MEDICAL STAFF BYLAWS, POLICIES, AND RULES & REGULATIONS OF INDIANA UNIVERSITY HEALTH FORT WAYNE HOSPITAL

MEDICAL STAFF CREDENTIALS POLICY

Board Approved: October 27, 2026

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ARTICLE 1
GENERAL

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.

B. ALLIED HEALTH PRACTITIONERS

1. Any Allied Health Practitioners seeking permission to practice at the Hospital shall be subject to the terms and conditions of appointment and reappointment as specified for members of the Medical Staff, unless otherwise expressly provided. Likewise, unless specified otherwise, applications for permission to practice by Allied Health Practitioners shall be submitted and processed in the same manner as outlined for Medical Staff members in this Policy. The Allied Health Staff is comprised of Allied Health Practitioners granted clinical privileges at the Hospital by the Board.
2. Dependent Practitioners are not granted clinical privileges by the Board, and Dependent Practitioners are not members of the Allied Health Staff. The clinical practice of Dependent Practitioners in the Hospital shall be in accordance with separate policies and procedures managed by the Medical Staff Office, and the provisions of this Policy shall specifically **not** apply (except for Appendix A, Section 4., of this Policy). Whenever a question or concern is raised about the care or conduct of a Dependent Practitioner, the Medical Executive Committee will have the discretion to determine the action, if any, needed to address and resolve such question orconcern.

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").

D. DELEGATION OF FUNCTIONS

When a function under this Policy is to be carried out by a member of Hospital management , by a Medical Staff member, or by a Medical Staff committee, the individual, or the committee through its chair, may delegate performance of the function to one or more qualified designees.

E. HOSPITAL EMPLOYEES

1. Any member of the Medical Staff or Allied Health Staff who is employed by IU Health or any of its affiliated entities is bound by all the same conditions and requirements in this Policy that apply to members who are not employed by IU Health or an affiliated entity.
2. This provision does not preclude IU Health or any of its affiliated entities from addressing an in accordance with its employment policies/manuals or in accordance with the terms of any applicable employment contract.

F. CONFIDENTIALITY AND PEER REVIEW PROTECTION

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 CMO or by legal counsel to the Hospital in accordance with applicable law.

Any breach of confidentiality may result in a professional review action and/or appropriate sanctions. Any such breaches are unauthorized and do not waive the peer review privilege. Any member of the Medical Staff who becomes aware of a breach of confidentiality must immediately inform the IU Health Arnett Fort Wayne Hospital President, CMO, or President of the Medical Staff.

2. **Peer Review Protection:**

All credentialing and professional practice evaluation and review activities pursuant to this Policy and related Medical Staff documents shall be performed by peer review committees in accordance with the relevant state law. These peer review committees include, but are not limited to:

a. all standing and ad hoc Medical Staff and Hospital committees;

b. all Section and Standard Committees;

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, including, but not limited to the Medical Staff leaders, CMO, all Hospital personnel, and experts or consultants retained to assist in peer review activities.

All peer review committees shall also be deemed to be "professional review bodies" as that term is defined in the Health Care Quality Improvement Act of 1986, 42 U.S.C. §11101 *et seq.*

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

ARTICLE 2

QUALIFICATIONS, CONDITIONS, AND RESPONSIBILITIES

A. QUALIFICATIONS

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. where applicable, have a current, unrestricted DEA registration and state controlled substance license;

c. be located within the geographic proximity of the Hospital to fulfill their Medical Staff responsibilities, to provide timely and continuous care for their patients in the Hospital, and respond in a reasonable time, as defined by specialty and / or call responsibility.

d. have current, valid professional liability insurance coverage in a form and in amounts satisfactory to the Hospital;

e. have never been convicted of , or entered a plea of guilty or no contest to, 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, precluded or debarred 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, suspended, 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 any IU Health entity;

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 involving controlled substances, illegal drugs, Medicare, Medicaid, or insurance or health care fraud or abuse, or violence;

j. agree to personally fulfill all responsibilities regarding emergency service call coverage for their specialty or to obtain appropriate coverage (as determined by the Credentials Committee) by another member of the Medical Staff;

k. have or agree to make appropriate coverage arrangements (as determined by the Credentials Committee)with other members of the Medical Staff for those times when the individual will be unavailable;

l. if applying for privileges in an area that is covered by an exclusive contract meet the specific requirements set forth in that contract;

m. document compliance with all applicable training and educational protocols as well as orientation requirements that may be adopted by the MEC or required by the Board, including, but not limited to, those involving electronic medical records, the privacy and security of protected health information, infection control, and patient safety;

n. provide documentation showing evidence of any immunizations, vaccinations, and/or screening tests required by Medical Staff or Hospital Policy;

o. demonstrate recent clinical activity in their primary area of practice during at least two of the last four (4) years;

p. if seeking to practice as an Advanced Practice Provider, have a written agreement with a Collaborating Physician, which agreement must meet all applicable requirements of state law, Hospital policy and related Medical Staff documents;

q. 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.

r. be board certified in their primary area of practice at the Hospital and maintain such certification throughout the period of appointment unless one of the following exceptions apply:

    1. Initial applicants who are not board certified at the time of application but who have completed their residency or fellowship training within five (5) years shall be eligible for Medical Staff appointment and shall obtain certification within five (5) years from the date of completion of

their residency or fellowship training.

2. Board certification in another country that may be considered equivalent to the American boards, which exception shall be evaluated on a case-by-case basis.

s. Maintain board certification and, to the extent required by the applicable specialty/subspecialty board, satisfy recertification requirements. Certification or Recertification, as applicable, shall be assessed at reappointment.

2. Waiver of Threshold Eligibility Criteria:

a. Any applicant who does not satisfy one or more of the threshold eligibility criteria outlined above may request that it be waived. Waivers of threshold eligibility criteria shall not be granted routinely. The applicant requesting the waiver bears the burden of demonstrating (i) that he or she is otherwise qualified, and (ii) exceptional circumstances exist (e.g., when there is a demonstrated Hospital or Medical Staff need for the services in question). Exceptional circumstances generally do not include situations where a waiver is sought for the convenience of an applicant (e.g., applicants who wish to defer taking Board examinations).

b. A request for a waiver shall be submitted to the Credentials Committee for consideration. In reviewing the request for a waiver, the Credentials Committee may consider the specific qualifications of the applicant in question, input from the relevant Section chair, and the best interests of the Hospital and the communities it serves. Additionally, the Credentials Committee may, in its discretion, consider the application form and other information supplied by the applicant. The Credentials Committee's recommendation will be forwarded to the MEC. Any recommendation to grant a waiver must include the specific basis for the recommendation.

c. 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. Any recommendation to grant a waiver must include the specific basis for the recommendation.

d. 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, reappointment, or clinical privileges, and the applicant who requested the waiver is not entitled to a hearing. Rather, that individual is ineligible to request appointment or clinical privileges. A determination of ineligibility is not a matter that is reportable to either the state board or the National Practitioner Data Bank.

e. The granting of a waiver in a particular case does not set a precedent for any other applicant or group of applicants.

f. If a waiver is granted by the Board that does not specifically include a time limitation, the waiver is considered to be permanent and the individual does not have to request a waiver at subsequent reappointment cycles, unless the Board otherwise directs prospectively at a subsequent reappointment cycle.

g. An application for appointment that does not satisfy an threshold a will not be processed until the Board has determined that a waiver should be granted.

3. Factors for Evaluation:

The six ACGME general competencies (patient care, medical knowledge, professionalism, system-based practice, practice-based learning and improvement, and interpersonal communications) will be evaluated as part of the appointment and reappointment processes, as reflected in the following factors:

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.

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 employed by IU Health or its affiliated entities or has a contract with the Hospital;
b. Is or is not a member or employee of any particular physician group;
c. is licensed to practice a profession in this or any other state;
d. is board certified;
e. is a member of any particular professional organization;
f. has had in the past, or currently has, Medical Staff appointment or privileges at any hospital or health care facility;
g. resides in the geographic service area of the Hospital; or
h. is affiliated with, or under contract to, any managed care plan, insurance plan, HMO, PPO, or other entity.

5. Nondiscrimination:

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

B. GENERAL CONDITIONS OF APPOINTMENT AND REAPPOINTMENT

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 quality care to all patients for whom the individual has responsibility;

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 professional practice evaluation/peer review activities, and to perform such other reasonable duties and responsibilities as may be assigned within the scope of his or her privileges, to provide emergency call coverage, consultations, and care for unassigned patients;

4. to comply with applicable clinical practice or evidence-based protocols and guidelines, as may be adopted by the Medical Staff or the Medical Staff leadership, or clearly document the clinical reasons for variance;

5. to comply with all applicable training and educational protocols as well as orientation requirements that may be adopted by the MEC or required by the Board, including, but not limited to, completion of training involving electronic medical records, the privacy and security of protected health information, infection control, and patient safety.

6. To inform the CMO or President of the Medical Staff, in writing or via e-mail, as soon as possible but in all cases within three (3) days of any change in the individual's application form as defined on the Indiana University Health Authorization, Consent and Release form. This information shall be provided, with or without request, and shall include, but not be limited to:
    - any and all complaints regarding, or changes in, licensure status or DEA certificate;
    - adverse changes in professional liability insurance coverage;
    - the filing of a professional liability lawsuit against the individual;
    - changes in the individual's status (appointment, privileges, and/or scope of practice) at any other hospital or health care entity as a result of peer review activities or in order to avoid initiation of peer review activities;
    - changes in the individual's employment status at any medical group or hospital as a result of issues related to clinical competence or professional conduct;
    - any arrest, charge, indictment, conviction, or a plea of guilty or no contest related to a felony or to any misdemeanor relating to controlled substances, illegal drugs, insurance or health care fraud or abuse, child abuse, elder abuse, or violence;
    - exclusion or preclusion from participation in Medicare/Medicaid or any sanctions imposed;
    - any changes in the individual's ability to safely and competently exercise clinical privileges or perform the duties and responsibilities of appointment or permission to practice because of health status issues, including, but not limited to, a physical, mental, or emotional condition that could adversely affect the individual's ability to practice safely and competently, or impairment due to addiction, alcohol use, or other similar issue (all of which shall be referred for review under the Medical Staff's health policy);
    - any referral to a state board health-related program; and
    - any charge of, or arrest for, driving under the influence (DUI).

