's character, professional competence, qualifications, prior behavior, and ethical standing and shall determine whether the applicant has established and satisfied all of the necessary qualifications for the clinical privileges requested.

- (b) The Credentials Committee may use the expertise of any individual on the Medical Staff or in the Hospital, or an outside consultant, if additional information is required regarding the applicant's qualifications. The Credentials Committee may also meet with the applicant and, when applicable, the supervising physician. The appropriate service chief may participate in this interview.
- (c) After determining that an applicant is otherwise qualified for permission to practice and the clinical privileges requested, the Credentials Committee shall review the applicant's application and request for privileges to determine if there is any question about the applicant's ability to perform the clinical privileges requested and the responsibilities of permission to practice. If so, the Credentials Committee may require the applicant to undergo a physical and/or mental examination by a physician(s) satisfactory to the Credentials Committee. The results of this examination shall be made available to the Committee for its consideration. Failure of an applicant to undergo an examination within a reasonable time after being requested to do so in writing by the Credentials Committee shall be considered an incomplete application and all processing of the application shall cease.

4.5 Medical Staff Executive Committee Procedure:

- (a) At its next meeting, after receipt of the written findings and recommendation of the Credentials Committee, the Medical Staff Executive Committee shall:
 - (1) adopt the findings and recommendations of the Credentials Committee as its own; or
 - (2) refer the matter back to the Credentials Committee for further consideration and responses to specific questions raised by the Medical Staff Executive Committee; or
 - (3) set forth in its report and recommendation clear and convincing reasons, along with supporting information for its disagreement with the Credentials Committee's recommendation.
- (b) If the Medical Staff Executive Committee's recommendation is favorable to the applicant, the Committee shall forward its recommendation to the Board, through the Chief Executive Officer, including the findings and recommendation of the service chief and the Credentials Committee. The Medical Staff Executive Committee's recommendation must specifically address the clinical privileges

requested by the applicant, which may be qualified by any probationary or other conditions or restrictions relating to such clinical privileges.

- (c) If the Medical Staff Executive Committee's recommendation would entitle the applicant to the procedural rights set forth in this Policy, the Medical Staff Executive Committee shall forward its recommendation to the Chief Executive Officer who shall notify the applicant of the recommendation and his or her procedural rights. The Chief Executive Officer shall then hold the Medical Staff Executive Committee's recommendation until after the individual has completed or waived the procedural rights outlined in this Policy.

4.6 Board Action:

- (a) Upon receipt of a recommendation that the applicant be granted permission to practice and clinical privileges, the Board may:
 - (1) grant the applicant permission to practice and clinical privileges as recommended; or
 - (2) refer the matter back to the Credentials Committee or Medical Staff Executive Committee or to another source inside or outside the Hospital for additional research or information; or
 - (3) reject or modify the recommendation.
- (b) If the Board determines to reject a favorable recommendation, it will first discuss the matter with the chair of the Credentials Committee and the Chief of Staff. If the Board's determination remains unfavorable, the Chief Executive Officer shall notify the applicant of its determination and the applicant's procedural rights as outlined in this Policy.

4.7 Renewal of Permission to Practice:

- (a) Renewal of an Allied Health Professional's clinical privileges shall be considered only upon submission of a completed application for renewed permission to practice. Four months prior to the date of expiration of an Allied Health Professional's clinical privileges, Medical Staff Services shall give the individual notice of the date of expiration and an application form for renewed clinical privileges.
- (b) Failure to return a completed application to Medical Staff Services within 30 days may result in the assessment of a reappointment processing fee. In addition, failure to submit an application at least two months prior to the expiration of the individual's current term shall result in automatic expiration of permission to

practice and clinical privileges at the end of the then current term, and the individual may not practice until an application is processed.

- (c) Renewed permission to practice, if granted, shall be for a period of not more than two years.
- (d) Once an application for renewed permission to practice has been completed and submitted to Medical Staff Services, it shall be evaluated in the same manner and follow the same procedures outlined in this Policy for initial applicants.
- (e) As part of the process for renewal of permission to practice for Dependent Practitioners, the competency of the Dependent Practitioner shall be assessed by the supervising physician(s) and the applicable service chief or designee biennially. The evaluation along with other reasonable indicators of continuing qualifications shall be factors for the renewal of the Dependent Practitioner's permission to practice.
- (f) As part of the process for renewal of permission to practice for Licensed Independent Practitioners, the following factors shall be considered:
 - (i) the competency of the Licensed Independent Practitioner as assessed by the appropriate service chief(s) or designee and documented on a biennial evaluation form;
 - (ii) a recommendation from a peer; and
 - (iii) use of the Hospitals' facilities taking into consideration practitioner-specific information concerning other individuals in the same or similar specialty.

