MGHS CREDENTIALS MANUAL

POLICY FOR MEMBERSHIP TO THE MARQUETTE GENERAL HEALTH SYSTEM (MGHS) MEDICAL STAFF

Applications for Medical Staff membership to MGHS shall be provided to physicians, dentists, podiatrists, psychologists, registered nurse practitioners, Nurse Midwives, physician assistants and appropriate others who are duly licensed to practice in the State of Michigan.

The process for requesting said application is as follows:

1. Application is requested by the applicant from the Chief Executive Office.
2. Application request is to contain information as to whether or not clinical privileges are being requested so appropriate privilege forms may be provided to applicant.

Policy for Processing Application

1. Upon request, eligible applicants will be given an application, departmental privilege request form(s), if appropriate, a letter detailing requirements for completion of the application and a copy of the Medical Staff Bylaws.
2. In order to consider an application complete, the following documentation is necessary.
    - A. A completed, signed application and request for privileges (if appropriate). (Application packet attached).
    - B. A copy of current Michigan State License, Michigan State Board of Pharmacy License (if applicable), and Drug Enforcement Administration Registration Certificate (if applicable).
    - C. A copy of current professional malpractice liability insurance coverage face sheet reflecting amounts of coverage approved by the Medical Staff and Board of Trustees.
    - D. Copies of certificates or letters confirming completion of an approved residency/training program or other educational curriculum.
    - E. Verification (copy of certificate or copy of letter from appropriate specialty board) of board status, i.e. Board Certification or Board Eligibility.
    - F. Documentation as to past history record of malpractice activity, if any.
3. Upon receipt of an application, the Chief Executive Officer and his designee will review the application for system-focused need and completion of the application respectively. Information contained in the application will be primary source verified as follows:** (A brief summary of verifications will be maintained on a checklist, copy of which is attached to this policy).
    - A. Verification from past insurance carriers concerning claims, suits and settlements (if any) during the past five years (Attachment 1).
    - B. Verification of completion of undergraduate, post-graduate and medical school; query of ECFMG if foreign medical graduate. (Attachment 2).
    - C. Verification of completion of internship, residency and fellowship (Attachment 3).
    - D. Verification of any previous affiliations at health care institutions or office practices (Attachment 4).
    - E. Completion of Reference Questionnaire from Chief of Department of specialty at any affiliations and/or Program Director of internship/residency/fellowship if within the past 10 years (Attachment 5).
    - F. Verification of three medical references (Attachment 6).

G. Verification of Michigan licensures from Michigan Professional Credentialing Verification Service (Attachment 7) and other State licensures from AMA.
H. Query of the National Practitioner Data Bank as per the laws outlined. Verification of no sanctions, etc. (Attached 8).
I. Query of the AMA. Verification of no sanctions, etc. (Attachment 9).

**Information received from the AMA and/or other Credentialing Verification Organizations may be used as primary source verification if applicable and acceptable standards are met.

Upon receipt of a completed and verified application for Medical Staff membership, the Medical Staff and Board of Trustees will take action on that application within 120 days of the verified application. In the event of undue delay in obtaining required information, requests may be made to the applicant for assistance in obtaining information.

All Attachments are subject to minor changes as they relate to the applicant and the request.

Upon verification of the applicant's file, the CEO or designee will transmit the file to the appropriate Department (determined by which departmental privileges the applicant has requested) for their review. The Department Chair shall appoint a sponsor/supervisor(s) of the same specialty or sub-specialty for the applicant's first year on provisional staff and shall recommend a course of action to the Credentials Committee. The sponsor must be an Active Staff Member, or a Provisional Active Staff Member when it is necessary to sponsor a Member of Allied Health Professional status.

(If an applicant is requesting Adjunct or Honorary Staff status, the CEO, or designee, will review the credential file for completion, competency and experience as necessary to make a recommendation to the Credentials Committee) (Attachment 10)

The Credentials Committee shall recommend a course of action to the Medical Staff Executive Committee at the next regularly scheduled meeting of that group.

In the event a Credentials Committee meeting is scheduled prior to a Department meeting during any given month, the CEO, or designee, will transmit the credential file to the Credentials Committee initially. The Credentials Committee shall recommend a course of action to the Medical Staff Executive Committee at the next regularly scheduled meeting of that group pending review and approval by the Department.

The Chief of Staff, at the next regularly scheduled Board of Trustees meeting, will present the credentials file of the applicant to the Board and give a summary of the applicant's request for medical staff status. The Board of Trustees will, upon recommendation by the Chief Executive Officer, act upon the file.

