

**MEDICAL STAFF BYLAWS, POLICIES, AND  
RULES & REGULATIONS OF  
INDIANA UNIVERSITY HEALTH  
BALL MEMORIAL HOSPITAL**

**MEDICAL STAFF  
CREDENTIALS POLICY**

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## **ARTICLE 1**

### **GENERAL**

#### **1.A. PREAMBLE**

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

#### **1.B. ALLIED HEALTH PRACTITIONERS**

Allied Health Practitioners who seek permission to practice at the Hospital shall be subject to the same terms and conditions of appointment and reappointment as specified for members of the Medical Staff. 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. For ease of use, when applicable to an Allied Health Practitioners, any reference in this Policy to “appointment” or “reappointment” shall be interpreted as a reference to initial or continued permission to practice.

#### **1.C. TIME LIMITS**

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

#### **1.D. DELEGATION OF FUNCTIONS**

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

#### **1.E. CONFIDENTIALITY AND PEER REVIEW PROTECTION**

##### **1.E.1. Confidentiality**

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

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

Any breach of confidentiality may result in appropriate sanctions.

##### **1.E.2. Peer Review Protection**

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

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

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

**1.F. INDEMNIFICATION**

The Hospital shall provide a legal defense for, and shall indemnify, all Medical Staff leaders, peer review committees, members, and authorized representatives when engaged in professional review activity, to the fullest extent permitted by law, in accordance with the Hospital's Bylaws.

## ARTICLE 2

### **QUALIFICATIONS, CONDITIONS, AND RESPONSIBILITIES**

#### **2.A. QUALIFICATIONS**

##### **2.A.1. Threshold Eligibility Criteria**

To be eligible to apply for initial appointment or reappointment to the Medical Staff or Allied Health Staff, or for the grant of clinical privileges or a scope of practice, the applicant must, as applicable:

- (a) have a current, unrestricted license to practice in this state and have never had a license to practice revoked, restricted or suspended by any state licensing agency;
- (b) have a current, unrestricted DEA registration and state controlled substance license;
- (c) be located (office and residence) within the geographic service area of the Hospital, as defined by the Board, close enough to fulfill their Medical Staff responsibilities and to provide timely and continuous care for their patients in the Hospital;
- (d) have current, valid professional liability insurance coverage in a form and in amounts satisfactory to the Hospital;
- (e) have never been convicted of Medicare, Medicaid, or other federal or state governmental or private third-party payer fraud or program abuse, nor have been required to pay civil monetary penalties for the same;
- (f) have never been, and not currently be, excluded or precluded from participation in Medicare, Medicaid, or other federal or state governmental health care program;
- (g) have never had Medical Staff appointment, permission to practice, clinical privileges, scope of practice, or status as a participating provider denied, revoked, or terminated by any health care facility or health plan for reasons related to clinical competence or professional conduct;
- (h) have never resigned Medical Staff appointment or permission to practice or relinquished privileges or a scope of practice during a Medical Staff investigation or in exchange for not conducting such an investigation;
- (i) have not been convicted of, or entered a plea of guilty or no contest, to any felony; or to any misdemeanor relating to controlled substances, illegal drugs, insurance or health care fraud or abuse, or violence;
- (j) demonstrate recent clinical activity in their primary area of practice during at least two of the last four years;
- (k) if seeking to practice as an Advanced Dependent Practitioner or Dependent Practitioner, have a written agreement with a Supervising Physician, which agreement must meet all applicable requirements of state law and Medical Staff policy;
- (l) have successfully completed a residency training program approved by the Accreditation Council for Graduate Medical Education or the AOA in the specialty in which the applicant seeks clinical privileges, or an oral and maxillofacial surgery training program accredited by the Commission on Dental Accreditation of the American Dental Association (“ADA”), or a podiatric

- surgical residency program accredited by the Council on Podiatric Medical Education of the American Podiatric Medical Association;
- (m) be board certified in their primary area of practice at the Hospital by the appropriate specialty/subspecialty board of the American Board of Medical Specialties (“ABMS”), the AOA, the American Board of Oral and Maxillofacial Surgery, the ADA, or the American Board of Podiatric Surgery, as applicable. (The approved boards for certification for members of the Allied Health Staff are included in Appendix D.) Applicants who are not board certified at the time of application but who have completed their residency or fellowship training within the last five years shall be eligible for Medical Staff appointment. However, in order to remain eligible, applicants must achieve board certification in their primary area of practice within five years from the date of completion of their residency or fellowship training;
  - (n) maintain board certification and, to the extent required by the applicable specialty/subspecialty board, demonstrate ongoing maintenance of certification requirements. Maintenance certification shall be assessed at reappointment; and
  - (o) receive and maintain board certification in another country that may be considered equivalent to the American boards (e.g., United Kingdom or Canada), which exception shall be evaluated on a case-by-case basis.

The requirements in (l) and (m) shall be applicable only to those individuals who applied for initial staff appointment on or after January 1, 2005 and shall thereafter apply to those individuals at reappointment. The requirements in (n) and (o) shall be applicable only to those individuals who applied for initial staff appointment on or after November 20, 2013 and shall thereafter apply to those individuals at reappointment. All members appointed prior to these dates shall be governed by the residency training, board certification, and board maintenance certification requirements in effect at the time of their initial appointment.

For non-certified members of the Medical Staff who have been “grandfathered” under the board certification and recertification requirements in effect at the time of their initial appointment and those members who are non-certified who have been granted a waiver of the board certification and recertification requirements, the CME requirement will be 75 Category I AMA approved CME hours for each reappointment cycle.

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

- (a) Waivers of threshold eligibility criteria shall not be granted routinely. No one is entitled to a waiver. An application from an applicant who does not meet the threshold criteria for appointment, reappointment, clinical privileges, or scope of practice shall not be processed unless the Board has granted the requested waiver.
- (b) A request for a waiver shall only be considered if the applicant provides information sufficient to demonstrate that his or her qualifications are equivalent to, or exceed, the criterion in question and that there are exceptional circumstances that warrant a waiver.
- (c) The Credentials Committee may consider supporting documentation submitted by the applicant, any relevant information from third parties, input from the relevant department chair, and the best interests of the Hospital and the communities it



serves. The Credentials Committee shall forward its recommendation, including the basis for such, to the Executive Committee.

- (d) The Executive Committee shall review the recommendation of the Credentials Committee and make a recommendation to the Board regarding whether to grant or deny the request for a waiver and the basis for its recommendation.
- (e) The Board's determination regarding whether to grant a waiver is final. A determination not to grant a waiver is not a "denial" of appointment, reappointment, clinical privileges, or scope of practice and the applicant who requested the waiver is not entitled to a hearing. A determination to grant a waiver in a particular case is not intended to set a precedent. A determination to grant a waiver does not mean that appointment, reappointment, clinical privileges, or scope of practice shall be granted, only that processing of the application can begin.

### 2.A.3. Factors for Evaluation

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

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

### 2.A.4. No Entitlement to Appointment

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

- (a) is employed by the Hospital or its subsidiaries 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 a member of any particular professional organization;

- (e) has had in the past, or currently has, Medical Staff or Allied Health Staff appointment, clinical privileges, or scope of practice at any hospital or health care facility;
- (f) resides in the geographic service area of the Hospital; or
- (g) is affiliated with, or under contract to, any managed care plan, insurance plan, HMO, PPO, or other entity.

