

**MEDICAL STAFF BYLAWS, POLICIES, AND
RULES AND REGULATIONS
OF
INDIANA UNIVERSITY HEALTH
TIPTON HOSPITAL**



CREDENTIALS MANUAL

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ARTICLE 1
GENERAL

1.A. PREAMBLE

All Medical Staff members commit to working cooperatively and professionally with each other and Hospital employees and management to promote safe, appropriate patient care. Medical Staff leaders shall strive to address professional practice issues fairly, reasonably, and collegially in a manner that is consistent with quality care and patient safety.

1.B. ALLIED HEALTH PRACTITIONERS

- (1) Any Allied Health Practitioner seeking permission to practice at the Hospital as a Licensed Independent Practitioner or an Advanced Dependent Practitioner shall be subject to the terms and conditions outlined in this Policy. (See Appendix C for approved categories of Allied Health Practitioners.)
- (2) This Policy will not apply to Allied Health Practitioners who function as Dependent Practitioners. Whenever a question or concern is raised about the care or conduct of a Dependent Practitioner, MEC will have the discretion to determine the action, if any, needed to address and resolve such question or concern. If the question or concern about a Dependent Practitioner originates from the Medical Staff, a report shall be provided to the MEC upon resolution of the issue.

1.C. TIME LIMITS

Time limits referred to in this Policy and related policies and manuals are advisory only and are not mandatory, unless it is expressly stated. Medical Staff leaders shall strive to be fair under the circumstances and to comply with the provisions of the Health Care Quality Improvement Act of 1986, 42 U.S.C. Section 11101 et seq. (“HCQIA”).

1.D. DELEGATION OF FUNCTIONS

Functions assigned to an identified individual or committee may be delegated to one or more designees.

1.E. CONFIDENTIALITY AND PEER REVIEW PROTECTION

1.E.1. Confidentiality:

All professional review activity and recommendations shall be strictly confidential. No disclosures of any such information (discussions or documentation) may be made outside of the meetings of the Peer Review Committees, except:

- (a) to another authorized individual and for the purpose of conducting professional review activity;
- (b) as authorized by a policy; or
- (c) as authorized, in writing, by the CEO or by legal counsel to the Hospital.

Any breach of confidentiality may result in appropriate sanctions.

1.E.2. Peer Review Protection:

All professional review activity shall be performed by the peer review committees. Peer Review Committees include, but are not limited to:

- (a) all standing and ad hoc Medical Staff and Hospital committees;
- (b) all sections;
- (c) hearing and appellate review panels;
- (d) the Board and its committees; and
- (e) any individual acting for or on behalf of any such entity, Medical Staff leaders, and experts or consultants retained to assist in professional review activities.

All reports, recommendations, actions, and minutes made or taken by peer review committees are confidential and covered by the provisions of applicable law.

1.F. INDEMNIFICATION

The Hospital shall provide a legal defense for, and shall indemnify, all Medical Staff leaders, peer review committees, members, and authorized representatives when engaged

in professional review activity, to the fullest extent permitted by law, in accordance with the Hospital's Bylaws.

ARTICLE 2

QUALIFICATIONS, CONDITIONS, AND RESPONSIBILITIES

2.A. QUALIFICATIONS

2.A.1. Threshold Eligibility Criteria:

To be eligible to apply for initial appointment, reappointment or clinical privileges, the applicant must, as applicable:

- (a) have a current, unrestricted license to practice in this state and have never had a license to practice revoked, restricted or suspended by any state licensing agency;
- (b) have a current, unrestricted DEA registration and state controlled substance license;
- (c) be located (office and residence) within the geographic service area of the Hospital, as defined by the Board, close enough to fulfill their Medical Staff responsibilities and to provide timely and continuous care for their patients in the Hospital;
- (d) have current, valid professional liability insurance coverage in a form and in amounts satisfactory to the Hospital and the state of Indiana;
- (e) have never been convicted of Medicare, Medicaid, or other federal or state governmental or private third-party payer fraud or program abuse, nor have been required to pay civil monetary penalties for the same;
- (f) have never been, and not currently be, excluded or precluded from participation in Medicare, Medicaid, or other federal or state governmental health care program;
- (g) have never had Medical Staff appointment, permission to practice, or clinical privileges, or status as a participating provider denied, revoked, or terminated by any health care facility or health plan for reasons related to clinical competence or professional conduct, or termination of employment with "do not rehire" status from IU Health;

- (h) have never resigned Medical Staff appointment or permission to practice or relinquished privileges during a Medical Staff investigation or in exchange for not conducting such an investigation;
- (i) have never been convicted of, or entered a plea of guilty or no contest, to any felony; or to any misdemeanor relating to controlled substances, illegal drugs, insurance or health care fraud or abuse, or violence;
- (j) demonstrate recent clinical activity in their primary area of practice during at least two of the last four years;
- (k) if seeking to practice as an Advanced Dependent Practitioner, have a written agreement with a Supervising Physician, which agreement must meet all applicable requirements of state law and Hospital policy;
- (l) have successfully completed a residency training program approved by the Accreditation Council for Graduate Medical Education (“ACGME”) or the American Osteopathic Association (“AOA”) in the specialty in which the applicant seeks clinical privileges, or an oral and maxillofacial surgery training program accredited by the Commission on Dental Accreditation of the American Dental Association (“ADA”), or a podiatric surgical residency program accredited by the Council on Podiatric Medical Education of the American Podiatric Medical Association;
- (m) be board certified in their primary area of practice at the Hospital. Applicants who are not board certified at the time of application but who have completed their residency or fellowship training within the last five years shall be eligible for Medical Staff appointment. However, in order to remain eligible, applicants must achieve board certification in their primary area of practice within five years from the date of completion of their residency or fellowship training; and
- (n) maintain board certification and, to the extent required by the applicable specialty/subspecialty board, satisfy recertification requirements. Recertification shall be assessed at reappointment.

The requirements in (l), (m) and (n) shall be applicable only to those individuals who apply for initial staff appointment after the date of adoption of this Policy. Existing

members shall be governed by the residency training and board certification requirements in effect at the time of their initial appointment.

2.A.2. Waiver of Threshold Eligibility Criteria:

- (a) Waivers of threshold eligibility criteria shall not be granted routinely. No one is entitled to a waiver. An application from an applicant who does not meet the threshold criteria for appointment, reappointment, or clinical privileges shall not be processed unless the Board has granted the requested waiver.
- (b) A request for a waiver shall only be considered if the applicant provides information sufficient to demonstrate that his or her qualifications are equivalent to, or exceed, the criterion in question and that there are exceptional circumstances that warrant a waiver.
- (c) The Credentials Committee may consider supporting documentation submitted by the applicant, any relevant information from third parties, input from the relevant Credentials Advisor, and the best interests of the Hospital and the communities it serves. The Credentials Committee shall forward its recommendation, including the basis for such, to the MEC.
- (d) The MEC shall review the recommendation of the Credentials Committee and make a recommendation to the Board regarding whether to grant or deny the request for a waiver and the basis for its recommendation.
- (e) The Board's determination regarding whether to grant a waiver is final. A determination not to grant a waiver is not a "denial" of appointment or clinical privileges and the applicant who requested the waiver is not entitled to a hearing. A determination to grant a waiver in a particular case is not intended to set a precedent. A determination to grant a waiver does not mean that appointment shall be granted; only that processing of the application can begin.

2.A.3. Factors for Evaluation:

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

- (a) relevant training, experience, and demonstrated current competence, including medical/clinical knowledge, technical and clinical skills, clinical judgment and an understanding of the contexts and systems within which care is provided;
- (b) adherence to the ethics of the profession, continuous professional development, an understanding of and sensitivity to diversity, and responsible attitude toward patients and the profession;
- (c) good reputation and character;
- (d) ability to safely and competently perform the clinical privileges requested;
- (e) ability to work harmoniously with others, including, but not limited to, interpersonal and communication skills sufficient to enable them to maintain professional relationships with patients, families, and other members of health care teams; and
- (f) recognition of the importance of, and willingness to support, the Hospital's and Medical Staff's commitment to quality care and a recognition that interpersonal skills and collegiality are essential to the provision of quality patient care.

2.A.4. No Entitlement to Appointment:

No one is entitled to receive an application or to be appointed or reappointed to the Medical Staff or Allied Health Staff or to be granted particular clinical privileges merely because he or she:

- (a) is licensed to practice a profession in this or any other state;
- (b) is a member of any particular professional organization;
- (c) has had in the past, or currently has, Medical Staff appointment or privileges at any hospital or health care facility;
- (d) resides in the geographic service area of the Hospital; or
- (e) is affiliated with, or under contract to, any managed care plan, insurance plan, HMO, PPO, or other entity.

Any decision not to tender an application to a physician or Allied Health practitioner will be made by the Credentials Committee.

2.A.5. Nondiscrimination:

No one shall be denied appointment on the basis of gender, race, creed, or national origin.

2.B. GENERAL CONDITIONS OF APPOINTMENT AND REAPPOINTMENT

2.B.1. Basic Responsibilities and Requirements:

- (a) As a condition of Medical Staff or Allied Health Staff membership, every applicant and member specifically agree to the following, as applicable:
- (1) to provide continuous and timely care;
 - (2) to abide by the bylaws, policies, and rules and regulations of the Hospital and Medical Staff and any revisions or amendments thereto;
 - (3) to participate in Medical Staff affairs through committee service and participation in performance improvement and peer review activities, and to perform such other reasonable duties and responsibilities as may be assigned;
 - (4) to provide emergency call coverage, consultations, and care for unassigned patients;
 - (5) to comply with applicable clinical practice protocols and guidelines or document the clinical reasons for variance;
 - (6) to immediately submit to a blood, hair or urine test, or to a complete physical or mental evaluation, if at least two Medical Staff leaders (or one Medical Staff leader and the CEO or CMO) are concerned about his or her ability to safely and competently care for patients. The health care professional(s) to perform the testing or evaluations shall be determined by the Medical Staff leaders;
 - (7) to participate in personal or phone interviews in regard to an application for initial appointment or reappointment, if requested;
 - (8) to use the Hospital sufficiently to allow continuing assessment of current competence;
 - (9) to seek consultation whenever necessary;
 - (10) to complete in a timely manner all medical and other required records;
 - (11) to perform all services and to act in a cooperative and professional manner;
 - (12) to promptly pay any applicable dues, assessments, or fines; and

- (13) to satisfy continuing medical education requirements.
 - (14) Results of annual TB surveillance must be submitted with completed application for reappointment as condition to practice in the Hospital. TB tests are required for providers in Emergency Medicine and surgical specialties while TB questionnaires can be completed for all other providers.
- (b) In addition to the above, every individual seeking to practice as an Advanced Dependent Practitioner and his or her respective Supervising Physician specifically agree that:
- (1) any privileges granted by the Board to any Allied Health Practitioner who is an Advanced Dependent Practitioner will be performed in the Hospital only under the supervision of a Supervising Physician;
 - (2) the number of Advanced Dependent Practitioners employed by or under the supervision of a Member of the Medical Staff will be consistent with state law and the rules and regulations of the Medical Staff; and
 - (3) an Advanced Dependent Practitioner will give notice, within three business days, to the Medical Staff Office of any revisions or modifications that are made to the supervision agreement.
- (c) Additional supervision requirements are set forth in Appendix A.

2.B.2. Burden of Providing Information:

- (a) All applicants and members have the burden of producing information deemed adequate by the Hospital for a proper evaluation of current competence, character, ethics, and other qualifications and for resolving any doubts.
- (b) Applicants have the burden of providing evidence that all the statements made and information given on the application are accurate and complete.
- (c) An application shall be complete when all questions on the application form have been answered, all supporting documentation has been supplied, and all information has been verified from primary sources. An application shall become incomplete if the need arises for new, additional, or clarifying information. Any

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

- (d) Applicants are responsible for providing a complete application, including adequate responses from references. An incomplete application shall not be processed.
- (e) Notification of any change in status or any change in the information provided on the application form shall be given to the President of the Medical Staff or the CEO or their designee. This information shall be provided with or without request, at the time the change occurs. Failure to provide this information shall deem the applicant ineligible for staff membership or clinical privileges. Failure to provide this information as a member shall result in automatic relinquishment.