7. to immediately submit to an appropriate evaluation, which may include diagnostic testing (including, but not limited to a blood, hair and/or urine test), or to a complete physical or mental evaluation, or behavioral health evaluation, if at least two Medical Staff leaders (or one Medical Staff leader and the IU Health Fort Wayne Hospital President 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 (or the Medical Staff leader and member of the administrative team) and the Medical Staff member must execute all appropriate releases to permit the sharing of information with the Medical Staff leaders;

8. to meet with Medical Staff Leaders and/or Hospital administration upon request, to provide information regarding professional qualifications, and to participate in collegial efforts as may be requested;

9. to participate in personal or phone interviews in regard to an application for initial appointment or reappointment, if requested;

10. to maintain, monitor and use his or her IU Health issued e-mail account in HIPAA compliant fashion and use for communication with the Medical Staff Office, which will be the primary mechanism used to communicate all Medical Staff information to the member;

11. to provide valid contact information in order to facilitate practitioner-to-practitioner communication (e.g., mobile phone number or valid answering service information);
12. if exercising clinical privileges, to use the Hospital sufficiently to allow continuing assessment of current competence;
13. to seek consultation whenever necessary;
14. to complete in a timely manner all medical and other required records;
15. to perform all services and to act in a cooperative and professional manner;
16. to promptly pay any applicable dues, assessments, or fines; and
17. to satisfy continuing medical education requirements.

b. In addition to the above, every individual seeking to practice as an Advanced Practice Provider may function in the Hospital only so long as they have a Collaborating Physician, and they adhere to their applicable law and scope of privileges, and clinical privileges granted by the Board. The Collaborating Physician of the APP shall member a member of the Medical Staff, and the APP and Collaborating Physician specifically agrees:
    1. to collaborate with one another whether pursuant to a Collaborative Practice Agreement, written practice protocol or by satisfying other requirements as may be required by state law;
    2. to serve as the Collaborating Physician for no more than the maximum number of APPs as permitted by state law and the rules and regulations of the Medical Staff; and
    3. to provide written notice, within three (3) days, to the Medical Staff Office of any revisions or modifications that are made to the Collaborative Practice Agreement or other written practice protocol.
c. Additional requirements of a Collaborating Physician are set forth in Appendix A.

2. Burden of Providing Information:

a. Individuals seeking appointment and reappointment 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 about an individual's qualifications. The information to be produced includes such quality data and other information as may be needed to assist in appropriate assessment of overall qualifications for appointment, reappointment, and current clinical competence for any requested clinical privileges, including, but not limited to, information from other hospitals, information from the individual's office practice, information from insurers or managed care organizations in which the individual participates, and/or receipts of confidential evaluation forms completed by referring/referred to physicians.

b. Individuals seeking appointment and reappointment 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, all information has been verified from primary sources, and all application fees have been paid. An application shall become incomplete if the need arises for new, additional, or clarifying information at any time during the credentialing process. Whenever there is a need for new, additional, or clarifying information – outside of the normal, routine credentialing process – the application will not be processed until the information is provided. If the application continues to be incomplete thirty (30) days after the individual has been notified of the need for new, additional, or clarifying information, the application shall be deemed to be withdrawn.

d. The individual seeking appointment or reappointment is responsible for providing a complete application, including adequate responses from references. An incomplete application shall not be processed.

C. APPLICATION

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.

The applications for initial appointment and reappointment will be managed by the IU Health Credentials Verification Office ("CVO") in conjunction with the Medical Staff Office.

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 Chief Medical Officer 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 Article 6., Section E.4.a.

c. No action taken pursuant to this section shall entitle the applicant or member to a hearing or appeal.

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 individual releases from any and all liability, extends immunity to, and agrees not to sue IU Health, the Hospital, the CVO, 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, communications, and/or disclosures involving the individual that are made, taken, or received by the Medical Staff, the CVO, the Hospital IU Health and their authorized representatives, or third parties in the course of credentialing and peer review activities. The individual agrees not to sue any individuals for acts that are covered under the immunities set forth above. This immunity also extends to any reports that are made to government regulatory and licensure board or agencies pursuant to federal or state law.

b. **Authorization to Obtain Information from Third Parties**:
The individual authorizes IU Health, the Hospital, the CVO, Medical Staff leaders, and their authorized representatives (1) to consult with any third party who may have information bearing on the applicant's professional qualifications, credentials, clinical competence, character ability to perform safely and competently, ethics, behavior, or any other matter reasonably having a bearing on his or her qualifications for initial and continued appointment to the Medical Staff or the Allied

Health Staff and (2) to obtain any and all communications, reports, records, statements, documents, recommendations or disclosures of third parties that may be relevant to such questions. The individual also specifically authorizes third parties to release this information to the Hospital and its authorized representatives upon request. Further, the individual also agrees to sign necessary consent forms to permit a consumer reporting agency to conduct a criminal background check on the applicant and report the results to the Hospital.

c. **Authorization to Release Information to Third Parties**:
The individual also authorizes Hospital representatives to release information to (i) other hospitals, health care facilities, managed care organizations, and their agents when information is requested in order to evaluate his or her professional qualifications for appointment, privileges, and/or participation at the requesting organization/facility and (ii) government regulatory and licensure boards or agencies, all in accordance with applicable law. The disclosure of any such information or documentation in response to such inquiries does not waive any privilege, and all such disclosures shall be made with the understanding that the receiving entity will only use such information and documentation for peer review purposes, unless otherwise permitted by law.

d. Authorization to Share Information Among IU Health Entities:
The individual specifically authorizes the Hospital, IU Health and its affiliated entities to share information pertaining to the individual's clinical competence or professional conduct within the IU Health system. Further, the individual authorizes the sharing of peer review privileged information within the IU Health system in accordance with the IU Health Medical Staff Peer Review Information Policy, as amended from time to time.

e. **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.

f. **Legal Actions**:
If, notwithstanding the provisions in this Section, an applicant institutes legal action challenging credentialing, privileging, peer review, or other action affecting appointment or privileges, or any report that may be made to government regulatory and licensure board or agencies, 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, and expert witness fees.

g. **Scope of Section**:
All of the provisions in this Article 2., Section 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;
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; and
5. as applicable, to any reports that may be made to government regulatory and licensing board or agencies pursuant to federal or state law.

ARTICLE 3
PROCEDURE FOR INITIAL APPOINTMENT AND

PRIVILEGES

A. PROCEDURE FOR INITIAL APPOINTMENT AND PRIVILEGES

1. Application:

a. Applications for appointment and clinical privileges shall be in writing and shall be on forms provided by the CVO or the Medical Staff Office and shall be approved by the Board, upon recommendation by the MEC.

b. Applicants shall have access to Medical Staff Bylaws which outline the threshold eligibility criteria.

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. Please refer to the Medical Staff policies for moonlighter eligibility.

d. An Allied Health Staff 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 Staff appear in Appendix B.

e. As Dependent Practitioners are not granted clinical privileges by the Board and are not members of the Allied Health Staff, they shall be ineligible to receive an application. See Appendix A as to the separate policies and procedures managed by the Medical Staff Office.

2. Initial Review of Application:

a. A completed application form with copies of all required documents must be returned to the CVO within thirty (30) days after receipt. The application must be accompanied by the application fee, if applicable.

b. As a preliminary step, the application shall be reviewed by the CVO (and the CMO and Medical Staff Office, if necessary) 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 the hearing and appeal rights outlines in this Policy, and is not reportable to any state agency or to the National Practitioner Data Bank.

c. The CVO 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 section 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 Section chair, the Medical Staff Quality Committee (“MSQC”) chair, the Credentials Committee or a Credentials Committee representative, the MEC or a MEC representative, the President of the Medical Staff, Chief Medical Officer, or the IU Health Fort Wayne Hospital President.

3. Section Chairs and MSQC Procedure:

a. The chair(s) or vice-chair(s) in each Section in which the applicant has requested clinical privileges,

or the MSQC, shall review the application and all supporting materials and prepare a report regarding whether the applicant has satisfied all of the qualifications for appointment and the clinical privileges requested on a form provided by the CVO or Medical Staff Office.

b. The applicable Section chair(s) or vice-chair(s) or MSQC chair shall be available to the Credentials Committee, the MEC, and the Board to answer any questions that may be raised with respect to that chairperson's report and findings.

4. Credentials Committee Procedure:

a. The composition of the Credentials Committee is set forth in the Medical Staff Organizational Manual.

b. The Credentials Committee shall consider the report prepared by the Section chair(s) or vice-chair(s) or MSQC and shall make a recommendation.

c. The Credentials Committee may use the expertise of the Section chair(s) or vice-chair(s), any member of the section, any member of the MSQC, or an outside consultant, if additional information is required regarding the applicant's qualifications.

d. 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 that the applicant undergo a physical and/or mental examination by a physician(s) satisfactory to the Credentials Committee. The results of this examination shall be made available to the Committee for its consideration. Failure of an applicant 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 and all processing of the application shall cease.

e. 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 (2) years to permit closer monitoring of the applicant's compliance with any conditions. Unless these matters involve the specific recommendations set forth in Article 7. Section A.1(a), Article 8. Section A., or Article 8. Section B. of this Policy, such conditions do not entitle an individual to request the procedural rights set forth in Article 7 or Article 8 of this Policy.

f. If the recommendation of the Credentials Committee is delayed longer than sixty (60) days, the chair of the Credentials Committee shall send a letter to the applicant, with a copy to the CMO, explaining the reasons for the delay.

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 findings 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 CMO, who shall promptly send special notice to the applicant. The CMO shall then hold the application until after the applicant has completed or waived a hearing and appeal.

6. **Board Action:**

   a. Board: Upon receipt of a recommendation from the Credentials Committee and the MEC, the Board may: (i) appoint the applicant and grant clinical privileges as recommended, (ii) 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 (iii) reject of modify the recommendation. Any final decision by the Board to grant, deny, revise, or otherwise revoke appointment or clinical privileges will be disseminated to appropriate individuals and as required, reported to appropriate entities

   b. Board Delegated Authority: The Board may delegate to a Board committee, consisting of at least three (3) Board members, Board delegated authority for Board action upon receipt of a recommendation from the Credentials Committee and the MEC to: (i) appoint the applicant and grant clinical privileges as recommended, (ii) 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 (iii) reject of modify the recommendation. Any final decision by such committee delegated Board authority to grant, deny, revise, or otherwise revoke appointment or clinical privileges will be disseminated to appropriate individuals and as required, reported to appropriate entities.

7. **Time Periods for Processing:**
   Once an application is deemed complete, it is expected to be processed within one hundred twenty (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.

8. **FPPE to Confirm Competence and Professionalism**

   All initially granted clinical privileges, whether at the time of initial appointment, reappointment, or during the term of appointment, will be subject to focused professional practice evaluation (FPPE) in order to confirm competence. The FPPE process for these situations is outlined in the relevant Medical Staff policy.

ARTICLE 4
CLINICAL PRIVILEGES

A. CLINICAL PRIVILEGES

1. **General:**

   a. Appointment or reappointment shall not confer any clinical privileges or right to admit or treat patients at the Hospital. Each individual who has been appointed to the Medical Staff or Allied Health Staff is entitled to exercise only those clinical privileges specifically granted by the Board.

   b. A request for privileges shall be processed only when an applicant satisfies threshold eligibility criteria.

   c. Privileges and any associated criteria shall be developed by the relevant Section or Committee and shall be forwarded to the Credentials Committee for review and recommendation. The Credentials Committee will forward its recommendations to the MEC which will review the matter and forward its recommendations to the Board for final action.

   d. Requests for clinical privileges that are subject to an exclusive contract shall not be processed

except as consistent with the applicable contract.

e. 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 other qualified staff members with appropriate privileges (as determined by the Credentials Committee) to provide 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; and
11. professional liability actions, especially any such actions that reflect an unusual pattern or number of actions.

f. 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.

g. The applicant has the burden of establishing his or her qualifications and current competence for all clinical privileges requested.

h. The report of the chair(s) or vice-chair(s) in each Section in which the applicant has requested clinical privileges, or the MSQC, shall be forwarded to the chair of the Credentials Committee and process as part of the application for appointment.