#### 2.A.5. Nondiscrimination

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

### 2.B. GENERAL CONDITIONS OF APPOINTMENT AND REAPPOINTMENT

#### 2.B.1. Basic Responsibilities and Requirements

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

- (b) In addition to the above, every individual seeking to practice as an Advanced Dependent Practitioner or Dependent Practitioner and his or her respective Supervising Physician specifically agree that:
- (1) any privileges or scope of practice granted by the Board to any Allied Health Practitioner who is an Advanced Dependent Practitioner or Dependent Practitioner will be performed in the Hospital only under the supervision of a Supervising Physician;
  - (2) the number of Advanced Dependent Practitioners or Dependent Practitioners employed by or under the supervision of a Member of the Medical Staff will be consistent with state law and the rules and regulations of the Medical Staff; and
  - (3) an Advanced Dependent Practitioner or Dependent Practitioner will give notice, within three days, to the CMO of any revisions or modifications that are made to the supervision agreement.

Additional supervision requirements are set forth in Appendix A.

### 2.B.2. FPPE to Confirm Competence

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 applicable professional practice evaluation policy.

### 2.B.3. 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 an appropriate assessment of overall qualifications for appointment, reappointment, and current clinical competence for any requested clinical privileges or scope of practice, 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 receipt of confidential evaluation forms completed by referring/referred to physicians.
- (b) Individuals seeking appointment or 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, 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 during the credentialing process. Any application that continues to be incomplete 30 days after the individual has been notified of the additional information required shall be deemed to be withdrawn.

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

## 2.C. APPLICATION

### 2.C.1. Information

- (a) Applications for appointment and reappointment shall contain a request for specific clinical privileges or scope of practice and shall require detailed information concerning the individual's professional qualifications. The applicant shall sign the application and certify that he or she is able to perform the privileges or scope of practice requested and the responsibilities of appointment.
- (b) The applications for initial appointment and reappointment will be managed by the Credentials Verification Office ("CVO") in conjunction with Physician Support Services.

### 2.C.2. Misstatements and Omissions

- (a) Any misstatement in, or omission from, the application is grounds to stop processing the application. The individual seeking appointment or reappointment shall be informed in writing of the nature of the misstatement or omission and permitted to provide a written response. The Chairman of the Medical Staff and CMO 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 or scope of practice may be deemed to be automatically relinquished pursuant to Section 6.E.3.
- (c) No action taken pursuant to this section shall entitle the individual to a hearing or appeal.

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

By requesting an application and/or applying for appointment, reappointment, clinical privileges, or scope of practice, the individual expressly accepts the conditions set forth in this Section:

- (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 System, 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, scope of practice, or the individual's qualifications for the same. This immunity covers

any actions, recommendations, reports, statements, communications, and/or disclosures involving the individual that are made, taken, or received by the Hospital, its authorized representatives, or third parties in the course of credentialing and peer review activities.

(b) Authorization to Obtain Information from Third Parties:

The individual specifically authorizes IU Health System, 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 individual'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, 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 agrees to sign necessary consent forms to permit a consumer reporting agency to conduct a criminal background check on the individual 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 other hospitals, health care facilities, managed care organizations, government regulatory and licensure boards or agencies, and their representatives when information is requested in order to evaluate his or her qualifications.

(d) Hearing and Appeal Procedures:

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

(e) Legal Actions:

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

(f) Authorization to Share Information within the System:

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

(g) Scope of Section:

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

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

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

## ARTICLE 3

### **PROCEDURE FOR INITIAL APPOINTMENT, CLINICAL PRIVILEGES, AND SCOPE OF PRACTICE**

#### **3.A. PROCEDURE FOR INITIAL APPOINTMENT, CLINICAL PRIVILEGES, & SCOPE OF PRACTICE**

##### **3.A.1. Application**

- (a) Applications for appointment and clinical privileges or scope of practice shall be provided by the CVO or Physician Support Services and shall be approved by the Board, upon recommendation by the Executive Committee.
- (b) Applications may be provided to residents or fellows who are in the final six months of their training. Such applications may be processed, but final action shall not be taken until all applicable threshold eligibility criteria are satisfied.
- (c) An Allied Health Practitioner who is in a category of practitioners that has not been approved by the Board to practice at the Hospital shall be ineligible to receive an application. A determination of ineligibility does not entitle an Allied Health Practitioner to the procedural rights set forth in this Policy. Guidelines for determining the need for new categories of Allied Health Practitioners appear in Appendix B.

##### **3.A.2. Initial Review of Application**

- (a) A completed application form with copies of all required documents must be returned to the CVO within 30 days after receipt. The application must be accompanied by the application fee.
- (b) As a preliminary step, the application shall be reviewed by the CVO (and the CMO if necessary) to determine that all questions have been answered and that the individual satisfies all threshold eligibility criteria. Incomplete applications shall not be processed. Individuals 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 outlined in this Policy.
- (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 department chair at other health care entities, residency training director, and others who may have knowledge about the applicant's education, training, experience, and ability to work with others.
- (e) The names of applicants shall be posted so that members of the Medical Staff may submit, in writing, information bearing on the applicant's qualifications for appointment, clinical privileges, or scope of practice.

- (f) An interview(s) with the applicant will be conducted by a Medical Staff leader or designee, in combination with any of the following: the department chair, the Credentials Committee, a Credentials Committee representative, the Executive Committee, the Chairman of the Medical Staff or the CMO.

### 3.A.3. Department Chair Procedure

- (a) Physician Support Services shall transmit the complete application and all supporting materials to the chair of each department in which the applicant seeks clinical privileges or scope of practice. The department chair shall prepare a written report regarding whether the applicant has satisfied all of the qualifications for appointment and the clinical privileges or scope of practice requested on a form provided by the CVO or Physician Support Services.
- (b) The department chair shall be available to the Credentials Committee, the Executive Committee, and the Board to answer any questions that may be raised with respect to the report and findings of that individual.

### 3.A.4. Credentials Committee Procedure

- (a) The Credentials Committee shall review and consider the report prepared by the department chair and shall make a recommendation.
- (b) The Credentials Committee may use the expertise of the department chair, or any member of the department, or an outside consultant, if additional information is required regarding the applicant's qualifications.
- (c) After determining that an applicant is otherwise qualified for appointment and privileges or scope of practice, 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 or scope of practice requested and the responsibilities of appointment. If so, the Credentials Committee may require the applicant to 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 being requested to do so in writing by the Credentials Committee shall be considered a voluntary withdrawal of the application and all processing of the application shall cease.
- (d) The Credentials Committee may recommend the imposition of specific conditions. These conditions may relate to behavior (e.g., personal code of conduct) or to clinical issues (e.g., general consultation requirements, appropriate documentation requirements, proctoring, completion of CME requirements). The Credentials Committee may also recommend that appointment be granted for a period of less than two years in order to permit closer monitoring of an individual's compliance with any conditions. Unless these matters involve the specific recommendations set forth in Section 7.A.1(a) of this Policy, such conditions do not entitle an individual to request the procedural rights set forth in Article 7 of this Policy.
- (e) If the recommendation of the Credentials Committee on a completed application is delayed longer than 60 days, the chairman of the Credentials Committee shall



send a letter to the applicant, with a copy to the CMO explaining the reasons for the delay.

### 3.A.5. Executive Committee Recommendation

- (a) At its next regular meeting after receipt of the written report and recommendation of the Credentials Committee, the Executive Committee 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 Executive Committee is to appoint, the recommendation shall be forwarded to the Board.
- (c) If the recommendation of the Executive Committee would entitle the applicant to request a hearing in accordance with Section 7.A.1(a) of this Policy, the Executive Committee shall forward its recommendation to the CMO, who shall (i) promptly send special notice to the applicant, and (ii) then hold the application until after the applicant has completed or waived a hearing and appeal.

