Hunterdon Medical Center
Your full circle of care.

Credentials Manual of the Medical Staff

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Hunterdon Medical Center

Credentials Manual of the Medical Staff

Table of Contents

CHAPTER 1 - APPOINTMENT

1.1 PRE-APPLICATION

The pre-application process serves as a screening mechanism to ensure that applications for membership and/or clinical privileges are given only to those practitioners who are qualified to apply for membership and/or clinical privileges. The purpose of the pre-application process is to determine the ability of an applicant to meet general qualifications for membership and/or clinical privileges and to protect the hospital and the practitioner from the administrative expense of processing an application and providing due process to applicants who do not meet the general criteria. Advanced practice providers, providers who will be employed by Hunterdon Healthcare System and/or providers joining contracted provider groups are not subject to the pre-application process.

1.1.1 Pre-application Form

A pre-application form shall be sent upon request to a practitioner who is interested in applying for Medical Staff membership and/or clinical privileges. The form shall ask for information on at least the following basic criteria:

1.1.1.1 Board Eligibility or Board Certification in the specialty for which the applicant is requesting privileges;

1.1.1.2 Location of office practice in the service area of the hospital as determined by the Governing Body;

1.1.1.3 The specialty of the practitioner and the medical staff category sought.

1.1.1.4 Status of licensure to practice medicine/dentistry in the State of New Jersey

1.1.1.5 Current and anticipated hospital affiliations

1.1.2 Process

1.1.2.1 Eligibility to Receive Application

An application packet will be sent to those practitioners who meet all general eligibility requirements as determined by information provided on the pre-application form. Practitioners who do not meet the basic eligibility requirements or for whom no openings exist as determined by the Board of Trustees upon recommendation of the Needs Committee will be notified in writing that they are not eligible to receive an application for membership and/or clinical privileges.

1.2 APPLICATION

An application must be submitted by the applicant in writing and on the application form as designated by the Medical Executive Committee and approved by the Governing Body within thirty days of receipt of the application packet.

1.2.1 Application Packet

HMC shall provide to each applicant an application packet which includes at least the following:

(a) Application form;
(b) Delineation of Privileges form;
(c) Medical Staff Bylaws;
(d) Medical Staff Rules and Regulations;
(e) Credentials Manual;
(f) Departmental Rules and Regulations;

1.3 APPLICATION CONTENT

Each applicant must furnish complete information concerning the following:

1.3.1 Graduate and post-graduate training, including the name of each institution, degrees granted, programs begun and/or completed, month and year of dates attended, and names of practitioners responsible for the applicant's performance.

1.3.2 Evidence of all currently valid medical, dental, and/or other professional licenses or certificates, Drug Enforcement Administration registration, and State of New Jersey Controlled Dangerous Substance certificate.

1.3.3 Specialty or subspecialty Board Certification and Recertification, or eligibility status, including the full name of the Board, if Board, if applicable.

1.3.4 Professional liability insurance coverage in the amount specified by the Governing Body, and information on malpractice claims history and experience (suits and settlements made, concluded and pending), including the name of the insurance carrier.

1.3.5 Valid National Provider Identifier (NPI)

1.3.6 Physical or mental conditions which could affect the practitioner's ability to safely and competently perform any requested privileges or medical staff duties.

1.3.7 Any pending actions which could result in, and completed actions which have resulted in denial, revocation, suspension, reduction, limitation, probation, non-renewal or voluntary or involuntary relinquishment of:

(a) License or certificate to practice in any profession in any state or country;
(b) Drug Enforcement Administration or State of New Jersey Controlled Dangerous Substance certificate;
(c) Membership or fellowship in local, state or national professional organization;
(d) Faculty membership at any medical or other professional school;
(e) Staff membership or clinical privileges at any other hospital, clinic or health care institution;
(f) Professional liability insurance.
(g) Participation in any private, Federal or State health insurance program, including Medicare or Medicaid.

1.3.8 All previous and current affiliations, including hospitals, clinics, other health care institutions, practitioners with whom the applicant is or was associated, and inclusive dates of each affiliation and association.

1.3.9 Professional references (see 1.4)

1.3.10 Department(s) in which the applicant intends to hold clinical privileges.

1.3.11 Any current criminal charges pending against the applicant and any past charges including their resolution.

1.3.12 Current photograph for verification identification purposes.

1.3.13 Copy of government issued photo identification (e.g., passport, driver's license or military identification).

1.3.14 PPD and immunization status.

1.4 PROFESSIONAL REFERENCES

The applicant must provide the names of at least three practitioners in the health care field, not currently partners with the applicant in professional practice or related to him/her, who have personal knowledge of the applicant's current clinical ability, ethical character, health status and ability to work harmoniously

with others and who will provide specific written comments on these matters upon request from the hospital or Medical Staff authorities. The named individuals must have acquired the requisite knowledge through recent observation of the applicant's professional performance over a reasonable period of time and, at least one should have had organizational responsibility for applicant's performance, i.e., residency director, department chairperson, hospital administrator, etc.

1.5 EFFECT OF APPLICATION

The applicant must sign the application form and in so doing:

1.5.1 Attests to the correctness and completeness of all information furnished;

1.5.2 Signifies his/her willingness to appear for interviews in connection with the application;

1.5.3 Agrees to abide by the terms of the Bylaws of the Medical Staff and related documents, departmental Rules and Regulations, and those of the hospital if granted membership and/or clinical privileges, and to abide by the terms thereof in all matters relating to consideration of the application without regard to whether or not membership and/or privileges are granted and to abide by such bylaws, rules regulations and policies as may from time to time be enacted.