2. Privilege Modifications, Waivers, and Resignations:

a. Scope. This Section applies to all requests for modification of clinical privileges during the term of appointment (increases and relinquishments), waivers related to eligibility criteria for privileges or the scope of those privileges, and resignations of all clinical privileges and appointment to the Medical Staff or Allied Health Staff. Any such requests should be submitted in writing or via e-mail to the Medical Staff Office.

b. Increased Privileges.

1. Requests for increased privileges must state the specific additional clinical privileges requested and provide information sufficient to establish eligibility, as specified in applicable criteria, and current clinical competence.

2. If the individual is eligible and the application is complete, it will be processed in the same manner as all other privilege requests.

c. Relinquishment of Individual Privileges.

A request to relinquish any individual clinical privilege will be processed in accordance with the following:

1. Formal Request: The individual must forward a written or electronic request to the Medical Staff Office, which must indicate the specific privilege that the member does not wish to provide.

2. On-Call Obligations: By limiting the scope of privileges, the individual nevertheless agrees to participate in the general on-call schedule for the relevant specialty and to maintain sufficient competency to assist other physicians on the Medical Staff in assessing and stabilizing patients who require services within that specialty, if this call responsibility is required by the Medical Staff. If, upon assessment, a patient needs a service that is no longer provided by the individual due to this request, the individual shall work cooperatively with the other practitioners in arranging for another individual with appropriate clinical privileges to care for the patient or, if such an individual is not available, in arranging for the patient's transfer.

3. Review Process: A request for a relinquishment shall be submitted to the Credentials Committee for consideration. In reviewing the request, the Credentials Committee may obtain input from the relevant Section chair(s) or vice-chair(s) and shall consider the following factors:

- the Hospital's mission and ability to serve the health care needs of the community by providing timely, appropriate care within its facilities;
- the effect of the request on the Hospital's ability to comply with applicable regulatory requirements, including the Emergency Medical Treatment and Active Labor Act ("EMTALA");
- the expectations of Medical Staff members who are in different specialties but who rely on the specialty in question in the care of patients to present to the Hospital;
- fairness to the individual requesting the waiver, including past service and the other demands placed on the individual;
- an undue burden to other members who serve on the call roster in the relevant specialty, including the effect that the relinquishment would have on them and any inequalities that may be created; and
- any gaps in call coverage that might result from an individual's removal from the call roster for the relevant privilege and the feasibility of safely transferring patients to other facilities in that situation.

Upon completion of its review, the Credentials Committee will forward its recommendation to the MEC, which shall review the recommendation of the Credentials Committee and make its own recommendation to the Board regarding whether to grant or deny the request. Any recommendation to grant a request should include the specific basis for the recommendation.

If the Board grants a relinquishment of privileges, it shall specify the date that the relinquishment will be effective. Failure of a member to request a relinquishment in accordance with this section shall, as applicable, result in the member retaining his or her clinical privileges and all associated responsibilities.

No one is entitled to a modification or waiver as to a request to relinquishment of privileges request, and there are not hearing or appeal rights if such modification or waiver is not granted.

3. **Resignation of Privileges**:
   A request to resign all clinical privileges must (a) specify the desired date of resignation, at least thirty (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.

4. **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 (1) a determination has been made that the procedure shall be offered by the Hospital; and (2) criteria to be eligible to request those clinical privileges have been established.

   b. The individual seeking to perform the new procedure will prepare and submit a report to the appropriate committee addressing the following:

      1. appropriate 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 appropriate committee shall review this report, conduct additional research as necessary, consult with individuals including the CMO and Hospital President and committees as needed, 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 appropriate committee shall then develop threshold credentialing criteria to determine those individuals who are eligible to request the clinical privileges. In developing the criteria, the committee may conduct additional research and consult with experts, as necessary, and develop recommendations.

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

5. **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 in terms of patient care outcomes and quality of care. 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 regarding:

    1. the appropriate education, training, and experience necessary to perform the clinical privileges in question;
    2. the clinical indications for when the procedure is appropriate;
    3. the manner of addressing the most common complications that arise which may be outside of the scope of the clinical privileges that have been granted to the requesting individual;
    4. the extent (time frame and mechanism) or focused monitoring and supervision that should occur if the privileges are granted in order to confirm competence;
    5. the manner in which the procedures would be reviewed as part of the Hospital's ongoing and focused professional practice evaluation activities (which may include assessment of both long-term and short-term outcomes for all relevant specialties); and
    6. the impact, if any, on emergency call responsibilities

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

6. **Clinical Privileges for Podiatrists, Dentists and Oral and Maxillofacial Surgeons**:

    a. The scope and extent of surgical procedures that a podiatrist, dentist or oral and maxillofacial surgeon may perform in the Hospital shall be delineated and recommended in the same manner as other clinical privileges.

    b. A pre-operative history and physical examination may be performed by a podiatrist, dentist, or oral and maxillofacial surgeon, within the scope of their license.

    c. Podiatric, dental, and oral and maxillofacial surgery patients requiring hospital admission shall be admitted by a member of the Medical Staff with admitting privileges.

    d. For patients requiring admission, 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 and a designated physician shall be responsible for the medical care of the patient throughout the period of hospitalization.

    e. Podiatrists, dentists, and oral and maxillofacial surgeons shall be responsible for the podiatric, dental, and oral/maxillofacial care of the patient, including documentation of all appropriate elements of the patient's record.

    f. Podiatrists, 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.

7. **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, and the Graduate Medical Education Medical

Director. The applicable program director shall be responsible for verifying and evaluating the qualifications of each physician in training.

A physician in training at the fellowship level may request clinical privileges in an area for which he or she has already completed residency training if he or she can demonstrate that all necessary eligibility criteria as set forth in this Policy have been met. Requests for privileges shall be reviewed in accordance with the initial credentialing process outlined in this Policy and, if granted, shall be subject to al relevant oversight provisions including ongoing and focused professional practice evaluation, Physicians in training at the fellowship level may only be granted clinical privileges in those areas for which they can demonstrate current clinical competence.

8. **Telemedicine Privileges**:

   a. A qualified individual may be granted telemedicine privileges regardless of whether the individual is appointed to the Medical Staff.

   b. Requests for initial or renewed telemedicine privileges shall be processed through one of the following options, as determined by the CMO in consultation with the President of the Medical Staff:

      1. A request for telemedicine privileges shall be processed through the same process for Medical Staff applications, as set forth in this Policy. In such case, the individual must satisfy all qualifications and requirements set forth in this Policy, except those relating to geographic location, coverage arrangement, and emergency call responsibilities.

   c. If the individual requesting telemedicine privileges is practicing at a distant hospital that participates in Medicare or a telemedicine entity (as that term is defined by Medicare), a request for telemedicine privileges may be processed using an abbreviated process that relies on the credentialing and privileges decisions made by the distant hospital or telemedicine entity. In such cases, the Hospital must ensure, through a written agreement, that the distant hospital or telemedicine entity will comply with all applicable legal, regulatory, and accreditation standards. The Hospital may enter into one or more delegated credentialing and privileging agreements with qualified entities. The Board and Hospital retains the right, at any time, to audit, independently review the credentials of and make privileging recommendations for any individual in accordance herewith (rather than relying on the privileging decisions of the distant hospital), or revoke delegated credentialing authority and to take any action necessary to ensure patient safety, quality of care, and compliance with applicable requirements. This information shall be provided to the MEC for review and recommendation to the Board for final action. Notwithstanding the process set forth in this subsection, the Hospital may determine that an applicant for telemedicine privileges is ineligible for appointment or clinical privileges if the applicant fails to satisfy the threshold eligibility criteria set forth in this Policy.

   d. Telemedicine privileges, if granted, shall be for a period of not more than two (2) years.

   e. Individuals granted telemedicine privileges shall be subject to the Hospital's peer review activities. The results of the peer review activities, including any adverse events and complaints filed about the practitioner providing telemedicine services from patients, other practitioners or staff, will be shared with the hospital or entity providing telemedicine services.

   f. Telemedicine privileges granted in conjunction with a contractual agreement shall be incident to and coterminous with the agreement.

   g. Notwithstanding the forgoing, if the Hospital provides secure platforms for telemedicine services that may also be used by Members, in addition to those granted telemedicine privileges who exclusively provide telemedicine, then nothing shall preclude such Members with appropriate clinical privileges

from utilizing Hospital approved technology to provide telemedicine services within the Hospital, subject to applicable Hospital policies and law.

9. Refer and Follow Privileges (only) - no patient care privileges.

a. A request for refer and follow privileges shall be processed through the same process for Medical Staff applications, as set forth in this Policy.

b. Individuals granted refer and follow privileges (only) means the individual may refer patients to the Hospital (i.e., their patients in an ambulatory medical office setting) and access information regarding the care and treatment of those patients while in the Hospital for continuity of care purposes, without admitting, treating, or otherwise exercising clinical privileges within the Hospital. Such privileges do not authorize the individual to provide patient care services within the Hospital.

c. Individuals granted refer and follow privileges (only) shall be subject to applicable Medical Staff Bylaws, Rules & Regulations, Related Medical Staff Documents, and Hospital policies, including without limitation compliance with confidentiality, privacy and professional conduct, but shall not be eligible to admit patients, exercise clinical privileges, vote, hold office, or serve in Medical Staff leadership positions.

B. TEMPORARY CLINICAL PRIVILEGES

1. Temporary Clinical Privileges-General:

a. Temporary privileges may be granted by the CMO, upon recommendation of the President of the Medical Staff, to:

1. applicants for initial appointment whose complete application is pending review by the MEC and Board, following a favorable recommendation of the Credentials Committee. 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.

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, 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 not exceed one hundred twenty (120) days.

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.

2. Termination of Temporary Clinical Privileges-General:

a. The granting of temporary privileges is a courtesy and may be terminated for any reason by the CMO at any time, after consulting with the President of the Medical Staff, the chairman of the Credentials Committee or the Section chair. The individual may be afforded an opportunity to

voluntarily refrain from exercising privileges.

b. The appropriate administrative or medical staff leader 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.

d. A report of actions on temporary privileges will be shared with the Credentials Committee, MEC and Board for ratification.

