MEDICAL STAFF BYLAWS, POLICIES, AND RULES AND REGULATIONS

POLICY ON ADVANCED PRACTICE AND ALLIED HEALTH PROFESSIONALS

OF

EMORY JOHNS CREEK HOSPITAL, EMORY SAINT JOSEPH'S HOSPITAL, EMORY UNIVERSITY HOSPITAL, EMORY UNIVERSITY HOSPITAL MIDTOWN

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POLICY ON
ADVANCED PRACTICE AND ALLIED HEALTH PROFESSIONALS

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ARTICLE 1

GENERAL

1 .A. DEFINITIONS

The definitions that apply to terms used in all the Medical Staff documents are set forth in the Emory Healthcare Credentials Policy.

1.B. TIME LIMITS

Time limits referred to in this Policy and related policies and manuals are advisory only and are not mandatory, unless it is expressly stated that a particular right is waived by failing to take action within a specified period.

1.C. DELEGATION OF FUNCTIONS

(1) When a function is to be carried out by a Medical Staff Leader or by a Medical Staff committee, the individual, or the committee through its chair, may delegate performance of the function to one or more designees.

(2) When a Medical Staff member is unavailable or unable to perform an assigned function, one or more of the Medical Staff Leaders may perform the function personally or delegate it to another appropriate individual.

1.D. CONFIDENTIALITY AND PEER REVIEW PROTECTION

1.D.1. Confidentiality:

All professional review activity and recommendations will be strictly confidential. No disclosures of any such information (discussions or documentation) may be made outside of the meetings of the committees charged with such functions, except:

(a) to another authorized individual and for the purpose of conducting professional review activity;

(b) as authorized by a policy; or

(c) as authorized by the Chief Executive Officer or by legal counsel to the Hospital.

Any breach of confidentiality may result in appropriate sanctions, including but not limited to a professional review action or appropriate legal action. Breaches of confidentiality will not constitute a waiver of any privilege. Any member of the Medical Staff who becomes aware of a breach of confidentiality is encouraged to inform the Chief Executive Officer, the Chief Medical Officer, or the Chief of Staff (or the Vice Chief of Staff if the Chief of Staff is the person committing the claimed breach).

1.D.2. Peer Review Protection:

All professional review activity will be performed by the professional practice evaluation committees. Professional Practice Evaluation Committees include, but are not limited to:

(a) all standing and ad hoc Medical Staff and Hospital committees;

(b) all clinical services and sections;

(c) hearing and appellate review panels;

(d) the Board and its committees; and

(e) any individual or body acting for or on behalf of a professional committee, Medical Staff Leaders, and experts or consultants retained to assist in professional review activity.

All oral and written communications, reports, recommendations, actions, and minutes made or taken by peer review committees are confidential and covered by the provisions of applicable law, including the protections offered by Ga. Code Ann. §31-7-15 and §31-7-131 et seq. or the corresponding provisions of any subsequent state statute providing protection to peer review or related activities, and are deemed to be "professional review bodies" as that term is defined in the Health Care Quality Improvement Act of 1986 ("HCQIA"), 42 U.S.C. §11101 et seq.

ARTICLE 2

SCOPE AND OVERVIEW OF POLICY

2.A. SCOPE OF POLICY

(1) This Policy addresses those Advanced Practice and Allied Health Professionals who are not members of the Medical Staff but who are permitted to provide patient care services in the Hospital and are listed in the Appendices to this Policy. It also addresses those practitioners who do not desire Medical Staff Appointment, but who nevertheless seek to execute certain limited privileges at the Hospital under the conditions set forth in this Policy.

(2) This Policy 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 Advanced Practice and Allied Health Professionals at the Hospital.

2.B. CATEGORIES OF ADVANCED PRACTICE AND ALLIED HEALTH PROFESSIONALS

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

2.B.1. Licensed Independent Practitioners

(1) "Licensed Independent Practitioners" (hereinafter referred to as Category I practitioners) shall include all those Advanced Practice and Allied Health Professionals who are licensed or certified under state law, authorized to function independently in the Hospital, and granted clinical privileges. These individuals require no formal or direct supervision by a physician.

(2) A current listing of the specific categories of Allied Health Professionals functioning in the Hospital as Category I 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 Medical Executive Committee, without the necessity of further amendment of this Policy.

2.B.2. Advanced Dependent Practitioners

(1) "Advanced Dependent Practitioners" (hereinafter referred to as Category II practitioners) shall include all those Allied Health Professionals who provide a medical level of care or perform surgical tasks consistent with granted clinical privileges, but who are required by law and/or the Hospital to exercise some or all of those clinical privileges under the direction of, or in collaboration with, a Delegating/Supervising Physician pursuant to a written supervision or collaborative agreement. The Delegating/Supervising physician(s) is responsible for the actions of the Category II practitioner in the Hospital.

(2) A current listing of the specific categories of Advanced Practice and Allied Health Professionals functioning in the Hospital as Category II 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 Medical Executive Committee, without the necessity of further amendment of this Policy.

2.B.3. Dependent Practitioners

(1) "Dependent Practitioners" (hereinafter referred to as Category III practitioners) shall include all those Advanced Practice and Allied Health Professionals who are permitted to practice in the Hospital only under the direct supervision of a physician(s) appointed to the Medical Staff and who function pursuant to a scope of practice. The Delegating/Supervising physician(s) is responsible for the actions of the Category III practitioner in the Hospital.

(2) A current listing of the specific categories of Advanced Practice or Allied Health Professionals functioning in the Hospital as Category III practitioners is attached to this Policy as Appendix C. This Appendix may be modified or supplemented by action of the Board, after receiving the recommendations of the Medical Executive Committee, without the necessity of further amendment of this Policy.