1.5.4 Agrees to maintain an ethical practice and to provide continuous care to his/her patients;

1.5.5 Authorizes and gives consent to hospital representatives to consult with institutions, organizations and individuals who may have information bearing on the applicant's professional and ethical qualifications and competence and consents to inspection of all records and documents that may be material to evaluation of said qualifications and competence;

1.5.6 Releases from any liability all those who, in good faith and without malice, review, act on or provide information regarding the applicant's competence, professional ethics, character, health status, and other qualifications for Staff appointment and clinical privileges.

1.5.7 Assumes the burden of producing adequate information for proper evaluation of professional, ethical and other qualifications for membership and clinical privileges and for resolving any doubts about such qualifications.

1.6 APPLICATION FEE

The applicant shall pay a non-refundable application fee as determined by the Governing Body after consultation with the Medical Executive Committee. Application fees are waived for providers who will be employed by Hunterdon Healthcare System.

1.7 DEFINITION OF HOSPITAL REPRESENTATIVE

Representative includes the Governing Body, its members and committees; the President and Chief Executive Officer of the hospital or designees; the Medical Staff organization and all Medical Staff members and committees which have responsibility for providing information about or collecting and evaluating the applicant's credentials or acting upon his/her application, and any authorized representative of any of the foregoing.

1.8 PROCESSING THE APPLICATION

1.8.1 Responsibility of the Applicant

The applicant has the responsibility and burden to produce all information necessary at the sole discretion of HMC for an evaluation of his/her experience, training, demonstrated ability, health status, and attitude, and of resolving any doubts about these or any of the qualifications required for Staff appointment and/or clinical privileges, and of satisfying any reasonable request for information or clarification, including health examinations, made by the appropriate authorities of the Medical Staff or Governing Body. Failure of the applicant to meet the required responsibilities within 6 months of receipt of the application shall constitute voluntary withdrawal of the application after notification of the applicant. In such situations, the application shall be considered to be incomplete with no requirement to further process the application. There shall be no right of appeal.

1.8.2 Verification of Information

When a completed application is received by the Medical Staff Office, references shall be obtained from among the most relevant of the following:

(a) Professional school(s), begun and/or completed;
(b) Professional school(s), begun and/or completed;
(c) Post-graduate training programs, begun and/or completed;
(d) Fellowship programs, begun and/or completed;
(e) Two professional references, as previously defined;
(f) Preceptors and/or service chiefs listed on the application, one of whom shall be the clinical department chair at the applicant's primary affiliation;
(g) Previous and current hospital affiliations;
(h) Previous and current practice affiliations;
(i) Specialty Boards;
(j) Applicable data banks;

The following information shall be verified:

(aa) State Licensure;
(bb) DEA and CDS Certificates;
(cc) Malpractice insurance and a 10-year claims history .
Copies of the privileging request form and the signed release from liability statement shall be included with the requests for reference.

1.8.2.1 Copies of the privilege request form and the signed release from liability statement shall be included with requests for reference.

1.8.2.2 Applicants shall be required to have a personal interview with the Selection and Credentials Committee.

1.8.2.3 Additional reference checks and/or candidate interviews may be required by the Department Chairperson or Selection and Credentials Committee as appropriate.

1.8.3 Responsibilities of Department Chairperson

1.8.3.1 After all information and reference checks are received, the Department Chairperson or designee shall be responsible to review the applications for all practitioners requesting appointment and/or clinical privileges in his/her department. The department chairperson is an ad hoc member of the Selection and Credentials Committee and may participate in the Committee's interview of the candidate.

1.8.3.2 The Department Chairperson in collaboration with the Division Director (where applicable) shall specifically assess each privilege requested and make a recommendation to grant or not grant the requests.

1.8.3.3 The Department Chairperson shall make a recommendation for approval or denial of the application. If the recommendation is to deny appointment and clinical privileges, the reasons for the recommendation shall be specifically documented.

1.8.4 Responsibilities of Selection and Credentials Committee

1.8.4.1 Interview of Applicant
The Selection and Credentials Committee shall interview each applicant for privileges. The Interview shall include at least the following: a review of the applicant's training and experience, plans for practice, coverage arrangements, plans for hospital practice, and a review of privilege requests. Clinical questions may be asked. The applicant shall be informed of the responsibilities of practitioners holding privileges as stated in the

Medical Staff Bylaws and related documents, including but not limited to meeting committee responsibilities, requirements for Provisional Staff members, and responsibilities for medical records and the suspension policy for incomplete records.

1.8.4.2 Review of Operative Reports
If requested, the applicant shall be required to submit a case listing of procedures performed during post-graduate training and/or the last two years of practice, as appropriate, and may be asked for operative reports. The Selection and Credentials Committee Chairperson or designees shall have the authority to ask for more documentation where deemed necessary.

1.8.4.5 Assessment of Each Privilege
The Selection and Credentials Committee shall specifically assess each privilege requested and make a decision to grant or not grant each request. The applicant must have documented sufficient training and sufficient volume of procedures performed.

1.8.5 Procedure for Recommendation and Final Action

1.8.5.1 Selection and Credentials Committee Recommendation
After review of the completed application, Department Chair recommendation, supporting documentation and a personal interview with the applicant, the Selection and Credentials Committee shall make a recommendation to the Medical Executive Committee regarding Staff appointment and/or clinical privileges.