The newly appointed Member of the Medical Staff will be notified in writing by the Chief Executive Officer of the Board decision (Attachment 11). This welcome letter will contain information relevant to the Department to which the Member is assigned as appropriate, requirements for committee attendance as appropriate, the privileges approved for the Member's first year on the Medical Staff as appropriate, the committee

assignment for the Member as appropriate, as well as the name of the Member's sponsor as appropriate.

The CEO and/or designee will provide a formal orientation, if necessary.

PROVISIONAL STAFF SPONSOR/SUPERVISOR

1. Administration will request quarterly and annual evaluations (Attachments 12 & 13) from Provisional staff sponsors/supervisors pertaining to the Member's qualifications, competency, experience, patient encounters, attendance at meetings (if applicable), adherence to Bylaws and Hospital policies, peer review activity, unusual occurrence reports, administrative/disciplinary suspensions and patient satisfaction comments, if any. All evaluations will be reviewed by the Credentials Committee.

2. Upon receipt of annual evaluation, the Credentials Committee will make a recommendation to the Medical Staff Executive Committee pertaining to advancement to non-provisional staff membership. The MSEC will forward their recommendation to the Board for their action.

LOCUM TENENS

LOCUM TENENS APPLICATION PROCESS: Applications for Locum Tenens status will be processed in the same fashion as all other applicants to the Medical Staff, except as provided below. Requests for Locum Tenens should specify the recommended MGH Active Staff physician sponsor and the anticipated date(s) the locum tenens is needed.

LOCUM TENENS TEMPORARY PRIVILEGES: In the event a Locum Tenens is needed prior to completion of the standard credentialing process, the CEO, Chief of Staff, appointed Sponsor and Chair of appropriate medical staff Department may approve Locum Tenens status and temporary privileges (Attachment 14), provided the following information has been received:

A. A completed, signed application and request for privileges (if appropriate)
B. A copy of current Michigan State License, Michigan State Board of Pharmacy License (if applicable), and Drug Enforcement Administration Registration Certificate (if applicable)
C. Proof of current professional malpractice liability insurance reflecting amounts of coverage approved by the Medical Staff and Board of Trustees.

Upon receipt of the above information, the following primary source verification will be obtained:

A. Three recent affiliations at health care institutions (if applicable)
B. Michigan licensure(s)
C. National Practitioner Data Bank and AMA/AOA
D. Education
E. Determination and adequate explanation of any prior malpractice activity.

The respective Department, Credentials Committee, Medical Staff Executive Committee and Board of Trustees will be informed, at their next regularly scheduled meeting, or via the monthly Board of Trustees Newsletter, of all Locum Tenens who have been granted temporary privileges.

Administration will request an evaluation (Attachment 15) from the appointed sponsor immediately following completion of actual period Locum Tenens worked and/or prior to consideration of extending Locum Tenens status. Upon receipt of this evaluation the Credentials Committee will make a recommendation to the Medical Staff Executive Committee pertaining to return of the Locum Tenens if requested. Exceptions to the evaluation and affiliation verification processes may be granted when determined necessary by the Chief of Staff and CEO.

RETURNING LOCUM TENENS PHYSICIANS: In the event Locum Tenens Staff Status is requested beyond 90 cumulative days within one 12-month period, or upon recommendation from the COS and CEO, the Credentials Committee may recommend Provisional Staff Status.

Prior to a Locum Tenens physician's return to MGH, the following verifications will be obtained:

A. Three most recent affiliations at health care institutions (if applicable)
B. Michigan licensure(s)
C. National Practitioner Data Bank, if necessary.
D. Proof of current professional malpractice liability insurance reflecting amounts of coverage approved by the Medical Staff and Board of Trustees.
E. Current Medical Staff Privilege request

If a Locum Tenens physician has been previously approved to return by the Credentials Committee, Medical Staff Executive Committee and Board of Trustees, and following the above verifications, notification only to those bodies need occur.

EXPEDITED PROCESS

(a) The following expedited process may be used for initial appointments to membership and granting of clinical Privileges, reappointment to membership, or renewal or modification of clinical Privileges when specific criteria is met as defined in Section 6.6.1 of the Medical Staff Bylaws.

(b) Approval Process:

1. Each Department Chair or Vice Chair in whose department the applicant seeks clinical Privileges shall review the application and forward a recommendation to the Vice Chief of Staff or designee.

2. The Vice Chief of Staff (on behalf of the Credentials Committee) or designee shall review the application and forward a recommendation to the Chief of Staff or designee.

3. The Chief of Staff (on behalf of the Medical Staff Executive Committee) or

designee will review and forward a recommendation to the Chief Executive Officer acting on behalf of the Board of Trustees.

