Northwest Regional Appointment and Credentialing Policy and Procedure

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PREAMBLE

Pursuant to the *Corporations Act* and the *Public Hospitals Act* (PHA), the Board of Directors of a public hospital is responsible for the governance and management of the hospital. This includes responsibility for the appointment of physicians to the medical staff of the Hospital and conferring privileges upon such appointed physicians as more particularly identified at section 36 of the *PHA*.

The Board is also responsible for ensuring and monitoring the quality of care provided by physicians, dentists, midwives, and registered nurses in the extended class ("RN(EC)s"), collectively referred to as Professional Staff, in the Hospital. The Board fulfills this obligation by passing by-laws and policies to provide for: the organization and duties of the medical staff; criteria with respect to the appointment and reappointment of members of the medical staff; and the establishment of one or more committees of the medical staff to assess, among other things, credentials. In addition, Regulation 965 provides that where the hospital has dental, midwifery or extended class nursing staff, the by-laws must similarly provide for the organization, duties, appointment and reappointment of such staff

The *Northwest Regional Appointment and Credentialing Policy and Procedure*, ("NRACPP") endorsed and agreed upon by 13 Participating Organizations outlines the standardized requirements and processes to be adhered to by each organization when considering an application for professional staff appointment, reappointment or request for an expansion of privileges. This process is commonly referred to as the Northwest Regional Appointment and Credentialing process.

While responsibility for the implementation of this Policy lies with the Board, the operation of this Policy is delegated by the Board to the MAC.

The benefits of this process will be to ensure a consistent and efficient process for the appointment and reappointment of Professional Staff in the Northwest Region and at each Participating Organization, to ensure the most effective use of Professional Staff human resources within the Northwest Region and to facilitate the ordering of diagnostic tests and other outpatient treatment for patient's closer to their home.

The NRACPP shall ensure that the data/information as identified by this policy shall be shared as between each organization to which the applicant makes application and maintains privileges.

The appointment and reappointment process identified by the NRACPP shall be supported by the electronic Northwest Regional E-Credentialing System (NRECS). Completed applications will be processed by each organization in a manner consistent with the by-laws of the respective hospital.

This policy shall be reviewed every three (3) years by participating organizations of the Northwest Regional Appointment and Credentialing process.

PART "A" POLICY

1. POLICY

The Participating Organizations are committed to ensuring that those individuals appointed to the Participating Organizations' professional staff:

- are appropriately trained and qualified for the position to which they are appointed;

- are competent in respect of the privileges received;

- can meet the Hospital's ongoing professional staff needs and will make effective use of the Hospital's available resources for the provision of patient care; and

- will meet the community's needs for quality services including such teaching and research needs as may be determined.

The purpose of the Northwest Regional Appointment and Credentialing Policy and Procedure is to support this commitment by providing a clear and specific process for effective decision-making regarding appointment and re-appointment of professional staff, by establishing standardized criteria, processes and procedures for the Participating Organizations as set out in this policy.

To this end, the NRACPP credentialing system includes:

- An *Initial Appointment Process*, which establishes specific qualifications and criteria for appointment to the Professional Staff of the Participating Organizations;

- A *Re-Appointment Process* that shall take place each year and is a detailed and comprehensive review and update of the Professional Staff member's file, which requires the Professional Staff member to produce evidence of his/her current registration, insurance, competence, history of practice and continuing professional education in addition to other criteria as established from time to time;

- A process of review and assessment for members of the Professional Staff who wish to change the nature or scope of their privileges*;* and

- Consistent with the Board's general obligations regarding quality care and specific requirements under the *Public Hospitals Act* for immediate action where a serious problem exists with the diagnosis, care or treatment of a patient or outpatient and/or a serious issue with respect to the conduct or behaviour of such member has been identified, the Hospital has also identified a specific process for review and mid-term action with respect to a Professional Staff's privileges where concerns have been raised with respect to his/her conduct, performance or competence.

The policy provides direction to the applicant regarding required information, documentation, as well as timelines for completion of the processes. The information collected shall be used by a Participating Organization to evaluate each applicant and shall be considered in making a recommendation to the Board of a Participating Organization with respect to appointment or reappointment or generally any matter concerning an applicant's/member's appointment and privileges.