2.B.3. Provisional Period:

- (a) Initial appointment to the Medical Staff (regardless of the staff category), Allied Health Staff, and all initial grants of clinical privileges, whether at the time of appointment, reappointment, or during the term of an appointment, shall be provisional.
- (b) During the provisional period, the exercise of clinical privileges shall be evaluated by the Credentials Advisor or by a physician(s) designated by the Credentials Committee. This evaluation may include chart review, monitoring, proctoring, external review, and other information. The numbers and types of cases to be reviewed shall be determined by the Credentials Committee.
- (c) The duration of the provisional period for initial appointment and privileges shall be recommended by the Credentials Committee. The duration of the provisional period for all other initial grants of privileges shall be as recommended by the Credentials Committee.
- (d) During the provisional period, a member must arrange for, or cooperate in the arrangement of, the required numbers and types of cases to be reviewed by the Credentials Advisor or by other designated physicians.

- (e) A newly appointed member shall automatically relinquish his or her appointment and privileges at the end of the provisional period if he or she fails, during the provisional period, to:
- (1) participate in the required number of cases or provide documentation of competence;
 - (2) cooperate with the monitoring and review conditions; or
 - (3) fulfill all requirements of appointment, including but not limited to those relating to completion of medical records or emergency call responsibilities.
- In such case, the individual may not reapply for initial appointment or privileges for two years.
- (f) If a member who has been granted additional clinical privileges fails, during the provisional period, to participate in the required number of cases, or provide documentation of competence, or cooperate with the monitoring and review conditions, the additional clinical privileges shall be automatically relinquished at the end of the provisional period. The member may not reapply for the privileges in question for two years.
- (g) When, based on the evaluation performed during the provisional period, clinical privileges are terminated, revoked, or restricted for reasons related to clinical competence or professional conduct, the member shall be entitled to a hearing and appeal.

2.C. APPLICATION

2.C.1. Information:

Applications for appointment and reappointment shall contain a request for specific clinical privileges and shall require detailed information concerning the applicant's professional qualifications. The applications for initial appointment and reappointment existing now and as may be revised are incorporated by reference and made a part of this Policy. The applicant shall sign the application and certify that he or she is able to perform the privileges requested and the responsibilities of appointment.

2.C.2. Misstatements and Omissions:

- (a) Any misstatement in, or omission from, the application is grounds to stop processing the application. The applicant shall be informed in writing of the nature of the misstatement or omission and permitted to provide a written response. The President of the Medical Staff and CEO or their designee shall review the response and determine whether the application should be processed further.
- (b) If appointment has been granted prior to the discovery of a misstatement or omission, appointment and privileges may be deemed to be automatically relinquished pursuant to Section 6.D.3.
- (c) No action taken pursuant to this section shall entitle the applicant or member to a hearing or appeal.

2.C.3. Grant of Immunity and Authorization to Obtain/Release Information:

By applying for appointment, reappointment, or clinical privileges, the applicant accepts the following conditions throughout the term of appointment and thereafter as to any inquiries received about the applicant:

(a) Immunity:

To the fullest extent permitted by law, the applicant releases from any and all liability, extends immunity to, and agrees not to sue the Hospital or the Board, any member of the Medical Staff or Board, their authorized representatives, and third parties who provide information for any matter relating to appointment, reappointment, clinical privileges, or the applicant's qualifications for the same. This immunity covers any actions, recommendations, reports, statements, communications, or disclosures that are made, taken, or received by the Medical Staff, the Hospital, its representatives, or third parties in the course of credentialing and peer review activities. The participant agrees not to sue any individuals for acts that are covered under the immunities set forth above.

(b) Authorization to Obtain Information from Third Parties:

The applicant authorizes the Hospital, Medical Staff leaders, and their representatives (1) to consult with any third party who may have information

bearing on the applicant's qualifications, and (2) to obtain any and all information from third parties that may be relevant. The applicant authorizes third parties to release this information to the Hospital and its representatives upon request. The applicant also agrees to sign consent forms to permit a consumer reporting agency to conduct a criminal background check and report the results to the Hospital.

(c) Authorization to Release Information to Third Parties:

The applicant also authorizes Hospital representatives to release information to other hospitals, health care facilities, managed care organizations, government regulatory and licensure boards or agencies, and their representatives when information is requested in order to evaluate his or her qualifications.

(d) Hearing and Appeal Procedures:

The applicant agrees that the hearing and appeal procedures set forth in this Policy shall be the sole and exclusive remedy with respect to any professional review action taken by the Hospital.

(e) Legal Actions:

If an applicant institutes legal action challenging any professional review action and does not prevail, he or she shall reimburse the Hospital and any member of the Medical Staff or Board involved in the action for all costs incurred in defending such legal action, including reasonable attorney's fees.

(f) Authorization to Share Information within the System:

The applicant specifically authorizes the Hospital and its affiliates to share information pertaining to the applicant's clinical competence or professional conduct.

(g) Scope of Section:

All of the provisions in this Section 2.C.3 are applicable in the following situations:

- (1) whether or not appointment or clinical privileges are granted;
- (2) throughout the term of any appointment or reappointment period and thereafter;

- (3) should appointment, reappointment, or clinical privileges be revoked, reduced, restricted, suspended, and/or otherwise affected as part of the Hospital's professional review activities; and
- (4) as applicable, to any third-party inquiries received after the individual leaves the Medical Staff or Allied Health Staff about his/her tenure at the Hospital.

ARTICLE 3

PROCEDURE FOR INITIAL APPOINTMENT AND PRIVILEGES

3.A. PROCEDURE FOR INITIAL APPOINTMENT AND PRIVILEGES

3.A.1. Application:

- (a) Applications for appointment and clinical privileges shall be in writing and shall be on forms approved by the Board, upon recommendation by the MEC.
- (b) Prospective applicants shall be sent a letter that outlines the threshold eligibility criteria for appointment and the applicable criteria for clinical privileges, and the application form.
- (c) Applications may be provided to residents who are in the final six months of their training. Final action shall not be taken until all applicable threshold eligibility criteria are satisfied.
- (d) An Allied Health Practitioner who is in a category of practitioners that has not been approved by the Board to practice at the Hospital shall be ineligible to receive an application. A determination of ineligibility does not entitle an Allied Health Practitioner to the procedural rights set forth in this Policy. Guidelines for determining the need for new categories of Allied Health Practitioners appear in Appendix B.

3.A.2. Initial Review of Application:

- (a) A completed application form with copies of all required documents must be returned to the Medical Staff Office within 30 days after receipt.

- (b) As a preliminary step, the application shall be reviewed by the Medical Staff Office to determine that all questions have been answered and that the applicant satisfies all threshold eligibility criteria. Applicants who fail to return completed applications or fail to meet the threshold eligibility criteria shall be notified that their applications shall not be processed. A determination of ineligibility does not entitle the individual to a hearing and appeal.
- (c) The Medical Staff Office shall oversee the process of gathering and verifying relevant information, and confirming that all references and other information deemed pertinent have been received.
- (d) Evidence of the applicant's character, professional competence, qualifications, behavior, and ethical standing shall be examined. This information may be contained in the application, and obtained from references and other available sources, including the applicant's past or current department chair at other health care entities, residency training director, and others who may have knowledge about the applicant's education, training, experience, and ability to work with others.
- (e) An interview(s) with the applicant may be conducted by one of or a combination of any of the following: the Credentials Advisor, the Credentials Committee, a Credentials Committee representative, the MEC, the President of the Medical Staff, CMO, or the CEO.

3.A.3. Credentials Advisors Procedure:

The Credentials Advisors for the area in which the applicant has requested clinical privileges (Surgery or Medicine) shall review the application and all supporting materials and prepare a report.

3.A.4. Credentials Committee Procedure:

- (a) The Credentials Committee shall consider the report prepared by the Credentials Advisor and shall make a recommendation.

- (b) The Credentials Committee may use the expertise of the Credentials Advisor, or an outside consultant, if additional information is required regarding the applicant's qualifications.
- (c) After determining that an applicant is otherwise qualified for appointment and privileges, the Credentials Committee shall review the health status information to determine if there is any question about the applicant's ability to perform the privileges requested and the responsibilities of appointment. If so, the Credentials Committee may require a physical or mental examination by a physician(s) satisfactory to the Credentials Committee. The results of this examination shall be made available to the Committee. Failure to undergo an examination within a reasonable time after a written request from the Credentials Committee shall be considered a voluntary withdrawal of the application.
- (d) The Credentials Committee may recommend the imposition of specific conditions related to behavior, health or clinical issues. The Credentials Committee may also recommend that appointment be granted for a period of less than two years in order to permit closer monitoring of the applicant's compliance with any conditions.
- (e) If the recommendation of the Credentials Committee is delayed longer than 60 days, the chairman of the Credentials Committee shall send a letter to the applicant, with a copy to the CEO, explaining the reasons for the delay.

3.A.5. MEC Recommendation:

- (a) At its next regular meeting after receipt of the written report and recommendation of the Credentials Committee, the MEC shall:
 - (1) adopt the report and recommendation of the Credentials Committee as its own; or
 - (2) refer the matter back to the Credentials Committee for further consideration of specific questions; or
 - (3) state its reasons for disagreement with the report and recommendation of the Credentials Committee.

- (b) If the recommendation of the MEC is to appoint, the recommendation shall be forwarded to the Board.
- (c) If the recommendation of the MEC would entitle the applicant to request a hearing, the MEC shall forward its recommendation to the CEO, who shall promptly send special notice to the applicant. The CEO shall then hold the application until after the applicant has completed or waived a hearing and appeal.
- (d) The Credentials Committee will recommend applicants and reapplicants to the MEC as “expedited” if the conditions specified in the Expedited Credentials policy are all applicable.

3.A.6. Board Action:

- (a) The Board may delegate to a committee, consisting of at least two Board members, action on appointment, reappointment, and clinical privileges if there has been a favorable recommendation from the Credentials Committee and the MEC
Any decision reached by the Board Committee to appoint shall be effective immediately and shall be forwarded to the Board for ratification at its next meeting.
- (b) When there has been no delegation to the Board Committee, upon receipt of a recommendation for appointment and clinical privileges, the Board may:
 - (1) grant appointment and clinical privileges as recommended; or
 - (2) refer the matter back to the Credentials Committee or MEC or to another source inside or outside the Hospital for additional research or information; or
 - (3) disagree with or modify the recommendation.
- (c) If the Board disagrees with a favorable recommendation, it should first discuss the matter with the chairman of the Credentials Committee and the chairman of the MEC. If the Board’s determination remains unfavorable, the CEO shall promptly send special notice that the applicant is entitled to request a hearing.

- (d) Any final decision by the Board to grant, deny, revise, or revoke appointment or clinical privileges is disseminated to appropriate individuals and, as required, reported to appropriate entities.

3.A.7. Time Periods for Processing:

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

ARTICLE 4

CLINICAL PRIVILEGES

4.A. CLINICAL PRIVILEGES

4.A.1. General:

- (a) Appointment or reappointment shall not confer any clinical privileges or right to practice at the Hospital. Only those clinical privileges granted by the Board may be exercised.
- (b) A request for privileges shall be processed only when an applicant satisfies threshold eligibility criteria.
- (c) Requests for clinical privileges that are subject to an exclusive contract shall not be processed except as consistent with the applicable contract.
- (d) Recommendations for clinical privileges shall be based on consideration of the following:
 - (1) education, relevant training, experience, and demonstrated current competence, including medical/clinical knowledge, technical and clinical skills, judgment, interpersonal and communication skills, and professionalism with patients, families, and other members of the health care team and peer evaluations relating to these criteria;
 - (2) appropriateness of utilization patterns;
 - (3) ability to perform the privileges requested competently and safely;

- (4) information resulting from ongoing and focused professional practice evaluation and other performance improvement activities, as applicable;
 - (5) availability of coverage in case of the applicant's illness or unavailability;
 - (6) adequate professional liability insurance coverage for the clinical privileges requested;
 - (7) the Hospital's available resources and personnel;
 - (8) any previously successful or currently pending challenges to any licensure or registration, or the voluntary or involuntary relinquishment of such licensure or registration;
 - (9) any information concerning professional review actions or voluntary or involuntary termination, limitation, reduction, or loss of appointment or clinical privileges at another hospital;
 - (10) practitioner-specific data as compared to aggregate data, when available;
 - (11) morbidity and mortality data, when available; and
 - (12) professional liability actions, especially any such actions that reflect an unusual pattern or number of actions. The Credentials Committee will be made aware of any malpractice claims that a new applicant has had regardless of number, the only exceptions being claims for incidents which occurred while the applicant was a resident or claims that were dismissed with no payment.
- (e) Requests for increased privileges must state the additional clinical privileges requested and provide information sufficient to establish eligibility. If the member is eligible and the application is complete, it shall be processed in the same manner as an application for initial clinical privileges.