4. The Chief Executive Officer (on behalf of the Board of Trustees) shall consider the recommendation of the Medical Staff Executive Committee and take final action. If the Chief Executive Officer's decision is adverse to the applicant, the matter is referred to the Medical Staff Executive Committee for further evaluation.

5. The applicant shall be notified in writing by the Chief Executive Officer of final decisions made on the application.

6. The full governing body considers and ratifies (if appropriate) all approved expedited applications at their next regularly scheduled meeting.

REQUESTS FOR ADDITIONAL OR MODIFIED PRIVILEGES

A Practitioner or AHP, during their term of appointment to the Medical Staff, requesting additional or modified Privileges due to introduction of new technology or new techniques or procedures shall present a new privilege request and training plan in writing to the Chief Executive Officer on the prescribed application form, including:

(a) Specific description of privilege,
(b) A plan for obtaining training and competencies (or documentation of training if training has been completed),
(c) Relevant articles and national training/competency standards, and
(d) Quality indicators proposed for monitoring proficiency and outcomes.

If the request is made at the time of reappointment and renewal of privileges, it will be considered during the normal reappointment approval process, provided the appropriate documentation is included with the request.

Initial review of applications for additional or modified Privileges shall be conducted in the same manner as all other applications, and will proceed as follows (unless the applicant is eligible for the Expedited Process):

(Refer to attached Flow Chart)

1. Practitioner presents training plan to the Chief Executive Officer. System need is determined by the Chief Executive Officer and Chief of Staff.

2. Practitioner presents training plan to Credentials Committee including:
   a) Specific proposed privilege
   b) Mechanism to obtain training (or documentation of training)
   c) Relevant articles / standards
   d) Quality indicators proposed for monitoring of proficiency and outcomes, if approved

3. Credentials Committee reviews plan and recommends approval, referral to subcommittee or department, or denial.

4. Medical Staff Executive Committee reviews plan and Credentials Committee recommendation and recommends approval, referral, or denial.

5. Practitioner proceeds with training, if appropriate after above steps.

6. Practitioner submits actual privilege request with training documentation (including # of procedures) to Chief Executive Officer. The CEO's Office conducts the following:
   a) Query of National Practitioner Data Bank and Office of Inspector General data base.
   b) Verification of State of Michigan licenses.
   c) Verification of Drug Enforcement Administration (DEA) Registration Certificate (if applicable).
   d) Verification of current professional malpractice liability insurance coverage including appropriate amounts of coverage

7. Privilege request is considered through the same process as initial requests for Privileges: Department, Credentials Committee, Medical Staff Executive Committee, and Board of Trustees.

8. Notification of the final action taken on the request by the Board of Trustees will be sent to the Practitioner by the Chief Executive Officer.

DISASTER PRIVILEGES

Disaster Privileges are temporary privileges awarded when the Hospital's Emergency Management Plan is activated. The Chief of Staff and/or CEO, or their designee(s), may grant Disaster Privileges when any of the following are presented: a currently valid MGHS picture ID, currently valid license to practice and valid picture ID issued by a government agency; identification that indicates the individual is a member of a Disaster Medical Assistance Team (DMAT); or a government-issued identification that confirms the authority to provide disaster care. Privileges may also be granted if a person related to MGHS vouches for the individual. The CEO and/or Chief of Staff, or their designee(s) reserve the right not to grant disaster privileges.

As soon as the disaster response is under control, priority will be given by the Medical Staff/CEO's Office to verify the basic credentials of any practitioner who may have been granted Disaster Privileges. At a minimum, the items specified above for Temporary Privileges for Locum Tenens practitioners will be verified.

Practitioners granted Disaster Privileges will be given color-coded vests and/or nametags identifying them as working with Disaster Privileges.

Practitioners granted Disaster Privileges will be under the overall supervision of the Chief of Staff, and/or designee(s).

EMERGENCY PRIVILEGES

In the event it becomes necessary to grant Emergency Privileges in accord with the MGHS Medical Staff Bylaws 6.5-1(b), the CEO and Chief of Staff may approve Temporary Privileges provided proof of licensure has been received.

PRIVATE EMPLOYEES

1. Requests from Practitioners for permission to utilize private employees, e.g. registered nurses, pathology assistants, dental assistants, etc. on Marquette General Health System premises must be submitted in writing to the Chief Executive Office.

2. Practitioners will be given an application by the Chief Executive Office (Attachment 16) to request procedures to be performed at the Hospital by a private employee. Additional information provided to the Chief Executive Office by the Practitioner will consist of proof of current malpractice liability insurance for the private employee, current licensure (if applicable), and documentation of the private employee's education, training, and competency for procedures requested.

3. Review and approval of the completed application will be processed in the same fashion as all other applicants to the Medical Staff.