### 3.A.6. Board Action

- (a) The Board may delegate to a committee, consisting of at least two Board members, action on appointment, reappointment, clinical privileges, and scope of practice if there has been a favorable recommendation from the Credentials Committee and the Executive Committee and there is no evidence of any of the following:
  - (1) a current or previously successful challenge to any license or registration;
  - (2) an involuntary termination, limitation, reduction, denial, or loss of appointment, clinical privileges, or scope of practice at any other hospital or other entity; or
  - (3) an unusual pattern of, or an excessive number of, professional liability actions resulting in a final judgment against the applicant.Any decision reached by the Board Committee to appoint shall be effective immediately and shall be forwarded to the Board for ratification at its next meeting.
- (b) When there has been no delegation to the Board Committee, upon receipt of a recommendation that the applicant be granted appointment and clinical privileges or scope of practice, the Board may:
  - (1) appoint the applicant and grant clinical privileges or scope of practice as recommended; or
  - (2) refer the matter back to the Credentials Committee or Executive Committee or to another source inside or outside the Hospital for additional research or information; or
  - (3) reject or modify the recommendation.

- (c) If the Board makes a determination to reject a favorable recommendation, it should first discuss the matter with the chairman of the Credentials Committee and the chairman of the Executive Committee. If the Board's determination remains unfavorable to the applicant, the CMO shall promptly send special notice to the applicant that he or she is entitled to request a hearing.
- (d) Any final decision by the Board to grant, deny, revise, or revoke appointment, clinical privileges, or scope of practice will be disseminated to appropriate individuals and, as required, reported to appropriate entities.

3.A.7. Time Periods for Processing

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

## ARTICLE 4

### CLINICAL PRIVILEGES

#### 4.A. CLINICAL PRIVILEGES

##### 4.A.1. General

- (a) Appointment or reappointment shall not confer any clinical privileges or right to admit or treat patients at the Hospital. Only those clinical privileges granted by the Board may be exercised.
- (b) A request for privileges shall be processed only when an applicant satisfies any applicable threshold eligibility criteria.
- (c) Requests for clinical privileges that have been grouped into core privileges will not be processed unless the individual has applied for the full core and satisfied all threshold eligibility criteria (or has obtained a waiver in accordance with Section 4.A.2).
- (d) Recommendations for clinical privileges shall be based on consideration of the following:
  - (1) education, relevant training, experience, and demonstrated current competence, including medical/clinical knowledge, technical and clinical skills, clinical 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;
  - (11) morbidity and mortality data related to the specific individual, and when statistically and qualitatively significant and meaningful, when available; and
  - (12) professional liability actions, especially any such actions that reflect an unusual pattern or number of actions.

- (e) The applicant has the burden of establishing his or her qualifications and current competence for all clinical privileges requested.
- (f) The report of the chair of the clinical department in which privileges are sought shall be forwarded to the Chair of the Credentials Committee and processed as a part of the initial application for staff appointment.

#### 4.A.2. Privilege Modifications and Waivers

- (a) Scope: This Section applies to all requests for modification of clinical privileges during the term of appointment (increases and relinquishments), resignation from the Medical Staff, and waivers of eligibility criteria for privileges.
- (b) Submitting a Request: Requests for privilege modifications and waivers must be submitted in writing to Physician Support Services.
- (c) 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 an application for initial clinical privileges.
- (d) Waivers:
  - (1) Any individual who does not satisfy one or more eligibility criteria for clinical privileges may request that it be waived. The individual requesting the waiver bears the burden of demonstrating exceptional circumstances, and that his or her qualifications are equivalent to, or exceed, the criterion in question.
  - (2) If the individual is requesting a waiver of the requirement that each member apply for the full core of privileges in his or her specialty, the request must indicate the specific patient care services within the core that the member does not wish to provide, state a good cause basis for the request, and include evidence that the individual does not provide the patient care services at issue in any health care facility.
  - (3) By applying for a waiver related to limiting the scope of core 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, upon assessment, a patient needs a service that is no longer provided by the individual pursuant to the waiver, the individual shall work cooperatively with the other physicians 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.
  - (4) Requests for waivers in this Section will be processed in the same manner as requests for waivers of appointment criteria, as described in

Section 2.A.2 of this Policy, and will consider the factors outlined in Paragraph (f) below.

- (e) Relinquishment and Resignation of Privileges:
- (1) Relinquishment of Individual Privileges: A request to relinquish any individual clinical privilege, whether or not part of the core, must provide a good cause basis for the modification of privileges. All such requests will be processed in the same manner as a request for waiver, as described above.
  - (2) Resignation of Appointment and Privilege: A request to resign Medical Staff appointment and relinquish all clinical privileges must specify the desired date of resignation, which must be at least 30 days from the date of the request, and be accompanied by evidence that the individual:
    - (i) has completed all medical records;
    - (ii) will be able to appropriately discharge or transfer responsibility for the care of any hospitalized patient who is under the individual's care at the time of resignation; and
    - (iii) has completed scheduled emergency service call or has arranged appropriate coverage to satisfy this responsibility.After consulting with the Chairman of the Medical Staff, the CMO (or his or her designee) will act on the resignation request and report the matter to the Executive Committee.
- (f) Factors for Consideration: The Medical Staff Leaders and Board may consider the following factors, among others, when deciding whether to recommend or grant a modification (increases and/or relinquishments) or waiver related to privileges:
- (1) the Hospital's mission and ability to serve the health care needs of the community by providing timely, appropriate care within its facilities;
  - (2) whether sufficient notice has been given to provide a smooth transition of patient care services;
  - (3) fairness to the individual requesting the modification or waiver, including past service and the other demands placed upon the individual;
  - (4) fairness to other Medical Staff members who serve on the call roster in the relevant specialty, including the effect that the modification would have on them;
  - (5) the expectations of other members of the Medical Staff who are in different specialties but who rely on the specialty in question in the care of patients who present to the Hospital;
  - (6) any perceived inequities in modifications or waivers being provided to some, but not others;
  - (7) any gaps in call coverage that might/would result from an individual's removal from the call roster for the relevant privilege and the feasibility and safety of transferring patients to other facilities in that situation; and

- (8) how the request may affect the Hospital's ability to comply with applicable regulatory requirements, including the Emergency Medical Treatment and Active Labor Act.
- (g) Effective Date: If the Board grants a modification or waiver related to privileges, it shall specify the date that the modification or waiver will be effective. Failure of a member to request privilege modifications or waivers in accordance with this section shall, as applicable, result in the member retaining Medical Staff appointment and clinical privileges and all associated responsibilities.
- (h) Procedural Rights: No individual is entitled to a modification or waiver related to privileges. Individuals are also not entitled to a hearing or appeal or other process if a waiver or a modification related to a relinquishment of privileges is not granted.

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

- (a) Requests for clinical privileges to perform either a procedure not currently being performed at the Hospital or a new technique to perform an existing procedure (hereafter "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) As an initial step in the process, the individual seeking to perform the new procedure shall prepare and submit a report to the Credentials Committee addressing the following:
  - (1) minimum education, training, and experience necessary to perform the new procedure safely and competently;
  - (2) clinical indications for when the new procedure is appropriate;
  - (3) whether there is empirical evidence of improved patient outcomes with the new procedure or other clinical benefits to patients;
  - (4) whether proficiency for the new procedure is volume-sensitive and if the requisite volume would be available;
  - (5) whether the new procedure is being performed at other similar hospitals and the experiences of those institutions; and
  - (6) whether the Hospital currently has the resources, including space, equipment, personnel, and other support services, to safely and effectively perform the new procedure.