1.8.5.2 Medical Executive Committee Recommendation
At its next regular meeting following receipt of the recommendation of the Selection and Credentials Committee, the Medical Executive Committee shall review the reports and recommendation of the Selection and Credentials Committee as well as a recommendation from the Department Chairperson and shall either make a recommendation to the Governing Body or refer the matter back to the Selection and Credentials Committee for further information or clarification. If the recommendation of the Medical Executive Committee is to deny or modify the request of the applicant, the applicant shall be given the opportunity to appeal the recommendation. The hearing and appellate procedures shall apply if requested by the applicant.

1.8.5.3 Action by the Governing Body
The Medical Executive Committee will forward its recommendations to the Governing Body. The Governing Body shall make the final decision regarding the applicant's request for Staff appointment and/or clinical privileges with final decision being made no more than 120 days after the application is considered complete.

1.8.5.4 Notice of Final Decision
Written notice of the Governing Body's final decision regarding the application shall be given to the applicant through the office of the President and Chief Executive Officer of the hospital. The notice shall include at least the following: a) the Staff category to which the applicant is appointed; b) the department to which he/she is assigned; c) the clinical privileges granted; and d) any special conditions attached to the appointment.

1.8.5.5 Granting of Temporary Privileges
Temporary privileges may be granted in the interest of patient care upon written request of the applicant after the interview and an affirmative recommendation by the Selection and Credentials Committees.

1.9 REAPPLICATION AFTER ADVERSE CREDENTIALS DECISION
An applicant who has received a denial of appointment from the Governing Body shall be eligible to reapply for appointment and/or the same clinical privileges after a period of two years and only if he/she has additional information not previously reviewed to support the request. The applicant shall also be required to supply any additional information required by HMC at its sole discretion. Failure to provide

such additional information to the satisfaction of HMC shall constitute a voluntary withdrawal of the reapplication. There shall be no right of appeal in such an instance.

CHAPTER 2 – REAPPOINTMENT

2.1 REAPPOINTMENT

Reappointment to the Medical Staff shall be for a period not to exceed two (2) years. More frequent reappointments may be required for practitioners under specific circumstances including but not limited to an excessive number of suspensions for incomplete records, significant noncompliance with performance improvement issues, or a recommendation for denial or modification pending further investigation.

2.2 REAPPOINTMENT PROCESS

2.2.1 Application

Approximately four (4) months prior to the date of expiration of Medical Staff appointment, the practitioner shall be given the following:

2.2.1.1 Application for reappointment;
2.2.1.2 A new Delineation of Privileges form;
2.2.1.3 A copy of the current Delineation of Privileges form.

2.2.2 Responsibilities of the Practitioner

2.2.2.1 The practitioner shall submit the following:

2.2.2..1.1 Completed and signed reappointment application form;
2.2.2.1.2 Completed and signed Delineation of Privileges form: supporting documentation of training and experience if new or additional privileges are requested;
2.2.2.1.3 Copies of current CDS and DEA certificates;
2.2.2.1.4 Copy of current licensure;
2.2.2.1.5 Completion of CME Attestation and documentation of continuing medical education credits;
2.2.2.1.6 Copy of current liability insurance;
2.2.2.1.7 Statement of PPD and Health status; and
2.2.2.1.8 Affiliation verifications, addressed to the Hunterdon Medical Center Medical Staff Office, from all hospitals at which the applicant is currently a member or has relinquished membership since their previous reappointment.

2.2.2.2 Failure to provide the above listed information shall be deemed a voluntary and automatic resignation of staff appointment and clinical privileges at the expiration of the current term of appointment. A practitioner whose staff appointment and clinical privileges are so resigned shall not be entitled to a hearing as provided in the Medical Staff Bylaws.

2.2.3 Responsibilities of the Hospital

2.2.3.1 The Medical Staff Office shall collect at least the following information and submit it to the Department Chair for each practitioner who is being evaluated for reappointment:

2.2.3.1.1 Information on findings of the Medical Staff Performance Improvement Committee regarding cases reviewed and/or patterns identified;
2.2.3.1.2 The level of clinical activity at the Hospital, including at least the numbers of admissions consultations and procedures;
2.2.3.1.3 Sanctions imposed or pending;
2.2.3.1.5 Record of suspensions for incomplete charts;
2.2.3.1.6 Appropriate data of utilization of the hospital, blood usage, drug usage and infection rates.

2.2.3.1.7 The above information will be consolidated into an Ongoing Professional Practice Evaluation (OPPE) which is described in detail in Chapter 4.

2.2.3.2 Information shall be requested from all applicable data banks and licensure shall be verified.

2.2.3.3 Information regarding current clinical competence shall be requested from other institutions or from other individuals with whom the practitioner has worked when deemed necessary by the Credentials or Medical Executive Committee.

2.2.3.4 Recommendations from peers shall be obtained. For the purpose of this requirement, all physicians are considered peers; all dentists are considered peers; all podiatrists are considered peers.

2.2.3.5 Providers with fewer than ten (10) patient contacts (low/no volume) will be required to provide documentation, preferably an OPPE report, from their primary facility indicating that the provider is meeting reappointment requirements and that no quality issues have been identified.

2.2.4 Procedure for Recommendation and Decision

2.2.4.1 Selection and Credentials Committee

The Selection and Credentials Committee shall review applications for reappointment, recommendations from the Department Chair, and supporting documentation as noted in 2.2.3.1, and shall make a recommendation to the Medical Executive Committee for each application. The recommendation shall include duration of reappointment or no reappointment, staff category, department to which assigned and clinical privileges.