AGE-SPECIFIC REQUIREMENTS

In accordance with the Medical Staff Bylaws Rules and Regulations pertaining to Age-Specific Guidelines, by October 1 of each year, the Credentials Committee will request appropriate age-specific information for their review.

REAPPOINTMENT PROCESS

1. Reappointment Application (Attachment 17), release of information and Privilege forms, if applicable, will be distributed to and completed by all Members of the Medical Staff, including private employees, every two years.

2. The National Practitioner Data Bank will be queried at reappointment time (i.e. every two years) for each Member by the CEO's office.

3. State of Michigan licensure will be verified.

4. Upon receipt of information requested in 1, 2 and 3, along with the Activity Summary (Attachment 18), said information shall be forwarded for review and recommendation to the appropriate Department and Credentials Committee. The Credentials Committee will recommend a course of action to the MSEC, with the COS presenting the MSEC's recommendation to the Board of Trustees.

MAINTENANCE OF CREDENTIAL FILES

Each Member of the Marquette General Health System Medical Staff will have on file, in the Chief Executive Office, a confidential credential file containing all information relative to the individual's request for Medical Staff membership and privileges.

At all times, the Member will assure current copies of the following information are maintained in the Member's file:

1. State Licensure (will be verified at time of expiration)
2. State Pharmacy License (if applicable)
3. Federal Controlled Substance Registration (if applicable)
4. Current Malpractice Certificate showing limits of liability.
5. Statement that the practitioner is mentally and physically capable of discharging staff duties as attested to by the Department Chairs.

Credential files will also contain all privilege forms, i.e. previous privileges held and other pertinent information compiled relative to the credentialing process.

Access to all Member's confidential credential files shall be controlled by Executive Office personnel and, other than the Member, be granted to the Chief of Staff, Vice-Chief of Staff, the Department Chair, the Chair of Departmental Credentials Committee or Chair of Medical Staff Credentials Committee, only for legitimate Medical Staff credentialing and privileging purposes, as necessitated and allowed according to the Bylaws, Rules and Policy Manual.

The CEO, or designee, will notify the Chief of Staff, Board of Trustees Chairperson, and appropriate others when a Member's membership/privileges have changed as per the Medical Staff Bylaws.

Medical Staff Telemedicine Policy Language

Policy: It is the policy of Marquette General Hospital that telemedicine services will be provided here as an originating site and distant site in a manner that seeks to ensure a high level of care consistent with the standards of care for other hospital services.

Telemedicine Services: Clinical services provided via televideo shall include physician-to-physician consultations, physician to patient consultations and diagnostic imaging services.

Telemedicine Privileges: All Practitioners who are responsible for the care of the patient *(evidenced by having the authority to write orders and direct care, treatment or services)* via telemedicine link are credentialed and privileged to do so at MGH, through one of the following mechanisms:

a. The practitioner may be privileged at MGH, using credentialing information from the Distant Site if the Distant Site is a JCAHO accredited organization; or

b. MGH may use both credentialing and privileging information from the Distant Site if all the following requirements are met:

1. The Distant Site is JCAHO accredited.
2. The practitioner is privileged at the Distant Site for the services being provided at the Originating Site.
3. The Originating Site has evidence of an internal review of the performance of these privileges and sends information useful to assess the quality of care and services for use in privileging and performance improvement to the Distant Site. At a minimum, this information includes the following information:
   A. All adverse events related to telemedicine services,
   B. Complaints about the Distant Site Licensed Independent Practitioners, or staff at MGH.

c. If there is a pressing clinical need and a practitioner can supply that service through a telemedicine link, consideration can be given to the use of emergency/temporary privileges (MS Bylaw 6.5) for this clinical situation.

d. Practitioners who provide telemedicine services limited to interpretation and second opinions do not require privileges at this hospital. Practitioners providing official readings of images, tracings, or specimens through a telemedicine mechanism must do so under one of the following two arrangements:
   1. The practitioner is granted clinical privileges at MGH.
   2. MGH contracts for the provision of these services by the provider. These services must be provided consistent with existing hospital and medical staff policies addressing contracted services.

e. In order for a practitioner to be eligible to request telemedicine privileges, the following requirements must be met:
   1. The Medical Staff Executive Committee has recommended that the scope of telemedicine services at this originating site and distant site hospital and the distant/originating site hospital include the privileges requested by the practitioner.
   2. The practitioner must concurrently maintain privileges, at a minimum, for the same scope of services at the distant-site hospital as he or she is requesting at the originating-site hospital.
   3. Requests for telemedicine privileges will be processed through the Credentials Committee, Medical Staff Executive Committee and Board of Trustees.