ARTICLE 3

GUIDELINES FOR DETERMINING THE NEED FOR NEW CATEGORIES OF ADVANCED PRACTICE AND ALLIED HEALTH PROFESSIONALS

3.A. DETERMINATION OF NEED

(1) Whenever an Advanced Practice or Allied Health Professional in a category that has not been approved by the Board requests permission to practice at the Hospital, the System Bylaws Committee shall appoint an ad hoc committee with representation from each Hospital to evaluate the need for that particular category of Advanced Practice or Allied Health Professional to make a recommendation to the respective MECs for its review and recommendation to the Board for final action.

(2) As part of the process of determining need, the Advanced Practice or 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 of having such services available at the Hospital.

(3) The ad hoc committee may consider the following factors when making a recommendation to the MEC and the Board as to the need for the services of this category of Advanced Practice or Allied Health Professionals:

(a) the nature of the services that would be offered;

(b) any state license or regulation which outlines the scope of practice for the Advanced Practice or Allied Health Professional,

(c) any state "non-discrimination" or "any willing provider" laws that would apply to the Advanced Practice or Allied Health Professional;

(d) the business and patient care objectives of the Hospital, including patient convenience;

(e) how well the community's needs are currently being met or could be better met if the services offered by the Advanced Practice or Allied Health Professional were provided at the Hospital;

(f) the type of training that is necessary to perform the services that would 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 need for, and availability of, trained staff to support the services that would be offered; and

(i) the ability to appropriately supervise performance and monitor quality of care.

3.B. DEVELOPMENT OF RECOMMENDATIONS

(1) If the MEC determines that there is a need for the particular category of Advanced Practice or Allied Health Professional at the Hospital, the committee shall make any amendments to this policy that may be needed to address:

(a) any specific qualifications and/or training that they must possess beyond those set forth in this Policy;

(b) a detailed description of their authorized scope of practice or clinical privileges;

(c) any specific conditions that apply to their functioning within the Hospital beyond those set forth in this Policy; and

(d) any supervision requirements, if applicable.

(2) In making the determination, the MEC shall consult the appropriate department chair(s) or division directors and consider relevant state law and may contact applicable professional societies or associations. The MEC may also consider the number of Advanced Practice or Allied Health Professionals that are needed in a particular category.

ARTICLE 4

QUALIFICATIONS, CONDITIONS, AND RESPONSIBILITIES

4.A. GENERAL QUALIFICATIONS

4.A.1. Eligibility Criteria:

To be eligible to apply for initial or renewal of clinical privileges or permission to practice, as applicable,[1] an applicant must meet the following criteria unless in exceptional circumstances the Board has determined that a waiver will serve the best interests of the patients and of the Hospital[2]:

(a) have a current, unrestricted license, certification, or registration to practice in Georgia (if applicable), that is not subject to any restrictions, probationary terms, or conditions not generally applicable to all licensees, and have never had a license, certification, or registration to practice revoked or suspended by any state licensing agency;

(b) as applicable to their practice, have a current, unrestricted DEA registration;

(c) provide continuous and timely quality care to all patients in the Hospital for whom the individual has responsibility;

(d) have current, valid professional liability insurance coverage in a form and in amounts satisfactory to the Hospital. Minimum coverage and sufficient amounts and terms will be established from time to time by the Board after consulting with the MEC. Generally, applicants shall carry prior acts or tail coverage required per the applicable Georgia statute of limitations, with a company licensed or authorized to do business in the State of Georgia, or participate in the Professional Liability Program of Emory Healthcare, Inc.;

(e) have never been, and are not currently, excluded, precluded, or debarred from participation in Medicare, Medicaid, or other federal or state governmental health care program;

(f) have never voluntarily or involuntarily had clinical privileges, scope of practice, employment, or status as a participating provider denied revoked, resigned, relinquished, or terminated by any health care facility, including this Hospital, or health plan for reasons related to clinical competence or professional conduct;

[1] All references to permission to practice are deemed to include privileges and scope of practice, as appropriate to the circumstances.

[2] An applicant bears the burden of demonstrating exceptional circumstances, and that his or her qualifications are equivalent to, or exceed, the criterion in question.

(g) have never voluntarily or involuntarily restricted, relinquished or resigned affiliation, clinical privileges, or a scope of practice during an investigation or in exchange for not conducting such an investigation at any health care facility, including this Hospital, or have never had affiliation, privileges or scope of practice automatically resigned due to an omission;

(h) have not been convicted of, or entered a plea of guilty or no contest to, any felony or misdemeanor related to: (i) controlled substances; (ii) illegal drugs; (iii) insurance or health care fraud (including Medicare, Medicaid or other federal or state governmental or private third-party payer fraud or program abuse); (iv) violent acts, (v) sexual misconduct, (vi) moral turpitude, or (vii) child or elder abuse; or been required to pay a civil money penalty for governmental fraud or program abuse;

(i) have not resigned permission to practice within an Emory Hospital within 365 days preceding the date of the application;

(j) have not had an application seeking privileges or permission to practice deemed to have been withdrawn or ineligible for continued processing due to failure of the applicant to respond timely to a request for information;

(k) have not had permission to practice, clinical privileges, or scope of practice automatically relinquished at this or any affiliated Hospital as the result of an omission or misrepresentation on the application or supporting materials (unless waived by the Credentials Committee, MEC and Board for good cause demonstrated by the applicant);

(l) satisfy all additional eligibility qualifications relating to their specific area of practice that may be established by the Hospital;

(m) document compliance with all applicable training and/or educational protocols that may be adopted by the MEC, including, but not limited to, those involving electronic medical records, patient safety, and infection control; and

(n) if seeking to practice as a Category II or Category III practitioner, have a supervision agreement and/or collaborative agreement with a physician who is appointed to the Medical Staff (the "Supervising/Delegating Physician"), as applicable.

4.A.2. Waiver of Threshold Eligibility 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 Committee, Medical Executive Committee, 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.

(d) A determination that an individual is not entitled to a waiver is not a "denial" of appointment or clinical privileges.