The Credentials Committee shall review this report, conduct additional research as necessary, and make a preliminary recommendation as to whether the new procedure should be offered to the community.
- (c) If the preliminary recommendation is favorable, the applicable department chair and/or Credentials Committee shall then develop threshold credentialing criteria, subject to Credentials Committee approval, to determine those individuals who are eligible to request the clinical privileges at the Hospital. In developing the criteria, the department chair and the Credentials Committee may conduct additional research and consult with experts, as necessary, and develop recommendations regarding:

- (1) the minimum education, training, and experience necessary to perform the procedure or service;
  - (2) the clinical indications for when the procedure or service is appropriate;
  - (3) the extent (time frame and mechanism) of focused monitoring and supervision that should occur if the privileges are granted; and
  - (4) the manner in which the procedure would be reviewed as part of the Hospital's ongoing and focused professional practice evaluation activities.
- (d) The Credentials Committee shall forward its recommendations to the Executive Committee, which shall review the matter and forward its recommendations to the Board for final action.
- (e) The Board will make a reasonable effort to render the final decision within 60 days of receipt of the Executive Committee's recommendation. If the Board determines to offer the procedure or service, it will then establish the minimum threshold qualifications that an individual must demonstrate in order to be eligible to request the clinical privileges in question.
- (f) Once the foregoing steps are completed, specific requests from eligible Medical Staff members who wish to perform the procedure or service may be processed.

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

- (a) Requests for clinical privileges that previously have been exercised only by individuals from another specialty shall not be processed until the steps outlined in this Section have been completed and a determination has been made regarding the individual's eligibility to request the clinical privileges in question.
- (b) As an initial step in the process, the individual seeking the privilege shall prepare and 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.
- (c) The Credentials Committee shall then conduct additional research and consult with experts, as necessary, including those on the Medical Staff (e.g., department chairs, individuals on the Medical Staff with special interest and/or expertise) and those outside the Hospital (e.g., other hospitals, residency training programs, specialty societies).
- (d) 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 minimum 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) of focused monitoring and supervision that should occur if the privileges are granted;

- (5) the manner in which the procedure 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.
- (e) The Credentials Committee shall forward its recommendations to the Executive Committee, which shall review the matter and forward its recommendations to the Board for final action. The Board shall make a reasonable effort to render the final decision within 60 days of receipt of the Executive Committee's recommendation.
- (f) Once the foregoing steps are completed, specific requests from eligible Medical Staff members who wish to exercise the privileges in question may be processed.

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

- (a) For any patient who meets the classification of ASA 1 (normal, healthy patients) or ASA 2 (patients with mild systemic disease with no functional limitations), dentists and oral and maxillofacial surgeons may admit such patients, perform a complete admission history and physical examination, and assess the medical risks of any surgical procedure to be performed or the medical management of the patient's condition, if they are deemed qualified to do so by the Credentials Committee and Executive Committee. They must, nevertheless, have a relationship with a physician on the Medical Staff (established and declared in advance) relevant to a particular patient's underlying condition who is available to respond and become involved with that individual's care should any medical issue arise with the patient.
- (b) For any patient who meets ASA 3 (patient with severe systemic disease) or ASA 4 (patient with incapacitating systemic disease that is a constant threat to life) classifications, a medical history and physical examination of the patient shall be made and recorded by a physician who is a member of the Medical Staff before dental or oral surgery may be performed. In addition, a designated physician shall be responsible for the medical care of the patient throughout the period of hospitalization.
- (c) The dentist or oral and maxillofacial surgeon shall be responsible for the oral surgery care of the patient, including the appropriate history and physical examination, as well as all other appropriate elements of the patient's record and will remain available to the patient and care team throughout the patient stay as needed. Dentists and oral and maxillofacial surgeons may write orders within the scope of their licenses and consistent with relevant Hospital policies and rules and regulations.

#### 4.A.6. Clinical Privileges for Podiatrists

- (a) For any patient who meets the classification of ASA 1 (normal, healthy patients) or ASA 2 (patients with mild systemic disease with no functional limitations), podiatrists may perform a complete admission history and physical examination,



and assess the medical risks of any surgical procedure to be performed or the medical management of the patient’s condition, if they are deemed qualified to do so by the Credentials Committee and Executive Committee. They must, nevertheless, have a relationship with a physician on the Medical Staff (established and declared in advance) relevant to a particular patient’s underlying condition who is available to respond and become involved with that individual’s care should any medical issue arise with the patient.

- (b) For any patient who meets ASA 3 (patient with severe systemic disease) or ASA 4 (patient with incapacitating systemic disease that is a constant threat to life) classifications, a medical history and physical examination of the patient shall be made and recorded by a physician who is a member of the Medical Staff before podiatric surgery shall be performed. In addition, a designated physician shall be responsible for the medical care of the patient throughout the period of hospitalization.
- (c) The podiatrist shall be responsible for the podiatric care of the patient, including the podiatric history and the podiatric physical examination, as well as all appropriate elements of the patient’s record and will remain available to the patient and care team through the patient stay as needed. Podiatrists may write orders which are within the scope of their license and consistent with relevant Hospital policies and rules and regulations.

#### 4.A.7. Physicians in Training

- (a) Physicians in training shall not hold appointments to the Medical Staff and shall not be granted specific 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 Executive Committee or its designee, and the Graduate Medical Education Committee of the Hospital. The applicable program director shall be responsible for verifying and evaluating the qualifications of each physician in training.
- (b) A physician in training wishing to “moonlight” in the Emergency Department, ~~or~~ as a Hospitalist, or in Psychiatry may submit an application for appropriate clinical privileges beyond the scope of his or her residency and which may be exercised outside of the supervision requirements of his or her training program.

#### 4.A.8. Telemedicine Privileges

- (a) A qualified individual may be granted telemedicine privileges – regardless of whether the individual is appointed to the Medical Staff – whenever local coverage is not available.
- (b) Requests for initial or renewed telemedicine privileges shall be processed through one of the following options, as determined by the CMO (or his or her designee) in consultation with the Chairman of the Medical Staff:

- (1) A request for telemedicine privileges may 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 arrangements, and emergency call responsibilities.
- (2) 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 privileging 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 Medicare regulations and accreditation standards. The distant hospital or telemedicine entity must provide:
  - (i) confirmation that the practitioner is licensed in Indiana;
  - (ii) a current list of privileges granted to the practitioner;
  - (iii) information indicating that the applicant has actively exercised the relevant privileges during the previous 12 months and has done so in a competent manner;
  - (iv) such quality data and other information that may be requested to assist in an appropriate assessment of current clinical competence and overall qualifications for telemedicine privileges;
  - (v) a signed attestation that the applicant satisfies all of the distant hospital or telemedicine entity's qualifications for the clinical privileges granted;
  - (vi) a signed attestation that all information provided by the distant hospital or telemedicine entity is complete, accurate, and up-to-date; and
  - (vii) any other attestations or information required by the agreement or requested by the Credentials Committee, Executive Committee, Board or Hospital.

This information shall be provided to the Executive Committee 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.

- (c) Telemedicine privileges, if granted, shall be for a period of not more than two years.
- (d) 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.
- (e) Telemedicine privileges granted in conjunction with a contractual agreement shall be incident to and coterminous with the agreement.