4.A.2. Resignation of Privileges:

A request to resign all clinical privileges must (a) specify the desired date of resignation, at least 30 days from the date of the request, and (b) provide evidence that the individual has completed all medical records and shall be able to appropriately discharge or transfer responsibility for the care of any hospitalized patient. After consulting with the President

of the Medical Staff, the CEO or their designee shall act on the request. Resignations of Privileges shall be reviewed by the Credentials Committee as an informational item.

4.A.3. Clinical Privileges for New Procedures:

- (a) Requests for clinical privileges to perform either a procedure not currently being performed or a new technique to perform an existing procedure (“new procedure”) shall not be processed until a determination has been made that the procedure shall be offered by the Hospital and criteria for the privilege have been adopted.
- (b) The individual seeking to perform the new procedure shall submit a report to the Credentials Committee addressing the following:
 - (1) minimum education, training, and experience necessary to perform the new procedure safely and competently;
 - (2) clinical indications for when the new procedure is appropriate;
 - (3) whether there is empirical evidence of improved patient outcomes with the new procedure or other clinical benefits to patients;
 - (4) whether proficiency for the new procedure is volume-sensitive and if the requisite volume would be available;
 - (5) whether the new procedure is being performed at other similar hospitals and the experiences of those institutions; and
 - (6) whether the Hospital currently has the resources, including space, equipment, personnel, and other support services, to safely and effectively perform the new procedure.

The Credentials Committee shall review this report, conduct additional research as necessary, and make a preliminary recommendation as to whether the new procedure should be offered to the community.

- (c) If the preliminary recommendation is favorable, the Credentials Committee shall then develop threshold credentialing criteria to determine those individuals who are eligible to request the clinical privileges. In developing the criteria, the Credentials Committee may conduct additional research and consult with experts, as necessary, and develop recommendations.

- (d) The Credentials Committee shall forward its recommendations to the MEC, which shall review the matter and forward its recommendations to the Board for final action.

4.A.4. Clinical Privileges That Cross Specialty Lines:

- (a) Requests for clinical privileges that previously have been exercised only by members in another specialty shall not be processed until the steps outlined in this section have been completed and a determination has been made regarding the member's eligibility to request the clinical privilege(s) in question.
- (b) The individual seeking the privilege shall submit a report to the Credentials Committee that specifies the minimum qualifications needed to perform the procedure safely and competently, whether the individual's specialty is performing the privilege at other similar hospitals, and the experiences of those other hospitals. The Credentials Committee shall then conduct additional research and consult with experts, as necessary.
- (c) The Credentials Committee may or may not recommend that individuals from different specialties be permitted to request the privileges at issue. If it does, the Committee may develop recommendations.
- (d) The Credentials Committee shall forward its recommendations to the MEC, which shall review the matter and forward its recommendations to the Board for final action.

4.A.5. Clinical Privileges for Dentists and Oral and Maxillofacial Surgeons:

- (a) The scope and extent of surgical procedures that a dentist or an oral and maxillofacial surgeon may perform in the Hospital shall be delineated and recommended in the same manner as other clinical privileges.
- (b) A medical history and physical examination of the patient shall be made and recorded by a physician who is a member of the Medical Staff before dental surgery shall be performed, and a designated physician shall be responsible for the medical care of the patient throughout the period of hospitalization.

- (d) The dentist or oral and maxillofacial surgeon shall be responsible for the dental care of the patient, including the dental history and dental physical examination, as well as all appropriate elements of the patient's record. Dentists and oral and maxillofacial surgeons may write orders within the scope of their license and consistent with the Medical Staff Rules and Regulations and in compliance with the Hospital and Medical Staff Bylaws and this Policy.

4.A.6. Physicians in Training:

Physicians in training shall not be granted appointment to the Medical Staff or clinical privileges. The program director, clinical faculty, or attending staff member shall be responsible for the direction and supervision of the on-site or day-to-day patient care activities of each trainee, who shall be permitted to perform only those clinical functions set out in curriculum requirements, affiliation agreements, or training protocols approved by the MEC or its designee. The applicable program director shall be responsible for verifying and evaluating the qualifications of each physician in training.

4.A.7. Telemedicine Privileges:

- (a) Telemedicine is the exchange of medical information from one site to another via electronic communications for the purpose of providing patient care, treatment, and services. The Board shall determine the clinical services to be provided through telemedicine after considering the recommendations of the appropriate Section chief or co-chiefs, the Credentials Committee and the MEC.
- (b) Individuals applying for telemedicine privileges must meet the qualifications for Medical Staff appointment outlined in this Policy, except for those requirements relating to geographic residency, coverage arrangements, and emergency call responsibilities.
- (c) Qualified applicants may be granted telemedicine privileges but not be appointed to the Medical Staff. Telemedicine privileges granted in conjunction with a contractual agreement shall be incident to and coterminous with the agreement.
- (d) Applications for telemedicine privileges shall be processed in accordance with the provisions of this Policy in the same manner as for any other applicant, except

that the Hospital may use the credentialing information provided by the applicant's primary hospital if that hospital is a Medicare-participating hospital and provides: (1) a list of all privileges granted to the practitioner; (2) information indicating that the applicant has exercised such privileges in a competent manner; and (3) a signed attestation that the information is complete, accurate, and up-to-date.

- (e) Telemedicine privileges, if granted, shall be for a period of not more than two years. Individuals seeking to renew telemedicine privileges shall be required to complete an application and, upon request, provide the Hospital with evidence of current clinical competence. This information may include, but is not limited to, a quality profile from the applicant's primary practice affiliation and an evaluation form(s) from a qualified supervisor(s). If all requested information is not received by dates established by the Hospital, the individual's telemedicine privileges shall expire at the end of the current term. Once all information is received and verified, an application to renew telemedicine privileges shall be processed as set forth above.
- (f) Individuals granted telemedicine privileges shall be subject to the Hospital's performance improvement, ongoing and focused professional practice evaluations and peer review activities.

4.B. TEMPORARY CLINICAL PRIVILEGES

4.B.1. Temporary Clinical Privileges:

- (a) Temporary privileges may be granted by the CEO or their designee, upon recommendation of the President of the Medical Staff, to:
 - (1) applicants for initial appointment whose complete application is pending review by the Credentials Committee, MEC and Board, or following a favorable recommendation of the Credentials Committee or MEC. In order to be eligible for temporary privileges, an applicant must have demonstrated ability to perform the privileges requested and have had no
 - (i) current or previously successful challenges to licensure or registration
 - or (ii) involuntary restriction, reduction, denial or termination of Medical

- Staff membership or clinical privileges at another health care facility, (iii) meet the requirements for expedited credentialing.
- (2) non-applicants, when there is an important patient care, treatment, or service need, including the following:
- (i) the care of a specific patient;
 - (ii) when necessary to prevent a lack of services in a needed specialty area;
 - (iii) proctoring; or
 - (iv) locum tenens for a member of the Medical Staff.
- (b) The following verified information shall be considered prior to the granting of any temporary privileges: current licensure, relevant training, experience, current competence, current professional liability coverage acceptable to the Hospital and results of a query to the National Practitioner Data Bank.
- (c) The grant of temporary clinical privileges shall be for 60 days and can be extended. However, they may not exceed 120 days. For non-applicants the days need not be consecutive and may be renewed.
- (d) Prior to any temporary privileges being granted, the individual must agree in writing to be bound by the Bylaws, Rules and Regulations, policies, procedures and protocols of the Medical Staff and the Hospital.

4.B.2. Termination of Temporary Clinical Privileges:

- (a) The granting of temporary privileges is a courtesy and may be terminated for any reason by the CEO at any time, after consulting with the President of the Medical Staff, the chairman of the Credentials Committee. The individual may be afforded an opportunity to refrain from exercising privileges.
- (b) The President of the Medical Staff shall assign to another member of the Medical Staff responsibility for the care of patients until they are discharged. Whenever possible, consideration shall be given to the wishes of the patient in the selection of a substitute physician.
- (c) Neither the denial nor termination of temporary privileges shall entitle the individual to a hearing or appeal.

4.C. EMERGENCY SITUATIONS

- (1) For the purpose of this section, an “emergency” is defined as a condition which could result in serious or permanent harm to patient(s) and in which any delay in administering treatment would add to that harm.
- (2) In an emergency situation, a member may administer treatment to the extent permitted by his or her license, regardless of service status or specific grant of clinical privileges.
- (3) When the emergency situation no longer exists, the patient shall be assigned by the President of the Medical Staff to a member with appropriate clinical privileges, considering the wishes of the patient.

4.D. DISASTER PRIVILEGES

- (1) Upon activation of IU Health Tipton Hospital’s Emergency Operations Plan, any licensed independent practitioner not on the medical staff of IU Health Tipton Hospital and presenting themselves as volunteers to render their services during an emergency or disaster shall be eligible for disaster privileges.
- (2) The eligible practitioners shall be directed to the Medical Staff office (or designated representatives) where they will need to present the following:
 1. Valid government issued photo ID;
 2. Current and valid Indiana state license/certificate to practice, or other state license/certificate to practice (if authorized by declaration of Indiana state emergency medical services system);
 3. Identity of their current primary hospital affiliation;
 4. Information with regard to their current malpractice carrier;
 5. Social security number, date of birth, specialty training information, and all other necessary information required to conduct a National Practitioner Data Bank (NPDB) query and complete the Application for Emergency Credentialing form; and

6. Signed Emergency Privileges Form indicating their willingness to volunteer medical services and attesting to current clinical competence and unrestricted license to practice.
7. Information obtained from each of the practitioners shall be documented on an Application for Emergency Credentialing form.
8. If time and logistics permit, attempts will be made to verify immediately their licensure status and query the NPDB. Recognizing the credentials verification process as a high priority, all verifications shall be initiated as soon as possible (once the immediate situation is under control). Primary source verification of licensure will be completed within 72 hours from the time the volunteer practitioner presents to the organization. If, due to extraordinary circumstances, primary source verification of licensure of the volunteer licensed independent practitioner cannot be completed within 72 hours of the practitioner's arrival, it is performed as soon as possible. Any adverse information will be brought to the immediate attention of the Chief of Staff and CEO.
9. Emergency Privileges Form shall be completed and include the signatures of the practitioner and the Chief of Staff or the CEO (or their designees).
10. The practitioner will be issued an identification badge and access card that denotes Emergency Privileges Provider. This badge and an access card must be worn at all times.
11. A folder shall be prepared for each individual practitioner to maintain credentials and other relevant information.
12. The Credentials Committee Chairman will review the credentials file for each practitioner within 72 hours of approval. He or she will call a full Credentials Committee meeting if necessary. A recommendation regarding the practitioner's Emergency Privileges will be presented to the Chief of Staff or the CEO (or their designees).

13. If at all possible, the volunteer shall be assigned to a current member of the IU Health Tipton Hospital Medical Staff who is in the same specialty. The volunteer is to act under the supervision of the Medical Staff member.
14. All disaster privileges shall immediately terminate once the emergency is over and may be terminated at any time without any reason or cause. Termination of these privileges will not give rise to a hearing or review.
15. A list of patients treated by the volunteer shall be maintained in the practitioner's file.4.E.

CONTRACTS FOR SERVICES

- (1) From time to time, the Hospital may enter into contracts with practitioners or groups of practitioners for the performance of clinical and administrative services. All individuals functioning pursuant to such contracts shall obtain and maintain clinical privileges, in accordance with the terms of this Policy. In addition, if any such individual is the subject of an adverse credentialing or peer review recommendation by the MEC based upon the individual's clinical competence or professional conduct, the individual shall be entitled to the procedural rights set forth in this Policy before the Board takes final action on the matter.
- (2) To the extent that:
 - (a) any such contract confers the exclusive right to perform specified services to one or more practitioners or groups of practitioners, OR
 - (b) the Board adopts a resolution that limits the practitioners who may exercise privileges in any clinical specialty to employees of Indiana University Health or its affiliates,no other practitioner except those authorized by the exclusive contract or Board resolution may exercise clinical privileges to perform the specified services while the contract or resolution is in effect. This means that only practitioners authorized by the exclusive contract or Board resolution are eligible to apply for the clinical privileges in question at the time of initial appointment, during the term of an appointment, or at reappointment. No other applications shall be processed.