4.A.3. Factors for Evaluation:

The following factors will be evaluated as part of the appointment and reappointment processes:

(a) relevant training, experience, and demonstrated current competence, including medical/clinical knowledge, technical and clinical skills, clinical judgment and an understanding of the contexts and systems within which care is provided;

(b) adherence to the ethics of the profession, continuous professional development, an understanding of and sensitivity to diversity, and responsible attitude toward patients and the profession;

(c) good reputation and character;

(d) ability to safely and competently perform the clinical privileges requested;

(e) ability to work harmoniously with others, including, but not limited to, interpersonal and communication skills sufficient to enable them to maintain professional relationships with patients, families, and other members of health care teams; and

(f) recognition of the importance of, and willingness to support, a commitment to quality care and recognition that interpersonal skills and collegiality are essential to the provision of quality patient care.

4.A.4. No Entitlement to Medical Staff Appointment:

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

4.A.5. Non-Discrimination Policy:

The Hospital will not discriminate in granting permission to practice at the hospital on the basis of gender, race, religion, age, national origin, disability unrelated to the provision of patient care or required responsibilities, or any other basis prohibited by applicable law, to

the extent the applicant is otherwise qualified.

4.A.6. Ethical and Religious Directives:

All Advanced Practice and Allied Health Professionals at Emory Saint Joseph's Hospital shall abide by the terms of the Ethical and Religious Directives for Catholic Health Care Services promulgated by the National Conference of Catholic Bishops with respect to their practice at the Hospital. No activity prohibited by said directives shall be engaged in at the Hospital by any Member.

4.B. GENERAL CONDITIONS OF PRACTICE

4.B.1. Assumption of Duties and Responsibilities:

As a condition of permission to practice at the Hospital, all Advanced Practice and Allied Health Professionals (and their Delegating/Supervising Physicians, as applicable) shall specifically agree to the following:

(a) to attend and participate in an applicable orientation programs at the Hospital before actively seeing or treating patients;

(b) to provide continuous and timely quality care to all patients in the Hospital for whom the individual has responsibility;

(c) to abide by all bylaws, rules and regulations, policies of the Medical Staff and Hospital, and Corporate Compliance Programs of the Health System, Hospital, and Medical Staff;

(d) to accept committee assignments and such other reasonable duties and responsibilities as may be assigned;

(e) to immediately notify the Medical Staff Office, in writing, of any change in the practitioner's status or any change in the information provided on the practitioner's application form. Information to be provided will include, but not be limited to:

i. changes to contact information, including email and cell phone number;

ii. changes in licensure or certification status, DEA controlled substances authorization, or professional liability insurance coverage;

iii. the filing of a professional liability lawsuit against the practitioner;

iv. changes in the practitioner's status at any other hospital or health care entity as a result of peer review activities or in order to avoid initiation of peer review activities;

v. knowledge of a criminal investigation involving the practitioner, arrest,

charge, indictment, conviction, or a plea of guilty or no contest in any criminal matter other than a misdemeanor traffic citation;

vi. exclusion or preclusion from participation in Medicare/Medicaid or any sanctions imposed;

vii. any changes in the practitioner's ability to safely and competently exercise clinical privileges, or scope of practice, or to perform the duties and responsibilities of permission to practice because of health status issues, including, but not limited to, impairment due to addiction, alcohol use, or other similar issue (all of which shall be referred for review under the applicable policy); and

viii. any charge of, or arrest for, driving under the influence ("DUI") (Any DUI incident will be reviewed by the Chief of Staff, if applicable, and the CMO so that they may understand the circumstances surrounding it. If they have any concerns after doing so, they will forward the matter for further review under the applicable policy.);

(f) to immediately submit to an appropriate fitness for practice evaluation which may include diagnostic testing (such as blood and/or urine test) or to a complete physical, mental, and/or behavioral evaluation, if at least two Medical Staff Leaders (or one Medical Staff Leader and one member of the Administrative team) are concerned with the individual's ability to safely and competently care for patients and request such testing and/or evaluation. The health care professional(s) to perform the testing and/or evaluations will be determined by the Medical Staff Leaders, and the Advanced Practice or Allied Health Professional will execute all appropriate releases to permit the sharing of information with the Medical Staff Leaders;

(g) to appear for personal or phone interviews in regard to an application for permission to practice as may be requested;

(h) to refrain from illegal fee splitting or other illegal inducements relating to patient referral;

(i) to refrain from assuming responsibility for diagnosis or care of hospitalized patients for which he or she is not qualified or without adequate supervision;

(j) to always wear proper Hospital identification of their name and status;

(k) to seek consultation when appropriate;

(l) to participate in the performance improvement and quality monitoring activities of the Hospital;

(m) to complete, in a timely manner, the medical and other required records, containing all information required by the Hospital;

(n) to cooperate with all utilization oversight activities;

(o) to perform all services and conduct himself/herself at all times in a cooperative and professional manner;

(p) to satisfy applicable continuing education requirements (e.g., state licensure; certification; privilege eligibility criteria);

(q) to pay any applicable application fees, assessments, and/or fines;

(r) to strictly comply with the standards of practice applicable to the functioning of Category II and Category III practitioners in the inpatient hospital setting, as set forth in Section 6.A of this Policy;

(s) to constructively participate in the development, review, and revision of clinical practice and evidence-based medicine protocols and pathways pertinent to his or her specialty (including those related to national patient safety initiatives and core measures), and to comply with all such protocols and pathways;

(t) to comply with all applicable training and/or educational protocols that may be adopted by the MEC, including, but not limited to, those involving electronic medical records, patient safety, and infection control; and

(u) that, if there is any misstatement in, or omission from, the application, the Hospital may stop processing the application (or, if privileges or permission to practice has been granted prior to the discovery of a misstatement or omission, the privileges or permission, as applicable, may be deemed to be automatically relinquished). In either situation, there shall be no entitlement to procedural rights provided in this Policy. The individual will be informed in writing of the nature of the misstatement or omission and permitted to provide a written response for the Credentials Committee's consideration.