#### 4.B. TEMPORARY CLINICAL PRIVILEGES

##### 4.B.1. Temporary Clinical Privileges

- (a) Applicants: Temporary privileges for an applicant for initial appointment may be granted by the CMO, in conjunction with the Chair of the Credentials Committee, under the following conditions:
- (1) the applicant has submitted a complete application, along with the application fee;
  - (2) the verification process is complete, including verification of current licensure, relevant training or experience, current competence, ability to exercise the privileges requested, and current professional liability coverage; compliance with privileges criteria; consideration of information from the National Practitioner Data Bank, a criminal background check, OIG queries; and, in the case of an Allied Health Practitioner, confirmation from the individual's Supervising Physician, as applicable;
  - (3) 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;
  - (4) the application is pending review by the Executive Committee and the Board, following a favorable recommendation by the Credentials Committee after considering the evaluation of the department chair; and
  - (5) temporary privileges for a Medical Staff applicant will be granted for a maximum period of 120 consecutive days.
- (b) Locum Tenens: The CMO, in conjunction with the Chair of the Credentials Committee, may grant temporary privileges (both admitting and treatment) to an individual serving as a locum tenens for a member of the Medical Staff who is on vacation, attending an educational seminar, or ill, and/or otherwise needs coverage assistance for a period of time, under the following conditions:
- (1) the applicant has submitted an appropriate application, along with the 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 privileges;
  - (2) 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 two 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, from a criminal background check, and from OIG queries;
  - (3) 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;
- (4) the applicant has received a favorable recommendation from the Credentials Committee Chair, after considering the evaluation of the department chair;
- (5) the applicant will be subject to any focused professional practice requirements established by the Hospital; and
- (6) the individual may exercise locum tenens privileges for a maximum of 120 days, consecutive or not, anytime during the 24-month period following the date they are granted, subject to the following conditions:
  - (i) the individual must notify Physician Support Services prior to each time that he or she will be exercising these privileges; and
  - (ii) along with this notification, the individual must inform the Physician Support Services of any change that has occurred to any of the information provided on the initial application for locum tenens privileges.
- (c) Visiting: Temporary privileges may also be granted in other limited situations by the CMO, in conjunction with the Chair of the Credentials Committee, when there is an important patient care, treatment, or service need. Specifically, temporary privileges may be granted for situations such as the following:
  - (1) the care of a specific patient;
  - (2) when a proctoring or consulting physician is needed, but is otherwise unavailable; or
  - (3) when necessary to prevent a lack or lapse of services in a needed specialty area.

The following factors will be considered and verified prior to the granting of temporary privileges in these situations: current licensure, relevant training or experience, current competence, current professional liability coverage acceptable to the Hospital, and results of a query to the National Practitioner Data Bank, and from OIG queries. The grant of clinical privileges in these situations will not exceed 60 days. In exceptional situations, this period of time may be extended in the discretion of the CMO and the Chairman of the Medical Staff.

- (d) Compliance with Bylaws and Policies. 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.
- (e) FPPE. Individuals who are granted temporary privileges will be subject to the Hospital policy regarding focused professional practice evaluation.

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

- (a) The CMO may, at any time after consulting with the Chairman of the Medical Staff, the Chair of the Credentials Committee, or the department chair, terminate temporary admitting privileges. Clinical privileges shall be terminated when the individual's inpatients are discharged.
- (b) If the care or safety of patients might be endangered by continued treatment by the individual granted temporary privileges, the CMO, and the department chair,

or a ranking member of the Executive Committee, may immediately terminate all temporary privileges. The department chair or the Chairman of the Medical Staff shall assign to another member of the Medical Staff responsibility for the care of such individual's patients until they are discharged or an appropriate transfer arranged. Whenever possible, consideration shall be given to the wishes of the patient in the selection of a substitute physician.

#### 4.C. EMERGENCY SITUATIONS

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

#### 4.D. DISASTER PRIVILEGES

- (1) When the disaster plan has been implemented and the immediate needs of patients in the facility cannot be met, the CMO, or the Chairman of the Medical Staff may use a modified credentialing process to grant disaster privileges to eligible volunteer licensed independent practitioners ("volunteers"). 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;
    - (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 volunteer licensed independent practitioners. This oversight shall be conducted through direct observation, mentoring, clinical record review, or other appropriate mechanism developed by the Medical Staff and Hospital.

## **ARTICLE 5**

### **PROCEDURE FOR REAPPOINTMENT**

#### **5.A. ELIGIBILITY FOR REAPPOINTMENT**

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

- (1) completed all medical records and be current at the time of reappointment;
- (2) completed all continuing medical education requirements as described in the Medical Staff Rules and Regulations;
- (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 or scope of practice requested;
- (5) paid any applicable reappointment processing fee; and
- (6) if applying for clinical privileges, had sufficient patient contacts to enable the assessment of current clinical judgment and competence for the privileges requested. Any member seeking reappointment who has minimal activity at the Hospital must submit such information as may be requested (such as a copy of his or her confidential quality profile from his or her primary hospital, clinical information from his or her private office practice, or a quality profile from a managed care organization or insurer), before the application shall be considered complete and processed further.

#### **5.B. FACTORS FOR EVALUATION**

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

- (1) compliance with the Bylaws, Rules and Regulations, and policies of the Medical Staff and the Hospital, as approved by the Executive Committee;
- (2) participation in Medical Staff duties, including committee assignments, emergency call, consultation requests, participation in quality improvement, utilization activities, and professional practice evaluation activities, and such other reasonable duties and responsibilities as assigned;
- (3) the results of the Hospital's performance improvement and professional practice evaluation 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, families, or staff;
- (6) any changes in the member's ability to safely and competently exercise clinical privileges or scope of practice or perform the duties and responsibilities of appointment because of health status issues, including, but not limited to, impairment due to addiction, alcohol use, or other similar issue (all of which shall be referred to the Practitioner Health and Well Being Committee); and

- (7) other reasonable indicators of continuing qualifications.

#### 5.C. REAPPOINTMENT APPLICATION

- (1) Reappointment shall be for a period of not more than two years.
- (2) An application for reappointment shall be furnished to members at least three 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 return a completed application within thirty (30) days shall result in the assessment of a reappointment processing fee, which must be paid prior to the application being processed. In addition, failure to submit a complete application at least two months prior to the expiration of the member's current term may result in automatic expiration of appointment and clinical privileges or scope of practice at the end of the then current term of appointment unless the application can still be processed in the normal course, without extraordinary effort on the part of the CVO and the Medical Staff Leaders.
- (4) If an application for reappointment is submitted timely, but the Medical Staff and/or Board has not acted on it prior to the end of the current term, the Member's appointment and clinical privileges or scope of practice shall expire at the end of the then current term of appointment. Subsequent Board action may be to grant reappointment and renewal of clinical privileges or scope of practice using the filed application.
- (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 or scope of practice 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.

#### 5.D. PROCESSING APPLICATIONS FOR REAPPOINTMENT

- (1) Physician Support Services shall forward the application to the relevant department 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.
- (3) If it becomes apparent to the Credentials Committee or the Executive Committee that it is considering a recommendation to deny reappointment or a requested change in staff category, or to reduce clinical privileges or scope of practice, the chair of the committee may notify the individual of the general tenor of the possible recommendation and invite the individual to meet prior to any final recommendation being made. At the meeting, the individual should be informed of the general nature of the information supporting the recommendation contemplated and shall be invited to discuss, explain or refute it. This meeting is not a hearing, and none of the procedural rules for hearings shall apply. The individual requesting reappointment shall not have the right to be represented by legal counsel at this meeting, but may bring a physician colleague to serve as an observer and counselor, so long as the colleague acknowledges that he or she is



bound by the same requirements of confidentiality as are the other participants. The committee shall indicate as part of its report whether such a meeting occurred and shall include a summary of the meeting with its minutes.

#### 5.E. CONDITIONAL REAPPOINTMENTS

- (1) Recommendations for reappointment and renewed privileges or scope of practice may be contingent upon the individual's compliance with certain specific conditions. These conditions may relate to behavior (e.g., personal code of conduct) or to clinical issues (e.g., general consultation requirements, proctoring, completion of CME requirements). Unless the conditions involve the matters set forth in Section 7.A.1(a) of this Policy, the imposition of such conditions does not entitle an individual to request the procedural rights set forth therein.
- (2) Reappointments may be recommended for periods of less than two years in order to permit closer monitoring of an individual's compliance with any conditions that may be imposed. A recommendation for reappointment for a period of less than two years does not, in and of itself, entitle an individual to the procedural rights set forth in Article 7 of this Policy.
- (3) In addition, 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 years may be granted pending the completion of that process.