3. **Temporary Locum Tenens Privileges**: The CMO, in conjunction with the chair of the Credentials Committee, may grant temporary Locum Tenens privileges (both admitting and treatment) to an individual serving as a locum tenens. Locum Tenens privileges are for providers hired as locum tenens when the Hospital is short-staffed or to work in place of the regular provider when the provider is absent. These professionals are still governed by their respective regulatory bodies, despite the transient or freelance nature of their positions under the following conditions:

a. Locum Tenens applicants must meet the threshold eligibility criteria as outlined in this Policy. Requests for waiver of the threshold eligibility criteria must be received at the time of submission of the application for temporary Locum Tenens privileges. The only exception to meeting the threshold eligibility criteria is to be located (office or clinic) within the geographic service area of the Hospital;

b. the applicant has submitted an appropriate application, along with the completed delineation of privileges form, application fee, and provided such quality data and other information that may be requested to assist in an appropriate assessment of current clinical competence and overall qualifications for temporary Locum Tenens privileges;

c. the verification process is complete, including verification of current licensure, relevant training or experience, current competence (verification of good standing in all hospitals where the individual practiced for at least the previous five years), ability to exercise the privileges requested, and current professional liability coverage; compliance with privileges criteria; and consideration of information from the National Practitioner Data Bank, a criminal background check, and OIG queries;

d. the applicant demonstrates that (i) there are no current or previously successful challenges to his or her licensure or registration, and (ii) he or she has not been subject to involuntary termination of Medical Staff membership or involuntary limitation, reduction, denial, or loss of clinical privileges at another health care facility;

e. upon completion of processing the application for, and approval of, temporary Locum Tenens privileges, a provider of documented competence who is serving as a Locum Tenens for a medical staff member may be granted temporary Locum Tenens privileges for an initial period of up to one hundred eighty (180) days.

(i) Such privileges may be renewed thereafter for up to three (3) successive periods of one hundred eight (180) days each not to exceed a maximum period of two (2) years with temporary Locum Tenens privileges.

(ii) If privileges are required beyond the aforesaid maximum time period referenced in this section, the individual must complete a full reappointment application.

f. the applicant has received a favorable recommendation from the chair of the Credentials Committee Chair, after considering the evaluation of the Section chair or vice-chair;

g. Focused Professional Practice Evaluation will be completed in three months from approval of temporary Locum Tenens privileges in addition to the standard Focused Professional Practice

Evaluation cycle;

h. Temporary Locum Tenens Privileges may be terminated for any reason by the CMO at any time, after consulting with the President of the Medical Staff, the chairman of the Credentials Committee or the Section chair or vice-chair. As temporary privileges, the termination, denial of or failure to renew temporary Locum Tenens privileges shall not 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; and

i. a report of actions on temporary Locum Tenens privileges will be shared with the Credentials Committee, MEC and Board for ratification.

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 appropriate administrative or medical staff leader to a member with appropriate clinical privileges, considering the wishes of the patient.

D. DISASTER PRIVILEGES

1. When the Emergency Operations Plan has been activated and the immediate needs of patients in the facility cannot be met, the IU Health Fort Wayne Hospital President or the President of the Medical Staff may use a modified credentialing process to grant disaster privileges to eligible licensed independent practitioners. Safeguards must be in place to verify that volunteers are competent to provide safe and adequate care.
2. Disaster privileges are granted on a case-by-case basis after verification of identity and licensure.
   a. A volunteer's identity may be verified through a valid government-issued photo identification (i.e., driver's license or passport).
   b. A volunteer's license may be verified in any of the following ways: (1) current Hospital picture ID card that clearly identifies the individual's professional designation; (2) current license to practice; (3) primary source verification of the license; (4) identification indicating that the individual has been granted authority to render patient care in disaster circumstances or is a member of a Disaster Medical Assistance Team, the Medical Resource Corps, the Emergency System for Advance Registration of Volunteer Health Professionals, or other recognized state or federal organizations or groups; or (5) identification by a current Hospital employee or Medical Staff member who possesses personal knowledge regarding the individual's ability to act as a volunteer during a disaster.
3. Primary source verification of a volunteer's license shall begin as soon as the immediate situation is under control and must be completed within 72 hours from the time the volunteer begins to provide service at the Hospital.
4. In extraordinary circumstances when primary source verification cannot be completed within 72 hours, it should be completed as soon as possible. In these situations, there must be documentation of the following: (a) the reason primary source verification could not be performed in the required time frame; (b) evidence of the volunteer's demonstrated ability to continue to provide adequate care; and (c) an attempt to obtain primary source verification as soon as possible. If a volunteer has not provided care, then primary source verification is not required.

5. The Medical Staff shall oversee the care provided by licensed independent practitioners. This oversight shall be conducted through direct observation, mentoring, clinical record review, or other appropriate mechanisms developed by the Medical Staff and Hospital. Oversight will determine if granted disaster privileges should continue beyond 72 hours.

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, unless otherwise provided herein.

2. Notwithstanding any other provision of this Policy and Related Medical Staff Documents, appointment to the Medical Staff and Allied Health Staff, and the grant of clinical privileges, may be expressly conditioned upon, and coterminous with, the existence of a valid and effective employment agreement or professional services agreement between the Hospital and the individual or the individual's employer or contracting entity ("Hospital Contract"). In the event that such Hospital Contract expires, terminates, or is otherwise no longer in effect for any reason, the individual's Medical Staff appointment and/or Allied Health Staff appointment, and all clinical privileges, shall automatically and simultaneously terminate upon the effective date of the termination of the Hospital Contract, without the need for further action by the Medical Executive Committee, the Board, or any hearing or appeal process. Such termination and expiration of clinical privileges and Medical Staff and/or Allied Health Staff member is generally deemed administrative in nature, not considered a professional review action and shall not be reported to any government agency, unless otherwise required by law.

ARTICLE 5
PROCEDURE FOR REAPPOINTMENT

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;
5. paid any applicable reappointment processing fee;
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; and

7. Practitioners who do not meet the patient-contact requirements for Active Staff status may be reassigned to Associate Staff in accordance with the Medical Staff Bylaws.

B. FACTORS FOR EVALUATION

In considering an application for reappointment, the factors listed in Article 2. Section 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.

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 CVO within thirty (30) days.
3. Failure to submit a complete application at least three 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 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 IU Health Fort Wayne Hospital President and Board chairman may grant conditional reappointment for a period not to exceed one hundred twenty (120) days to allow for Board action at its next meeting.
5. The application shall be reviewed by the CVO 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 CVO shall oversee the process of gathering and verifying relevant information. The CVO shall also be responsible for confirming that all relevant information has been received.

D. PROCESSING APPLICATIONS FOR REAPPOINTMENT

1. The Medical Staff Office shall forward the application to the relevant Sections chair and/or co-chair or the MSQC chair and the application for reappointment shall be processed in a manner consistent with applications for initial appointment.
2. Additional information may be requested from the applicant if any questions or concerns are raised with the application or if new privileges are requested.

E. CONDITIONAL REAPPOINTMENTS

1. Recommendations for reappointment and renewed privileges may be contingent upon an individual’s compliance with specific conditions that have been recommended. These conditions may relate to

behavior (e.g., personal code of conduct) or to clinical issues (e.g., general consultation requirements, appropriate documentation requirements, including timely completion of medical records, proctoring, completion of CME requirements). Unless the conditions involve the matters set forth in Section 7.A.1(a) or 8.A.1 of this Policy (as applicable), the imposition of such conditions does not entitle an individual to request the procedural rights set forth in Sections 7 and 8 of this Policy.

2. Reappointments may be recommended for periods of less than two (2) years in order to permit closer monitoring of an individual's compliance with any conditions that have been recommended. A recommendation of a conditional reappointment or for reappointment for a period of less than two (2) 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 unresolved professional practice evaluation concern, a formal investigation, or a hearing at the time reappointment is being considered, a conditional reappointment for a period of less than two (2) years may be granted pending the completion of that process.

F. **POTENTIAL ADVERSE RECOMMENDATION**

1. If the Credentials Committee or MEC is considering a recommendation to deny reappointment or to reduce clinical privileges, the committee chair will notify the member of the possible recommendation and invite the member to meet prior to any final recommendation being made.

2. Prior to this meeting, the member will be notified of the general nature of the information supporting the possible recommendation.

3. At the meeting, the member will be invited to discuss, explain, or refute this information, A summary of the interview will be made and included with the Credentials Committee's and/or MEC's recommendation.

4. This meeting is not a hearing and none of the procedural rules for hearings will apply. The member will not have the right to be accompanied by legal counsel at this meeting and no recordings (audio or video) of the meeting shall be permitted or made.

G. **FPPE TO CONFIRM COMPETENCE AND PROFESSIONALISM**

1. All initially granted clinical privileges, whether at the time of initial appointment, reappointment, or during the term of the appointment, will be subject to focused professional practice evaluation (FPPE) in order to confirm competence. The FPPE process for these situations is outlined in the relevant Medical Staff policy.

ARTICLE 6

PEER REVIEW PROCEDURES FOR QUESTIONS INVOLVING MEDICAL STAFF MEMBERS

A. COLLEGIAL EFFORTS AND PROGRESSIVE STEPS

1. This Policy encourages the use of collegial efforts and progressive steps by Medical Staff leaders and Hospital administration to address questions relating to an individual's clinical practice and/or professional conduct. The goal of these efforts is to arrive at voluntary, responsive actions by the individual to resolve questions that have been raised.

   Collegial efforts and progressive steps may include, but are not limited to:

   a. informal mentoring, coaching, or counseling by a Medical Staff Leader (e.g., advising an individual of policies regarding appropriate behavior, communication issues, emergency call

obligations, or the timely and adequate completion of medical records);

b. sharing comparative data, including any variations from clinical practice or evidence-based protocols or guidelines, in order to assist the individual with conforming his or her practice to appropriate norms;

c. addressing minor performance issues through an informational letter;

d. sending an educational letter that describes opportunities for improvement and provides guidance and suggestions;

e. facilitating a formal collegial intervention (i.e., a planned face-to-face meeting between an individual and one or more Medical Staff Leaders) in order to directly discuss a matter and the steps needed to be taken to resolve it; or

f. developing a Performance Improvement Plan, which may include a wide variety of tools and techniques that can result in a constructive and successful resolution of the concern.

2. All collegial efforts and progressive steps are fundamental and integral components of professional practice evaluation activities and are confidential and privileged in accordance with Indiana law.

3. Copies of any formal documentation that is prepared by a Medical Staff Leader regarding such collegial efforts and progressive steps, including letters that follow a formal collegial intervention, will be included in an individual's confidential file and maintained in a confidential manner consistent with its privileged status. Any written responses to collegial efforts and progressive steps that may be received from an individual shall also be included in the individual's confidential file.

4. Collegial efforts and progressive steps are encouraged, but are not mandatory, and shall be within the discretion of the appropriate Medical Staff Leaders. When a question arises, the Medical Staff and/or Hospital Leaders may:

   a. address it pursuant to the collegial efforts and progressive steps provisions of this Section;

   b. refer the matter for review in accordance with the professional practice evaluation policy and/or other relevant policy; or

   c. refer it to the MEC for its review and consideration in accordance with Article 6 Section C.