In the event that an applicant's/professional staff member's privileges or appointment is the subject of review or where the privileges or appointment of an applicant/member has been revoked, restricted or suspended or where the applicant/member has resigned their

appointment or privileges, the organization where such has occurred has the obligation to notify other Participating Organizations where the applicant has applied for privileges or is a member of the professional staff

Participating Organizations include:

1. Atikokan General Hospital (Atikokan, Ontario)
2. Dryden Regional Health Centre (Dryden, Ontario)
3. Geraldton District Hospital (Geraldton, Ontario)
4. Lake of the Woods District Hospital (Kenora, Ontario)
5. McCausland Hospital (Terrace Bay, Ontario)
6. Manitouwadge Health Centre (Manitouwadge, Ontario)
7. Nipigon District Memorial (Nipigon, Ontario)
8. Red Lake Margaret Cochenour Memorial Hospital (Red Lake, Ontario)
9. Riverside Health Care Facilities (Fort Frances, Ontario)
10. Sioux Lookout Meno-Ya-Win Health Centre (Sioux Lookout, Ontario)
11. St. Joseph's Care Group (Thunder Bay, Ontario)
12. Thunder Bay Regional Health Sciences Centre (Thunder Bay, Ontario)
13. Wilson Memorial General Hospital (Marathon, Ontario)

The criteria, processes and procedures established by this policy shall form part of each Participating Organization's appointment and credentialing processes.

2. REGIONAL STAFF CATEGORY

In support of this policy, each Participating Organization shall establish a professional staff category to be identified as *"Regional Staff".* A member of the Regional Staff category shall be permitted to order outpatient diagnostic procedures and receive reports with respect to such procedure(s).

Current Professional Staff who are appointed at a Participating Organization may obtain a Regional Staff appointment at another Participating Organization as provided for by this policy.

An applicant may apply for these privileges at the time with the privileges being contingent on the applicant obtaining/maintaining privileges at a Primary Organization.

Under this category, an applicant shall have the rights, obligations and responsibilities as established by the by-laws of the Participating Organization.

3. DEFINITIONS

In this Policy, the following terms shall have the following meanings:

"**Administrator**" means the person appointed by the Board of the Hospital with direct and actual superintendence and charge of the Hospital, as contemplated in the Hospital Management Regulation and shall include the President and Chief Executive Officer, the Chief Executive Officer or the Executive Director.

"**Appeal Board**" means the Health Professions Appeal and Review Board established pursuant to the Ministry of *Health Appeal and Review Boards Act*, 1998.

"**Applicant**" means the physician or other regulated health professional who is applying for appointment and privileges, for re-appointment, or for a change of privileges at a Participating Organization in accordance with this policy.

"**Board**" means the Board of Directors of the Hospital.

"**By-laws**" means the by-laws of the Hospitals as may be amended from time to time.

"**College**" means a professional regulatory College under the *Regulated Health Professions Act*.

"**Credentialing Staff**" means the individual most responsible for supporting the credentialing process at each organization

"**Credentials Committee Report**" means the report of the Hospital's Credentials Committee where applicable as described in section 4. (c) hereto.

"**Department**" means a department of the Professional Staff comprised of the chief/head of the department and such other persons who may be designated authority to recommend granting privileges.

"**Hospital Management Regulation**" means Regulation 965 "Hospital Management" passed pursuant to the Public Hospitals Act.

"Impact Analysis" means a study conducted by the Chief Executive Officer or designate, in consultation with the Chief of Staff/Chair of the MAC, Chief Nursing Executive and Chiefs of Department to determine the impact upon the resources of the Hospital of the proposed or continued appointment of any Applicant.

"**MAC**" means the Medical Advisory Committee of the Hospital.

"**Northwest Regional E-Credentialing System (NRECS)**" means a software application used by the participating Northwest organizations to support the NWO Shared Credentialing Process.

"**Participating Organization**" means each of the hospitals whose Board has approved this Policy and has provided the other hospitals whose Board have approved this Policy with a certificate signed by its Administrator indicating such approval.

"**Professional Staff**" means those physicians, dentists (including oral and maxillofacial surgeons), midwives, and registered nurses in the extended class who are appointed by the Board and who are granted specific privileges to practice.

"**Professional Staff Human Resources Plan**" means the plan developed by the Chief Executive Officer in consultation with the Chief of Staff/Chair of the MAC, Chief Nursing Executive and Chiefs of Department based on the mission and strategic plan of the Hospital and on the needs of the community, which provides information and future projections of this

information with respect to the management and appointment of physicians, dentists, midwives, and RN(EC)s who are or may become members of the Professional Staff.

"Professional Staff Officer" means the Chief of Staff, Chief of Department and President of the Medical Staff.

"**Public Hospitals Act**" means the Ontario Public Hospitals Act, together with all regulations there under, as amended from time to time.

"**University**" means an academic professional institution to which the applicant shall hold an affiliation.

4. APPLICATION FOR APPOINTMENT

The processes as established by the NRACPP for application, appointment, re-appointment, alteration of privileges, and mid-term action affecting privileges are reflective of the rights extended to physicians under the *Public Hospitals Act* and regulation in this respect.