## ARTICLE 6

### **PEER REVIEW PROCEDURES FOR QUESTIONS INVOLVING MEMBERS**

#### **6.A. COLLEGIAL INTERVENTION**

- (1) This Policy encourages the use of progressive steps by Medical Staff leaders and Hospital management, beginning with collegial and educational efforts, to address questions related to clinical practice or professional conduct. The goal of these efforts is to arrive at voluntary actions by the individual to resolve questions that have been raised.
- (2) Collegial intervention efforts are a part of the Hospital's ongoing and focused professional practice evaluation activities.
- (3) Collegial intervention efforts involve reviewing and following up on questions raised about the clinical practice and/or conduct of members and pursuing counseling, education, and related steps, such as the following:
  - (a) advising colleagues of applicable policies, such as policies regarding appropriate behavior, communication issues, emergency call obligations, and the timely and adequate completion of medical records;
  - (b) proctoring, monitoring, consultation, and letters of guidance; and
  - (c) sharing comparative quality, utilization, and other relevant information, including any variations from clinical protocols or guidelines, in order to assist individuals to conform their practices to appropriate norms.
- (4) If an issue is raised pertaining to clinical competence or professional conduct of a member of the Allied Health Staff, the Supervising Physician will be notified and may be invited to participate in the collegial intervention.
- (5) The relevant Medical Staff leader(s) shall document collegial intervention efforts in an individual's confidential file. The individual shall have an opportunity to review the documentation and respond to it in writing. The response shall be maintained in the individual's file along with the original documentation.
- (6) Collegial intervention efforts are encouraged, but are not mandatory, and shall be within the discretion of Medical Staff leaders and Hospital management.
- (7) The relevant Medical Staff leader(s), in conjunction with the CMO, may determine whether a matter should be handled in accordance with another policy (e.g., code of conduct policy, practitioner health policy, professional practice evaluation policy) or should be referred to the Executive Committee for further action.

#### **6.B. ONGOING AND FOCUSED PROFESSIONAL PRACTICE EVALUATIONS**

All ongoing and focused professional practice evaluations shall be conducted in accordance with the professional practice evaluation policy. Matters that cannot be appropriately resolved through collegial intervention or through the professional practice evaluation policy shall be referred to the Executive Committee for its review in accordance with Section 6.C below. Such interventions and evaluations, however, are not mandatory prerequisites to Executive Committee review.

## 6.C. INVESTIGATIONS

### 6.C.1. Initial Review

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

### 6.C.2. Initiation of Investigation

- (a) When a question involving clinical competence or professional conduct is referred to, or raised by, the Executive Committee, the Executive Committee shall review the matter, discuss the matter with the individual, if invited, and determine whether to conduct an investigation or direct that the question be handled pursuant to another policy (e.g., code of conduct policy; practitioner health policy; professional practice evaluation policy). An investigation shall commence only after a determination by the Executive Committee.
- (b) The Executive Committee shall inform the individual that an investigation has begun. Notification may be delayed if, in the judgment of the Executive Committee, informing the individual immediately would compromise the investigation or disrupt the operation of the Hospital or Medical Staff.
- (c) The Board may also determine to commence an investigation and may delegate the investigation to the Executive Committee, a subcommittee of the Board, or an ad hoc committee.

### 6.C.3. Investigative Procedure

- (a) Once a determination has been made to begin an investigation, the Executive Committee shall either 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 of the individual by a health care professional(s) acceptable to it. The individual being investigated shall execute a release (in a form approved or provided by the Investigating Committee) allowing (i) the Investigating Committee (or its representative) to discuss with the health care professional(s) conducting the examination the reasons for the examination; and (ii) the health care professional(s) conducting the examination to discuss and provide documentation of the results of such examination directly to the Investigating Committee. Failure to do so will result in the automatic relinquishment of the individual's clinical privileges or scope of practice.
- (c) The investigating committee shall make a reasonable effort to complete the investigation and issue its report within 30 days, provided that an outside review is not necessary. When an outside review is used, the investigating committee shall make a reasonable effort to complete the investigation and issue its report within 30 days of receiving the results of the outside review. These time frames are intended to serve as guidelines and, as such, shall not be deemed to create any right for an individual to have an investigation completed within such time periods.
- (d) As part of the investigation, the individual shall have an opportunity to meet with the Investigating Committee. Prior to this meeting, the individual shall be informed of the questions being investigated and shall be invited to discuss, explain, or refute the questions. If the individual who is the subject of the investigation is a member of the Allied Health Staff, the Supervising Physician may also be invited to meet with the Investigating Committee. 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 Executive Committee with its findings, conclusions, and recommendations.

#### 6.C.4. Recommendation

- (a) The Executive Committee may accept, modify, or reject any recommendation it receives from an Investigating Committee. Specifically, the Executive Committee 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 or scope of practice;

- (7) recommend suspension of clinical privileges or scope of practice for a term;
  - (8) recommend revocation of appointment or clinical privileges or scope of practice; or
  - (9) make any other recommendation that it deems necessary or appropriate.
- (b) If the Executive Committee 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 Executive Committee that would entitle the individual to request a hearing shall be forwarded to the CMO. The Chairman of the Medical Staff or the 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 Executive Committee that would entitle the individual to request a hearing, the Chairman of the Medical Staff 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.

#### 6.D. PRECAUTIONARY SUSPENSION OR RESTRICTION OF CLINICAL PRIVILEGES OR SCOPE OF PRACTICE

##### 6.D.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 of the following are authorized to (1) afford the individual an opportunity to voluntarily refrain from exercising privileges or a scope of practice pending an investigation; or (2) suspend or restrict all or any portion of an individual's clinical privileges or scope of practice as a precaution: the CMO, Board Chairman *and* a ranking member of the Executive Committee.
- (b) A precautionary suspension can be imposed at any time including, but not limited to, immediately after the occurrence of an event that causes concern, following a pattern of occurrences that raise concerns, or following a recommendation of the Executive Committee that would entitle the individual to request a hearing. When possible, prior to the imposition of a precautionary suspension, the person(s) considering the suspension shall meet with the individual and review the concerns that support the suspension and afford the individual an opportunity to respond.
- (c) Precautionary suspension is an interim step in the professional review activity and does not imply any final finding regarding the situation that caused the suspension.
- (d) A precautionary suspension is effective immediately and shall be promptly reported to the CMO, and the Chairman of the Medical Staff and documented in the Professional Standards Committee file. A precautionary suspension shall remain in effect unless it is modified by the CMO, Board Chairman *and* a ranking member of the Executive Committee.

- (e) Within three days of the imposition of a suspension, a brief written description of the reason(s) for the action, including the names and medical record numbers of the patient(s) involved (if any), shall be provided to the individual.

#### 6.D.2. Executive Committee Procedure

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

#### 6.D.3. Care of Patients

Immediately upon the imposition of a precautionary suspension or restriction, the Chairman of the Medical Staff shall assign to another individual with appropriate clinical privileges or scope of practice responsibility for care of the suspended individual's hospitalized patients, or to aid in implementing the precautionary restriction, as appropriate. The assignment shall be effective until the patients are discharged. The wishes of the patient shall be considered in the selection of a covering physician.