5. Individuals do not have the right to be accompanied by counsel when the Medical Staff Leaders and Hospital management are engaged in collegial efforts or other progressive steps. These efforts are intended to resolve issues in a constructive manner and do not involve the formal hearing process. In addition, there shall be no recording (audio or video) or transcript made of any meetings that involve collegial efforts or progressive steps activities.

B. **PROFESSIONAL PRACTICE EVALUATION ACTIVITIES**

1. Professional practice evaluation activities shall be conducted in accordance with the professional practice evaluation policy and/or other relevant policy. Matters that are not satisfactorily resolved through collegial intervention efforts or through one of these policies shall be referred to the MEC for its review in accordance with Section 6.C below. Such interventions and evaluations, however, are not mandatory prerequisites to MEC review.

C. INVESTIGATIONS

1. Initial Review:

a. Where collegial efforts or actions under one or more of the policies referenced in this Article have not resolved an issue and/or when there is a single instance of such severity that in the discretion of Medical Staff Leaders it requires further review, regarding:

1. clinical competence or clinical practice of any member, including the care, treatment or management of a patient or patients;
2. the safety or proper care being provided to patients;
3. the known or suspected violation by any member of applicable ethical standards or the Bylaws, policies, Rules and Regulations of the Hospital or the Medical Staff; and/or
4. conduct by any member 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. The matter may be referred to the President of the Medical Staff, the MSQC Chair, the Section Chair, the chair of a standing committee, the CMO, the IU Health Fort Wayne Hospital President, or the chair of the Board.

c. 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, or the CMO, for review and appropriate action in accordance with this Policy.

d. The person to whom the matter is referred shall conduct or arrange for an inquiry to determine whether the question raised has sufficient credibility to warrant further review and, if so, shall forward it in writing to the MEC.

e. No action taken pursuant to this section shall constitute an investigation.

2. Initiation of Investigation:

a. When a question involving clinical competence or professional conduct is referred to, or raised by, the MEC, that MEC shall review the matter and determine whether to conduct an investigation or to direct the matter to be handled pursuant to another relevant Medical Staff Policy (e.g., health, professionalism, etc.). In making this determination, the MEC may discuss the matter with the individual. An investigation shall begin only after a formal determination by the MEC to do so.

b. The MEC's determination shall be recorded in the minutes of the meeting where the determination is made. The MEC shall inform the individual that an investigation has begun. Notification shall include:

1. the date on which the investigation was commenced;
2. the committee that will be conducting the investigation, if already identified;
3. a statement that the individual will be given the opportunity to meet with the committee conducting the investigation before the investigation concludes; and
4. a copy of Section 6.C.3 of this Policy, which outlines the process for investigations.

c. This notification may be delayed if, in the MEC's judgement, informing the individual immediately would compromise the investigation or disrupt the operation of the Hospital or Medical Staff.

d. 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.

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 a physical, mental and/or behavioral examination or assessment of the individual 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. Failure to do so will result in the automatic relinquishment of the individual's clinical privileges.

c. The Investigating Committee shall make a reasonable effort to complete the investigation and issue its report within thirty (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 thirty (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.

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 CMO. The Medical Staff President or CMO 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 CMO shall inform the individual by special notice. No final action shall occur until the individual has completed or waived a hearing and appeal.

D. PRECAUTIONARY SUSPENSION OR RESTRICTION OF CLINICAL PRIVILEGES

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, at least two (2) of the following, the CMO, the IU Health Fort Wayne Hospital President, the Board Chair and member(s) of the MEC, are authorized to (1) afford the individual an opportunity to voluntarily refrain from exercising privileges pending the outcome of peer review, quality review, or the final action following a formal investigation, as applicable, ; or (2) immediately suspend or restrict all or any portion of an individual's clinical privileges as a precaution, which is the involuntary imposition of a precautionary suspension .

b. An involuntary precautionary suspension can be imposed at any time including, but not limited to, after a specific event, a pattern of events, or a recommendation by the MEC that would entitle the individual to request a hearing.

c. In the event an involuntary precautionary suspension is imposed, it is effective immediately and will remain in effect unless it is modified by the CMO, Indiana University Health Fort Wayne Hospital President, *and* a member of the MEC following MEC review.

d. Within three (3) days of the imposition of a precautionary 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.

2. **MEC Procedure**:

a. Within a reasonable time, not to exceed fourteen (14) days of the imposition of the precautionary 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 precautionary 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. Minutes of this meeting will be maintained 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 a formal investigation.

f. If the MEC decides to continue the precautionary suspension, it shall send the individual written

notice of its decision, including the basis for it and that suspensions lasting longer than thirty (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 thirty (30) days. The procedures outlined above are deemed to be fair under the circumstances. If the precautionary suspension last more than thirty (30) days, then the individual shall be entitled to request a hearing in accordance with Article 7 for members of the Medical Staff and in accordance with Article 8 for members of the Allied Health Staff.

h. Upon the imposition of a precautionary suspension, the CMO or 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.

E. AUTOMATIC RELINQUISHMENT

1. General:

a. Any of the occurrences described in this Section will constitute grounds for the automatic relinquishment of an individual's appointment and clinical privileges. An automatic relinquishment is considered an administrative action that happens by operation of this Policy and, as such, does not trigger an obligation on the part of the Hospital to file a report with the National Practitioner Data Bank and will take effect without hearing or appeal.

b. Automatic relinquishment of an individual's appointment and clinical privileges shall take effect immediately, without right to hearing or appeal, and shall continue until the matter is resolved, if applicable. The CVO, Medical Staff Office or other Hospital department (e.g., Medical Records or HIM) will notify the individual of the automatic relinquishment.

c. Unless otherwise provided in these Bylaws, Rules and Regulations or policies of the Hospital, if the underlying matter leading to automatic relinquishment is resolved within sixty (60) days, the individual may request reinstatement. However, failure to resolve the matter within sixty (60) days of the date of relinquishment shall result in the individual's automatic resignation from the Medical Staff or Allied Health Staff, as applicable.

d. Timely requests for reinstatement shall be reviewed by the relevant Section chair or vice-chair, Chair of the Credentials Committee, the President of the Medical Staff, and the CMO. 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 Credentials Committee, MEC and Board for review and recommendation.

e. An individual shall notify the CMO or President of the Medical Staff as soon as possible but in all cases within three (3) days of any change in any information provided on an application for initial appointment or reappointment, including without limitation any charges against the individual, as well as action against their medical license and/or privileges at another facility.

2. Failure to Complete Medical Records:

Failure to timely complete medical records in accordance with Hospital policies and related Medical Staff documents shall result in automatic relinquishment of all clinical privileges, without right to hearing or appeal. Relinquishment shall continue until all delinquent records are completed and reinstatement accomplished in accordance with Hospital policies and related Medical Staff documents. Failure to complete the medical records that caused relinquishment within the time required by applicable Hospital policies

and related Medical Staff documents shall result in automatic resignation from the Medical Staff or Allied Health Staff.

3. **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 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 of an individual's participation in the Medicare/Medicaid or other federal or state health care programs.
      5. **Criminal Activity**: Individual's arrest, indictment, conviction, or a plea of guilty or no contest pertaining to any felony, 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.
      6. **Satisfy Threshold Eligibility Criteria.** Individual fails to satisfy any of the threshold eligibility criteria.

4. **Failure to Provide Information:**
   An individual's appointment and clinical privileges shall be deemed to be automatically relinquished, without right to hearing or appeal, 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 CMO 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 CMO of any change in any information provided on an application for initial appointment or reappointment, determined by the President of the Medical Staff and CMO to be material and without good cause after considering any written or oral explanation provided by the individual; or

   c. failure to provide requested information, including 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 Medical Staff Office, Credentials Committee, the MEC, or CMO, or any other committee authorized to request such information, until the information is provided to the satisfaction of the requesting party.

5. **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. No legal counsel will be permitted at this meeting and no recording or transcript of the meeting shall be made.

b. Special notice shall be given at least three (3) 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. Failure to Meet Collaborating Physician Requirements:

If the Medical Staff appointment or clinical privileges of a Collaborating Physician are resigned, revoked or terminated, or the Allied Health Practitioner fails, for any reason, to maintain an appropriate collaborating relationship with a Collaborating Physician as defined in this Policy, the Advance Practice Practitioner's clinical privileges will be automatically relinquished, unless another Collaborating Physician is approved as part of the credentialing process.

7. Failure to Complete or Comply with Training, Educational, or Orientation Requirements:

a. An individual's failure to complete or comply with training, educational, or orientation requirements that are adopted by the MEC or required by the Board, including, but not limited to, those pertinent to electronic medical records, the privacy and security of protected health information, infection control, or patient safety, shall result in the automatic relinquishment of the individual's appointment and clinical privileges, without right to hearing or appeal, until the individual completes or complies with the applicable training, educational, or orientation requirements.

b. If the individual fails to complete or comply with the applicable training, educational, or orientation requirements within thirty (30) days of the automatic relinquishment, the individual's Medical Staff or Allied Health Staff appointment and clinical privileges will be deemed to have been automatically resigned.

F. LEAVES OF ABSENCE

1. Initiation:

a. A leave of absence of up to one (1) year must be requested in writing to the President of the Medical Staff and CMO, 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 thirty (30) days prior to the anticipated start of the leave.

b. The CMO shall determine whether a request for a leave of absence shall be granted, after consulting with the President of the Medical Staff and the relevant Section chairs. The granting of a leave of absence or reinstatement may be conditioned upon the individual's completion of all medical records.

c. With the exception of individuals with temporary locum tenens privileges, Members of the Medical Staff or Allied Health Staff must report to the Medical Staff Office and the CMO anytime they are away from Medical Staff or patient care responsibilities for longer than thirty (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 CMO, 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.

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.

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 relevant Section chair, MSQC Chair, the chair of the Credentials Committee, the President of the Medical Staff, the CMO or the IU Health Fort Wayne Hospital President, 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.

   d. Absence for longer than one year shall result in automatic relinquishment of appointment and clinical privileges unless an extension is granted by the MEC. Extensions shall only be considered in extraordinary cases.

ARTICLE 7
HEARING AND APPEAL PROCEDURES

The hearing and appeal procedures in this Article 7 are only applicable to members of the Medical Staff and are **not** applicable to members of the Allied Health Staff. The sole and exclusive procedural rights for Allied Health Staff members are set forth in Article 8 of this Policy. Notwithstanding the foregoing, see Article 4, Section E., above when the grant of privileges is coterminous with a Hospital Contract whereby such individual's Medical Staff appointment and/or Allied Health Staff appointment, and all clinical privileges, shall automatically and simultaneously terminate upon the effective date of the termination of the Hospital Contract, without any hearing and appeal rights.