Although the *Public Hospitals Act* does not require the appointment of dentists, midwives, and RN(EC)s, the *Act* provides that a Board may decide to provide for the appointment of such professionals within the by-laws. For consistency, the processes set out in this Policy and Procedure will be applicable to all health professionals seeking appointment and privileges at the Participating Organizations.

4.1 Appointment Term

Further to this Policy the Board of each Participating Organization shall appoint an applicant to the Professional Staff of the organization for a period of up to one year. All appointments shall end no later than on December 31st of the then current year.

Provided that where, within the exiting appointment year, a member of the Professional Staff, other than a member appointed to the Term Staff or Locum Staff has applied for re-appointment as provided for in this policy, his or her appointment shall be deemed to continue, except where provided otherwise in the By-laws or policies of a Participating Organization;

(a) until the re-appointment is granted; or

(b) where he or she is served with notice that the Board refuses to grant the re-appointment, until the time for giving notice requiring a hearing by the Appeal Board has expired and, where a hearing is required, until the decision of the Appeal Board has become final.

4.2 Timeline for Submission of Initial Application for Appointment

An applicant will have 45 calendar days to submit their electronic application from the date upon which they receive access to the electronic application. The submitted electronic application will remain active for 15 days thereafter for a total of 60 days, allowing for the receipt of references and Certificates of Professional Conduct and other documentation required from the applicant. Failure of the applicant to submit a fully completed application, within the time frame set out above will result in the application being considered as withdrawn.

4.3 **Qualifications and Criteria for Appointment**

4.3.1 Only an Applicant who is a registrant in good standing of the relevant College and qualified and licensed to practice medicine, dentistry, midwifery, or extended class nursing in Ontario, is eligible to be a member of and appointed to the Professional Staff of the Hospital, except as otherwise provided for in the By-laws.

4.3.2 The Applicant must have the following qualifications

(a) a current certificate of registration with the applicable College ;

(b) a demonstrated ability to provide patient care at an appropriate level of quality and efficiency;.

(c) a willingness to participate in the discharge of staff obligations appropriate to the applicable membership group, including, without limitation, a demonstrated ability to communicate, work with, and relate to members of the administrative staff, Professional Staff, and Hospital staff as well as patients and patients' families in a co-operative and professional manner; and

(d) adequate training and experience for the procedural privileges requested.

4.3.3 The Applicant must agree to participate in the on-call duty roster(s) as required by the Department Chief and/or Chief of Staff.

4.3.4 The Applicant must agree to undertake such duties in respect of those patients classed as emergency cases as may be specified by the Chief of Staff or by the Chief of the Department to which the staff member has been assigned.

4.3.5 The Applicant must agree to govern himself/herself in accordance with the requirements set out in the *Public Hospitals Act* and regulations thereunder, the By-laws, the Professional Staff Rules and Regulations of the Hospital, and all Hospital policies and procedures.

4.3.6 The Applicant must declare and indicate adequate control of any physical or behavioural impairment that may affect the Applicant's skill, attitude or judgement relevant to the appointment and privileges requested.

4.3.7 There must be a demonstrated need for the services in the community and/or region and sufficient resources to accommodate the Applicant, as demonstrated by an Impact Analysis.

4.3.8 The Applicant should meet the needs of the respective Department as described in a Professional Staff Human Resource Plan, and will be assessed on the basis of credentials and experience and such other factors as the Board may, from time to time, consider relevant, or as set out in the Professional Staff Rules and Regulations.

4.3.9 The Applicant must provide evidence of current immunization status as suggested in the Communicable Diseases Surveillance Protocols jointly published by the Ontario Hospital Association and the Ontario Medical Association.

4.3.10 Where required, and while the Applicant may not be required to hold an appointment with the University's faculty of Medicine/Dentistry, whether or not the Applicant is granted such an appointment shall be considered by the Credentials Committee,

where applicable, in assessing the application and, all things being equal, preference will be given to Applicants who are granted a University appointment.

4.4 **Initial Appointment**

4.4.1 The Administrator or delegate, of each Participating Organization shall provide an application package to every physician, dentist, midwife and RN(EC) who requests the opportunity to apply to the Hospital for Professional Staff appointment and privileges.

4.4.2 The application package provided to the Applicant shall consist of:

(a) an electronic copy of the Northwest Regional Appointment and Credentialing Policy and Procedure

(b) a Link to an electronic copy of the primary organization's By-laws and Departmental/Privileged Staff/Professional Staff Rules and Regulations

(c) an electronic copy of the primary organizations policies in respect to "medical directives" and "delegated medical acts"

(d) Link to the Public Hospitals Act

(e) a username for NRECS (password generated by NRECS will be emailed directly to the applicant)

Where an application is not returned, completed to the Administrator within sixty (60) days following receipt of the application package, the application shall be deemed void and a new application required.