## 6.E. AUTOMATIC RELINQUISHMENT

### 6.E.1. Failure to Complete Medical Records

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

### 6.E.2. Action by Government Agency or Insurer and Failure to Satisfy Threshold Eligibility

#### Criteria

- (a) Any action taken by any licensing board, professional liability insurance company, court or government agency regarding any of the matters set forth below, or failure to satisfy any of the threshold eligibility criteria, must be promptly reported to the CMO or Chairman of the Medical Staff.
- (b) An individual's appointment and clinical privileges or scope of practice shall be automatically relinquished, without right to hearing or appeal, if any of the following occur:
  - (1) Licensure: Revocation, expiration, suspension, or the placement of conditions or restrictions on an individual's license.
  - (2) Controlled Substance Authorization: Revocation, expiration, suspension, or the placement of conditions or restrictions on an individual's DEA or state controlled substance authorization.
  - (3) Insurance Coverage: Termination or lapse of an individual's professional liability insurance coverage, or other action causing the coverage to fall below the minimum required by the Hospital.
  - (4) Medicare and Medicaid Participation: Termination, exclusion, or preclusion by government action from participation in the Medicare/Medicaid or other federal or state health care programs.
  - (5) Criminal Activity: Arrest, indictment, conviction, or a plea of guilty or no contest pertaining to any felony, or to any misdemeanor involving (i) controlled substances; (ii) illegal drugs; (iii) Medicare, Medicaid, or insurance or health care fraud or abuse; or (iv) violence.
- (c) An individual's appointment and clinical privileges or scope of practice shall be automatically relinquished, without entitlement to a hearing and appeal, if the individual fails to satisfy any of the threshold eligibility criteria or his or her responsibilities during the provisional period.
- (d) Automatic relinquishment shall take effect immediately upon notice to the Hospital and continue until the matter is resolved and the individual is reinstated.
- (e) If the underlying matter leading to automatic relinquishment is resolved within 60 days, the individual may request reinstatement. Failure to resolve the matter within 60 days of the date of relinquishment shall result in an automatic resignation from the Medical Staff or Allied Health Staff.

### 6.F.3 Reinstatement

Requests for reinstatement shall be reviewed by the relevant department chair, chairman of the Credentials Committee, the Chairman 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 Executive Committee, and the Board for ratification. If, however, any of the individuals reviewing the request have any questions or concerns, those questions shall be noted and the reinstatement request shall be forwarded to the full Credentials Committee, Executive Committee and Board for review and recommendation.

#### 6.E.4. Failure to Provide Information

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

- (a) discovery of a misstatement or omission on an application for initial appointment or reappointment, determined by the Chairman 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 Chairman of the Medical Staff, or CMO, of any change in any information provided on an application for initial appointment or reappointment, determined by the Chairman 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 information pertaining to an individual's qualifications for appointment, clinical privileges, or scope of practice in response to a written request specifying the time frame for response from the Credentials Committee, the Executive Committee, or CMO, or any other committee authorized to request such information, until the information is provided to the satisfaction of the requesting party.

#### 6.E.5. Failure to Attend Special Meeting

- (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 meeting.
- (b) Special notice shall be given at least three days prior to the meeting and shall inform the individual that attendance at the meeting is mandatory.
- (c) Failure of the individual to attend the meeting shall be reported to the Executive Committee. Unless excused by the Executive Committee 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 or scope of practice as the Executive Committee may direct. Such relinquishment shall remain in effect until the individual attends the special meeting.
- (d) Individual practitioners will immediately inform the CMO and Credentials Committee of any charges against them, as well as action against their medical license and/or privileges at another facility.

#### 6.E.6. Failure to Meet Supervision Requirements



If the Medical Staff appointment or clinical privileges of a Supervising Physician are resigned, revoked or terminated, or the Advanced Dependent Practitioner or Dependent Practitioner fails, for any reason, to maintain an appropriate supervision relationship with a Supervising Physician as defined in this Policy, the Advanced Dependent Practitioner's clinical privileges or Dependent Practitioner's scope of practice will be automatically relinquished, unless another Supervising Physician is approved as part of the credentialing process.

6.E.7. Failure to Use Legible Handwriting in the Medical Record

In accordance with Article IX, Medical Records, Part K: Legible Handwriting Policy, of the Medical Staff Rules and Regulations, an individual's clinical privileges or scope of practice may be automatically relinquished pending the resolution of his or her failure to use legible handwriting in the medical record.

6.F. LEAVES OF ABSENCE

6.F.1. Initiation

- (a) With the exception of Locum Tenens and PRN providers, any absence from the Medical Staff or Allied Health Staff and/or patient care responsibilities for longer than 30 days shall require an individual to request a leave of absence.
- (b) A leave of absence must be requested in writing and submitted to the Credentials Committee Chair in order to permit adjustment of the call roster, assure adequate coverage of clinical and/or administrative activities, and to ensure completion of all medical records before the leave is granted. The request must state the beginning and ending dates of the leave, not to exceed one year, and the reasons for the leave.
- (c) The Credentials Committee Chair shall determine whether a request for a leave of absence shall be granted and may consult with the Chairman of the Medical Staff, the relevant department chair, and/or the full Credentials Committee, and may be conditioned upon the individual's completion of all medical records or other clinical or administrative duties.

6.F.2. Duties of Members on Leave

During the leave of absence, the individual shall not exercise any clinical privileges or practice within his or her scope of practice and shall be excused from all Medical Staff and Allied Staff responsibilities (e.g., meeting attendance, committee service, emergency service call obligations).

6.F.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, to the Credentials Committee Chair. The individual bears the burden of providing information sufficient to demonstrate current competence and all other applicable qualifications. If the leave of absence exceeds 60 days, the request for reinstatement must be made no later than 30 days prior to the conclusion of the leave.
- (b) Requests for reinstatement shall then be reviewed by the Chair of the Credentials Committee. The Credentials Committee Chair's recommendation shall then be

forwarded to the Executive Committee, which shall make a recommendation to the Board for final action. If, however, the Credentials Committee Chair in reviewing the request has any questions or concerns, those questions shall be noted and the reinstatement request shall be forwarded to the full Credentials Committee. The Credentials Committee may recommend to the Executive Committee reinstatement to the same or different staff category and/or may recommend limits on or modification of the individual's clinical privileges or scope of practice. If a request for reinstatement is not granted, for reasons related to clinical competence or professional conduct, the individual shall be entitled to request a hearing and appeal.

- (c) If the leave of absence was for health reasons, the request for reinstatement must be accompanied by a report from the individual's physician indicating that the individual is physically and/or mentally capable of resuming a hospital practice and safely exercising the clinical privileges or scope of practice requested.
- (d) Absence for longer than one year shall result in automatic relinquishment of Medical Staff or Allied Health Staff appointment and clinical privileges or scope of practice unless an extension is granted. Extensions will be considered only in extraordinary cases where the extension of a leave is in the best interest of the Hospital.
- (e) If an individual's current appointment is due to expire during the leave, the individual must apply for reappointment, or appointment and clinical privileges or scope of practice shall lapse at the end of the appointment period.
- (f) 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.

## ARTICLE 7

### HEARING AND APPEAL PROCEDURES

#### 7.A. INITIATION OF HEARING

##### 7.A.1. Grounds for Hearing

- (a) For the purpose of Article 7 of this Policy, “applicant” pertains only to an applicant to the Medical Staff and “member” pertains only to Medical Staff members. Allied Health members are not entitled to any hearing and appeal rights set forth in this article. The sole and exclusive procedural rights to which a member of the Allied Health Staff is entitled are set forth in Article 8.
- (b) An individual is entitled to request a hearing whenever the Executive Committee makes one of the following recommendations based upon the individual’s professional competence or professional conduct which affects or could affect adversely the health or welfare of a patient or patients:
  - (1) denial of initial appointment, reappointment or requested clinical privileges;
  - (2) revocation of appointment to the Medical Staff or clinical privileges;
  - (3) suspension of clinical privileges for more than 30 days (other than a precautionary suspension);
  - (4) restriction of clinical privileges, meaning a mandatory concurring consultation requirement, in which the consultant must approve the course of treatment in advance; or
  - (5) denial of reinstatement from a leave of absence if the reasons relate to professional competence or conduct.
- (c) No other recommendations shall entitle the individual to a hearing.
- (d) If the Board makes any of these recommendations without an adverse recommendation by the Executive Committee, an individual is entitled to request a hearing. For ease of use, this Article refers to adverse recommendations of the Executive Committee. When a hearing is triggered by an adverse recommendation of the Board, any reference in this Article to the “Executive Committee” shall be interpreted as a reference to the “Board.”