- (3) If any such exclusive contract or Board resolution would have the effect of preventing an existing Medical Staff member from exercising clinical privileges that had previously been granted, the following notice and review procedures apply:
- (a) The affected Medical Staff member shall be given at least 90 days advance notice of the exclusive contract or Board resolution and have the right to meet with the Board or a committee designated by the Board to discuss the matter prior to the contract in question being signed by the Hospital or the Board resolution becoming effective.
 - (b) At the meeting, the affected Medical Staff member shall be entitled to present any information relevant to the Hospital's decision to enter into the exclusive contract or enact the Board resolution. If, following this meeting, the Board decides to enter into the exclusive contract or enact the Board resolution, the affected Medical Staff member shall be ineligible to continue to exercise the clinical privileges covered by the exclusive contract or resolution unless a waiver has been granted. In that circumstance, the ineligibility begins as of the effective date of the exclusive contract or Board resolution and continues for as long as the contract or resolution is in effect.
 - (c) The affected Medical Staff member shall not be entitled to any other procedural rights beyond those outlined above with respect to the Board's decision or the effect of the decision on his or her clinical privileges, notwithstanding the provisions in Article 7 or any other provision of this Credentialing Policy or the Medical Staff Bylaws.
 - (d) The inability of a physician to exercise clinical privileges because of an exclusive contract or Board resolution is not a matter that requires a report to the Indiana licensure board or to the National Practitioner Data Bank.
- (4) In the event of any conflict between this Policy or the Medical Staff Bylaws and the terms of any contract, the terms of the contract shall control.

ARTICLE 5
PROCEDURE FOR REAPPOINTMENT

5.A. ELIGIBILITY FOR REAPPOINTMENT

All terms, conditions, requirements, and procedures relating to initial appointment shall apply to continued appointment and clinical privileges and to reappointment. In addition, to be eligible to apply for reappointment and renewal of clinical privileges, a member must have, as applicable:

- (1) completed all medical records;
- (2) completed all continuing medical education requirements;
- (3) satisfied all Medical Staff or Allied Health Staff responsibilities, including payment of any dues, fines, and assessments;
- (4) continued to meet all qualifications and criteria for appointment and the clinical privileges requested;and
- (6) had sufficient patient contacts to enable the assessment of current clinical judgment and competence for the privileges requested. Any member seeking reappointment who has minimal activity at the Hospital must submit such information as may be requested (such as a copy of his or her confidential quality profile from his or her primary hospital, clinical information from his or her private office practice, or a quality profile from a managed care organization or insurer), before the application shall be considered complete and processed further.

5.B. FACTORS FOR EVALUATION

In considering an application for reappointment, the factors listed in Section 2.A.3 of this Policy shall be considered, as shall the following additional factors relevant to the member's previous term:

- (1) compliance with the Bylaws, Rules and Regulations, and policies of the Medical Staff and the Hospital;
- (2) participation in Medical Staff duties, including committee assignments and emergency call;

- (3) the results of the Hospital's performance improvement activities, taking into consideration practitioner-specific information compared to aggregate information concerning other individuals in the same or similar specialty (provided that, other practitioners shall not be identified);
- (4) any focused professional practice evaluations;
- (5) verified complaints received from patients or staff; and
- (6) other reasonable indicators of continuing qualifications.

5.C. REAPPOINTMENT APPLICATION

- (1) Reappointment shall be for a period of not more than two years.
- (2) An application for reappointment shall be furnished to members at least four months prior to the expiration of their current appointment term. A completed reappointment application must be returned to the Medical Staff Office within ninety (90) days.
- (3) Failure to submit a complete application at least four months prior to the expiration of the member's current term may result in automatic expiration of appointment and clinical privileges at the end of the then current term of appointment.
- (4) If an application for reappointment is submitted timely, but the Board has not acted on it prior to the end of the current term, the Member's appointment and clinical privileges shall expire at the end of the then current term of appointment. However, if the inaction is due to circumstances beyond the applicant's control, and no issues have been raised about the application, the CEO and Board chairman may grant conditional reappointment for a period not to exceed 120 days to allow for Board action at its next meeting.
- (5) The application shall be reviewed by the Medical Staff Office to determine that all questions have been answered and that the member satisfies all threshold eligibility criteria for reappointment and for the clinical privileges requested.
- (6) The Medical Staff Office shall oversee the process of gathering and verifying relevant information. The Medical Staff Office shall also be responsible for confirming that all relevant information has been received.

- (7) If the Credentials Committee or the MEC is considering a recommendation to deny reappointment or to reduce clinical privileges, the committee chairman shall notify the member of the general tenor of the possible recommendation and may invite the member to meet prior to any final recommendation being made. Prior to this meeting, the member shall be notified of the general nature of the information supporting the recommendation contemplated. At the meeting, the member shall be invited to discuss, explain, or refute this information. A summary of the interview shall be made and included with the committee's recommendation. This meeting is not a hearing, and none of the procedural rules for hearings shall apply. The member shall not have the right to be represented by legal counsel at this meeting.

5.D. CONDITIONAL REAPPOINTMENTS

- (1) Recommendations for reappointment may be subject to an applicant's compliance with specific conditions. These conditions may relate to behavior (e.g., personal code of conduct) or to clinical issues (e.g., performance improvement steps such as general consultation requirements, proctoring, completion of CME requirements). Reappointments may be recommended for periods of less than two years in order to permit closer monitoring of a member's compliance with any conditions that may be imposed.
- (2) A recommendation of a conditional reappointment or for reappointment for a period of less than two years does not, in and of itself, entitle a member to request a hearing or appeal.
- (3) In the event the applicant for reappointment is the subject of an investigation or a hearing at the time reappointment is being considered, a conditional reappointment for a period of less than two years may be granted pending the completion of that process.

ARTICLE 6
PEER REVIEW PROCEDURES FOR QUESTIONS
INVOLVING MEDICAL STAFF MEMBERS

6.A. COLLEGIAL INTERVENTION

- (1) This Policy encourages the use of progressive steps by Medical Staff leaders and Hospital management, beginning with collegial and educational efforts, to address issues pertaining to clinical competence or professional conduct. The goal of these efforts is to arrive at voluntary actions by the individual to resolve an issue that has been raised. Collegial intervention may be carried out, within the discretion of Medical Staff leaders and Hospital management, but is not mandatory.
- (2) Collegial intervention is a part of the Hospital's professional review activities and may include counseling, education, and related steps, such as the following:
 - (a) advising colleagues of applicable policies, such as policies regarding appropriate behavior, emergency call obligations, and the timely and adequate completion of medical records;
 - (b) proctoring, monitoring, consultation, and letters of guidance; and
 - (c) sharing comparative quality, utilization, and other relevant information, including any variations from clinical protocols or guidelines, in order to assist individuals to conform their practices to appropriate norms.
- (3) The relevant Medical Staff leader(s), in conjunction with the CEO or CMO, may determine whether a matter should be handled in accordance with another policy (e.g., code of conduct policy, practitioner health policy, peer review policy) or should be referred to the MEC for further action.
- (4) The relevant Medical Staff leader(s) shall determine whether to document a collegial intervention effort. Any documentation that is prepared shall be placed in an individual's confidential file. The individual shall have an opportunity to review the documentation and respond to it. The response shall be maintained in the individual's file along with the original documentation.

- (5) All ongoing and focused professional practice evaluations shall be conducted in accordance with the peer review policy. Matters that cannot be appropriately resolved through collegial intervention or through the peer review policy shall be referred to the MEC.

6.B. INVESTIGATIONS

6.B.1. Initial Review:

- (a) Whenever a serious question has been raised, or where collegial efforts have not resolved an issue regarding the following, the question may be referred to the President of the Medical Staff, the chairman of a standing committee, the CMO, the CEO, or the chairman of the Board:
 - (1) clinical competence or clinical practice, including patient care, treatment or management;
 - (2) the known or suspected violation of applicable ethical standards or the Bylaws, policies, Rules and Regulations of the Hospital or the Medical Staff; or
 - (3) conduct that is considered lower than the standards of the Hospital or disruptive to the orderly operation of the Hospital or its Medical Staff, including the inability of the member to work harmoniously with others.
- (b) In addition, if the Board becomes aware of information that raises concerns about the qualifications of any member, the matter shall be referred to the President of the Medical Staff, the CMO, or the CEO.
- (c) The person to whom the question is referred shall make a sufficient inquiry to determine whether the question is credible and, if so, may forward it to the MEC.
- (d) No action taken pursuant to this section shall constitute an investigation.

6.B.2. Initiation of Investigation:

- (a) The MEC shall review the question, discuss the matter with the individual, if invited, and determine whether to conduct an investigation or direct that the question be handled pursuant to another policy. An investigation shall commence only after a determination by the MEC.

- (b) The MEC shall inform the individual that an investigation has begun. Notification may be delayed if, in the judgment of the MEC, informing the individual immediately would compromise the investigation or disrupt the operation of the Hospital or Medical Staff.
- (c) The Board may also determine to commence an investigation and may delegate the investigation to the MEC, a subcommittee of the Board, or an ad hoc committee.

6.B.3. Investigative Procedure:

- (a) Once a determination has been made to begin an investigation, the MEC shall investigate the matter itself or appoint an individual or committee (“Investigating Committee”) to do so. The Investigating Committee shall not include partners, associates, or relatives of the individual being investigated, but may include individuals not on the Medical Staff.
- (b) The Investigating Committee may:
 - (1) review relevant documents, which may include patient records, incident reports and relevant literature or guidelines;
 - (2) conduct interviews;
 - (3) use outside consultants, as needed, for timeliness, expertise, thoroughness and objectivity; or
 - (4) require an examination or assessment by a health care professional(s) acceptable to it. The individual being investigated shall execute a release allowing the Investigating Committee to discuss with the health care professional(s) the reasons for the examination or assessment and allowing the health care professional to discuss and report the results to the Investigating Committee.
- (c) The investigating committee shall make a reasonable effort to complete the investigation and issue its report within 30 days, provided that an outside review is not necessary. When an outside review is used, the investigating committee shall make a reasonable effort to complete the investigation and issue its report within 30 days of receiving the results of the outside review. These time frames

are intended to serve as guidelines and, as such, shall not be deemed to create any right for an individual to have an investigation completed within such time periods.

- (d) As part of the investigation, the individual shall have an opportunity to meet with the Investigating Committee. Prior to this meeting, the individual shall be informed of the questions being investigated and shall be invited to discuss, explain, or refute the questions. A summary of the interview shall be made and included with the Investigating Committee's report. This meeting is not a hearing, and none of the procedural rules for hearings shall apply. Lawyers shall not be present at this meeting.
- (e) At the conclusion of the investigation, the Investigating Committee shall prepare a report to the MEC with its findings, conclusions, and recommendations.

6.B.4. Recommendation:

- (a) The MEC may accept, modify, or reject any recommendation it receives from an Investigating Committee. Specifically, the MEC may:
 - (1) determine that no action is justified;
 - (2) issue a letter of guidance, counsel, warning, or reprimand;
 - (3) impose conditions for continued appointment;
 - (4) require monitoring, proctoring or consultation;
 - (5) require additional training or education;
 - (6) recommend reduction of clinical privileges;
 - (7) recommend suspension of clinical privileges for a term;
 - (8) recommend revocation of appointment or clinical privileges; or
 - (9) make any other recommendation that it deems necessary or appropriate.
- (b) If the MEC makes a recommendation that does not entitle the individual to request a hearing, it shall take effect immediately and shall remain in effect unless modified by the Board.
- (c) A recommendation by the MEC that would entitle the individual to request a hearing shall be forwarded to the CEO. The Medical Staff President or the CEO shall promptly inform the individual by special notice. The recommendation shall

not be forwarded to the Board until after the individual has completed or waived a hearing and appeal.

- (d) If the Board makes a modification to the recommendation of the MEC that would entitle the individual to request a hearing, the Medical Staff President or the CEO shall inform the individual by special notice. No final action shall occur until the individual has completed or waived a hearing and appeal.