4.4.3 The content of each initial application provided to an Applicant for appointment to the Professional Staff of the Hospital shall require from the applicant:

(a) a statement by the Applicant that s/he has read the Public Hospitals Act, the Hospital Management Regulation thereunder, the Hospital's By-laws, the Professional Staff Rules and Regulations, a copy of this Northwest Regional Appointment and Credentialing Policy, the Hospital's Policy in respect to "medical directives" and "delegated medical acts" and other relevant Hospital policies, the Hospital's mission statement, and the Code of Ethics of the Canadian Medical Association, and will abide by these documents;

(b) an undertaking that, if the Applicant is appointed to the Professional Staff of the Hospital, the Applicant will provide the services to the Hospital (and will govern him/herself) as stipulated in the Application in accordance with the Public Hospitals Act and the Hospital Management Regulation thereunder; and with the By-laws, Rules and Regulations, and Hospital policies, as established or revised by the Hospital from time to time;

(c) an acknowledgement by the Applicant that:

(i) the failure of the Applicant to provide the services as stipulated in the Application in accordance with applicable legislation, the By-laws, the Rules and Regulations and Hospital policies will constitute a breach of his or her obligations to the Hospital and the Hospital may, upon

consideration of the individual circumstances, remove access to any and all Hospital resources, including the limiting or restricting of operating room time, or take such action as is reasonable, in accordance with the By-laws and Rules and Regulations; and

(ii) the Hospital may refuse to appoint an Applicant to the Professional Staff where the Applicant refuses to acknowledge the responsibility to abide by a commitment to provide services in accordance with the privileges granted by the Board, the By-laws, the Rules and Regulations and applicable Hospital policies;

(iii) concurrent with the provision of the application the University where appropriate, will be notified of the Applicant's application for privileges;

(iv) a copy of the Applicant's resume and other any documents or information provided or disclosed to the Hospital by the Applicant or any other party as a result of the application for appointment to the Professional Staff of the Hospital may be shared by the University; and

(v) the failure of the Applicant to maintain an academic appointment where such academic appointment is a condition of the Applicant's Hospital appointment may result in the Applicant's privileges being restricted, suspended, revoked or the Applicant being denied reappointment;

(d) a copy of the Applicant's current registration, certificate or license to practice in Ontario;

(e) a copy of the Applicant's professional school certificate;

(f) a record of eligibility for certification for specialty/sub-specialty certifications and for re-certification;

(g) a copy of fellowship/certification documentation for specialties/sub-specialties, including a speciality certificate from the Royal College of Dental Surgeons of Ontario authorizing practice in oral and maxillofacial surgery as applicable;

(h) an up-to-date curriculum vitae, including a record of the Applicant's professional education and post-graduate training and a chronology of academic and professional career, organizational positions, and committee memberships;

(i) a current Certificate of Professional Conduct from the College of Physicians and Surgeons of Ontario, a current Certificate of Standing from the Royal College of Dental Surgeons of Ontario, a current Letter of Professional Standing from the College of Midwives of Ontario or an extended Certificate of Registration from the College of Nurses of Ontario (as applicable) and consent to the release of the information by the Registrar of the applicable College;

(j) for out-of-province applicants, a certificate from the licensing authority in their jurisdiction;

(k) a recital and description of pending or completed disciplinary actions, competency investigations, previous or ongoing performance reviews, and details with respect to prior privileges disputes with other hospitals regarding

appointment, re-appointment, change of privileges, or mid-term suspension or revocation of privileges;

(l) a statement with respect to failures to obtain, reduction in classification or voluntary or involuntary resignation of any professional license or certification, professional society membership or fellowship, professional academic appointment or privileges at any other hospital or health care institution;

(m) information regarding the Applicant's health, including any impairments, medical conditions, diseases or illnesses which may impact on the Applicant's practice relevant to the nature and scope of privileges requested, and where relevant, current treatments, the date of the Applicant's last medical examination, as well as the name of the treating health professional for those impairment(s), condition(s), disease(s) or illness(es) and an authorization to the treating health professional to release relevant information to the Hospital;

(n) confirmation of professional liability insurance coverage, membership in the Canadian Medical Protective Association or professional liability protection, satisfactory to the Board, including a record of the Applicant's past claims history;

(o) information regarding any criminal proceeding or record of any criminal convictions which may impact the Applicant's professional practice or responsibilities pursuant to their appointment;

(p) recital and description of completed civil liability actions that are related to the Applicant's professional practice or activities, including final judgements or settlements in which the Applicant was involved;