4.B.2. Burden of Providing Information:

(a) Advanced Practice and Allied Health Professionals seeking permission to practice or renewal of 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.

(b) Advanced Practice and Allied Health Professionals seeking permission or renewal of permission to practice have the burden of providing evidence that all the statements made and all information provided in support of the application are accurate and complete.

(c) An application will be complete when all questions on the application form have been answered, all supporting documentation has been supplied, and all information has been verified from primary sources. An application will become incomplete if the need arises for new, additional, or clarifying

information. Any application that continues to be incomplete 30 days after the applicant has been notified of the additional information required and the applicant has been unresponsive may be deemed to be withdrawn.

(d) It is the responsibility of the individual seeking permission to practice or renewal of permission to practice to provide a complete application, including adequate responses from references. An incomplete application will not be processed.

4.C. APPLICATION

Provisions related to application forms, information to be provided, misstatements and omissions, immunity and authorization to obtain/release information will be conducted in accordance with the Medical Staff Credentials Policy, as applicable to individual APP and AHP applicants.

ARTICLE 5
CREDENTIALING PROCEDURE

5.A PROCESSING OF INITIAL APPLICATION TO PRACTICE

(1) The applicable provisions of the Credentials Policy will govern the processing of applications for privileges or permission to practice for Category I and II APPs and AHPs.

(2) An APP or Allied Health Professional who is in a category of practitioners that has not been approved by the Board to practice at the Hospital shall be ineligible to receive an application. A determination of ineligibility does not entitle an APP or Allied Health Professional to the procedural rights outlined in Article 8 of this Policy.

(3) The chief nursing officer, or their designee, will also review and make a recommendation on the applications for all advanced practice registered nurses.

5.A.1. Procedure for Category III Practitioners

The Medical Staff Office will determine whether a Category III applicant has satisfied all of the qualifications for permission to practice and the scope of practice requested. Thereafter, the Chief Executive Officer may grant the Category III applicant permission to practice and a scope of practice. The Chief Executive Officer may impose specific conditions relating to behavior (e.g., code of conduct) or to clinical issues.

5.A. 2. Time Periods for Processing

Once an application is deemed complete, it is expected to be processed within 120 days, unless it becomes incomplete. This time period is intended to be a guideline only and will not create any right for the applicant to have the application processed within this precise time period.

5.A.3. Reapplication

An applicant who has received a final adverse action concerning permission to practice and/or a grant of clinical privileges, shall not be eligible to reapply for a period of five (5) years unless the Board expressly provides otherwise. Upon the reapplication, the applicant shall submit additional specific information showing the condition or basis for the earlier adverse determination no longer exists.

5.B. CLINICAL PRIVILEGES

5.B.1 General:

a) For Category I and Category II practitioners, only those clinical privileges granted by the Board may be exercised, subject to the terms of this Policy.

b) Category II practitioners will not be granted a clinical privilege by the Board if the Board has not granted their Delegating/Supervising physician the clinical privilege.

c) A request for privileges will be processed only when an applicant satisfies the threshold eligibility criteria for the delineated privileges. An individual who does not satisfy the eligibility criteria for the clinical privileges may request, in writing, that the criteria be waived and the basis for a proposed waiver. Waivers will not be routinely granted but rather will be at the discretion of the MEC based on an individual's excellent record and the best interests of the hospital. Waivers are expected to be rare and are not intended to be a precedent for any other individual or group.

d) Requests for clinical privileges that are subject to an exclusive contract or arrangement must be consistent with the applicable contract or arrangement.

e) Recommendations for clinical privileges for Category I and Category II practitioners may be based on consideration of the following:

(i) education, relevant training, experience, and demonstrated current competence, including medical/clinical knowledge, technical and clinical skills, judgement, interpersonal and communication skills, and professionalism with patients, families, and other members of the healthcare team and peer evaluations relating to these criteria;

(ii) appropriateness of utilization patters to the extent that such information is available and relevant;

(iii) ability to perform the privileges requested competently and safely;

(iv) information resulting from ongoing and focused professional practice evaluation and other performance improvement activities, as applicable;

(v) adequate professional liability insurance coverage for the clinical privileges requested in the amount of $1 million/$3 million or as determined by the Board;

(vi) the Hospital's available resources and personnel;

(vii) any previously successful or currently pending challenges to any licensure or registration, or the voluntary or involuntary relinquishment of such licensure or registration;

(viii) any information concerning professional review actions or voluntary or involuntary termination, limitation, reductions, or loss of appointment or clinical privileges at another hospital;

(ix) practitioner-specific data as compared to aggregate data, when available; and

(x) professional liability actions, especially any such actions that reflect an unusual pattern or number of actions.

f) Requests for additional clinical privileges must state the additional clinical privileges requested and provide information sufficient to establish eligibility.

5.B.2 Focused Professional Practice Evaluation for Initial Privileges

All initial grants of clinical privileges for Category I and Category II practitioners, whether at the time of initial permission to practice, renewal of permission to practice, or at any time in between, will be subject to focused professional practice evaluation ("FPPE") in order to confirm competence. The process for these situations is outlined in the Hospital's Focused Professional Practice Evaluation Policy.

5.C. TEMPORARY CLINICAL PRIVILEGES

5.C.1. Temporary Clinical Privileges:

(1) Applicants: Temporary privileges for an applicant for initial permission to practice may be granted by the Chief Executive Officer or his/her designee, upon recommendation of the Chief Medical Officer or his/her designee, as applicable, under the following conditions:

(a) The Category I or Category II practitioner has submitted a complete application, along with the application fee, if applicable;

(b) The verification process is complete, including verification of current licensure, relevant training or experience, current competence, ability to exercise the privileges requested, current professional liability coverage, compliance with privileges criteria, and consideration of information from the National Practitioner Data Bank, a criminal background check, and OIG inquiries;

(c) The applicant meets the Hospital's criteria for expedited credentialing and raises no concerns; and

(d) The application is pending review by the Credentials Committee, the MEC, and the Board, following a favorable report by the chief of service or section chief.