2.2.4.1.1 Options for Duration of Reappointment

- Reappointment for a period not to exceed two years.
- Reappointment for less than the maximum time for which the practitioner is eligible for reasons including but not limited to:
  (a) A pattern of non-compliance with staff obligations;
  (b) Health problems;
  (c) Questions concerning quality or appropriateness of care.

  Such recommendation is not considered to be a modification or denial of appointment or clinical privileges; the practitioner is not entitled to a hearing.

- Denial of appointment or modification of clinical privileges not requested by the practitioner; the practitioner shall have the opportunity for a hearing.

2.2.4.2 Department Chairperson

The Department Chairperson shall review all applications for reappointment and all supporting documentation as noted in 2.2.3.1 and make an appropriate recommendation for each. The chairperson shall also comment on the health status of each applicant to the best of his/her knowledge.

2.2.4.3 Medical Executive Committee

The Medical Executive Committee shall review the Department Chairperson's and Selection and Credentials Committee's recommendations and any other relevant information. It shall make recommendations to the Governing Body regarding appointment, clinical privileges, staff category, and department assignments. The Medical Executive Committee shall make recommendations for approval, denial, or modification of appointment and/or clinical privileges. The terms of reappointment shall also be specified.

2.2.4.3.1 When the Selection and Credentials Committee has recommended approval and the Medical Executive Committee plans denial or modification, the matter shall be referred back to the Selection and Credentials Committee for further study.

2.2.4.3.2 When the Medical Executive Committee's recommendation is for denial of reappointment or modification of requested privileges, the practitioner shall be so notified in writing by the Chief Executive Officer or his/her designee, stating the reasons for the recommendation and offering the opportunity for a hearing.

2.2.4.3.3 The reappointment process shall be conducted so that the Medical Executive Committee routinely considers applications for reappointment in time for them to be forwarded to the Governing Body for final action prior to the expiration of the appointment.

2.2.5 Governing Body
The Governing Body shall take final action on all applications for reappointment. This shall be done prior to the expiration of appointment.

2.3 TIME PERIODS FOR PROCESSING
All persons involved in the reappointment process, including applicants, Selection and Credentials Committees, Department Chairpersons, Medical Staff President, Medical Executive Committee, and the Governing Body, are required to complete all necessary paper work and recommendations in a timely fashion so that all reappointment recommendations and reports may be transmitted to the Medical Executive Committee and in turn to the Governing Body prior to the expiration date of staff appointment for those members whose reappointments are being processed. If a delay in processing is due to the practitioner's failure to provide information required in this section, his/her staff appointment and clinical privileges shall be considered a voluntary resignation effective on the expiration date.

2.4 REQUESTS FOR MODIFICATION OF STAFF STATUS OR CLINICAL PRIVILEGES

2.4.1 A practitioner may relinquish privileges or request additional privileges at any time by submitting the appropriate request, including documentation of training and experience, to the appropriate Selection and Credentials Committee for its consideration.

2.4.2 Requests for changes in staff status (other than to Honorary or Emeritus status) will be considered in accordance with Needs Committee policies on the creation of new positions on the Medical Staff.

CHAPTER 3 – PROCEDURE FOR PROVISIONAL STAFF EVALUATION AND FOCUSED PROFESSIONAL PRACTICE EVALUATION (FPPE)

3.1 FPPE - Assessing Competency

3.1.1 It is the policy of Hunterdon Medical Center to confirm the competency of members of the Medical Staff during the Provisional Staff time frame, as determined by the Board of Trustees based upon the recommendations of the Medical Staff. It is also done at the time of granting new privileges not previously performed by the practitioner and when indicated by an Ongoing Professional Practice Evaluation, (OPPE).

3.1.2 It is the responsibility of the Selection and Credentials Committee to review the results of the FPPE and recommend to the Medical Executive Committee whether further monitoring other than routine OPPE is needed. The Chair of the Department to which a practitioner has been assigned shall have primary responsibility for assuring that the practitioner's clinical competency and conduct is evaluated. The Department Chair may delegate the responsibility to conduct prospective, concurrent and/or retrospective evaluations of the practitioner to other members of the department or to practitioners in other departments who have expertise in the clinical privileges granted to the practitioner.

3.1.3 FPPE for new practitioners or for those requesting substantially new privileges will consist of retrospective or concurrent review of a minimum of five cases and/ or five procedures as determined by the Board of Trustees upon recommendation of the Medical Staff. The FPPE when triggered by an OPPE will be formulated by the Department Chair in consultation with the CMO. The duration of the evaluation will be at the discretion of the Department Chair. Concurrent proctoring may also be initiated at the recommendation of the Department Chair and/or the Selection and Credentials Committee.

3.2 FPPE – Procedure

3.2.1 The Medical Staff Quality Improvement Department in collaboration with the Department Chair shall facilitate and perform monitoring of aggregate measures related to a practitioner's clinical performance. These measures may include but are not limited to:

Documentation: timeliness of medical record completion, H&Ps, progress notes, operative notes, discharge summaries, etc., completion of all the required elements of the above including signature, date and timing; avoidance of unapproved abbreviations.

Clinical: Appropriateness of medical evaluations, appropriateness of obtaining consultations, timeliness of answering consultations, appropriateness of communication, appropriateness of medical tests and treatments including medications and blood products. Input from appropriate support staff may be utilized.

Invasive Procedures: Indications, complications, schedule delays, and/or direct observation by the Department Chair or appropriate physician designee. Input from appropriate support staff may be utilized.