6.C. PRECAUTIONARY SUSPENSION OR RESTRICTION OF CLINICAL PRIVILEGES

6.C.1. Grounds for Precautionary Suspension or Restriction:

- (a) Whenever failure to take action may result in imminent danger to the health and/or safety of any individual, the CEO, the President of the Medical Staff, the CMO, the MEC, or the Board chairman is authorized to (1) afford the individual an opportunity to voluntarily refrain from exercising privileges pending an investigation; or (2) suspend or restrict all or any portion of an individual's clinical privileges pending an investigation.
- (b) A precautionary suspension can be imposed at any time including after a specific event, a pattern of events, or a recommendation by the MEC that would entitle the individual to request a hearing. When possible, prior to the imposition of a precautionary suspension, the person(s) considering the suspension shall meet with the individual and review the concerns that support the suspension and afford the individual an opportunity to respond.
- (c) Precautionary suspension is an interim step in the professional review activity and does not imply any final finding regarding the concerns supporting the suspension.
- (d) A precautionary suspension is effective immediately and shall be promptly reported to the CEO and the President of the Medical Staff. A precautionary suspension shall remain in effect unless it is modified by the CEO or MEC.
- (e) Within three days of the imposition of a suspension, a brief written description of the reason(s) for the action, including the names and medical record numbers of the patient(s) involved (if any), shall be provided to the individual.

6.C.2. MEC Procedure:

- (a) Within a reasonable time, not to exceed 14 days of the imposition of the suspension, the MEC shall review the reasons for the suspension.
- (b) As part of this review, the individual shall be invited to meet with the MEC or with an ad hoc committee of the MEC designated by the President of the Medical Staff. In advance of the meeting, the individual may submit a written statement and other information to the MEC or the designated ad hoc committee of the Medical Staff.
- (c) At the meeting, the individual may provide information to the MEC or the designated ad hoc committee of the MEC and should respond to questions that may be raised by committee members. The individual may also propose ways, other than precautionary suspension, to protect patients, employees or others while an investigation is conducted.
- (d) The individual may be accompanied by counsel at this meeting. The meeting is not an appeal hearing and the role of counsel will be limited to providing advice to the individual subject to the suspension. Counsel may not make a presentation to or question members of the MEC or anyone else attending the meeting. The MEC may also have counsel present subject to the same conditions that counsel may not question the individual. A record of this meeting will be maintained by a stenographic reporter and reported to the MEC.
- (e) After considering the reasons for the suspension and the individual's response, if any, the MEC shall determine whether the precautionary suspension should be continued, modified, or lifted. The MEC shall also determine whether to begin or continue an investigation.
- (f) If the MEC decides to continue the suspension, it shall send the individual written notice of its decision, including the basis for it and that suspensions lasting longer than 30 days must be reported to the National Practitioner Data Bank, if applicable.
- (g) There is no right to a hearing based on the imposition or continuation of a precautionary suspension for a period of less than 30 days. The procedures outlined above are deemed to be fair under the circumstances. Unless the MEC terminates the suspension within 30 days after the imposition of the suspension, the individual shall be entitled to request a hearing in accordance with Article 7.

- (h) Upon the imposition of a precautionary suspension, the President of the Medical Staff shall assign responsibility for the care of any hospitalized patients to another individual with appropriate clinical privileges. Whenever possible, consideration shall be given to the wishes of the patient in the selection of a covering physician.

6.D. AUTOMATIC RELINQUISHMENT

6.D.1. Failure to Complete Medical Records:

Failure to complete medical records shall result in automatic relinquishment of all clinical privileges, after notification by the medical records service of delinquency. Relinquishment shall continue until all delinquent records are completed and reinstatement accomplished in accordance with applicable Rules and Regulations. Failure to complete the medical records that caused relinquishment within the time required by applicable Rules and Regulations shall result in automatic resignation from the Medical Staff or Allied Health Staff.

6.D.2. Action by Government Agency or Insurer and Failure to Satisfy Threshold Eligibility Criteria:

- (a) Any action taken by any licensing board, professional liability insurance company, court or government agency regarding any of the matters set forth below, or failure to satisfy any of the threshold eligibility criteria, must be promptly reported to the CMO or President of the Medical Staff.
- (b) An individual's appointment and clinical privileges shall be automatically relinquished, without right to hearing or appeal, if any of the following occur:
 - (1) Licensure: Revocation, expiration, suspension, or the placement of conditions or restrictions on an individual's license.
 - (2) Controlled Substance Authorization: Revocation, expiration, suspension, or the placement of conditions or restrictions on an individual's DEA or state controlled substance authorization.
 - (3) Insurance Coverage: Termination or lapse of an individual's professional liability insurance coverage, or other action causing the coverage to fall below the minimum required by the Hospital.

- (4) Medicare and Medicaid Participation: Termination, exclusion, or preclusion by government action from participation in the Medicare/Medicaid or other federal or state health care programs.
- (5) Criminal Activity: Arrest, indictment, conviction, or a plea of guilty or no contest pertaining to any felony; is conviction or a plea of guilty or no contest pertaining or to any misdemeanor involving (i) controlled substances; (ii) illegal drugs; (iii) Medicare, Medicaid, or insurance or health care fraud or abuse; or (iv) violence.
- (c) An individual's appointment and clinical privileges shall be automatically relinquished, without entitlement to a hearing and appeal, if the individual fails to satisfy any of the threshold eligibility criteria or his or her responsibilities during the provisional period.
- (d) Automatic relinquishment shall take effect immediately upon notice to the Hospital and continue until the matter is resolved and the individual is reinstated.
- (e) If the underlying matter leading to automatic relinquishment is resolved within 60 days, the individual may request reinstatement. Failure to resolve the matter within 60 days of the date of relinquishment shall result in an automatic resignation from the Medical Staff or Allied Health Staff.
- (f) Requests for reinstatement shall be reviewed by the chairman of the Credentials Committee, the President of the Medical Staff, the CMO, and the CEO. If all these individuals make a favorable recommendation on reinstatement, the individual may immediately resume clinical practice at the Hospital. This determination shall then be forwarded to the Credentials Committee, the MEC, and the Board for ratification. If, however, any of the individuals reviewing the request have any questions or concerns, those questions shall be noted and the reinstatement request shall be forwarded to the full Credentials Committee, MEC and Board for review and recommendation.

6.D.3. Failure to Provide Information:

Appointment and clinical privileges shall be deemed to be relinquished upon the occurrence of:

- (a) discovery of a misstatement or omission on an application for initial appointment or reappointment, determined by the President of the Medical Staff and CEO or their designee to be material and without good cause after considering any written or oral explanation provided by the individual;
- (b) failure to notify the President of the Medical Staff or CEO of any change in any information provided on an application for initial appointment or reappointment, determined by the President of the Medical Staff and CEO to be material and without good cause after considering any written or oral explanation provided by the individual; or
- (c) failure to provide information pertaining to an individual's qualifications for appointment or clinical privileges in response to a written request specifying the time frame for response from the Credentials Committee, the MEC, the CEO, or any other committee authorized to request such information, until the information is provided to the satisfaction of the requesting party.

6.D.4. Failure to Attend Special Conference:

- (a) Whenever there is a concern regarding an individual's clinical practice or professional conduct, Medical Staff leaders may require the individual to attend a special conference.
- (b) Special notice shall be given at least three days prior to the conference and shall inform the individual that attendance at the conference is mandatory.
- (c) Failure of the individual to attend the conference shall be reported to the MEC. Unless excused by the MEC upon a showing of good cause, such failure shall result in the automatic relinquishment of all or such portion of the individual's clinical privileges as the MEC may direct. Such relinquishment shall remain in effect until the individual attends the special conference.

6.D.5. Failure to Meet Supervision Requirements:

If the Medical Staff appointment or clinical privileges of a Supervising Physician are resigned, revoked or terminated, or the Advanced Dependent Practitioner fails, for any reason, to maintain an appropriate supervision relationship with a Supervising Physician

as defined in this Policy, the Advanced Dependent Practitioner's clinical privileges will be automatically relinquished, unless another Supervising Physician is approved as part of the credentialing process.

6.E. LEAVES OF ABSENCE

6.E.1. Initiation:

- (a) A leave of absence of up to one year must be requested in writing to the President of the Medical Staff and CEO, stating the beginning and ending dates of the leave and the reasons for the leave. Except in extraordinary circumstances, this request shall be submitted at least 30 days prior to the anticipated start of the leave.
- (b) The CEO shall determine whether a request for a leave of absence shall be granted, after consulting with the President of the Medical Staff and the Chair of the Credentials Committee. The granting of a leave of absence or reinstatement may be conditioned upon the individual's completion of all medical records.
- (c) Members of the Medical Staff or Allied Health Staff must report to the Medical Staff Office and the CEO anytime they are away from Medical Staff or patient care responsibilities for longer than 30 days and the reason for such absence is related to their physical or mental health or otherwise to their ability to care for patients safely and competently. Under such circumstances, the CEO, in consultation with the President of the Medical Staff, may trigger an automatic medical leave of absence.
- (d) Leaves of absence are matters of courtesy, not of right. In the event that it is determined that an individual has not demonstrated good cause for a leave, or where a request for extension is not granted, or where reinstatement is denied for reasons other than professional competence or conduct, the determination shall be final, with no recourse to a hearing and appeal.

6.E.2. Duties of Member on Leave:

During the leave of absence, the individual shall not exercise any clinical privileges and shall be excused from all Medical Staff responsibilities (e.g., meeting attendance, committee service, emergency service call obligations). All medical records must be

completed as soon as reasonably possible. The obligation to pay dues shall continue during a leave of absence except that a member granted a leave of absence for U.S. military service shall be exempt from this obligation.

6.E.3. Reinstatement:

- (a) Individuals requesting reinstatement shall submit a written summary of their professional activities during the leave and any other information that may be requested by the Hospital. Requests for reinstatement shall then be reviewed by the Chairman of the Credentials Committee, the President of the Medical Staff, the CMO or CEO, and in accordance with the practitioner health policy, if applicable.
- (b) If a favorable recommendation on reinstatement is made, the individual may immediately resume clinical practice. However, if any of the individuals reviewing the request have any questions or concerns, those questions shall be noted and the reinstatement request shall be forwarded to the full Credentials Committee, MEC, and Board. If any request for reinstatement is not granted for reasons related to clinical competence or professional conduct, and if a report to the National Practitioner Data Bank is determined to be required, the individual shall be entitled to request a hearing and appeal.
- (c) If an individual's current appointment is due to expire during the leave, the individual's appointment and clinical privileges shall expire at the end of the appointment period, and the individual shall be required to apply for appointment.

ARTICLE 7

HEARING AND APPEAL PROCEDURES

7.A. INITIATION OF HEARING

7.A.1. Grounds for Hearing:

- (a) For the purpose of Article 7 of this Policy, "applicant" pertains only to an applicant to the Medical Staff and "member" pertains only to Medical Staff members. Allied Health members are not entitled to any hearing and appeal

rights set forth in this article. The sole and exclusive procedural rights to which a member of the Allied Health Staff is entitled are set forth in Article 8.

- (b) An individual is entitled to request a hearing whenever the MEC makes one of the following recommendations based upon the individual's professional competence or professional conduct which affects or could affect adversely the health or welfare of a patient or patients:
- (1) denial of initial appointment, reappointment or requested clinical privileges;
 - (2) revocation of appointment to the Medical Staff or clinical privileges;
 - (3) suspension of clinical privileges for more than 30 days;
 - (4) restriction of clinical privileges, meaning a mandatory concurring consultation requirement, in which the consultant must approve the course of treatment in advance; or
 - (5) denial of reinstatement from a leave of absence if the reasons relate to professional competence or conduct.
- (c) No other recommendations shall entitle the individual to a hearing.
- (d) If the Board makes any of these recommendations without an adverse recommendation by the MEC, an individual is entitled to request a hearing. For ease of use, this Article refers to adverse recommendations of the MEC. When a hearing is triggered by an adverse recommendation of the Board, any reference in this Article to the "MEC" shall be interpreted as a reference to the "Board."