Temporary privileges for an applicant will be granted for a maximum period of 120 consecutive days.

(2) Visiting. Temporary privileges may also be granted in other limited and exceptional situations by the CEO, upon recommendation of the Chief Medical Officer and the applicable chief of service or section chief, when there is an important patient care, treatment, or service need. Specifically, temporary privileges may be granted for situations such as the following:

(a) the care of a specific patient or a critical care need;

(b) when a proctoring or consulting physician is needed, but is otherwise unavailable; or

(c) when necessary to prevent a lack or lapse of services in a needed specialty area.

At a minimum, the following factors will be considered and verified prior to the granting of temporary privileges in these situations: current licensure and current competence (verification of good standing at all hospitals where the individual practiced for at least the previous two years), current professional liability coverage acceptable to the Hospital, results of a query to the National Practitioner Data Bank and from OIG and SAM queries, and a determination that the provider meets the Hospital's expedited credentialing criteria. The grant of clinical privileges in these situations will not exceed 60 days. In exceptional situations, this period of time may be extended in the discretion of the CEO and the Chief Medical Officer.

(b) Locum Tenens: Requests for initial or renewed privileges as a locum tenens provider will be processed through the same process as set forth in this Policy. In such case, the individual must satisfy all qualifications and requirements set forth in this Policy.

(c) Prior to any temporary privileges being granted, the individual must agree in writing to be bound by the bylaws, rules and regulations, policies, procedures, and protocols of the Hospital.

(d) Individuals who are granted temporary privileges will be subject to the Hospital policy regarding focused professional practice evaluation.

(e) The granting of temporary privileges is a courtesy that may be withdrawn by the Chief Executive Officer at any time, after consulting with the Chief Medical Officer, the chair of the Credentials Committee or the Chief of Service. Neither the denial nor termination of temporary privileges will entitle the individual to the procedural rights set forth in Article 8.

5.D. PROCESSING APPLICATIONS FOR RENEWAL TO PRACTICE

5.D.1 Submission of Application:

(1) The grant of permission to practice will be for a period not to exceed two years. A request to renew clinical privileges or scope of practice will be considered only upon submission of a completed renewal application.

(2) At least four months prior to the date of expiration of a provider's clinical privileges or scope of practice, Medical Staff Services will notify the individual of the date of expiration and provide the individual with a renewal application. A completed renewal application should be returned to Medical Staff Services within 30-days.

(3) Failure to return a complete application within 60-days of receipt may result in the expiration of clinical privileges or permission to practice at the end of the then current term.

(4) Once an application for renewal of clinical privileges or scope of practice has been completed and submitted, it will be evaluated following the same procedures outlined in this policy regarding initial applications.

5.D.2. Renewal Process for Category I and Category II Practitioners:

(1) The procedures pertaining to an initial request for privileges, including eligibility criteria factors for evaluation, will be applicable in processing requests for renewal for these practitioners.

(2) As part of the process for renewal of clinical privileges, the following factors will be considered:

(a) A recommendation prepared by the applicable Chief of Service or Section Chief;

(b) An assessment prepared by a peer;

(c) results of the Hospital's performance improvement and ongoing and focused professional practice evaluation activities, taking into consideration, when applicable, practitioner-specific information compared to aggregate information concerning other individuals in the same or similar specialty (provided that, other practitioners will not be identified);

(d) resolution of any verified complaints received from patients or staff; and

(e) any focused professional practice evaluations.

(3) For Category II practitioners, an assessment prepared by the Supervising Physician(s) may also be considered.

5.D.3. Renewal Process for Category III Practitioners:

(1) The procedures pertaining to an initial request for a scope of practice, including eligibility criteria and factors for evaluation, will be applicable in processing requests for renewal for these practitioners.

(2) As part of the process for renewal of scope of practice, the following factors will be considered:

(a) a competency assessment of the individual performed by the Delegating/Supervising Physician(s) and/or the applicable Hospital supervisor (i.e. OR Supervisor, Nursing Supervisor); and

(b) resolution of any validated complaints received from patients or staff.

ARTICLE 6

CONDITIONS OF PRACTICE APPLICABLE TO
CATEGORY II AND CATEGORY III PRACTITIONERS

6.A. STANDARDS OF PRACTICE FOR THE UTILIZATION OF CATEGORY II AND CATEGORY III PRACTITIONERS IN THE INPATIENT HOSPITAL SETTING

(1) Category II and Category III practitioners are not permitted to function independently in the inpatient Hospital setting. As a condition of being granted permission to practice at the Hospital, all Category II and Category III practitioners specifically agree to abide by the standards of practice set forth in this Section. In addition, as a condition of being permitted to utilize the services of Category II and Category III practitioners in the Hospital, all Medical Staff members who serve as Delegating/Supervising Physicians to such individuals also specifically agree to abide by the standards set forth in this Section.

(2) The following standards of practice are applicable to Category II and Category III practitioners in the Hospital:

(a) Admitting Privileges. Category II and Category III practitioners are not granted inpatient admitting privileges and therefore may not admit patients independent of the Supervising Physician.

(b) Consultations. Category II practitioners may independently perform requested patient consultations as delegated by their Supervising Physicians. If it is agreed that the Category II practitioner may provide the consultation, the Supervising Physician shall review and countersign the consultation report in accordance with Hospital policies and procedures. Category III practitioners may not perform consultations but may, as directed by their Supervising/Delegating Physician, visit the patient to gather data to facilitate the physician's performance of the requested consultation.