Additional Data shall include admission, discharge and procedure volume during the evaluation time period. Behavior issues and rule violations shall be included if applicable.

3.3 FPPE – Reports

At the conclusion of the evaluation period, the Department Chair will review all relevant practitioner data and forward a report with recommendation(s) to the Selection and Credentials Committee.

3.3.1 The Selection and Credentials Committee will review the Department Chair report and determine if the applicant has completed the evaluation process satisfactorily and is deemed competent to perform the requested privileges. Alternatively they may ask the Department Chair to extend the evaluation period or forward a recommendation to the Medical Executive Committee supporting termination of the physician's appointment and/or clinical privileges due to questions concerning qualifications, behavior or clinical competence.

If the Medical Executive Committee upholds the recommendation of the Selection and Credentials Committee regarding termination of membership and/or privileges, the practitioner shall be entitled to the hearing and appeals process outlined in the Medical Staff Bylaws.

3.4 Provisional Advancement Process

Provisional appointments shall be for a period of at least one (1) year, at which time the practitioner will be given an opportunity to request advancement from provisional status as noted in section 5.4 of the Medical Staff Bylaws. The provisional advancement process is equivalent to the reappointment process noted in Chapter 2 of the Credentials Manual.

CHAPTER 4 – ONGOING PROFESSIONAL PRACTICE EVALUATION (OPPE)

4.1 OPPE PROCESS

4.1.1 It is the policy of Hunterdon Medical Center (HMC) to conduct appropriate objective, evidence based monitoring of the care delivered by its Medical Staff to promote safety and high quality health care for its patients.

4.1.2 Ongoing Professional Practice Evaluation will occur on an ongoing basis (every six months) to facilitate decisions about maintaining, revising or revoking existing privilege(s) prior to or at the time of biennial renewal.

4.1.3 The process may include an assessment of proficiency in the following six areas of general competencies:

1. Patient Care
2. Medical and clinical knowledge
3. Practice-based learning and improvement
4. Interpersonal and communication skills
5. Professionalism
6. Systems-based practice

4.2 OPPE PROCEDURE

4.2.1 At each six month review, every practitioner's OPPE will be reviewed by the department/specialty Chair or representative. The information on the OPPE will be provided by the Medical Staff QI Department.

4.2.2 The type of information and the process for evaluation of each practitioner has been approved by the departments through the Medical Executive Committee.

4.2.3 The type of monitoring may include but is not limited to:

1. Data review related to department/practitioner specific quality indicators.
2. Direct observation or proctoring.
3. Retrospective medical record review.
4. Feedback from colleagues, staff members, patients or families.
5. Monitoring of diagnostic and treatment techniques.
6. Management of information.

4.2.4 The OPPE will display the individual practitioner's data for the stated time period and the practitioner's department or specialty data for the same time period. This department or specialty data will be used for comparison purposes by the Department Chair.

4.2.5 The individual practitioner will receive a copy of his/her Ongoing Professional Practice Evaluation at the six month review period.

4.2.6 As this policy speaks to an ongoing process, at any time there may be data sources and/or triggers that identify the need for a Focused Professional Practice Evaluation. These may be a single incident or evidence of a clinical practice trend.

CHAPTER 5 - TEMPORARY PRIVILEGES

5.1 ELIGIBILITY FOR TEMPORARY PRIVILEGES

5.1.1 Temporary privileges may be granted by the medical center CEO to a practitioner who meets one of the following circumstances:

(a) Important Patient Care Need: Temporary privileges may be granted on a case-by-case basis when an important patient care need or service mandates an immediate authorization to practice for a limited time – up to one hundred and twenty (120) days.

In special circumstances upon receipt of a written request, an appropriately licensed practitioner of documented competence, who is not an applicant for membership or privileges, may be granted temporary privileges for the care of one of more specific patients. The following documentation is required for temporary privileges:

1. Unrestricted license in the State of New Jersey
2. Unrestricted Federal DEA, if appropriate

3. Current valid professional liability insurance coverage in a certificate form and in amounts satisfactory to the Medical Center
4. Confirmation of current competence from primary practicing facility, if applicable
5. National Practitioner Data Bank report processed by the HMC medical staff office
6. A verbal or written reference that establishes current competency

(b) Pendency of new application for medical staff membership and/or privileges: Temporary clinical privileges may be granted to applicants seeking new medical staff membership and/or clinical privileges, provided the application is complete and the applicant has not disclosed nor the credentialing process uncovered any of the following:

- No current or previously successful challenge to professional licensure or registration
- No involuntary termination of medical staff membership at any other organization
- No involuntary limitation, reduction, denial or loss of clinical privileges at any other organization.

All required verifications and processes as lined in appropriate medical staff credentials policies must be completed. The application must have received favorable recommendation from the Selection & Credentials Committee and be awaiting review and recommendation of the Medical Executive Committee (MEC).

Utilizing temporary privileges, a practitioner may only attend patients for a period not to exceed one hundred twenty (120) days.

(c) To a licensed practitioner who is taking the place of a Medical Staff member for a prescribed period of time (i.e., locum tenens) who will not become a member of the Medical Staff.

5.1.2 Temporary privileges shall be granted for a maximum period of 120 days. Locum Tenens practitioners may have their privileges renewed for two more consecutive 120 day cycles. Renewal for a fourth cycle will require application for membership on the Medical Staff.

5.2 PROCEDURE

5.2.1 All requests for temporary privileges must be made in writing to the Chief Medical Officer, who shall forward the request to the President of the Medical Center or his/her designee, who shall have the authority to grant temporary privileges after consultation with the appropriate Department Chairperson.