A. INITIATION OF HEARING

1. **Grounds for Hearing:**

   a. 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 to the Medical Staff;
      2. denial of reappointment to the Medical Staff;
      3. revocation of appointment to the Medical Staff;
      4. denial of requested clinical privileges;
      5. revocation of clinical privileges;
      6. suspension of clinical privileges for more than thirty (30) days (including a precautionary

suspension if it lasts for more than thirty (30) days);

7. mandatory concurring consultation requirement (i.e., the consultant must approve the course of treatment in advance); or

8. denial of reinstatement to the Medical Staff from a leave of absence if the reasons relate to clinical competence or professional conduct.

b. No other recommendations shall entitle the individual to a hearing.

c. If the Board makes any of these recommendations without an adverse recommendation by the MEC, an individual would also be 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."

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. determination that an applicant for membership fails to meet the threshold eligibility qualifications or criteria for membership;

b. ineligibility to request membership or privileges, or to continue privileges, because a relevant specialty is closed under a Medical Staff development plan or is covered under an exclusive provider agreement;

c. failure to process a request for a privilege when the individual does not meet the eligibility criteria to hold the privilege;

d. determination that an application is incomplete or untimely;

e. determination that an application shall not be processed due to a misstatement or omission;

f. change in assigned staff category or a determination that an individual is not eligible for a specific staff category;

g. expiration of membership and privileges as a result of failure to submit an application for reappointment within the allowable time period;

h. issuance of a letter of guidance, counsel, warning, or reprimand;

i. determination that conditions, monitoring, supervision, proctoring, or a general consultation requirement (i.e., the individual must obtain a consult but need not get prior approval for the treatment) is appropriate for an individual;

j. determination that a requirement for additional training or continuing education is appropriate for an individual;

k. the voluntary acceptance of a Performance Improvement Plan;

l. any requirement to complete a health assessment, diagnostic testing, a complete physical, mental or behavioral evaluation, or a clinical competency evaluation pursuant to any Bylaws-related document;

m. conducting an investigation into any matter or the appointment of an ad hoc investigating committee;

n. grant of conditional appointment or reappointment or of an appointment or reappointment period that is less than two years;

o. refusal of the Hospital to consider a request for appointment, reappointment, or privileges within five years of a final adverse decision regarding such request;

p. precautionary suspension imposed for less than thirty (30) days;

q. automatic relinquishment of appointment or privileges or automatic resignation;

r. 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 clinical competence or professional conduct;

s. removal from the on-call roster or any other reading panel;

t. termination of temporary privileges granted under Article 4, Section 4.B (temporary clinical privileges-general) or termination, denial of or failure to renew under Article 4, Section B.3. (temporary Locum Tenens Privileges);

u. requirement to appear for a special meeting; and

v. termination of any contract with or employed by the Hospital.

B. **THE HEARING**

1. **Notice of Recommendation:**
   The Medical Staff President or CMO 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 thirty (30) days of receipt of this notice; and

   c. a copy of this Article.

2. **Request for Hearing:**
   An individual has thirty (30) days following receipt of the notice to request a hearing. The request for hearing shall be in writing, to the President of the Medical Staff and CMO, and shall include 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.

3. **Notice of Hearing and Statement of Reasons:**

   a. The President of the Medical Staff or CMO 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 a general description of the information supporting the recommendation. This statement may be revised or amended at any time, even during the hearing and does not bar presentation of additional evidence or information at 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 thirty (30) days after the notice of the hearing, unless an earlier hearing date has been specifically agreed to in writing

by the parties.

4. Hearing Panel and Presiding Officer:

a. **Hearing Panel**:
The CMO 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 (3) members, one of whom shall be designated as chair and may include any combination of:
    i. any member of the Medical Staff, provided the member has not actively participated in the matter at any previous level, or
    ii. physicians not connected with the Hospital (i.e., physicians not on the Medical Staff).
2. Knowledge of the underlying peer review matter, in and of itself, shall not preclude the individual from serving on the Panel.
3. Employment by, or other contractual arrangement with, the Hospital or an affiliate shall not preclude an individual from serving on the Panel.
4. The Panel shall not include any individual who (i) is in direct economic competition with the individual requesting the hearing; or (ii) is demonstrated to have an actual bias, prejudice, or conflict of interest that would prevent the individual from fairly and impartially considering the matter.

b. Presiding Officer:

1. The CMO 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 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;
    ii. prohibit conduct or presentation of evidence that is cumulative, excessive, irrelevant or abusive or that causes undue delay;
    iii. maintain decorum throughout the hearing;
    iv. determine the order of procedure;
    v. rule on all matters of procedure and the admissibility of evidence; and
    vi. conduct argument by counsel on procedural points within or outside the presence of the Hearing Panel at the Presiding Officer's discretion.
3. The Presiding Officer may participate in the private deliberations of the Hearing Panel and be a legal advisor to it, but shall not be entitled to 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 (10) days of receipt of notice, to the CMO. 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. CMO shall rule on the objection and give notice to the parties. The CMO may request that the Presiding Officer make a recommendation as to the validity of the objection.

5. **Counsel:**
   Any attorneys who participate in the hearing process, whether as the Presiding Officer or as counsel for either party must be licensed to practice law, in good standing, in any state.

C. PRE-HEARING P R O C E D U R E S

1. **General Procedures:**
   a. The pre-hearing and hearing processes shall be conducted in an informal manner. Formal rules of evidence or procedure shall not apply.
   b. Neither party has the right to issue subpoenas or interrogatories or to depose witnesses or other individuals prior to the hearing or to otherwise compel any individual to participate in the hearing or pre-hearing process.
   c. Neither the individual who has requested the hearing, nor any other person acting on behalf of that 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 Article concerning the subject matter of the hearing, until the Hospital has notified such Hospital employees and/or Medical Staff members of the requested hearing. Any Hospital employee or Medical Staff member may agree or decline to be interviewed by or on behalf of the individual who requested a hearing.

2. **Time Frames**:
   a. The following time frames, unless modified by mutual written agreement of the parties, shall govern the timing of pre-hearing procedures:
      1. the pre-hearing conference shall be scheduled by the Presiding Officer at least fourteen (14) days prior to the hearing;
      2. the parties shall exchange witness lists and proposed documentary exhibits and accompanying exhibit lists at least ten (10) days prior to the pre-hearing conference and simultaneously provide a copy to the Presiding Officer (provided the individual has complied with the confidentiality requirements in Article 7., Section C.3.a. below);
      3. any objections to witnesses and/or proposed documentary exhibits must be provided to the Presiding Officer and the parties at least five (5) days prior to the pre-hearing conference; and
      4. If a party desires to submit a Pre-Hearing Conference Statement, the Pre-Hearing Conference Statement must be submitted to the parties and Hearing Officer at least seven (7) days prior to the hearing.

3. **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 with the individual requesting a hearing 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. non-attorney client privileged reports of experts relied upon by the MEC, if any;

3. copies of relevant minutes (with portions regarding other physicians and unrelated matters deleted); and

4. copies of any other non-attorney client privileged documents relied upon by the MEC. The provision of this information is not intended to waive any peer review 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.

4. Pre-Hearing Conference:

a. The Presiding Officer shall require the individual or an individual's representative (who may be the individual's counsel) and the CMO, MEC representative and/or the MEC's counsel (who may be Hospital counsel) to participate in a pre-hearing conference, which shall be held no later than fourteen (14) days prior to the hearing. At the pre-hearing conference, the Presiding Officer shall resolve all procedural questions, including any objections to exhibits or witnesses.

b. It is expected that the hearing shall be conducted in an expeditious manner. 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. It is generally expected that the hearing shall last no more than two (2) days or sixteen (16) hours, with each side being afforded approximately seven (7) hours each to present its case, in terms of both direct and cross-examination of witnesses along with thirty (30) minutes each for opening and closing statements. The Presiding Officer may, after considering any objections, grant limited extensions upon a demonstration of good cause and to the extent compelled by fundamental fairness.

5. Stipulations:

The parties and their counsel, if applicable, shall use their best efforts to develop and agree upon stipulations, so as to provide for a more orderly and efficient hearing by narrowing the issues on which live testimony is reasonably required.

6. Provision of Information to the Hearing Panel:

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

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.

The Presiding Officer shall obtain the information above from the parties (or their counsel), and the Presiding Officer shall ensure the above documents are placed in a hearing binder and submitted to the Hearing Panel.

D. HEARING PROCEDURES

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.

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.

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 on any matter relevant to the issues;
   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, through the Presiding Officer, as part of the Post-Hearing Statement as described below.

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, and/or request documentary evidence.

4. 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.

5. Persons to Be Present:

The hearing shall be restricted to those individuals involved in the hearing, including the Presiding Officer, Hearing Panel, individual requesting the hearing, individual's representative (who may be counsel), CMO, MEC representative, MEC's counsel, witnesses and stenographer/court reporter. Any other individuals in attendance must be agreed upon by the parties or approved by the Presiding Officer. All in attendance at the hearing must agree to confidentiality provisions and be admonished that it is a peer review privileged proceeding.

6. 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. 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, regardless of the admissibility of such evidence in a court of law. The guiding principle shall be that the record contains information sufficient to allow the Hearing Panel to make a recommendation whether the individual demonstrates that he or she satisfies, on a continuing basis, all criteria for initial appointment, reappointment and clinical privileges.

8. **Post-Hearing Statement and Proposed Findings, Conclusions and Recommendations**

Each party shall have the right to submit a Post-Hearing Statement, which may include a summary of the party's position, proposed findings, conclusions and recommendations (for consideration by the Panel in rendering its recommendation). No new exhibits not otherwise presented at the hearing are permitted to be attached to the Post-Hearing Statement. A Post-Hearing Statement, if any, shall be submitted to the parties and Presiding Officer no later than fourteen (14) days following the court reporter's completion of the Hearing transcript. The Post-Hearing Statement by the parties, if any, shall be provided to the Hearing

Panel by the Presiding Officer.

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

E. HEARING CONCLUSION, DELIBERATIONS, AND RECOMMENDATIONS

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.

2. **Deliberations and Recommendation of the Hearing Panel:**
   Within twenty (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 a recommendation, accompanied by a report, which shall contain a concise statement of the basis for its recommendation.

3. **Disposition of Hearing Panel Report:**
   The Hearing Panel shall deliver its report to the CMO and the President of the Medical Staff. The CMO or the President of the Medical Staff shall send by special notice a copy of the report to the individual who requested the hearing. The CMO or the President of the Medical Staff shall also provide a copy of the Hearing Panel's report to the MEC.

F. APPEAL PROCEDURE

1. **Time for Appeal:**

   a. Within ten (10) days after notice of the Hearing Panel's recommendation contained in its report, either party may request an appeal. The request shall be in writing, delivered to the CMO 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 (10) 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.

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; and/or

   b. the recommendations of the Hearing Panel were made arbitrarily or capriciously or were not supported by credible evidence.

3. **Time, Place and Notice:**
   Whenever an appeal is requested as set forth in the preceding sections, the chair of the Board shall schedule and arrange for an appeal before the Review Panel. 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.