(c) Emergency On-Call Coverage. Category II and Category III practitioners may not independently participate in the emergency on-call roster (formally, or informally by agreement with their Supervising Physicians), in lieu of the Supervising Physician. It shall be within the discretion of the Emergency Department personnel requesting assistance whether it is appropriate to contact a Category II practitioner prior to the Supervising Physician. However, when contacted by the Emergency Department, the Supervising Physician (or his or her covering physician) must personally respond to all calls in a timely manner, in accordance with requirements set forth in the Medical Staff Credentials Policy. Following discussion with the Emergency Department, the Supervising Physician may direct a Category II and Category III practitioners to see the patient, gather data, and order tests for further review by the Supervising Physician. However, the

Supervising Physician must personally see the patient when requested by the Emergency Department physician.

(d) Calls Regarding Supervising Physician's Hospitalized Inpatients. Category II and Category III practitioners may, in collaboration with the Supervising Physician, respond to calls from floors or special care units regarding hospitalized patients. It is within the discretion of the individual requesting assistance whether to contact a Category II or Category III practitioner prior to the Supervising Physician. However, if the individual requesting assistance determines that it is in the best interest of patient care to speak directly to the Supervising Physician, the Supervising Physician must personally respond.

(e) Daily Inpatient Rounds. A Category II practitioner (specifically an Advanced Practice Registered Nurse or Physician Assistant) is permitted to perform daily inpatient rounds; however, all inpatients must also be visited by the Delegating/Supervising Physician (or designated physician) when requested. Category III practitioners may only perform daily inpatient rounds in collaboration with the Delegating/Supervising Physician.

(f) Invasive Procedures. When performing invasive procedures, Category II and Category III practitioners must function under the supervision of their Delegating/Supervising Physician and in accordance with their written collaboration and/or supervision agreements and in accordance with the privileges or scope of practice granted.

6.B. OVERSIGHT BY DELEGATING/SUPERVISING PHYSICIAN

(1) Any activities permitted to be performed at the Hospital by a Category II or Category III practitioner shall be performed only under the supervision or direction of a Delegating/Supervising Physician.

(2) Category II or Category III practitioners may function in the Hospital only so long as:

(i) they are supervised by a Delegating/Supervising Physician who is currently appointed to the Medical staff, and

(ii) they have a current, written supervision agreement with the Delegating/Supervising Physician. In addition, should the Medical Staff appointment or clinical privileges of the Delegating/Supervising Physician be revoked or terminated, the Category II or Category III practitioner's permission to practice at the Hospital and clinical privileges or scope of practice shall be automatically relinquished (unless the individual will be supervised by another approved physician on the Medical Staff).

(3) As a condition of clinical privileges or a scope of practice, a Category II or

Category III practitioner and his/her Delegating/Supervising Physician must submit a copy of their written supervision or collaboration agreement to the Hospital. This agreement must meet the requirements of all applicable Georgia statutes and regulations, as well as any additional requirements of the Hospital. It is also the responsibility of the Category II and Category III practitioner and his/her Delegating/Supervising Physician to provide the Hospital with any revisions or modifications that are made to such agreements between them. This notice must be provided to the Hospital within three days of any such change.

6.C. QUESTIONS REGARDING AUTHORITY OF A CATEGORY II OR CATEGORY III PRACTITIONER

(1) Should any Medical Staff member or Hospital employee who is licensed or certified by the state have any question regarding the clinical competence or authority of a Category II or Category III practitioner, either to act or to issue instructions outside the physical presence of the Supervising Physician in a particular instance, the Medical Staff member or Hospital employee shall have the right to require that the Category II or Category III practitioner's Supervising Physician validate, either at the time or later, the instructions of the Category II or Category III practitioner. Any act or instruction of the Category II or Category III practitioner shall be delayed until such time as the staff member or Hospital employee can be certain that the act is clearly within the scope of the Category II or Category III practitioner's activities as permitted by the Board. In these situations, the Medical Staff member or Hospital employee shall first discuss the matter with the Supervising Physician. If that does not resolve the matter, the Chief of Staff or the CMO will be contacted.

(2) Any question regarding the clinical practice or professional conduct of a Category II or Category III practitioner shall immediately be reported to the Chief of Staff, Chair of the Credentials Committee, the relevant Chief of Service, the CMO, or the CEO, who shall undertake such action as may be appropriate under the circumstances. The individual to whom the concern has been reported will also discuss the matter with the Delegating/Supervising Physician, and in instance when the Category II provider is employed by the Hospital or Emory Healthcare, the Director of Advanced Practice Providers.

6.D. RESPONSIBILITIES OF SUPERVISING PHYSICIAN

(1) The Delegating/Supervising Physician shall be responsible for the actions of the Category II or Category III practitioner in the Hospital and will remain responsible for all care provided by the Category II or Category III practitioner in the Hospital.

(2) Physicians who wish to utilize the services of a Category II or Category III practitioner in their clinical practice at the Hospital must notify the Medical Staff Office of this fact in advance and must ensure that the individual has been appropriately credentialed in accordance with this Policy or with Human

Resources policies and procedures before the Category II or Category III practitioner participates in any clinical or direct patient care of any kind in the Hospital.

(3) Delegating/Supervising Physicians who wish to utilize the services of Category II and Category III practitioners in the inpatient setting specifically agree to abide by the standards of practice set forth in Section 6.A above.

(4) The number of Category II or Category III practitioners acting under the supervision of one Delegating/Supervising Physician, as well as the care they may provide, will be consistent with applicable state statutes and regulations and any other policies adopted by the Hospital. The Delegating/Supervising Physician will make all appropriate filings with the State Board of Medicine regarding the supervision and responsibilities of the Category II or Category III practitioner, to the extent that such filings are required and shall provide a copy of the same to Medical Staff Services.

(5) It will be the responsibility of the Delegating/Supervising Physician to ensure that the Category II or Category III practitioner maintains professional liability insurance coverage in amounts required by the Board. The insurance must cover any and all activities of the Category II or Category III practitioner in the Hospital. The Delegating/Supervising Physician will furnish evidence of such coverage to the Hospital. The Category II or Category III practitioner will act in the Hospital only while such coverage is in effect.