(q) a declaration of compliance with the Hospital's communicable diseases surveillance policies and practices, including proof of required immunization as demonstrated by the completion of the Regional Immunization Form (appendix "A");

(r) information regarding any other appointments at other hospitals and any existing responsibilities regarding on-call coverage at any other hospital or practice;

(s) names and addresses of references including:

(i) Administrator and Chief of Staff/Chair of the MAC of the last hospital where the Applicant held privileges or received training;

(ii) Departmental colleagues from the last hospital or institution in which the Applicant held an appointment or received training; and

(iii) Service Director or Head of Training Program if enrolled in a Graduate Training Program within the past three years;

(t) an authorization for release of information and release from harm for collecting and/or exchanging information and evaluation of the Applicant's credentials and suitability for the purposes of appointment to the Professional Staff;

(u) a statement indicating:

(i) the type of application being made;

(ii) the name of the Department or division to which the application is being made;

(iii) the category of privileges requested; and

(iv) the procedures requested;

(v) where the Applicant is requesting re-appointment, a list of all relevant changes to information previously provided;

(w) a signed confidentiality agreement (appendix "B") in the form attached hereto; and

(x) a passport size photograph.

5. APPLICATION FOR REAPPOINTMENT

The provisions set out in this section of the Policy represent terms generally accepted by the Participating Organizations and shall be in addition to the specific terms and conditions set by each individual organization with respect to reappointment.

5.1 Reappointment

Each eligible applicant for reappointment will receive an email granting them access to the NRECS system to complete their application for reappointment and confirming the applicant's NRECS Username.

All applicants will have 45 days to submit the application for reappointment. An application for reappointment must be completed by December 31st of the current appointment year.

5.2 The content of each application provided to an Applicant for reappointment to the Professional Staff of the Hospital shall require from the applicant:

(a) confirmation of professional liability insurance coverage, membership in the Canadian Medical Protective Association or professional liability protection, satisfactory to the Board, including a record of the Applicant's claims history over the past year;

(b) an acknowledgement that the documentation and certification provided during the initial application process remain valid and current;

(c) an update of information provided during the initial appointment or the Applicant's most recent re-appointment, as applicable, including information:

(i) regarding disciplinary actions, College investigations, civil suits, criminal proceedings or convictions, and/or any other relevant legal problems;

(ii) regarding the Applicant's health, including any impairments, medical conditions, diseases or illnesses, and current treatments therefore, as well as the date of the Applicant's last examination, which may impact on the Applicant's practice, as well as the name of the treating health professional and an authorization to the treating health professional to release relevant information to the Hospital;

(iii) regarding any changes to the Applicant's affiliation with the Faculty of Medicine/Dentistry at the University; and

(iv) pertaining to any appointments at other hospitals and potential effects on the duties/obligations of the Applicant to the Hospital.

5.3 Requests for Change of Status and/or Privileges following initial appointment/reappointment

(a) Where a physician, dentist, midwife, or RN(EC) wishes to change his/her privileges or appointment category, an original application (appendix "C") in the form attached hereto, shall be submitted to the Administrator identifying the changes requested, along with evidence of appropriate training, competence and professional liability protection and/or the reason(s) for the requested change in appointment category.

(b) Upon receipt, the Administrator or delegate shall immediately refer the application to the Chief of Staff, who, upon recording each application received, shall refer the application forthwith to the Chair of the Credentials Committee and to the relevant Department Chief, if any.

(c) An application for change in privileges or appointment category shall be processed in accordance with the Public Hospitals Act, the By-laws, the Rules and Regulations and the procedures for an Initial Application.

(d) The MAC may request any additional information or evidence that it deems necessary for consideration of the application for alteration in privileges.

Where a Participating Organization has approved a change of a Professional Staff member's appointment status or privileges, that Participating Organization shall communicate such change to any other Participating Organization where the member has an appointment and/or privileges.

6. MID – TERM ACTION

6.1 Suspension/Revocation of Privileges

The Board or Chief of Staff/Chair of MAC may at any time in accordance with the *Public Hospitals Act*, the By-laws and this Policy revoke, suspend, restrict or otherwise alter the privileges of a member of the Professional Staff or elicit an undertaking from a member of the Professional Staff not to exercise his/her Hospital privileges**.**

6.2 Standing to Issue a Complaint

(a) Any member of the Professional Staff or other person may advance a complaint concerning any alleged violation by a member of the Professional Staff (referred to as the "Respondent") of the By-laws, Rules or Regulations of the Hospital or alleged professional misconduct, incompetence, or incapacity, unethical behaviour, or other unprofessional conduct giving reasonable cause for complaint to the Administrator, and/or the relevant Professional Staff Officer(s).