5.2.2 Practitioners requesting temporary privileges shall undergo the same application and verification process outlined in section 1.8.2 of the Credentials Manual of the Medical Staff. Locum Tenens practitioners will not be required to meet with the Selection and Credentials Committee, but must be interviewed by the Department Chairperson and the Chief Medical Officer.

5.2.3 Before temporary privileges are granted, the practitioner must first acknowledge in writing that he/she has been given access to and read copies of the medical staff Bylaws and all other medical staff and hospital policies relevant to his/her performance of temporary privileges, and that he/she agrees to be bound by such.

5.2.4 The Medical Staff Office shall notify the practitioner in writing when temporary privileges have been granted. Practitioners are limited to perform only the privileges and/or functions indicated on the approval letter.

5.2.5 The Chief Executive Officer may at any time, upon the recommendation of the President of the Medical Staff or the appropriate Department Chairperson, terminate a practitioner's temporary privileges effective as of the discharge from the hospital of the practitioner's patient(s) then in the hospital. However, where it is determined that the life or health of such patient(s) would be

endangered by continued treatment by the practitioner, the termination may be imposed by any person entitled to impose a summary suspension and shall be effective immediately. In either case, there shall be no right to appeal.

In the event of such termination, the patients of such practitioner then in Hunterdon Medical Center shall be assigned to another practitioner by the chief of staff or designee.

5.2.6 No practitioner is entitled to temporary privileges as a matter of right. A practitioner shall not be entitled to the procedural rights afforded by the Plan because of his or her inability to obtain temporary privileges or because of any termination, modification or suspension of temporary privileges.

CHAPTER 6 – EXPEDITED CREDENTIALING

Expedited credentialing is done to ensure the timely processing of applications for appointment, reappointment and granting of the privileges to the Medical and APP staff at Hunterdon Medical Center. This applies to physici Expedited credentialing is done to ensure the timely processing of applications for appointment, reappointment and granting of the privileges to the Medical and APP staff at Hunterdon Medical Center. This applies to physicians, dentists, and APPs members applying to the Hunterdon Medical Center staff who fulfills the criteria for expedited credentialing and privileging.

Per the Joint Commission an expedited governing body approval process may be used for initial applications, reappointment applications and granting of privileges to the medical staff when criteria for that process are met.

A Practitioner's application is eligible for expedited process if the following criteria are met.

- A complete application is received
- All relevant primary source verifications are received
- No current challenge or previously successful challenge to the applicant's professional license or registration exists.
- No involuntary termination of the applicant's medical staff membership or participation in a managed care/clinically integrated provider panel, or limitation, reduction or loss of clinical privileges at the Hospital or another facility.
- No voluntary limitation, relinquishment or non-renewal of the applicant's professional license, registration, medical staff membership, or clinical privileges, in lieu of, or to avoid, a challenge thereto.
- Unqualified recommendations. Lack of a response from a facility that is still in existence precludes expedited credentialing.
- No more than three (3) changes in the applicant's practice locations in the past 10 years (excluding relocations for residency and fellowship training).
- No material discrepancy between information received from the Practitioner and references or verified information from other sources i.e. a failure to disclose, even if deemed inadvertent or an oversight.
- No evidence the applicant has potentially relevant physical, mental and/or emotional health problems. This also includes relevant history of alcohol or substance abuse.

- The applicant has not been the subject of review, non-routine FPPE, a request for corrective action, or resigned from a hospital or regulatory agency during a formal review.
- Applicant will have no periods with no clinical activity that exceed 6 months without explanation or greater than 2 years without any clinical activity.
- Applicant will have no gaps, or extensions of training prior to successful completion of medical school(s) or post graduate training program(s), (excluding transitional year PGY1 year)
- Applicant must have a clean background check, no license sanctions including lack of CME compliance.
- No open medical malpractice claims or professional liability history and National Practitioner Data Bank or settled claims that exceed the Department threshold are not eligible for expedited credentialing.

The following situations will be evaluated on a case-by-case basis and will usually result in ineligibility for the expedited process: The Selection & Credentials Committee members determine that there has been either an unusual pattern of, or an excessive number of, professional liability actions resulting in a final judgment against the applicant.

Procedure:

1. Medical Staff Office Personnel shall process the application, obtain all documentation and verifications, assess the application, and recommend expedited processing if all criteria are fulfilled.

2. Applications and requests for clinical privileges shall be forwarded to the appropriate Department/Division Chair, APP Committee Chairperson (if applicable) for review and recommendation to the Selection & Credentials Committee

3. Applications and requests for clinical privileges shall be reviewed to ensure it fulfills the established requirements for membership and clinical privileges. The applicant and their request for clinical privileges shall be presented to the Selection & Credentials Committee for review and recommendation.

4. If the Selection & Credentials Committee recommends approval for expedited processing, the Chair of the Selection & Credentials Committee shall sign the expedited credentialing form. The form will be forwarded to the Chairperson of the Medical Executive Committee for their recommendation and signature and to the Expedited Committee of the Board of Trustees will review for their final action.

5. If the expedited process is recommended:

   a. The recommendation of the Department/Division Chair, APP Committee, and Selection & Credentials Committee are forwarded to two (2) voting members of the Board of Trustees who are delegated the authority to render decisions and approve applications and clinical privileges on behalf of the Board of Trustees.

   b. The applicant shall be notified of appointment or reappointment and clinical privileges once approved by the Board of Trustees delegates.

c. The Medical Executive Committee and the Board of Trustees shall review and ratify all appointments, reappointments and clinical privileges at its next regularly scheduled meeting.

ans, dentists, and APPs members applying to the Hunterdon Medical Center staff who fulfills the criteria for expedited credentialing and privileging.