7.A.2. Actions Not Grounds for Hearing:

None of the following actions shall constitute grounds for a hearing, and shall take effect without hearing or appeal, provided that the individual shall be entitled to submit a written explanation into his or her file:

- (a) a letter of guidance, counsel, warning, or reprimand;
- (b) conditions, monitoring, proctoring, or a general consultation requirement;
- (c) a lapse or failure to renew temporary privileges;
- (d) automatic relinquishment of appointment or privileges;
- (e) a requirement for additional training or continuing education;

- (f) precautionary suspension of less than 30 days in accordance with Section 6.C;
- (g) denial of a request for leave of absence, for an extension of a leave or for reinstatement from a leave if the reasons do not relate to professional competence or conduct;
- (h) determination that an application is incomplete;
- (i) determination that an application shall not be processed due to a misstatement or omission; or
- (j) determination of ineligibility based on a failure to meet threshold eligibility criteria, a lack of need or resources, or because of an exclusive contract.

7.A.3. Notice of Recommendation:

The Medical Staff President or CEO shall promptly give special notice of a recommendation which entitles an individual to request a hearing. This notice shall contain:

- (a) a statement of the recommendation and the general reasons for it;
- (b) a statement that the individual has the right to request a hearing on the recommendation within 30 days of receipt of this notice; and
- (c) a copy of this Article.

7.A.4. Request for Hearing:

An individual has 30 days following receipt of the notice to request a hearing, in writing, to the President of the Medical Staff and CEO, including the name, address, and telephone number of the individual's counsel, if any. Failure to request a hearing shall constitute waiver of the right to a hearing, and the recommendation shall be transmitted to the Board for final action.

7.A.5. Notice of Hearing and Statement of Reasons:

- (a) The President of the Medical Staff or CEO shall schedule the hearing and provide, by special notice, the following:
 - (1) the time, place, and date of the hearing;

- (2) a proposed list of witnesses who shall give testimony at the hearing and a brief summary of the anticipated testimony;
 - (3) the names of the Hearing Panel members and Presiding Officer if known; and
 - (4) a statement of the specific reasons for the recommendation, including a list of patient records (if applicable), and information supporting the recommendation. This statement may be revised or amended at any time, even during the hearing, so long as the additional material is relevant to the recommendation or the individual's qualifications and the individual has had a sufficient opportunity to review and respond with additional information.
- (b) The hearing shall begin as soon as practicable, but no sooner than 30 days after the notice of the hearing, unless an earlier hearing date has been specifically agreed to in writing by the parties.

7.A.6. Witness List:

- (a) At least 15 days before the pre-hearing conference, the individual requesting the hearing shall provide a written list of the names of witnesses expected to offer testimony on his or her behalf.
- (b) The witness list shall include a brief summary of the anticipated testimony.
- (c) The witness list of either party may, in the discretion of the Presiding Officer, be amended at any time during the course of the hearing, provided that notice of the change is given to the other party.

7.A.7. Hearing Panel:

- (a) Hearing Panel:

The CEO or the President of the Medical Staff shall appoint a Hearing Panel in accordance with the following guidelines:

- (1) The Hearing Panel shall consist of at least three members, one of whom shall be designated as chairman.
- (2) The Hearing Panel may include any combination of:

- (i) any member of the Medical Staff, or
 - (ii) physicians not connected with the Hospital (i.e., physicians not on the Medical Staff).
- (3) Knowledge of the underlying peer review matter, in and of itself, shall not preclude the individual from serving on the Panel.
- (4) Employment by, or other contractual arrangement with, the Hospital or an affiliate shall not preclude an individual from serving on the Panel.
- (5) The Panel shall not include any individual who:
- (i) is in direct economic competition with the individual requesting the hearing;
 - (ii) is professionally associated with, related to, or involved in a referral relationship with, the individual requesting the hearing;
 - (iii) is demonstrated to have an actual bias, prejudice, or conflict of interest that would prevent the individual from fairly and impartially considering the matter; or
 - (iv) actively participated in the matter at any previous level.
- (b) Presiding Officer:
- (1) The CEO or President of the Medical Staff shall appoint a Presiding Officer who may be an attorney. The Presiding Officer shall not act as an advocate for either side at the hearing.
- (2) The Presiding Officer shall:
- (i) schedule and conduct a pre-hearing conference;
 - (ii) allow the participants in the hearing to have a reasonable opportunity to be heard and to present evidence, subject to reasonable limits on the number of witnesses and duration of direct and cross-examination;
 - (iii) prohibit conduct or presentation of evidence that is cumulative, excessive, irrelevant or abusive or that causes undue delay;
 - (iv) maintain decorum throughout the hearing;
 - (v) determine the order of procedure;

(vi) rule on all matters of procedure and the admissibility of evidence;
and

(vii) conduct argument by counsel on procedural points outside the presence of the Hearing Panel unless the Panel wishes to be present.

(3) The Presiding Officer may participate in the private deliberations of the Hearing Panel and be a legal advisor to it, but shall not vote on its recommendations.

(c) Objections:

Any objection to any member of the Hearing Panel or the Presiding Officer shall be made in writing, within ten days of receipt of notice, to the CEO. A copy of such written objection must be provided to the President of the Medical Staff and must include the basis for the objection. The President of the Medical Staff shall be given a reasonable opportunity to comment. The CEO shall rule on the objection and give notice to the parties. The CEO may request that the Presiding Officer make a recommendation as to the validity of the objection.

7.A.8. Counsel:

The Presiding Officer and counsel for either party may be an attorney at law who is licensed to practice, in good standing, in any state.

7.B. PRE-HEARING PROCEDURES

7.B.1. General Procedures:

The pre-hearing and hearing processes shall be conducted in an informal manner. Formal rules of evidence or procedure shall not apply.

7.B.2. Provision of Relevant Information:

(a) Prior to receiving any confidential documents, the individual requesting the hearing must agree that all documents and information shall be maintained as confidential and shall not be disclosed or used for any purpose outside of the hearing. The individual must also provide a written representation that his/her

counsel and any expert(s) have executed Business Associate agreements in connection with any patient Protected Health Information contained in any documents provided.

- (b) Upon receipt of the above agreement and representation, the individual requesting the hearing shall be provided with a copy of the following:
 - (1) copies of, or reasonable access to, all patient medical records referred to in the statement of reasons, at the individual's expense;
 - (2) reports of experts relied upon by the MEC;
 - (3) copies of relevant minutes (with portions regarding other physicians and unrelated matters deleted); and
 - (4) copies of any other documents relied upon by the MEC.

The provision of this information is not intended to waive any privilege.

- (c) The individual shall have no right to discovery beyond the above information. No information shall be provided regarding other practitioners on the Medical Staff. In addition, there is no right to depose, interrogate, or interview witnesses or other individuals prior to the hearing.
- (d) Ten days prior to the pre-hearing conference, or on dates set by the Presiding Officer or agreed upon by both sides, each party shall provide the other party with its proposed exhibits.
- (e) Neither the individual, nor any other person acting on behalf of the individual, may contact Hospital employees or Medical Staff members whose names appear on the MEC's witness list or in documents provided pursuant to this section concerning the subject matter of the hearing, until the Hospital has been notified and has contacted the individuals about their willingness to be interviewed. The Hospital shall advise the individual who requested the hearing once it has contacted such employees or Medical Staff members and confirmed their willingness to meet. Any employee or Medical Staff member may agree or decline to be interviewed by or on behalf of the individual who requested a hearing.

7.B.3. Pre-Hearing Conference:

- (a) The Presiding Officer shall require the individual or a representative (who may be counsel) for the individual and for the MEC to participate in a pre-hearing conference.
- (b) All objections to documents or witnesses shall be submitted in writing five days in advance of the pre-hearing conference. The Presiding Officer shall not entertain subsequent objections unless the party offering the objection demonstrates good cause.
- (c) At the pre-hearing conference, the Presiding Officer shall resolve all procedural questions, including any objections to exhibits or witnesses.
- (d) Evidence unrelated to the reasons for the recommendation or to the individual's qualifications for appointment or the relevant clinical privileges shall be excluded.
- (e) The Presiding Officer shall establish the time to be allotted to each witness's testimony and cross-examination and to any opening and closing statements.
- (f) It is expected that the hearing shall be conducted in an expeditious manner, with each side being afforded a reasonable opportunity to present its case, in terms of both direct and cross-examination of witnesses as determined by the Presiding Officer. The Presiding Officer may, after considering any objections, grant limited extensions to present evidence upon a demonstration of good cause and to the extent compelled by fundamental fairness.

7.B.4. Stipulations:

The parties shall use their best efforts to develop and agree upon stipulations to provide for a more efficient hearing.

7.B.5. Provision of Information to the Hearing Panel:

The following documents shall be provided to the Hearing Panel in advance of the hearing:

- (a) a pre-hearing statement that either party may choose to submit;

- (b) exhibits offered by the parties following the pre-hearing conference (without the need for authentication); and
- (c) stipulations agreed to by the parties.

7.B.6. Time Frames:

The following time frames, unless modified by mutual written agreement of the parties, shall govern the timing of pre-hearing procedures:

- (a) the pre-hearing conference shall be scheduled at least 14 days prior to the hearing;
- (b) the parties shall exchange witness lists and proposed documentary exhibits at least 10 days prior to the pre-hearing conference; and
- (c) any objections to witnesses and/or proposed documentary exhibits must be provided at least five days prior to the pre-hearing conference.

7.C. HEARING

7.C.1. Failure to Appear:

Failure, without good cause, to appear and proceed at the hearing shall constitute a waiver of the right to a hearing and the matter shall be forwarded to the Board for final action.

7.C.2. Record of Hearing:

A stenographic reporter shall be present to make a record of the hearing. The cost of the reporter shall be borne by the Hospital. Copies of the transcript shall be available at the individual's expense. Oral evidence shall be taken on oath or affirmation administered by any authorized person.

7.C.3. Rights of Both Sides and the Hearing Panel at the Hearing:

- (a) At a hearing, both sides shall have the following rights, subject to reasonable limits determined by the Presiding Officer:
 - (1) to call and examine witnesses, to the extent they are available and willing to testify;
 - (2) to introduce exhibits;

- (3) to cross-examine any witness;
 - (4) to have representation by counsel who may call, examine, and cross-examine witnesses and present the case;
 - (5) to submit a written statement at the close of the hearing; and
 - (6) to submit proposed findings, conclusions and recommendations to the Hearing Panel.
- (b) If the individual who requested the hearing does not testify, he or she may be called and questioned.
- (c) The Hearing Panel may question witnesses, request the presence of additional witnesses, or request documentary evidence.

7.C.4. Order of Presentation:

The MEC shall first present evidence in support of its recommendation. Thereafter, the burden shall shift to the individual who requested the hearing to present evidence.

7.C.5. Admissibility of Evidence:

The hearing shall not be conducted according to rules of evidence. Evidence shall not be excluded merely because it is hearsay. Any relevant evidence shall be admitted if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs. The guiding principle shall be that the record contains information sufficient to allow the Board to decide whether the individual is qualified for appointment and clinical privileges.

7.C.6. Persons to Be Present:

The hearing shall be restricted to those individuals involved in the proceeding. Administrative personnel may be present as requested by the CEO or the President of the Medical Staff.

7.C.7. Postponements and Extensions:

Postponements and extensions of time may be requested by anyone, but shall be permitted only by the Presiding Officer or the CEO on a showing of good cause.

7.C.8. Presence of Hearing Panel Members:

A majority of the Hearing Panel shall be present throughout the hearing. In unusual circumstances when a Hearing Panel member must be absent from any part of the hearing, he or she shall read the entire transcript of the portion of the hearing from which he or she was absent.

7.D. HEARING CONCLUSION, DELIBERATIONS, AND RECOMMENDATIONS

7.D.1. Basis of Hearing Panel Recommendation:

Consistent with the burden on the individual to demonstrate that he or she satisfies, on a continuing basis, all criteria for initial appointment, reappointment and clinical privileges, the Hearing Panel shall recommend in favor of the MEC unless it finds that the individual who requested the hearing has proved, by clear and convincing evidence, that the recommendation that prompted the hearing was arbitrary, capricious, or not supported by credible evidence.

7.D.2. Deliberations and Recommendation of the Hearing Panel:

Within 20 days after final adjournment of the hearing (which may be designated as the time the Hearing Panel receives the hearing transcript or any post-hearing statements, whichever is later), the Hearing Panel shall conduct its deliberations outside the presence of any other person except the Presiding Officer. The Hearing Panel shall render written findings, conclusions and its recommendation, accompanied by a report, which shall contain a statement of the basis for its recommendation.