(b) Upon receipt of a complaint about the Respondent, any one of the Professional Staff Officers and/or the Administrator shall forthwith advise the Respondent as

to the nature of the complaint and the manner in which the complaint is being handled.

(c) Where possible, the Professional Staff Officer or the Administrator notified shall consult with at least two (2) other Professional Staff Officers regarding the most appropriate course of action as provided for by the *Public Hospitals Act*, Hospital By-law and this Policy, including whether the Respondent's privileges shall be immediately and temporarily suspended in accordance with Section 6.3 or whether the appropriate action is to commence a preliminary investigation in accordance with Section 6.4.2.

(d) The Chief of Staff must be advised of all complaints.

6.3 Immediate Mid-Term Action in an Emergency Situation

(a) If at any time it becomes apparent that a Professional Staff member's conduct, performance or competence is such that it exposes, or is reasonably likely to expose, patient(s), staff or others to harm or injury, or is reasonably likely to be detrimental to the safety of patient(s), staff or others or delivery of quality care, immediate suspension must be undertaken to protect the patient(s), staff or others to cause or to ensure the delivery of quality care.

(b) Where a Professional Staff Officer becomes aware that a serious problem exists in the diagnosis, care or treatment of a patient, such Professional Staff Officer shall forthwith discuss the condition, diagnosis, care and treatment of the patient with the attending Professional Staff member, and if satisfactory changes in diagnosis, care or treatment are not made promptly, such Professional Staff Officer shall assume forthwith the responsibility for any necessary investigation and diagnosis of, prescribing for and treatment of the patient, and shall notify the attending member of the Professional Staff, the Administrator, and, if possible, the patient that the attending member of the Professional Staff shall cease forthwith to have any privileges as the attending. This may require immediate and temporary suspension of the privileges of the member of the Professional Staff. In all situations, the due process procedure set out in Section 6.4.2 through 6.4.3 must be followed.

(c) Where the Professional Staff Officer is unable to discuss the problem with the attending Professional Staff member, s/he shall proceed with his/her duties under this section as if s/he had the discussion with the attending member.

(d) The Professional Staff Officer shall inform two members of the MAC within twenty-four (24) hours of any action taken under Section 6.3(b) and shall file a written report with the secretary of the MAC within forty-eight (48) hours of an action under Section 6.3(b).

(e) The Professional Staff Officer responsible in Section 6.3(b) may delegate any or all of his/her responsibilities and duties hereunder to a member of the active Professional Staff in his/her department, but shall remain accountable to the MAC for the management of the patient by the Professional Staff member to whom any such responsibility or duty is delegated.

(f) In all instances other than those which are specific to a single patient as addressed in Section 6.3(b), where the professional conduct, performance or competence of a member is likely to expose patient(s) or Hospital staff to serious harm or injury such that immediate action must be taken to protect the patient(s) or staff, and there is no less restrictive measure available, the Chief of Staff/Chair of the MAC or the Chief of Department to which the Professional Staff member is assigned, or their respective delegates, may with notice to the Chief Executive Officer or his/her delegate, immediately and temporarily suspend the Professional Staff member's privileges, until such time as a meeting or hearing can be arranged in accordance with the Hospital By-laws and this Policy.

(g) Where immediate mid-term action is taken pursuant to this Section, the due process procedures established further to the Hospital By-laws and Schedule "A" of the By-laws shall be followed in finally determining the appropriate mid-term action.

6.4 Non-Immediate Mid-Term Action

6.4.1 Where the professional conduct, performance or competence of a member of the Professional Staff:

(a) is, or is reasonably likely to be, detrimental to patient or staff safety or to the delivery of quality patient care within the Hospital;

(b) results in the imposition of sanctions by the relevant professional College;

(c) is contrary to the By-laws, the Rules and Regulations, policies of the Hospital, the *Public Hospitals Act* or regulations thereunder, or any other applicable law or legislated requirement;

(d) constitutes abuse; or

(e) is, or is reasonably likely to be, detrimental to the operations of the Hospital;

the Chief of Staff, the Department Chief or their respective delegates, shall follow the due process procedures set out in the By-laws and Schedule "A" of the By-laws, respecting **"**Non-Immediate Mid-Term Action**.**

6.4.2 Investigation/Complaint Process

(a) The Professional Staff Officer(s) or the Administrator or their respective delegates shall be responsible for undertaking and directing the preliminary investigation of a complaint, in such a manner as is determined reasonably necessary and in accordance with any applicable Hospital policies and procedures.