4.8 Administrative Suspension:

- (a) The Chief of Staff, the relevant Service chief, the Chief Medical Officer, and the Chief Executive Officer shall each have the authority to impose an administrative suspension of all or any portion of the clinical privileges of any Allied Health Professional whenever a concern has been raised about such individual's clinical practice or conduct.
- (b) An administrative suspension shall become effective immediately upon imposition, shall immediately be reported in writing to the Chief Executive Officer or designee and the Chief of Staff, and shall remain in effect unless or until modified by the Chief Executive Officer, Chief of Staff or the Medical Staff Executive Committee.

- (c) Upon receipt of notice of the imposition of an administrative suspension, the Chief Executive Officer and the Chief of Staff shall forward the matter to the full Medical Staff Executive Committee, which shall review and consider the question(s) raised and thereafter make an appropriate recommendation to the Board. If the Medical Staff Executive Committee's recommendation is to restrict or terminate the Allied Health Professional's clinical privileges, the individual and, when applicable, the supervising physician shall be entitled to the procedural rights outlined in Article 6 of this Policy before the Medical Staff Executive Committee's recommendation is considered by the Board.

ARTICLE 5

CONDITIONS OF PRACTICE APPLICABLE TO DEPENDENT PRACTITIONERS

5.1 Supervision by Supervising Physician:

- (a) Any activities permitted by the Board to be done at the Hospital by a Dependent Practitioner shall be done only under the direct supervision of the physician supervising that individual. Except as provided by law or Hospital policy, "direct supervision" shall not require the actual physical presence of the employing or supervising physician.
- (b) Dependent Practitioners may function in the Hospital only so long as (i) they are directly supervised by a physician currently appointed to the Medical Staff, and (ii) they have a current, written supervision agreement with that physician. In addition, should the Medical Staff appointment or clinical privileges of the staff physician supervising a Dependent Practitioner be revoked or terminated, the Dependent Practitioner's permission to practice at the Hospital and clinical privileges shall be automatically relinquished (unless the individual will be supervised by another physician on the Medical Staff).
- (c) As a condition for permission to practice at the Hospital, each Dependent Practitioner and his/her supervising physician must submit a copy of their written supervision agreement to the Hospital. This agreement must meet the requirements of all applicable state statutes and regulations, as well as any additional requirements of the Hospital. It is also the responsibility of the Dependent Practitioner and his/her supervising physician to provide the Hospital, in a timely manner, with any revisions or modifications that are made to the agreement.

5.2 Questions Regarding Authority of a Dependent Practitioner:

- (a) Should any Medical Staff Appointee or Hospital employee who is licensed or certified by the state have any question regarding the clinical competence or authority of a Dependent Practitioner either to act or to issue instructions outside the physical presence of the supervising physician in a particular instance, the Medical Staff Appointee or Hospital employee shall have the right to require that the Dependent Practitioner's employer or supervisor validate, either at the time or later, the instructions of the Dependent Practitioner. Any act or instruction of the Dependent Practitioner shall be delayed until such time as the staff Appointee or Hospital employee can be certain that the act is clearly within the scope of the Dependent Practitioner's clinical privileges as permitted by the Board.
- (b) Any question regarding the clinical practice or professional conduct of a Dependent Practitioner shall be immediately reported to the Chief of Staff, the relevant Service chief, the Chief Medical Officer or the Chief Executive Officer, who shall undertake such action as may be appropriate under the circumstances.

5.3 Responsibilities of Supervising Physician:

- (a) The supervising physician shall be responsible for the actions of the Dependent Practitioner in the Hospital.
- (b) The number of Dependent Practitioners acting under the supervision of one physician, as well as the acts they may undertake, shall be consistent with applicable state statutes and regulations, the rules and regulations of the Medical Staff, and the policies of the Board.
- (c) It shall be the responsibility of the physician supervising the Dependent Practitioner to provide, or to arrange for, professional liability insurance coverage for the Dependent Practitioner in amounts required by the Board that covers any activities of the Dependent Practitioner at the Hospital, and to furnish evidence of such coverage to the Hospital. The Dependent Practitioner shall act at the Hospital only while such coverage is in effect.

ARTICLE 6

PROCEDURAL RIGHTS FOR ALLIED HEALTH PROFESSIONALS

6.1 General:

Allied Health Professionals shall not be entitled to the hearing and appeals procedures set forth in Medical Staff Governance. Any and all procedural rights to which these individuals are entitled are set forth in this Article.