Per the Joint Commission an expedited governing body approval process may be used for initial applications, reappointment applications and granting of privileges to the medical staff when criteria for that process are met.

A Practitioner's application is eligible for expedited process if the following criteria are met.

- A complete application is received
- All relevant primary source verifications are received
- No current challenge or previously successful challenge to the applicant's professional license or registration exists.
- No involuntary termination of the applicant's medical staff membership or participation in a managed care/clinically integrated provider panel, or limitation, reduction or loss of clinical privileges at the Hospital or another facility.
- No voluntary limitation, relinquishment or non-renewal of the applicant's professional license, registration, medical staff membership, or clinical privileges, in lieu of, or to avoid, a challenge thereto.
- Unqualified recommendations. Lack of a response from a facility that is still in existence precludes expedited credentialing.
- No more than three (3) changes in the applicant's practice locations in the past 10 years (excluding relocations for residency and fellowship training).
- No material discrepancy between information received from the Practitioner and references or verified information from other sources i.e. a failure to disclose, even if deemed inadvertent or an oversight.
- No evidence the applicant has potentially relevant physical, mental and/or emotional health problems. This also includes relevant history of alcohol or substance abuse.
- The applicant has not been the subject of review, non-routine FPPE, a request for corrective action, or resigned from a hospital or regulatory agency during a formal review.
- Applicant will have no periods with no clinical activity that exceed 6 months without explanation or greater than 2 years without any clinical activity.
- Applicant will have no gaps, or extensions of training prior to successful completion of medical school(s) or post graduate training program(s), (excluding transitional year PGY1 year)
- Applicant must have a clean background check, no license sanctions including lack of CME compliance.
- No open medical malpractice claims or professional liability history and National Practitioner Data Bank or settled claims that exceed the Department threshold are not eligible for expedited credentialing.

The following situations will be evaluated on a case-by-case basis and will usually result in ineligibility for the expedited process: The Selection & Credentials Committee members determine

that there has been either an unusual pattern of, or an excessive number of, professional liability actions resulting in a final judgment against the applicant.

Procedure:

1. Medical Staff Office Personnel shall process the application, obtain all documentation and verifications, assess the application, and recommend expedited processing if all criteria are fulfilled.
2. Applications and requests for clinical privileges shall be forwarded to the appropriate Department/Division Chair, APP Committee Chairperson (if applicable) for review and recommendation to the Selection & Credentials Committee
3. Applications and requests for clinical privileges shall be reviewed to ensure it fulfills the established requirements for membership and clinical privileges. The applicant and their request for clinical privileges shall be presented to the Selection & Credentials Committee for review and recommendation.
4. If the Selection & Credentials Committee recommends approval for expedited processing, the Chair of the Selection & Credentials Committee shall sign the expedited credentialing form. The form will be forwarded to the Chairperson of the Medical Executive Committee for their recommendation and signature and to the Expedited Committee of the Board of Trustees will review for their final action.
5. If the expedited process is recommended:
   a. The recommendation of the Department/Division Chair, APP Committee, and Selection & Credentials Committee are forwarded to two (2) voting members of the Board of Trustees who are delegated the authority to render decisions and approve applications and clinical privileges on behalf of the Board of Trustees.
   b. The applicant shall be notified of appointment or reappointment and clinical privileges once approved by the Board of Trustees delegates.
   c. The Medical Executive Committee and the Board of Trustees shall review and ratify all appointments, reappointments and clinical privileges at its next regularly scheduled meeting.

CHAPTER 7- EMERGENCY AND DISASTER PRIVILEGES

7.1 ELIGIBILITY FOR AND SCOPE OF EMERGENCY AND DISASTER PRIVILEGES

For the purpose of this section, an "emergency" is defined as a condition in which serious or permanent harm to a patient is likely to occur, or in which the life of a patient is in immediate danger, and delay in administering treatment would add to that danger.

A “disaster” for purposes of this section is defined as a community-wide disaster or mass injury situation in which the number of existing, available medical staff members is not adequate to provide all clinical services required by the citizens served by this facility.

7.2 PROCEDURE

7.2.1 Emergency Privileges

In the case of a medical emergency, any practitioner is authorized to do everything possible to save the patient’s life or to save the patient from serious harm, to the degree permitted by the practitioner’s license, regardless of Department affiliation, staff category, or level of privileges. A practitioner exercising emergency privileges is obligated to summon all consultative assistance deemed necessary and to arrange appropriate follow-up.

7.2.2 Disaster Privileges

If the institution's Disaster Plan has been activated and the organization is unable to meet immediate patient needs, the CEO and other individuals as identified in the institution's Disaster Plan with similar authority may, on a case by case basis consistent with medical licensing and other relevant state statutes, grant disaster privileges to selected LIPs. These practitioners must present a valid government-issued photo identification issued by a state or federal agency (e.g., driver's license or passport) and at least one of the following:

1. A current picture hospital ID card that clearly identifies professional designation;
2. A current license to practice;
3. Primary source verification of the license;
4. Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT), or Medical Reserve Corps (MRC), Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP), or other recognized state or federal organizations or groups;
5. Identification indicating that the individual has been granted authority to render patient care, treatment, and services in disaster circumstances (such authority having been granted by a federal, state, or municipal entity); or
6. Identification by a current hospital or medical staff member (s) who possesses personal knowledge regarding the volunteer's ability to act as a licensed independent practitioner during a disaster.