(b) Following preliminary investigation, the Professional Staff Officer(s) and/or the Administrator of the Hospital, where deemed appropriate, shall place the complaint before the MAC and report upon the investigation of the complaint. In such circumstances the MAC shall follow the applicable due process procedures under Schedule "A" of the By-laws.

(c) Where the complaint and report of the preliminary investigation of the complaint is not placed before the MAC, the Respondent in question shall be informed of such decision. Where a complaint issued is not placed before the MAC, documentation of such complaint and any report created will not form part of the Professional Staff member's appointment record.

(d) Where the MAC has made a recommendation and the Respondent requests a Board hearing, the matter shall be referred to the Board and a Board hearing shall be conducted in accordance with procedures under Schedule "A" of the By-laws.

6.4.3 Members of the Board holding a meeting shall not have taken part in investigation or consideration of the subject matter of the meeting before the meeting and shall not communicate directly or indirectly in relation to the subject matter of the meeting with any person or with any party or representative of a party.

PART "B" PROCEDURE

1. PURPOSE

The purpose of this procedure is to outline the detailed steps and actions required by each participating organization when processing an application for appointment or reappointment for hospital privileges.

A detailed procedure for applicants submitting an application for a first time appointment is set out in the *Northwest Regional Appointment and Credentialing – Applicant Letter and Checklist.*

The process for granting appointments and privileges to physicians is clearly set out in the Public Hospitals Act, the Hospital Management Regulation, and the By-laws. Pursuant to this Policy, the same process shall be used for physicians, dentists, midwives and RN(EC)s, utilizing the NRECS electronic application. An Applicant for appointment or re-appointment to any group of the Professional Staff, or for an alteration or change in privileges shall submit an electronic application in accordance with Part I of this policy to the Administrator.

The Administrator shall refer the application immediately to the Chief of Staff and the credentialing staff, who shall keep a record of each application received and then refer copies forthwith where relevant to the Chair of the Credentials Committee and to the relevant Department Chief if any.

2. APPLICATION FOR APPOINTMENT

2.1 Upon receiving a written or electronic request for an application, the CEO or designate at the Primary organization will supply the applicant via email with an invitation to apply. The email will include the following:

(a) Applicant Letter – including a Username for *Northwest Regional E-Credentialing System (NRECS)*, timeframe for submission and information on Regional Ordering Privileges (a password generated by NRECS will be emailed directly to the applicant);

(b) Application Check List;

(c) A copy of the Northwest Regional Appointment and Credentialing Policy and Procedure;

(d) A copy of the organization's By-laws and Privileged Staff/Professional Staff Rules and Regulations;

(e) a "Web Link" to the Public Hospitals Act.

2.2 **Time for Completion**

(a) Applicants shall submit their electronic application 45 days from the date on which the original invitation email is sent;

(b) A notification/reminder will be sent from NRECS to the applicant at day(s) 14, 21 and again at day 35, if the electronic application has not been submitted;

(c) Applicants shall submit their supporting documents within 60 days from the date on which the original invitation email is sent;

(d) Once the electronic application has been submitted by the applicant, the electronic application is "locked" by the NRECS and unavailable for changes by the applicant. Credentialing staff will have the ability to add documents to the application ie reference questionnaires, Certificates of Professional Conduct, OHIP Billing Numbers, etc.;

(e) Where the required information to complete the application is not submitted within the time prescribed above, the application will be marked as 'Incomplete and Void' by NRECS. If all the required information has been submitted, the credentialing staff will mark the application as 'Verified' and proceed to process the application.

3. APPLICATION FOR RE-APPOINTMENT

3.1 Each eligible applicant for reappointment will receive an email granting them access to the NRECS system to complete their application for reappointment and confirming the applicant's NRECS Username. All applicants will have 45 days to submit the application for reappointment. An application for reappointment must be completed by December 31st of the current appointment year in order to permit continuation of the Professional Staff's appointment beyond the then current appointment year.

NOTE: Staff Status and Privileges Lists are Facility Specific

4. APPLICATION PROCESSING AND APPROVAL PROCESS

The Administrator or the credentialing staff on behalf of the administrator shall refer the application immediately to the Chief of Staff and the credentialing staff, who shall keep a record of each application received and then refer copies forthwith where relevant to the Chair of the Credentials Committee and to the relevant Department Chief if any.

(a) The relevant Department Chief if any or the Chief of Staff shall:

(i) review all completed applications received from the Administrator;

(ii) for initial applications, contact the Applicant's referees as provided to confirm information and review any concerns raised by recommendations from referees;

(iii) complete and provide to the Credentials Committee, if any or to the MAC, the Initial Report, or, for re-applications, the Review Report.