6.2 Procedural Rights for Allied Health Professionals:

- (a) In the event that a recommendation is made by the Medical Staff Executive Committee that an Allied Health Professional not be granted the clinical privileges requested, or that the clinical privileges previously granted be restricted or terminated, the practitioner shall be notified of the recommendation. The notice shall include the specific reasons for the recommendation and shall advise the individual that he or she may request a hearing before the adverse recommendation is transmitted to the Board for final action.
- (b) If the Allied Health Professional desires to request a hearing, he or she must make such request in writing and direct it to the Chief Executive Officer within 30 days after receipt of the written notice of the adverse recommendation.
- (c) If a request for a hearing is made in a timely manner, the Chief Executive Officer, in conjunction with the Chief of Staff, shall appoint an Ad Hoc Committee composed of up to three individuals (including, but not limited to, individuals appointed to the Medical Staff, Allied Health Professionals, Hospital management, individuals not connected to the Hospital, or any combination of these individuals) and a Presiding Officer, who may be legal counsel to the Hospital. The Ad Hoc Committee shall not include anyone who previously participated in the recommendation, any relatives or practice partners of the Allied Health Professional, or any competitors of the affected individual.
- (d) As an alternative to the Ad Hoc Committee described in paragraph (c) of this Section, the Chief Executive Officer, in conjunction with the Chief of Staff, may instead appoint a Hearing Officer to perform the functions that would otherwise be carried out by the Ad Hoc Committee. The Hearing Officer shall preferably be an attorney at law. The Hearing Officer may not be in direct economic competition with the individual requesting the hearing and shall not act as a prosecuting officer or as an advocate to either side at the hearing. If the Hearing Officer is an attorney, he or she shall not represent clients who are in direct economic competition with the affected individual. In the event a Hearing Officer is appointed instead of an Ad Hoc Committee, all references in this Article to the Ad Hoc Committee shall be deemed to refer instead to the Hearing Officer, unless the context would clearly otherwise require.

- (e) The hearing shall be convened as soon as is practical, but no sooner than 30 days after the notice of the hearing, unless an earlier hearing date has been specifically agreed to by the parties.

6.3 Hearing Process for Allied Health Professionals:

- (a) At the hearing, a representative of the Medical Staff Executive Committee shall first present the reasons for the recommendation. The Allied Health Professional shall be invited to present information, both orally and in writing, to refute the reasons for the recommendation, subject to a determination by the Presiding Officer (or the Hearing Officer) that the information is relevant. The Presiding Officer (or the Hearing Officer) shall have the discretion to determine the amount of time allotted to the presentation by the representative of the Medical Staff Executive Committee and the Allied Health Professional.
- (b) The Allied Health Professional shall not have the right to present other witnesses unless he or she can demonstrate to the satisfaction of the Presiding Officer (or the Hearing Officer) that the failure to permit witnesses to appear would be fundamentally unfair. In the event witnesses are allowed, the Presiding Officer (or the Hearing Officer) shall permit reasonable questioning of such witnesses.
- (c) Neither the Allied Health Professional nor the Medical Staff Executive Committee shall be represented by counsel at this hearing.
- (d) The affected practitioner shall have the burden of demonstrating that the recommendation of the Medical Staff Executive Committee was arbitrary, capricious, or not supported by substantial evidence. The quality of care provided to patients and the smooth operation of the Hospital shall be the paramount considerations. Minutes of this proceeding shall be kept and shall be attached to the report and recommendation of the Ad Hoc Committee.

6.4 Ad Hoc Committee or Hearing Officer Report:

- (a) The Ad Hoc Committee (or the Hearing Officer) shall prepare a written report and recommendation within 30 days after the conclusion of the proceeding, and shall forward it along with all supporting information to the Chief Executive Officer. The Chief Executive Officer shall send a copy of the written report and recommendation, via certified mail, return receipt requested, to the Allied Health Professional. A copy shall also be provided to the Medical Staff Executive Committee.
- (b) Within ten days after receiving notice of the recommendation, either the Allied Health Professional or the Medical Staff Executive Committee may make a request for an appeal. The request must be in writing and must include a

statement of the reasons for appeal, including the specific facts, which justify further review. The request shall be delivered to the Chief Executive Officer either in person or by certified mail.

- (c) If a written request for appeal is not submitted within the ten day time frame specified above, the recommendation and supporting information shall be forwarded by the Chief Executive Officer to the Board for final action. If a timely request for appeal is submitted, the Chief Executive Officer shall forward the report and recommendation, the supporting information, and the request for appeal to the Chairman of the Board.