4. **Nature of Appellate Review:**

   a. The Board as a whole may serve as the Review Panel or the chair of the Board may appoint

a Review Panel, composed of at least three (3) members of the Board.

b. 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 (Appeal Statement). The party requesting the appeal shall submit an Appeal Statement first and the other party shall then have ten (10) days to respond and present its Appeal Statement.

c. In its sole discretion, the Review Panel may allow each party or its representative (who may be counsel) to appear personally before the Review Panel and make an oral argument not to exceed thirty (30) minutes by each side.

d. The Review Panel may consider the record upon which the recommendation was made, including the hearing transcripts and exhibits, pre-hearing statements, post-hearing statements, appeal 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. The Presiding Officer will provide the Review Panel with the record and facilitate providing any other information requested by the Review Panel.

e. The Presiding Officer may participate in the private deliberations of the Review Panel and be a legal advisor to it, but shall not be entitled to vote.

f. 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 back to the Review Panel, which shall thereupon, without further notice to the individual or a hearing, for the Review Panel to take final action.

G. BOARD ACTION

1. Final Decision of the Board:

a. The decision of the Board, acting, in its discretion, when no appeal has been requested or when an appeal has been requested and is it role as a 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 of the Board decision to the individual. A copy shall also be provided to the CMO and President of the Medical Staff.

The final decision of the Board or Review Panel shall be effective immediately and shall not be subject to further review.

2. Right to One Hearing and One Appeal Only:

No member of the Medical Staff shall be entitled to more than one (1) hearing and one (1) appellate review on any matter. If the Board denies initial appointment or reappointment or revokes the appointment and/or clinical privileges, that individual may not apply for appointment or for those clinical privileges for a period of five (5) years unless the Board provides otherwise.

ARTICLE 8
PROCEDURAL RIGHTS FOR ALLIED HEALTH

STAFF

The procedures in this Article 8 are only applicable to members of the Allied Health Staff and are **not** applicable to Dependent Practitioners. Notwithstanding the foregoing, see Article 4, Section E., above when the grant of privileges is coterminous with a Hospital Contract whereby such individual's Medical Staff appointment and/or Allied Health Staff appointment, and all clinical privileges, shall automatically and simultaneously terminate upon the effective date of the termination of the Hospital Contract, without any hearing and appeal rights.

A. PROCEDURAL RIGHTS FOR ADVANCED PRACTICE PROVIDERS

a. In the event that the MEC recommends that an Advanced Practice Provider (*i.e.*, Nurse Practitioner, Physician Assistant, Certified Registered Nurse Anesthetist, Anesthesiologist Assistant, Certified Nurse Midwife, Clinical Nurse Specialist) not be granted clinical privileges or that the clinical privileges previously granted be suspended for a period more than thirty (30) days, terminated or not renewed, the President of the Medical Staff or CMO shall give special notice of the recommendation to the affected Advanced Practice Provider. The notice shall state that the Advanced Practice Provider has a right to request a hearing under this Article 8., Section A.

b. If the Advanced Practice Provider wants to request a hearing, the request must be made in writing, directed to the President of the Medical Staff and CMO, within thirty (30) days after receipt of the notice of the adverse recommendation. The hearing will be convened as soon as practical, but no sooner than thirty (30) days after the CMO receives the Advance Practice Provider's request for a hearing, unless an earlier hearing date has been specifically agreed to by the parties. The Advance Practice Provider will be informed of the nature of the information supporting the adverse recommendation at least thirty (30) days prior to the hearing.

c. 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 Advanced Practice Provider; provided, however, the employment by, or other contractual arrangement with, the Hospital or any of its affiliates shall not preclude an individual from serving on the Hearing Committee, which employee or contracted staff shall not be deemed to be in direct economic competition with the affected Advanced Practice Provider.

d. The Advanced Practice Provider, and if their Collaborating Physician, shall both appear personally before the Hearing Committee.

e. The record of the hearing will be maintained by a stenographic reporter or by a recording (audio or video) of the proceedings.

f. The hearing will last no longer than three hours. The Advanced Practice Provider may present affidavits as evidence in support of his/her case.

g. Both the Advanced Practice Provider and the Hearing Committee 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.

h. At the hearing, the Advanced Practice Provider, and their Collaborating Physician, shall be provided with an opportunity to refute the recommendation and the reasons supporting it. The Advanced Practice Provider 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.

i. The Advanced Practice Provider will have the right to submit a memorandum, for consideration by the Hearing Committee, at the close of the hearing.

j. The Hearing Committee shall forward its recommendation, along with all supporting information, to the President of the Medical Staff and the CMO. The CMO shall give notice of the recommendation to the affected Advanced Practice Provider.

k. The Advanced Practice Provider shall have thirty (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 CMO and the President of the Medical Staff. If a written request for appeal is not submitted by the Advanced Practice Provider to the CMO within the 30-day time frame specified herein, the Hearing Committee's recommendation shall be forwarded by the CMO to the Board for final action. If a timely request for appeal is submitted by the Advanced Practice Provider, the CMO shall then forward the Hearing Committee's recommendation, supporting information and the request for consideration to a three-person appeal panel appointed by the CMO ("Appeal Panel"). In no event will the members of the Appeal Panel be practitioners in direct economic competition with the affected Advanced Practice Provider. Employment by, or other contractual arrangement with, the Hospital or any of its affiliates shall not preclude an individual from serving on the Appeal Panel.

l. 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 Advanced Practice Provider 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 Advanced Practice Provider and a representative of the MEC may also appear personally to discuss and/or present their position to the Appeal Panel. Both the Advanced Practice Provider and the MEC may be represented before the Appeal Panel by legal counsel; however, counsel may not present to the Appeal Panel.

m. 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 Committee for further clarification, with a written explanation of the need for the clarification; and in such situation, the Hearing Committee will report to the Appeal Panel in thirty (30) days.

n. The final recommendation of the Appeal Panel shall be forwarded by the CMO to the Board for final action. The final decision of the Board shall be effective immediately and shall not be subject to further review.

B. PROCEDURAL RIGHTS FOR ALL OTHER ALLIED HEALTH PRACITIONERS

a. In the event that a recommendation is made by the MEC or the Board that an Allied Health Practitioner (who is not otherwise covered under Article 8., Section A. above) not be granted clinical privileges or that a such clinical privileges previously granted be suspended for a period of more than thirty (30) days, terminated, or not renewed, the CMO shall provide the individual with special notice of the recommendation when first made by the MEC or Board. The notice shall include a general statement of the reasons for the recommendation and shall advise the individual that he or she may request a meeting with the MEC or the Board (including a subset thereof of no less than 3 members), depending on who first made the recommendation.

b. If a meeting is requested, the one meeting shall be scheduled following the recommendation to take place within a reasonable time frame. The meeting shall be informal and shall not be considered a hearing. The Collaborating Physician along with the Allied Health Practitioner shall be permitted to attend this meeting. However, no counsel shall be present.

c. Following this meeting, the Credentials Committee shall be informed as to matters discussed in the meeting and make its final recommendation to the MEC. Upon receipt of a recommendation from the MEC, the Board shall take final action. The final decision of the Board shall be effective immediately and shall not be subject to further review.

ARTICLE 9
CONFLICTS OF INTEREST

a. When performing a function outlined in this Policy, the Bylaws, the Organization Manual, the Rules and Regulations or related Medical Staff documents, 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 CMO) or the applicable Section chair or committee chair. The President of the Medical Staff or the applicable Section chair or committee Chair shall make a final determination as to whether the provisions in this Article should be triggered.

c. The fact that a Section chair 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 Section chair 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
AMENDMENTS

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

ARTICLE 11
ADOPTION

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

GLOSSARY

The following definitions apply to terms used in this Policy:

1. ALLIED HEALTH PRACTITIONERS (AHP): individuals other than Medical Staff members (i.e., physicians, dentists and podiatrists appointed to the Medical Staff) who are licensed or certified under state law and granted clinical privileges by the Board to provide patient care services. Allied Health Practitioners includes Advanced Practice Providers (see definition above). Dependent Practitioners (defined below) are not Allied Health Practitioners.
2. ADVANCED PRACTICE PROVIDERS (APP): refers to a sub-category of Allied Health Practitioners with additional knowledge and skill, who are licensed or certified under state law and granted clinical privileges by the Board to provide patient care services, such as a Nurse Practitioner, Physician Assistant, Certified Registered Nurse Anesthetist, Anesthesiologist Assistant, Certified Nurse Midwife, Clinical Nurse Specialist or Licensed Clinical Social Worker providing independent level of care within the Hospital's inpatient, observation or emergency department setting. The degree of independence of an APP depends upon an APP's scope of practice based on law and function in the Hospital with a Collaborating Physician(s).
3. ALLIED HEALTH STAFF: consists of Allied Health Practitioners who satisfy the qualifications and conditions for appointment and clinical privileges or scope of practice to the Allied Health Staff contained in this Policy. The Allied Health Staff is not a category of the Medical Staff, but is included in this Policy, Medical Staff Bylaws, and related Medical Staff documents for convenient reference. For ease of use, any reference in this Policy, Medical Staff Bylaws and related Medical Staff documents to "members" shall include Allied Health Practitioners unless specifically limited to members of the Medical Staff.
4. BOARD: means the governing body of the Hospital with the overall responsibility for the Hospital, including without limitation the appointment of and operation of the Medical Staff, through its committees and officers, responsible and accountable to the Board to monitor the quality of medical care in the Hospital, to make recommendations concerning appointment or reappointment of an applicant to the Medical Staff and Allied Health Staff, to provide a means to address issues, and to establish bylaws, policies, rules and regulations that govern actions of appointees to the Medical Staff and Allied Health Staff.
5. BOARD CERTIFICATION: 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 Foot and Ankle 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.
6. CHIEF MEDICAL OFFICER (CMO): the individual appointed by the Board to act as the CMO of the Hospital, in cooperation with the President of the Medical Staff; provided, further, any associate chief medical officer of Hospital shall have the same authority as the CMO hereunder in instances when the CMO is unavailable.
7. CLINICAL PRIVILEGES or PRIVILEGES: the authorization granted by the Board to render specific patient care services in the Hospital, for which the Medical Staff leaders and Board have developed eligibility and credentialing criteria, and for whom focused and ongoing professional practice evaluation standards apply.
8. COLLABORATING PHYSICIAN: means a member of the Medical Staff with appropriate clinical privileges granted by the Board who has agreed to collaborate with an Advanced Practice Provider whether pursuant to a Collaborative Practice Agreement, written practice protocol or by satisfying other requirements as may be required by law. The Collaborating Physician also means a member of the Medical Staff with clinical privileges granted by the Board, who has agreed in writing to supervise a Dependent Practitioner upon notice to the Medical Staff Office and to accept full responsibility for the Dependent Practitioner's actions while the Dependent Practitioner is practicing in the Hospital.