ARTICLE 7

MATTERS INVOLVING PROFESSIONAL PERFORMANCE OF CATEGORY I, CATEGORY II, AND CATEGORY III PRACTITIONERS

7.A. OVERVIEW AND GENERAL PRINCIPLES

(1) Options Available to Medical Staff Leaders and procedures for addressing questions involving professional performance, competence, health or behavior will be addressed in accordance with the Medical Staff Credentials Policy, to the extent reasonable and as applicable to the circumstances, including where appropriate in the judgment of the involved leaders[3]:

(a) collegial intervention and progressive steps;

(b) ongoing and focused professional practice evaluations;

(c) mandatory meeting;

(d) fitness for practice evaluation (including blood and/or urine test);

(e) automatic relinquishment of appointment and clinical privileges;

(f) leaves of absence;

(g) precautionary suspension;

(h) formal investigation; or

(i) referral in accordance with another policy (e.g., code of conduct policy, practitioner health policy, peer review policy) or referral to the Medical Executive Committee.

[3] The Hearing and Appeals procedures in the Credentials Policy will not apply; rather the procedural rights in Article 8 of this Policy will govern any proposed adverse actions.

ARTICLE 8

PROCEDURAL RIGHTS FOR CATEGORY I, CATEGORY II, AND CATEGORY III PRACTITIONERS

Category I, Category II, and Category III practitioners are not entitled to the hearing and appeals procedures set forth in the Medical Staff Credentials Policy. Any and all procedural rights to which these individuals are entitled are set forth in this Article.

8.A. PROCEDURAL RIGHTS FOR CATEGORY I AND CATEGORY II PRACTITIONERS

8.A.1. Notice of Rights:

(1) In the event a recommendation is made by the MEC that a Category I or Category II practitioner not be granted clinical privileges or that the privileges previously granted be restricted for a period of more than 30 days, terminated, or not renewed, the individual will receive special notice of the recommendation. The special notice will include a general statement of the reasons for the recommendation and will advise the individual that he or she may request a hearing.

(2) The rights and procedures in this Section will also apply if the Board, without a prior adverse recommendation from the MEC, makes a recommendation not to grant clinical privileges or that the privileges previously granted be restricted, terminated, or not renewed. In this instance, all references in this Article to the MEC will be interpreted as a reference to the Board.

(3) If the Category I or Category II practitioner wants to request a hearing, the request must be in writing, directed to the CEO, within 30 days after receipt of written notice of the adverse recommendation.

(4) The hearing will 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.

8.A.2. Hearing Committee:

(1) If a request for a hearing is made in a timely manner, the CEO, in conjunction with the Chief Medical Officer and the Chief of Staff, as applicable, shall appoint a Hearing Committee composed of up to three individuals (including, but not limited to, individuals appointed to the Medical Staff, Category I or Category II practitioners,, 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 Hearing Committee shall not include anyone who previously participated in the recommendation, any relatives or practice partners of the Category I or Category II practitioner, or any competitors of the affected individual.

(2) As an alternative to the Hearing Committee described in paragraph (a) of this Section, the CEO, in conjunction with the Chief Medical Officer and Chief of Staff, as applicable, may instead appoint a Hearing Officer to perform the functions that would otherwise be carried out by the Hearing 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 a Hearing Committee, all references in this Article to the Hearing Committee shall be deemed to refer instead to the Hearing Officer, unless the context would clearly otherwise require.

(3) 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.

8.A.3. Hearing Process:

(1) A record of the hearing will be maintained by a stenographic reporter or by a recording of the proceedings. Copies of the transcript will be available at the individual's expense.

(2) The hearing will last no more than six hours, with each side being afforded approximately three hours to present its case on consecutive days, in terms of both direct and cross-examination of witnesses.

(3) At the hearing, a representative of the MEC will first present the reasons for the recommendation. The Category I or Category II practitioner will be invited to present information to refute the reasons for the recommendation.

(4) Both parties will have the right to present witnesses. The Presiding Officer will permit reasonable questioning of such witnesses.

(5) The Category I or Category II practitioner and the MEC may be represented at the hearing by legal counsel. However, while counsel may be present at the hearing, counsel will not call, examine, or cross-examine witnesses or present the case.

(6) The Category I or Category II practitioner will have the burden of demonstrating, by clear and convincing evidence, that the recommendation of the MEC was arbitrary, capricious, or not supported by substantial evidence. The quality of care provided to patients and the smooth operation of the Hospital will be the paramount considerations.

(7) The Category I or Category II practitioner and the MEC will have the right to prepare a post-hearing memorandum for consideration by the Hearing Committee. The Presiding Officer will establish a reasonable schedule for the submission of such memoranda.

8.A.4. Hearing Committee Report:

(1) Within 20 days after the conclusion of the proceeding or submission of the post-hearing memoranda, whichever date is later, the Hearing Committee will prepare a written report and recommendation. The Hearing Committee will forward the report and recommendation, along with all supporting information, to the CEO. The CEO will send a copy of the written report and recommendation by special notice to the Category I or Category II practitioner and to the MEC.

(2) Within ten days after notice of such recommendation, the Category I or Category II practitioner and/or the MEC may make a written request for an appeal. The request must include a statement of the reasons, including specific facts, which justify an appeal.

(3) The grounds for appeal will be limited to an assertion that there was substantial failure to comply with this Policy during the hearing, so as to deny a fair hearing, and/or that the recommendation of the Hearing Committee was arbitrary, capricious, or not supported by substantial evidence.

(4) The request for an appeal will be delivered to the CEO by special notice.

(5) If a written request for appeal is not submitted timely, the appeal is deemed to be waived and the recommendation and supporting information will be forwarded to the Board for final action. If a timely request for appeal is submitted, the CEO will forward the report and recommendation, the supporting information and the request for appeal to the Board. The Chair of the Board will arrange for an appeal.