6.5 Appeals Process for Allied Health Professionals:

- (a) The grounds for appeal shall be limited to the following assertions: (i) there was substantial failure to comply with this Policy and/or other applicable bylaws or policies of the Hospital or the Medical Staff and/or (ii) the recommendation was arbitrary, capricious, or not supported by evidence.
- (b) The Chairman of the Board, or a committee of the Board appointed by the Chairman, will consider the request for appeal and the record upon which the adverse recommendation was made. This review shall be conducted within 30 days after receiving the request for appeal.
- (c) The Allied Health Professional and the Medical Staff Executive Committee shall each have the right to present a written statement in support of its position on appeal.
- (d) At the sole discretion of the Chairman of the Board or the committee appointed by the Chairman, the Allied Health Professional and a representative of the Medical Staff Executive Committee may also appear personally to discuss their position. In that event, however, neither party shall be represented by counsel at the appeal.
- (e) Upon completion of the review, the Chairman of the Board or the committee appointed by the Chairman shall provide a report and recommendation to the full Board for action. The Chairman (or the committee) may also refer the matter to any committee or individual deemed appropriate for further review and recommendation to the full Board. The Board shall then make its final decision based upon the Board's ultimate legal responsibility to grant privileges and to authorize the performance of clinical activities at the Hospital.

6.6 Exceptions to Procedural Rights:

An Allied Health Professional's clinical privileges shall automatically terminate, without entitlement to the procedural rights outlined in this Article, in the following circumstances:

- (a) an Allied Health Professional's license is revoked; or
- (b) an Allied Health Professional no longer satisfies all of the threshold eligibility criteria set forth in Section 3.1 (a-j) or any additional threshold credentialing qualification set forth in the specific Hospital policy relating to their discipline.

An Allied Health Professional's clinical privileges shall be automatically suspended, until reinstatement is verified by the Hospital's office of Medical Staff Services and granted by the Chief of Staff, without entitlement to the procedural rights outlined in this Article, in the following circumstances:

- (c) an Allied Health Professional's license expires or is suspended;
- (d) the Allied Health Professional's professional liability insurance coverage is not in effect.
- (e) a Dependent Practitioner ceases to be directly supervised by a physician currently appointed to the Medical Staff (unless the Dependent Practitioner will be supervised by another physician on the Medical Staff). A two (2) week suspension shall automatically give rise to a termination of appointment unless reinstatement is granted by the Chief of Staff.

ARTICLE 7

HOSPITAL EMPLOYEES

- (a) Allied Health Professionals who are employees of the Hospital shall not be governed by this Policy, except as expressly indicated in this Article. Rather, they shall be governed by such Hospital employment policies, manuals, and descriptions as are appropriate and as may be established from time to time.
- (b) Licensed Independent Practitioners who are employed by, or seeking employment with, the Hospital shall be credentialed and recredentialed using the same process set forth in Article 4 of this Policy. In these situations, a report regarding their qualifications shall be made to Hospital management personnel or Human

Resources (as appropriate) to assist them in making employment decisions. In addition, these employed Licensed Independent Practitioners shall be subject to the procedural rights set forth in Article 6 of this Policy.

- (c) Dependent Practitioners who are seeking employment with, or are employed by, the Hospital will be credentialed and/or recredentialed using the same process set forth in Article 4 of this Policy. As they are credentialed through Article 4 of this Policy, a report regarding their qualifications shall be made to the Hospital to assist it in making employment decisions. In addition, all employed Dependent Practitioners shall be subject to the same supervision requirements set forth in Article 5 of this Policy.

ARTICLE 8

AMENDMENTS

This Policy may be amended by a majority vote of the members of the Medical Staff Executive Committee present and voting at any meeting of that committee where a quorum exists. Notice of all proposed amendments shall be posted on the Medical Staff bulletin board at least 14 days prior to the Medical Staff Executive Committee meeting where action on the amendments will be taken, and any member of the Medical Staff may submit written comments to the Medical Staff Executive Committee. No amendment to this Policy shall be effective unless and until it has been approved by the Board.

ARTICLE 9

ADOPTION

This Policy is adopted and made effective upon approval of the Board, superseding and replacing any and all other Medical Staff bylaws, rules and regulations, or Hospital policies pertaining to the subject matter thereof.

Adopted by the Medical Staff:

Date: October 21, 2009

Chief of Staff

Approved by the Board:

Date: September 21, 2009

Chair, Board of Directors

APPENDIX A

Those individuals currently practicing as Licensed Independent Practitioners, categorized as Professional Associates, at the Nebraska Medical Center are as follows:

Podiatrist

Psychologist

Licensed Mental Health Practitioner

APPENDIX B

Those individuals currently practicing as Dependent Practitioners, categorized as Mid-Level Practitioners, at The Nebraska Medical Center are as follows:

Physician Assistant

Advance Practice Registered Nurse – Nurse Practitioner

Advance Practice Registered Nurse – Certified Nurse Midwife

Advance Practice Registered Nurse – Certified Registered Nurse Anesthetist