9. COMPLETED APPLICATION: 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 thirty (30) days after the applicant has been notified of the additional information required shall be deemed to be withdrawn.
10. CORE PRIVILEGES: a defined grouping of privileges for a specialty or subspecialty that includes the fundamental patient care services that are routinely taught in residency and/or fellowship training for that specialty or subspecialty and which have been determined by the Medical Staff leader and Board to require closely related skills and experiences.
11. CREDENTIALS POLICY: the Hospital's Medical Staff Credentials Policy (also referred to herein as the "Policy").
12. DAYS: calendar days.
13. DENTIST: a doctor of dental surgery (D.D.S.) or doctor of dental medicine (D.M.D.).
14. DEPENDENT PRACTITIONERS: means health care professionals who are permitted to practice in the Hospital only under the supervision of a Collaborating Physician appointed to the Medical Staff and who function pursuant to a defined scope of practice. The Collaborating Physician(s) is responsible for the actions of the Dependent Practitioner in the Hospital, and Dependent Practitioners are not granted clinical privileges by the Board. Dependent Practitioners are not members of the Allied Health Staff. The clinical practice of Dependent Practitioners in the Hospital shall be in accordance with separate policies and procedures managed by the Medical Staff Office, and the provisions of this Policy shall specifically **not** apply (except for Appendix A, Section 4., of this Policy). Area leaders within the Hospital where Dependent Practitioners are utilized shall work collaboratively with the Medical Staff Office and the Collaborating Physician to ensure the separate policies and procedures are followed. Examples of Dependent Practitioners following the separate pathway may include registered nurses (RNs), licensed practical nurses (LPNs), certified surgical technologists (CSTs), mental health counselors, dental assistants, pathologist assistants, and medical assistants. Dependent Practitioners are not afforded protections and due process rights.
15. HOSPITAL: Indiana University Health Fort Wayne Hospital.
16. MEDICAL STAFF all physicians, dentist, and podiatrist who have been appointed to the Medical Staff by the Board.
17. MEDICAL STAFF MEDICAL EXECUTIVE COMMITTEE (MEC): the Medical Executive Committee of the Medical Staff.
18. MEDICAL STAFF LEADER: any Medical Staff Officer, member of the MEC, Section Chair or Co-Chair, or committee chair.
19. MEMBER: any physician, dentist, or podiatrist 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.
20. NOTICE: communication by regular U.S. mail, e-mail, facsimile, hand delivery or Hospital mail.
21. PATIENT CONTACTS: includes any direct interaction between a physician and a patient in the hospital setting (including outpatient areas that are included in the hospital licensure) excluding any diagnostic outpatient orders and specifically including performance of History and Physicals, diagnosis treatment, and interpretation of diagnostic studies.
22. PEER REVIEW COMMITTEES: 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.

23. PHYSICIAN: includes both doctors of medicine (MD) and doctors of osteopathy (DO).
24. PODIATRIST: a doctor of podiatric medicine (DPM).
25. PRESIDENT: the individual appointed by the Board to act on its behalf in the overall management of Hospital.
26. 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.
27. 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.
28. RELATED MEDICAL STAFF DOCUMENTS: has the meaning set forth in the Medical Staff Bylaws, including the Medical Staff Organization Manual, the Credentials Policy, the Medical Staff Rules and Regulations, the Medical Staff application forms, and those Medical Staff and Hospital policies governing the relationship between members of the Medical Staff, Allied Health Staff and the Hospital.
29. SCOPE OF PRACTICE: those clinical activities that the individual is permitted to perform by law and authorization granted by the Board, which clinical activities and functions may be without supervision, or under the supervision of, or in collaboration with, a Collaborating Physician or other health care professional.
30. SPECIAL NOTICE: hand delivery, certified mail (return receipt requested), or overnight delivery service providing receipt.
31. SPECIAL PRIVILEGES: privileges that fall outside of the core privileges for a given specialty, which require additional education, training, and/or experience beyond that required for core privileges in order to demonstrate competence.

APPENDIX A

CONDITIONS OF PRACTICE APPLICABLE TO ALLIED HEALTH STAFF

1. **Role of Collaborating Physician**:

   a. The role of a Collaborating Physician rendering supervision to an Allied Health Practitioner will vary depending upon the applicable law and scope of practice of the APP.

   b. Advanced Practice Providers may function in the Hospital only so long as they have a Collaborating Physician, and they adhere to their applicable law and scope of practice, clinical privileges granted by the Board, and requirements of related Medical Staff documents. Likewise, a Collaborating Physician of the APP should be a member of the Medical Staff.

   c. Dependent Practitioners may function in the Hospital only so long as the have a Collaborating Physician (see Dependent Practitioner requirements in this Appendix A., Section 4. below).

   d. If the Medical Staff appointment or clinical privileges of a Collaborating Physician are resigned, revoked or terminated, or the Advanced Practice Provider fails, for any reason, to maintain an appropriate collaborating relationship with a Collaborating Physician as required by law and related Medical Staff documents , then such Advanced Practice Provider's clinical privileges or scope of practice will be automatically relinquished until another Collaborating Physician is simultaneously approved as part of the credentialing process, without right to hearing or appeal.

   e. As a condition of clinical privileges or scope of practice, an Advanced Practice Provider and his or her Collaborating 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 Medical Staff Office within three (3) days of any such change.

2. **Questions Regarding the Authority of Allied Health Practitioners:**

   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 Allied Health Practitioner will have the right to request that the Collaborating Physician validate such authority, either at the time or later. Any act or the instructions of the Allied Health Practitioner may 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 Allied Health Practitioner may be reported to the President of the Medical Staff, the Credentials Committee Chair, the relevant Section chair, or the CMO for appropriate action. The individual(s) to whom the concern has been reported should attempt to discuss the matter with the Collaborating Physician to the extent practical under the circumstances.

3. **Responsibilities of Collaborating Physicians**:

   a. Physicians who wish to serve as a Collaborating Physician at the Hospital must notify the Medical Staff Office of this fact in advance and must ensure that the individual has been appropriately credentialed, or scope of practice approved in accordance with this Policy and any other polices adopted by the Hospital.

   b. The number of Allied Health Practitioners for which a Collaborating Physician may serve will be consistent with applicable law and any other policies adopted by the Hospital. The Collaborating Physician will make all appropriate filings with the state regarding the supervision and responsibilities, to the extent that such filings are required.

4. **Responsibilities of Collaborating Physician in Oversight of Dependent Practitioners (not Allied Health Staff members)**

a. Dependent Practitioners are not granted clinical privileges by the Board, are not members of the Allied Health Staff, and are not managed by the CVO in conjunction with the Medical Staff. All Dependent Practitioners must follow separate policies and procedures managed by the Medical Staff Office to function within the Hospital and only so long as they have a Collaborating Physician as described under this Policy.

b. Any activities permitted to be performed at the Hospital by a Dependent Practitioner shall be performed only under the oversight of the Collaborating Physician.

c. A Collaborating Physician who will be supervising or using the services of a Dependent Practitioner in their clinical practice at the Hospital must notify the Medical Staff Office in writing of this fact in advance and must ensure that the Dependent Practitioner has followed the relevant process before the Dependent Practitioner participates in any clinical or direct patient care of any kind in the Hospital.

d. If the Medical Staff appointment or clinical privileges of a Collaborating Physician is resigned, revoked, suspended or terminated, or the Dependent Practitioner fails, for any reason, to maintain an appropriate supervision relationship with a Collaborating Physician as defined in this Policy, the Dependent Practitioner shall automatically cease performance of patient care at the Hospital, unless another Collaborating Physician is approved as part of the credentialing process.

e. As a condition to practice, the Dependent Practitioner may only practice within their scope of practice under the oversight of the Collaborating Physician, and the Collaborating Physician must provide the Hospital with written notice of any revisions or modifications made to the agreement between them. This notice must be provided to the Chief Medical Officer within three (3) days of any such change.

f. Should any member of the Medical Staff, Allied Health 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 a Dependent Practitioner to act or issue instructions outside the presence of the Collaborating Physician, such individual will have the right to request that the Collaborating Physician validate, either at the time or later, the instructions of the Dependent Practitioner. Any act or instruction of the Dependent Practitioner will be delayed until such time as the individual with the question has ascertained that the act is clearly within the scope of the Dependent Practitioner.

g. Any question raised about the conduct of a Dependent Practitioner will be reported to Medical Staff Office and CMO for appropriate action. The individual(s) to whom the concern has been reported will also discuss the matter with the Collaborating Physician.

h. The number of Dependent Practitioners acting under the supervision of one Collaborating Physician, as well as the care they may provide, will be consistent with applicable state statutes and regulations and any other policies adopted by the Hospital. The Collaborating Physician will make all appropriate filings with the state regarding the supervision and responsibilities of the Dependent Practitioner, to the extent that such filings are required.

i. It will be the responsibility of the Collaborating Physician to provide, or to arrange for, professional liability insurance coverage for the Dependent Practitioner in such amounts required by the Board. The insurance must cover any and all activities of the Dependent Practitioner in the Hospital. The Collaborating Physician will furnish evidence of such insurance coverage to the Hospital. The 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

1. **Review of Need**:

   a. Whenever an individual in a category of Allied Health Practitioner that has not been approved by the Board requests to practice at the Hospital, the Board shall refer the matter to the Credentials Committee to evaluate the need for that particular category of practitioner and make a recommendation to the MEC for its review and recommendation and then to the Board for final action.

   b. As part of the process of determining need, the individual requesting permission to practice at the Hospital shall be invited to submit information about the nature of the proposed practice, why Hospital access is sought, and the potential benefits to the community by having such services available at the Hospital.

   c. Credentials Committee will review any information submitted by the individual and consider the following factors:

      1. the nature of the services that would be offered;
      2. any state license or regulation which outlines the scope of practice that the individual is authorized by law to perform;
      3. any state "non-discrimination" or "any willing provider" laws that would apply to individual;
      4. the business and 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 individual 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.

   d. The Credentials Committee will then forward its recommendation on whether there is a need for the particular category of Allied Health Practitioner at the Hospital to the MEC, which will review the matter and forward its recommendation to the Board for final action.

2. **Additional Recommendations**:

   a. If the Credentials Committee makes a recommendation that there is a need for the particular category of Allied Health Staff 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 Section

chairs and consider relevant Indiana law and may contact professional societies or associations. The Credentials Committee may also recommend the number of Allied Health Staff that are needed.

APPENDIX C
ALLIED HEALTH STAFF
and Non-Allied Health Staff

The following are examples of potential members of the Allied Health Staff:

Anesthesiology Assistant (AA)
Certified Registered Nurse Anesthetist (CRNA)
Clinical Nurse Specialist (CNS)
Moonlighting Residents/Fellows
Nurse Practitioner (NP)
Optometrist
Physician Assistant (PA)
Psychologist
Registered Radiology Assistants (RRA)

The following are examples of **Dependent Practitioners** who are **not** members of the Allied Health Staff, **not** granted clinical privileges by the Board and follow procedures set forth in Appendix A, Section 4. above**:**

Certified Surgical Technologist (CST)
Certified Surgical First Assistant (CSFA)
Dental Assistant (DA)
Licensed Mental Health Counselors (LMHC)
Licensed Practical Nurse (LPN)
Medical Assistant (MA)
Registered Nurse First Assistant (RNFA)
Registered Nurse (RN)