(b) If, in the view of the Department Chief and/or the Chief of Staff, an Applicant for re-appointment has not met his or her academic or clinical responsibilities, the Department Chief/Chief of Staff may make an appropriate recommendation to the MAC.

(c) Where the Hospital has a Credentials Committee, the Credentials Committee shall:

(i) investigate the application, with specific attention to the Applicant's qualifications, experience and his/her professional reputation;

(ii) where not already completed by the Chief of Department, for initial applications, contact each reference listed on the application to obtain information relating to the past performance, experience and reputation of the Applicant, and make a detailed note to file regarding the time and substance of the conversation;

(iii) if a re-application, review and consider the Applicant's privileges file;

(iv) review the Hospital-approved Professional Staff Human Resource Plan to confirm the availability of the position;

(v) receive and review the Initial Department Report or Department Review Report as applicable;

(vi) confirm the completion of an Impact Analysis Report and support by the applicable Department;

(vii) if applicable, take into consideration the impact, if any, that may result if the Applicant does not hold an appointment in the Faculty of Medicine/Dentistry at the University;

(viii) complete the Credentials Committee Report and forward such report, including any and all reports, documents, memorandums etc. that were reviewed or considered by the Credentials Committee to the MAC; and

(ix) complete the Professional Staff Application Checklist and forward it to the MAC.

(d) The MAC shall:

(i) receive and consider the Application along with the Professional Staff Application Checklist, the Credentials Committee Report, the Initial Department Report or, for re-applications, the Department Review Report, and further consider the application in the context of the Professional Staff Human Resource Plan and the Impact Analysis Report completed by the relevant Department;

(ii) based on the documents reviewed and considered, make a recommendation with respect to the Applicant's appointment in writing to the Board within sixty (60) days from the date of the application;

(iii) send notice of its recommendation to the Applicant pursuant to the Public Hospitals Act. Where the recommendation is in favour of appointment, the MAC shall specify its recommendation with respect to the privileges the Applicant should be granted and procedures the Applicant should be permitted to perform.

(e) If the MAC's recommendation is against appointment or re-appointment, the MAC shall provide written notice to the Applicant which shall inform the Applicant that s/he is entitled to:

(i) written reasons for the recommendation if a request for reasons is received by the MAC within seven (7) days of the receipt of a notice of the recommendation by the Applicant; and

(ii) a hearing before the Board if a written request is received by the Board and the MAC within seven (7) days of the Applicant's receipt of the written reasons.

(f) The MAC may make its recommendation later than the sixty (60) day period set out in the Public Hospitals Act if, prior to the expiry of the sixty (60) day period, it indicates in writing to the Board and the Applicant that a final recommendation cannot yet be made, and gives the written reasons therefore.

(g) Subject to the provisions of the Public Hospitals Act, where no hearing is requested, the Board shall either implement the recommendation of the MAC or reject the MAC's recommendation. In either case, the Board shall cause the MAC and the Applicant to be informed of the Board's decision regarding the recommendation.

(h) The Board may, in accordance with the Public Hospitals Act, refuse to appoint or reappoint and Applicant to the Professional Staff on any ground, including a failure to obtain or reduction in/loss of academic status at the University.

(i) Where an Applicant requests a hearing before the Board within seven (7) days of the Applicant's receipt of the written reasons, the Board shall appoint a time for and hold the hearing and shall decide the matter within its authority. The parties to the proceedings before the Board are the Applicant, the MAC and such other persons as the Board may specify.

(j) Where the Board is required to hold a hearing, the person requiring the hearing shall be afforded all of the rights set out in the Hospital's By-laws and Schedule "A" thereto and specifically may examine any documentary evidence that will be produced or any report, the contents of which will be given orally in evidence at the hearing, prior to the hearing.

(k) The Board may make a decision under certain conditions without holding a hearing, unless a hearing is required by or under the Public Hospitals Act.

5. APPLICATION FOR CHANGE IN PRIVILEGES OR APPOINTMENT CATEGORY

(a) Where a physician, dentist, midwife, or RN(EC) wishes to change his/her privileges or appointment category, an original application in the form as provided for above, shall be submitted to the Administrator identifying the changes requested, along with evidence of appropriate training, competence and professional liability protection and/or the reason(s) for the requested change in appointment category.

(b) Upon receipt, the Administrator or delegate shall immediately refer the application to the Chief of Staff, who, upon recording each application received, shall refer the application forthwith to the Chair of the Credentials Committee and to the relevant Department Chief if any and to the MAC.

(c) An application for change in privileges or appointment category shall be processed in accordance with the Public Hospitals Act, the By-laws, the Rules and Regulations and the procedures for an Initial Application.

(d) The MAC may request any additional information or evidence that it deems necessary for consideration of the application for alteration in privileges.