7.D.3. Disposition of Hearing Panel Report:

The Hearing Panel shall deliver its report to the CEO and the President of the Medical Staff. The CEO or the President of the Medical Staff shall send by special notice a copy of the report to the individual who requested the hearing.

7.E. APPEAL PROCEDURE

7.E.1. Time for Appeal:

- (a) Within ten days after notice of the Hearing Panel's recommendation, either party may request an appeal. The request shall be in writing, delivered to the CEO either in person or by certified mail, return receipt requested, and shall include a statement of the reasons for appeal and the specific facts or circumstances which justify further review.
- (b) If an appeal is not requested within ten days, an appeal is deemed to be waived and the Hearing Panel's report and recommendation shall be forwarded to the Board for final action.

7.E.2. Grounds for Appeal:

The grounds for appeal shall be limited to the following:

- (a) there was substantial failure by the Hearing Panel to comply with this Policy or the Medical Staff Bylaws during the hearing, so as to deny a fair hearing; or
- (b) the recommendations of the Hearing Panel were made arbitrarily or capriciously or were not supported by credible evidence.

7.E.3. Time, Place and Notice:

Whenever an appeal is requested, the chairman of the Board shall schedule and arrange for an appeal. The individual shall be given special notice of the time, place, and date of the appeal. The appeal shall be held as soon as arrangements can reasonably be made, taking into account the schedules of all the individuals involved.

7.E.4. Nature of Appellate Review:

- (a) The Board may serve as the Review Panel or the chair of the Board may appoint a Review Panel, composed of members of the Board.
- (b) The Review Panel may consider the record upon which the recommendation was made, including the hearing transcripts and exhibits, post-hearing statements, the

findings and recommendations of the MEC and Hearing Panel and any other information that it deems relevant, and recommend final action to the Board.

- (c) The hearing before the Review Panel shall be an appellate and not an evidentiary hearing. Each party shall have the right to present a written statement in support of its position on appeal. The party requesting the appeal shall submit a statement first and the other party shall then have ten days to respond. In its sole discretion, the Review Panel may allow each party or its representative to appear personally and make an oral presentation. The Review Panel may limit the amount of time for any such presentation.
- (d) The Review Panel may (i) affirm the recommendation of the Hearing Panel, (ii) reverse the recommendation of the Hearing Panel, or (iii) refer the recommendation back to the Hearing Panel for further consideration with reasons for doing so. If the decision is to refer the matter back, the Hearing Panel shall give the matter further consideration and respond to the directions of the Review Panel and may, in its discretion, hold a further hearing or act on the record and make a further recommendation to the Review Panel, which shall thereupon, without further notice to the individual or a hearing, take final action.

7.F. BOARD ACTION

7.F.1. Final Decision of the Board:

- (a) The decision of the Board, acting, in its discretion, as a whole or through the appointed Review Panel, shall be final after it either (i) considers the appeal as a Review Panel, or (ii) receives the Hearing Panel's report when no appeal has been requested.
- (b) The Board or Review Panel shall render its final decision in writing, including the basis for its decision, and shall send special notice to the individual. A copy shall also be provided to the President of the Medical Staff.
- (c) The final decision of the Board or Review Panel shall be effective immediately and shall not be subject to further review.

7.F.2. Right to One Hearing and One Appeal Only:

No individual shall be entitled to more than one hearing and one appeal on any matter. If the Board denies initial appointment or reappointment or revokes appointment or clinical privileges, that individual may not apply for appointment or clinical privileges for a period of five years unless the Board provides otherwise.

ARTICLE 8
PROCEDURAL RIGHTS FOR
ALLIED HEALTH PRACTITIONERS

8.A. PROCEDURAL RIGHTS FOR LICENSED INDEPENDENT PRACTITIONERS
AND ADVANCED DEPENDENT PRACTITIONERS

- (1) In the event that the MEC recommends that a Licensed Independent Practitioner or Advanced Dependent Practitioner (hereinafter, for the purpose of this Section only, “Allied Health Practitioner”) not be granted privileges or that the privileges granted be terminated or not renewed, the Medical Staff President or CEO shall give notice of the recommendation to the affected Allied Health Practitioner. The notice shall state that the Allied Health Practitioner has a right to request a hearing.
- (2) If the Allied Health Practitioner wants to request a hearing, the request must be made in writing, directed to the Medical Staff President and CEO, within 30 days after receipt of the notice of the adverse recommendation. The hearing will be convened as soon as practical, but no sooner than 30 days after the CEO receives the Allied Health Practitioner’s request for a hearing, unless an earlier hearing date has been specifically agreed to by the parties. The Allied Health Practitioner will be informed of the nature of the information supporting the adverse recommendation at least 30 days prior to the hearing.
- (3) The hearing to review the adverse recommendation will be held before the MEC or a subcommittee of the MEC (“Hearing Committee”). The Hearing Committee will not include any individual who is in direct economic competition with the

affected Allied Health Practitioner or his/her Supervising Physician(s). Employment by, or a contractual arrangement with, the Hospital or an affiliate shall not preclude an individual from serving on the Hearing Committee.

- (4) The Allied Health Practitioner and his/her Supervising Physician shall both appear personally before the Hearing Committee.
- (5) The record of the hearing will be maintained by a stenographic reporter or by a recording of the proceedings. Copies of the transcript will be available at the Allied Health Practitioner's individual expense.
- (6) The hearing will last no longer than three hours. The Allied Health Practitioner may present affidavits, but no more than four, as evidence in support of his/her case.
- (7) Both the Allied Health Practitioner and the MEC may be represented at the hearing by legal counsel. However, while counsel may be present at the hearing, in no event will counsel present evidence, direct any questions to either party or present the case.
- (8) At the hearing, the Allied Health Practitioner and his/her Supervising Physician shall be provided with an opportunity to refute the recommendation and the reasons supporting it. The Allied Health Practitioner will have the burden of demonstrating that the recommendation was arbitrary, capricious, or not supported by substantial evidence. The quality of care provided to patients and the smooth operation of the Hospital will be the paramount considerations.
- (9) The Allied Health Practitioner will have the right to submit a memorandum, for consideration by the Hearing Committee, at the close of the hearing.
- (10) The Hearing Committee shall forward its recommendation, along with all supporting information, to the CEO. The CEO shall give notice of the recommendation to the affected Allied Health Practitioner.
- (11) The Allied Health Practitioner shall have 30 days from the receipt of the notice of the Hearing Committee's recommendation to request an appeal, and such a request must be in writing to the CEO and the President of the Medical Staff. If a written request for appeal is not submitted by the Allied Health Practitioner to the CEO within the 30-day time frame specified herein, the Hearing Committee's

recommendation shall be forwarded by the CEO to the Board for final action. If a timely request for appeal is submitted by the Allied Health Practitioner, the CEO shall then forward the Hearing Committee's recommendation, supporting information and the request for consideration to a three-person appeal panel appointed by the CEO ("Appeal Panel"). In no event will the members of the Appeal Panel be practitioners in economic competition with the affected Allied Health Practitioner or his/her Supervising Physician(s). Employment by, or a contractual arrangement with, the Hospital or an affiliate shall not preclude an individual from serving on the Appeal Panel.

- (12) The appeal shall be performed by the Appeal Panel, and the Appeal Panel will consider the record upon which the adverse recommendation was made and may accept additional written information, provided the information is new and relevant and was not made available to the Hearing Committee during its consideration of the matter. The Allied Health Practitioner and the MEC will each have the right to submit a written statement to the Appeal Panel. At the sole discretion of the Appeal Panel, the Allied Health Practitioner and a representative of the MEC may also appear personally to discuss their position.
- (13) Upon completion of the review, the Appeal Panel may recommend that the Board affirm, modify or reverse the recommendation of the Hearing Committee. Alternatively, the Appeal Panel may recommend that the matter be referred back to the Hearing Panel for further clarification, with a written explanation of the need for the clarification. Thereafter, the Hearing Panel will report to the Appeal Panel in 30 days.
- (14) The final recommendation of the Appeal Panel shall be forwarded by the CEO to the Board for final action.

ARTICLE 9

CONFLICTS OF INTEREST

- (a) When performing a function outlined in this Policy, the Bylaws, the Organization Manual, or the Rules and Regulations, if any member has or reasonably could be

perceived as having a conflict of interest or a bias, that member shall not participate in the final discussion or voting on the matter, and shall be excused from any meeting during that time. However, the member may provide relevant information and may answer any questions concerning the matter before leaving.

- (b) Any member with knowledge of the existence of a potential conflict of interest or bias on the part of any other member may call the conflict of interest to the attention of the President of the Medical Staff (or the President of the Medical Staff-Elect if the President of the Medical Staff is the person with the potential conflict) or committee chairman. The President of the Medical Staff or committee chairman shall make a final determination as to whether the provisions in this Article should be triggered.
- (c) The fact that a Credentials Advisor or a member is in the same specialty as a member whose performance is being reviewed does not automatically create a conflict. In addition, the assessment of whether a conflict of interest exists shall be interpreted reasonably by the persons involved, taking into consideration common sense and objective principles of fairness. No member has a right to compel disqualification of another member based on an allegation of conflict of interest.
- (d) The fact that a Credentials Advisor or committee member or Medical Staff leader chooses to refrain from participation, or is excused from participation, shall not be interpreted as a finding of actual conflict.

ARTICLE 10

HOSPITAL EMPLOYEES

- (a) Except as provided below, the employment of an individual by the Hospital shall be governed by the Hospital's employment policies and manuals and the terms of the individual's employment relationship or written contract. To the extent that the Hospital's employment policies or manuals, or the terms of any applicable employment contract, conflict with this Policy, the employment policies, manuals

and descriptions and terms of the individual's employment relationship or written contract shall apply.

- (b) A request for appointment, reappointment or clinical privileges, submitted by an applicant or Member who is employed by the Hospital, shall be processed in accordance with the terms of this Policy. A report regarding each practitioner's qualifications shall be made to Administration or Human Resources (as appropriate) to assist the Hospital in making employment decisions. Such report shall consist of the patient's status as a member of the Medical Staff but shall not include peer review material.
- (c) If a concern about an employed member's clinical conduct or competence originates with the Medical Staff, the concern shall be reviewed and addressed in accordance with this Policy, after which a report shall be provided to Human Resources.

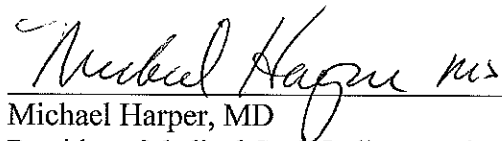
ARTICLE 11
AMENDMENTS

This Policy may be amended in accordance with Article 8 of the Medical Staff Bylaws.

ARTICLE 12
ADOPTION

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

Adopted by the Medical Staff: September 12, 2016

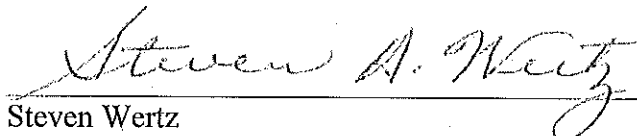


Michael Harper, MD
President, Medical Staff Indiana University Health Tipton Hospital

Approved by the Board: September 22, 2016



Michael Harlowe, MHA, MS, FACHE
President and CEO Indiana University Health Tipton Hospital



Steven Wertz
Chairman, Board of Directors Indiana University Health Tipton Hospital

GLOSSARY

The following definitions apply to terms used in this Policy:

- (1) “ADVANCED DEPENDENT PRACTITIONERS” means all those Allied Health Practitioners who are licensed or certified under state law, are granted clinical privileges, and function in the Hospital under the supervision of a practitioner(s) appointed to the Medical Staff. The Supervising Physician(s) is responsible for the actions of the Advanced Dependent Practitioner in the Hospital.
- (2) “ALLIED HEALTH PRACTITIONERS” (“AHPs”) means individuals other than Medical Staff members who are authorized by law and by the Hospital to provide patient care services.
- (3) “BOARD” means the Board of Directors of the Hospital, which has the overall responsibility for the Hospital, or its designated committee.
- (4) “BOARD CERTIFICATION” is the designation conferred by one of the affiliated specialties of the American Board of Medical Specialties (“ABMS”), the American Osteopathic Association (“AOA”), the American Board of Oral and Maxillofacial Surgery, or the American Board of Podiatric Surgery, upon an individual, as applicable, who has successfully completed an approved educational training program and an evaluation process, including passing an examination, in the individual’s area of clinical practice.
- (5) “CHIEF EXECUTIVE OFFICER” (“CEO”) means the individual appointed by the Board to act on its behalf in the overall management of Hospital.
- (6) “CHIEF MEDICAL OFFICER” (“CMO”) means the individual appointed by the Board to act as the CMO of the Hospital, in cooperation with the President of the Medical Staff.
- (7) “CLINICAL PRIVILEGES” or “PRIVILEGES” means the authorization granted by the Board to render specific patient care services, for which the Medical Staff leaders and Board have developed eligibility and other credentialing criteria and focused and ongoing professional practice evaluation standards.
- (8) “COMPLETED APPLICATION” means that all questions on the application form have been answered, all supporting documentation has been supplied, and

all information has been verified from primary sources. An application shall become incomplete if the need arises for new, additional, or clarifying information at any time. Any application that continues to be incomplete [30] days after the applicant has been notified of the additional information required shall be deemed to be withdrawn.