7.2.3 Medical Staff Oversight

The practitioner shall be under the general supervision of the Chairperson of the department involved. The medical staff oversees the professional performance of volunteer practitioners who have been granted disaster privileges by direct observation, mentoring, or clinical record review. The organization makes a decision (based on information obtained regarding the professional practice of the volunteer) within 72 hours whether disaster privileges should be continued.

7.2.4 Provider Identification

The medical staff has a mechanism (i.e., badging) to readily identify volunteer practitioners who have been granted disaster privileges.

7.25 Primary source verification of licensure begins as soon as the immediate situation is under control, and is completed within 72 hours from the time the volunteer practitioner presents to the organization. If primary source verification cannot be completed in 72 hours, there is documentation of the following: 1) why primary source verification could not be performed in 72 hours; 2) evidence of a demonstrated ability to continue to provide adequate care, treatment, and services; and 3) an attempt to rectify the situation as soon as possible.

7.26 Once the immediate situation has passed and such determination has been made consistent with the institution's Disaster Plan, the practitioner's disaster privileges will terminate immediately.

7.27 Any individual identified in the institution's Disaster Plan with the authority to grant disaster privileges shall also have the authority to terminate disaster privileges. Such authority may be exercised in the sole discretion of the hospital and will not give rise to a right to a fair hearing or an appeal.

CHAPTER 8 – FAMILY MEDICINE OBSTETRICAL PRIVILEGE CRITERIA

8.1 CANDIDATES TRAINED AT HUNTERDON MEDICAL CENTER FAMILY MEDICINE RESIDENCY PROGRAM

8.1.1 Minimum of 75 labors managed during residency training

8.1.2 Experience outside of HMC with exposure to high risk maternity patients

8.1.3 Current ALSO certification

8.1.4 Fetal monitoring course to be successfully completed as a resident

8.2 CANDIDATES NOT TRAINED AT HUNTERDON MEDICAL CENTER FAMILY MEDICINE RESIDENCY PROGRAM

8.2.1 Minimum of 75 labors managed, of which 30 must have been within the preceding two (2) years

8.2.2 Exposure to high risk maternity patients

8.2.3 Current ALSO certification

8.2.4 Fetal monitoring course to be successfully completed within 6 months after starting at HMC

8.3 CREDENTIALING REVIEW

The credentials of all Family Medicine physicians who request obstetrical privileges will be presented to a deputized subcommittee of the Selection and Credentials Committee to be comprised of the Chairs of the Department of Obstetrics and Gynecology and the Chair of the Department of Family Medicine who has obstetrical privileges. If the Chair of the Department of Family Medicine does not have obstetrical privileges, he or she will designate a member of the Department of Family Medicine who has obstetrical privileges. The subcommittee will present their findings to the Selection and Credentials Committee for final approval.

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8.4 CREDENTIALING DISPUTES

Credentialing disputes involving the requested obstetrical privileges of Family Medicine candidates will be referred to the Medical Executive Committee and reviewed only when both the Chairs of the Departments of Family Medicine and Obstetrics and Gynecology are in attendance to present their assessments.

8.5 MAINTENANCE OF PRIVILEGES

All Family Medicine physicians with obstetrical privileges will be required to maintain current competence according to the following guidelines:

8.5.1 A minimum of 15 maternity care patients the initial 24 months of active staff membership;

8.5.2 A minimum of 30 maternity care patients each successive 24 months of active staff membership;

8.5.3 30 Hours of CME per 24-month credentialing cycle, which is maternity care focused;

8.5.4 Mandatory attendance of at least 50% of the Obstetrics/Perinatal Morbidity and Mortality Conferences at Hunterdon Medical Center;

8.5.5 Mandatory attendance of four (4) hours per year of Hunterdon Medical Center Risk Management Programs;

8.5.6 Current Advanced Life Support in Obstetrics (ALSO) certification;

8.5.7 100% case review of Family Medicine obstetrical admissions; and

8.5.8 Joint approval of Family Medicine obstetrical privileges by the Chair of the Department of Family Medicine and the Chair of the Department of Obstetrics and Gynecology (or their designees). Disputes regarding Chair recommendations will be presented to the Selection and Credentials Committee for their review and recommendation, which will then be presented to the Medical Executive Committee for review and ratification.

*Maternity care is defined as a performance of a substantive portion of the patient's total maternity care from the time of diagnosis through the six-week post-partum recovery period of the patient's labor or delivery.

8.5.9 If a physician does not meet this threshold, an FPPE (Focused Professional Practice Evaluation) will be performed jointly by the Chairs of both Family Medicine and Obstetrics/Gynecology Departments. Action may be: Required attendance at the Family Centered Maternity Course sponsored by the American Academy of Family Physicians (which is held every 2 years) if not taken within the prior two years; attendance at an ALSO (Advanced Life Support in Obstetrics) course if not taken within the prior two years; and 5 deliveries proctored by other family physicians with OB privileges.

APPROVAL SIGNATURES

ADOPTED BY MEDICAL STAFF:

_____ _____
President, Medical Staff Chair, Medical Executive Committee Date

_____ _____
President and CEO Date

APPROVED BY GOVERNING BODY:

_____ _____
Chair, Board of Trustees Date

AMENDMENTS:
July 25, 2013
September 2016
January 2020
March 2020