8.A.5. Appellate Review:

(1) An Appellate Review Committee appointed by the Chair of the Board will consider the record upon which the adverse recommendation was made. New or additional written information that is relevant and could not have been made available to the Hearing Committee may be considered at the discretion of the Appellate Review Committee. This review will be conducted within 30 days after receiving the request for appeal.

(2) The Category I or Category II practitioner and the MEC will each have the right to present a written statement on appeal.

(3) At the sole discretion of the Appellate Review Committee, the Category I or Category II practitioner and a representative of the MEC may also appear personally to discuss their position.

(4) Upon completion of the review, the Appellate Review Committee will provide a report and recommendation to the full Board for action. The Board will 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.

(5) The Category I or Category II practitioner will receive special notice of the Board's action. A copy of the Board's final action will also be sent to the MEC for information.

8.B. PROCEDURAL RIGHTS FOR CATEGORY III PRACTITIONERS

(1) In the event that a recommendation is made by the MEC that a Category III practitioner not be granted the scope of practice requested or that a scope of practice previously granted be restricted or terminated, the individual shall be notified of the recommendation. The notice shall include a specific statement of the reasons for the recommendation and shall advise the individual that he or she may request a meeting with the MEC before the recommendation is forwarded to the Board for final action.

(2) If the Category III practitioner desires to request a meeting, he or she must make such request in writing and direct it to the Hospital CEO within 30 days after receipt of the written notice of the adverse recommendation.

(3) If a meeting is requested in a timely manner, it shall be scheduled to take place within a reasonable time frame. The meeting shall be informal and shall not be considered a hearing. The Category III practitioner and his or her Supervising Physician shall both be permitted to attend and participate in the meeting. However, no counsel for either the Category III practitioner or the MEC shall be present.

(4) Following this meeting, the MEC shall make a final recommendation to the Hospital Board.

ARTICLE 9

HOSPITAL EMPLOYEES

(1) Except as provided below, the employment of a Category I, Category II, or Category III practitioner by the Hospital or one of its affiliates will be governed by applicable employment policies and manuals and the terms of the individual's employment relationship or written contract. To the extent that applicable employment policies or manuals, or the terms of any employment contract, conflict with this Policy, the employment policies, manuals and descriptions and terms of the individual's employment relationship or written contract will apply.

(2) Hospital-employed Category I, Category II, and Category III practitioners that are credentialed under this Policy are bound by all of the same conditions and requirements in this Policy that apply to non-Hospital employed Category I, Category II, and Category III practitioners.

(3) A request for clinical privileges, on an initial basis or for renewal, submitted by a Category I or Category II practitioner who is seeking employment or who is employed by the Hospital, shall be processed in accordance with the terms of this Policy. A report regarding each practitioner's qualifications will be made to appropriate management personnel to assist with employment decisions.

(4) If a concern about an employed Category I, Category II, or Category III practitioner's clinical competence or professional conduct originates with the Medical Staff, the concern will be reviewed and addressed in accordance with this Policy, after which a report will be provided to appropriate management personnel. However, nothing herein will require the individual's employer to follow this policy.

ARTICLE 10

AMENDMENTS

Amendments to the Emory Healthcare Policy on Advanced Practice and Allied Health Professionals shall be made in accordance with the provisions in the Medical Staff Bylaws.

ARTICLE 11

ADOPTION

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

APPENDIX A

Those individuals currently practicing as Category I practitioners at the Hospital are as follows:

Hospital	**Category I Practitioners**
Emory Johns Creek Hospital	Clinical Psychologists
Emory Saint Joseph's Hospital	Clinical Psychologists, Optometrists
Emory University Hospital	Clinical Psychologists, Optometrists, Doctor of Philosophy (Pathology)
Emory University Hospital Midtown	Clinical Psychologists, Optometrists, Doctor of Philosophy (Pathology)

APPENDIX B

Those individuals currently practicing as Category II practitioners at the Hospital are as follows:

Hospital	**Category II Practitioners**
Emory Johns Creek Hospital	Anesthesia Assistants, Certified Nurse Midwives, Clinical Nurse Specialists, Clinical Nurse Specialists-MH, Certified Registered Nurse Anesthetists, Nurse Practitioners, Physician Assistants, Surgical Assistants, Certified Surgical Assistants, Certified Surgical First Assistants, Orthopedic Tech – Surgery Certified, RN First Assistants
Emory Saint Joseph's Hospital	Anesthesia Assistants, Certified Registered Nurse Anesthetists, Nurse Practitioners, Pathology Assistants, Physician Assistants, Surgical Assistants, Certified Surgical Assistants, Certified Surgical First Assistants, and RN First Assistants
Emory University Hospital	Acupuncturist, Anesthesia Assistants, Certified Nurse Midwives, Clinical Nurse Specialists, Clinical Nurse Specialists-MH, Certified Registered Nurse Anesthetists, Nurse Practitioners, Physician Assistants, Surgical Assistants, Certified Surgical Assistants, Certified Surgical First Assistants, Orthopedic Tech – Surgery Certified, and RN First Assistants
Emory University Hospital Midtown	Acupuncturist, Anesthesia Assistants, Certified Nurse Midwives, Clinical Nurse Specialists, Clinical Nurse Specialists-MH, Certified Registered Nurse Anesthetists, Nurse Practitioners, Physician Assistants, Surgical Assistants, Certified Surgical Assistants, Certified Surgical First Assistants, Orthopedic Tech – Surgery Certified, and RN First Assistants

APPENDIX C

Those individuals currently practicing as Category III practitioners at the Hospital are as follows:

Hospital	**Category III Practitioners**
Emory Johns Creek Hospital	Orthopedic Technicians Certified, Non-Hospital Employed Registered Nurses
Emory Saint Joseph's Hospital	Non-Hospital Employed Registered Nurses
Emory University Hospital	Orthopedic Technicians Certified
Emory University Hospital Midtown	Orthopedic Technicians Certified