- (9) “CREDENTIALS POLICY” means the Hospital’s Medical Staff Credentials Policy.
- (10) “DAYS” means calendar days unless otherwise specified.
- (11) “DENTIST” means a doctor of dental surgery (“D.D.S.”) or doctor of dental medicine (“D.M.D.”).
- (12) “DEPENDENT PRACTITIONERS” means all those Allied Health Practitioners who are permitted to practice in the Hospital only under the supervision of a practitioner(s) appointed to the Medical Staff and who function pursuant to a defined scope of practice. The Supervising Physician(s) is responsible for the actions of the Dependent Practitioner in the Hospital.
- (13) “HOSPITAL” means IU Health Tipton Hospital and any related outpatient facilities for which Medical Staff privileges are required or appropriate.
- (14) “HOUSE STAFF” or “Resident” or “Fellow” means all physicians who are assigned for graduate medical education and will ordinarily carry the title of resident or fellow.
- (15) “LICENSED INDEPENDENT PRACTITIONERS” means all those Allied Health Practitioners who are licensed or certified under state law, authorized to function independently in the Hospital, and granted clinical privileges. These individuals require no formal or direct supervision by a physician.
- (16) “MEDICAL STAFF” means all physicians and dentists who have been appointed to the Medical Staff by the Board.
- (17) “MEDICAL EXECUTIVE COMMITTEE” or “MEC” means the MEC of the Medical Staff.
- (18) “MEMBER” means any physician or dentist who has been granted Medical Staff appointment to the Medical Staff and/or any allied health practitioner who has

been granted appointment to the Allied Health Staff, by the Board, to practice at the Hospital.

- (19) “NOTICE” means written communication by regular U.S. mail, e-mail, facsimile, or Hospital mail.
- (20) “PATIENT CONTACTS” includes any direct interaction between a physician and a patient in the hospital (including outpatient areas that are included in the hospital licensure) setting excluding any diagnostic outpatient orders and specifically including performance of History and Physicals, diagnosis treatment, and interpretation of diagnostic studies.
- (21) “PEER REVIEW COMMITTEES” includes professional review bodies, as defined in the HCQIA, that is, a health care entity and the governing body or any committee of a health care entity which conducts professional review activity, and includes any committee of the Medical Staff of such an entity when assisting the governing body in a professional review activity.
- (22) “PERMISSION TO PRACTICE” means the authorization granted to Allied Health Practitioners by the Board to exercise a scope of practice or clinical privileges. For ease of use, when applicable to an Allied Health Practitioner, any reference in this Policy to “appointment” or “reappointment” shall be interpreted as a reference to initial or continued permission to practice.
- (23) “PHYSICIAN” includes both doctors of medicine (“M.D.s”) and doctors of osteopathy (“D.O.s”).
- (24) “PROFESSIONAL REVIEW ACTION” has the meaning defined in the HCQIA, that is, an action by the Board or recommendation of the MEC taken or made in the conduct of professional review activity, which is based on the competence or professional conduct of an individual, which conduct affects or could affect adversely the health or welfare of a patient or patients, and which affects (or may affect) adversely the clinical privileges, or appointment, and includes a formal decision of a professional review body not to take an action or make a recommendation described in the previous sentence, and also includes professional review activities relating to a professional review action.

- (25) “PROFESSIONAL REVIEW ACTIVITY” has the meaning defined in the HCQIA, that is, activity to determine whether an individual may be granted, to determine the scope or conditions of, or to change or modify, appointment or clinical privileges. All such activity is also intended to be encompassed within the scope of any applicable federal or state privilege, and includes but is not limited to credentialing, privileging, reappointment, ongoing and focused professional practice evaluations, collegial intervention, performance improvement plans, investigations and hearings.
- (26) “SCOPE OF PRACTICE” means the authorization granted by the Board or CEO, as applicable, to perform certain clinical activities and functions under the supervision of, or in collaboration with, a Supervising Physician.
- (27) “SPECIAL NOTICE” means hand delivery, certified mail (return receipt requested), or overnight delivery service providing receipt.
- (28) “SUPERVISING PHYSICIAN” means a member of the Medical Staff with clinical privileges, who has agreed in writing to supervise a Dependent Practitioner or an Advanced Dependent Practitioner and to accept full responsibility for the actions of the Dependent Practitioner or Advanced Dependent Practitioner while he or she is practicing in the Hospital.
- (29) “SUPERVISION” means the supervision of, or collaboration with, an Advanced Dependent Practitioner or a Dependent Practitioner and a Supervising Physician that generally does not require the actual presence of the Supervising Physician, but that does require that the Supervising Physician be readily available for consultation, unless otherwise required by law or Hospital policy.

APPENDIX A
CONDITIONS OF PRACTICE APPLICABLE TO
ALLIED HEALTH PRACTITIONERS

A.1. Oversight by Supervising Physician:

- (a) Advanced Dependent Practitioners and Dependent Practitioners may function in the Hospital only so long as they have a Supervising Physician.
- (b) Any activities permitted to be performed at the Hospital by an Advanced Dependent Practitioner or Dependent Practitioner will be performed only under the oversight of the Supervising Physician.
- (c) If the Medical Staff appointment or clinical privileges of a Supervising Physician are resigned, revoked or terminated, or the Advanced Dependent Practitioner or Dependent Practitioner fails, for any reason, to maintain an appropriate supervision relationship with a Supervising Physician as defined in this Policy, the Advanced Dependent Practitioner or Dependent Practitioner's clinical privileges or scope of practice will be automatically relinquished, unless another Supervising Physician is approved as part of the credentialing process.
- (d) As a condition of clinical privileges or scope of practice, an Advanced Dependent Practitioner or Dependent Practitioner and his or her Supervising Physician must provide the Hospital with notice of any revisions or modifications that are made to the agreement between them. This notice must be provided to the CMO or Medical Staff Office within three business days of any such change.

A.2. Questions Regarding the Authority of an Advanced Dependent Practitioner or Dependent Practitioner:

- (a) Should any member of the Medical Staff, or any employee of the Hospital who is licensed or certified by the state, have a reasonable question regarding the clinical competence or authority of an Advanced Dependent Practitioner or Dependent Practitioner to act or issue instructions outside the presence of the Supervising Physician, such individual will have the right to request that the Supervising Physician validate, either at the time or later, the instructions of the Advanced

Dependent Practitioner or Dependent Practitioner. Any act or instruction of the Advanced Dependent Practitioner or Dependent Practitioner will be delayed until such time as the individual with the question has ascertained that the act is clearly within the clinical privileges or scope of practice granted to the individual.

- (b) Any question regarding the conduct of an Advanced Dependent Practitioner will be reported to the President of the Medical Staff, the Chair of the Credentials Committee, or the CEO or their designee for appropriate action. Any question raised about the conduct of a Dependent Practitioner will be reported to MEC and the CMO for appropriate action. The individual(s) to whom the concern has been reported will also discuss the matter with the Supervising Physician.

A.3. Responsibilities of Supervising Physicians:

- (a) Physicians who wish to use the services of an Advanced Dependent Practitioner or Dependent Practitioner in their clinical practice at the Hospital must notify the Medical Staff Office of this fact in advance and must ensure that the individual has been appropriately credentialed in accordance with this Policy or the relevant Medical Staff process before the Advanced Dependent Practitioner or Dependent Practitioner participates in any clinical or direct patient care of any kind in the Hospital.
- (b) The number of Advanced Dependent Practitioners or Dependent Practitioners acting under the supervision of one Medical Staff member, as well as the care they may provide, will be consistent with applicable state statutes and regulations and any other policies adopted by the Hospital. The Supervising Physician will make all appropriate filings with the state regarding the supervision and responsibilities of the Advanced Dependent Practitioner or Dependent Practitioner, to the extent that such filings are required.
- (c) It will be the responsibility of the Supervising Physician to provide, or to arrange for, professional liability insurance coverage for the Advanced Dependent Practitioner or Dependent Practitioner in amounts required by the Board. The insurance must cover any and all activities of the Advanced Dependent Practitioner or Dependent Practitioner in the Hospital. The Supervising Physician

will furnish evidence of such coverage to the Hospital. The Advanced Dependent Practitioner or Dependent Practitioner will act in the Hospital only while such coverage is in effect.

APPENDIX B
GUIDELINES FOR DETERMINING THE NEED FOR
NEW CATEGORIES OF ALLIED HEALTH PRACTITIONERS

B.1. Review of Need:

- (a) Whenever an Allied Health Practitioner requests to practice at the Hospital, and the Board has not already approved the category of practitioner for practice at the Hospital, the Credentials Committee will evaluate the need for that category of Allied Health Practitioner. The Credentials Committee shall report to the MEC, which shall make a recommendation to the Board for final action.
- (b) As part of the process of determining need, the Allied Health Practitioner shall be invited to submit information about the nature of the proposed practice, the reason access to the Hospital is sought, and the potential benefits to the community of having such services available at the Hospital.
- (c) The Credentials Committee may consider the following factors when making a recommendation as to the need for the services of a specific category of Allied Health Practitioner:
 - (1) the nature of the services that would be offered;
 - (2) any state license or regulation which outlines the specific patient care services and/or activities that the Allied Health Practitioner is authorized by law to perform;
 - (3) any state “nondiscrimination” or “any willing provider” laws that would apply to the Allied Health Practitioner;
 - (4) the patient care objectives of the Hospital, including patient convenience;
 - (5) the community’s needs and whether those needs are currently being met or could be better met if the services offered by the Allied Health Practitioner were provided at the Hospital;
 - (6) the type of training that is necessary to perform the services that would be offered and whether there are individuals with more training currently providing those services;

- (7) the availability of supplies, equipment, and other necessary Hospital resources;
- (8) the need for, and availability of, trained staff to support the services that would be offered; and
- (9) the ability to appropriately supervise performance and monitor quality of care.

B.2. Additional Recommendations:

- (a) If the ad hoc committee makes a recommendation that there is a need for the particular category of Allied Health Practitioner at the Hospital, it shall also recommend:
 - (1) any specific qualifications and/or training that must be possessed beyond those set forth in this Policy;
 - (2) a detailed description of a scope of practice or clinical privileges;
 - (3) any specific conditions that apply to practice within the Hospital; and
 - (4) any supervision requirements, if applicable.
- (b) In developing such recommendations, the Credentials Committee shall consult the appropriate Credentials Advisor and consider relevant Indiana law and may contact professional societies or associations. The Credentials Committee may also recommend the number of Allied Health Practitioners that are needed.

APPENDIX C
ALLIED HEALTH PRACTITIONERS

The Allied Health Practitioners currently practicing at the Hospital as Licensed Independent Practitioners are as follows:

Psychologist

Podiatrist

The Allied Health Practitioners currently practicing at the Hospital as Advanced Dependent Practitioners are as follows:

Certified Registered Nurse Anesthetist

Certified Nurse Specialist

Nurse Practitioner

Physician Assistant - Certified

The Allied Health Practitioners currently practicing at the Hospital as Dependent Practitioners are as follows:

Certified Surgical Technologist

Certified First Assist

Certified Ophthalmology Technician/Assistant

Dental Assistant

Licensed Practical Nurse

Medical Assistant

Orthopedic Technologist/Assistant

Registered Nurse