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

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

- (a) a letter of guidance, counsel, warning, or reprimand;
- (b) conditions, monitoring, proctoring, or a general consultation requirement;
- (c) a lapse or failure to renew temporary privileges;
- (d) automatic relinquishment of appointment or privileges;
- (e) a requirement for additional training or continuing education;
- (f) precautionary suspension in accordance with Section 6.D;
- (g) denial of a request for leave of absence, for an extension of a leave or for reinstatement from a leave if the reasons do not relate to professional competence or conduct;

- (h) determination that an application is incomplete;
- (i) determination that an application shall not be processed due to a misstatement or omission; or
- (j) determination of ineligibility based on a failure to meet threshold eligibility criteria or a lack of need or resources.

#### 7.A.3. Notice of Recommendation

The Chairman of the Medical Staff, 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 30 days of receipt of this notice; and
- (c) a copy of this Article.

#### 7.A.4. Request for Hearing

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

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

- (a) The Chairman 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 information supporting the recommendation. This statement may be revised or amended at any time, even during the hearing, so long as the additional material is relevant to the recommendation or the individual's qualifications and the individual has had a sufficient opportunity to review and respond with additional information.
- (b) The hearing shall begin as soon as practicable, but no sooner than 30 days after the notice of the hearing, unless an earlier hearing date has been specifically agreed to in writing by the parties.

#### 7.A.6. Witness List

- (a) At least 15 days before the pre-hearing conference, the individual requesting the hearing shall provide a written list of the names of witnesses expected to offer testimony on his or her behalf.
- (b) The witness list shall include a brief summary of the anticipated testimony.

- (c) The witness list of either party may, in the discretion of the Presiding Officer, be amended at any time during the course of the hearing, provided that notice of the change is given to the other party.

#### 7.A.7. Hearing Panel

(a) Hearing Panel:

A Hearing Panel shall be appointed by the CMO or the Chairman of the Medical Staff in accordance with the following guidelines:

- (1) The Hearing Panel shall consist of at least three members, one of whom shall be designated as chairman.
- (2) The Hearing Panel may include any combination of:
  - (i) any member of the Medical Staff, but at least one who is not employed by the Hospital, or
  - (ii) physicians not connected with the Hospital (i.e., physicians not on the Medical Staff).
- (3) Knowledge of the underlying peer review matter, in and of itself, shall not preclude the individual from serving on the Panel.
- (4) Employment by, or other contractual arrangement with, the Hospital or an affiliate shall not preclude an individual from serving on the Panel.
- (5) The Panel shall not include any individual who:
  - (i) is in direct economic competition with the individual requesting the hearing;
  - (ii) is professionally associated with, related to, or involved in a referral relationship with, the individual requesting the hearing;
  - (iii) is demonstrated to have an actual bias, prejudice, or conflict of interest that would prevent the individual from fairly and impartially considering the matter; or
  - (iv) actively participated in the matter at any previous level.

(b) Presiding Officer:

- (1) The CMO or Chairman of the Medical Staff shall appoint a Presiding Officer who may be an attorney. The Presiding Officer shall not act as an advocate for either side at the hearing.
- (2) The Presiding Officer shall:
  - (i) schedule and conduct a pre-hearing conference;
  - (ii) allow the participants in the hearing to have a reasonable opportunity to be heard and to present evidence, subject to reasonable limits on the number of witnesses and duration of direct and cross-examination;
  - (iii) prohibit conduct or presentation of evidence that is cumulative, excessive, irrelevant or abusive or that causes undue delay;
  - (iv) maintain decorum throughout the hearing;
  - (v) determine the order of procedure;
  - (vi) rule on all matters of procedure and the admissibility of evidence;and

- (vii) conduct argument by counsel on procedural points outside the presence of the Hearing Panel unless the Panel wishes to be present.
- (3) The Presiding Officer may participate in the private deliberations of the Hearing Panel and be a legal advisor to it, but shall not vote on its recommendations.
- (c) **Objections:**  
Any objection to any member of the Hearing Panel or the Presiding Officer shall be made in writing, within ten days of receipt of notice, to the CMO. A copy of such written objection must be provided to the Chairman of the Medical Staff and must include the basis for the objection. The Chairman of the Medical Staff shall be given a reasonable opportunity to comment. The 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.

#### 7.A.8. Counsel

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

### 7.B. PRE-HEARING PROCEDURES

#### 7.B.1. General Procedures

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

#### 7.B.2. Provision of Relevant Information

- (a) Prior to receiving any confidential documents, the individual requesting the hearing must agree that all documents and information shall be maintained as confidential and shall not be disclosed or used for any purpose outside of the hearing. The individual must also provide a written representation that his/her counsel and any expert(s) have executed Business Associate agreements in connection with any patient Protected Health Information contained in any documents provided.
- (b) Upon receipt of the above agreement and representation, the individual requesting the hearing shall be provided with a copy of the following:
  - (1) copies of, or reasonable access to, all patient medical records referred to in the statement of reasons, at the individual's expense;
  - (2) reports of experts relied upon by the Executive Committee;
  - (3) copies of relevant minutes (with portions regarding other physicians and unrelated matters deleted); and
  - (4) copies of any other documents relied upon by the Executive Committee.The provision of this information is not intended to waive any privilege.
- (c) The individual shall have no right to discovery beyond the above information. No information shall be provided regarding other practitioners on the Medical Staff. In addition, there is no right to depose, interrogate, or interview witnesses or other individuals prior to the hearing.

- (d) Ten days prior to the pre-hearing conference, or on dates set by the Presiding Officer or agreed upon by both sides, each party shall provide the other party with its proposed exhibits.
- (e) Neither the individual, nor any other person acting on behalf of the individual, may contact Hospital employees or Medical Staff members whose names appear on the Executive Committee's witness list or in documents provided pursuant to this section concerning the subject matter of the hearing, until the Hospital has been notified and has contacted the individuals about their willingness to be interviewed. The Hospital shall advise the individual who requested the hearing once it has contacted such employees or Medical Staff members and confirmed their willingness to meet. Any employee or Medical Staff member may agree or decline to be interviewed by or on behalf of the individual who requested a hearing.

#### 7.B.3. Pre-Hearing Conference

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

#### 7.B.4. Stipulations

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

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

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

- (a) a pre-hearing statement that either party may choose to submit;
- (b) exhibits offered by the parties following the pre-hearing conference (without the need for authentication); and
- (c) stipulations agreed to by the parties.

#### 7.B.6. Time Frames

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

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

### 7.C. HEARING

#### 7.C.1. Failure to Appear

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

#### 7.C.2. Record of Hearing

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

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

- (a) At a hearing, both sides shall have the following rights, subject to reasonable limits determined by the Presiding Officer:
  - (1) to call and examine witnesses, to the extent they are available and willing to testify;
  - (2) to introduce exhibits;
  - (3) to cross-examine any witness;
  - (4) to have representation by counsel who may call, examine, and cross-examine witnesses and present the case;
  - (5) to submit a written statement at the close of the hearing; and
  - (6) to submit proposed findings, conclusions and recommendations to the Hearing Panel.
- (b) If the individual who requested the hearing does not testify, he or she may be called and questioned.
- (c) The Hearing Panel may question witnesses, request the presence of additional witnesses, or request documentary evidence.

#### 7.C.4. Order of Presentation

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

#### 7.C.5. Admissibility of Evidence

The hearing shall not be conducted according to rules of evidence. Evidence shall not be excluded merely because it is hearsay. Any relevant evidence shall be admitted if it is the



sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs. The guiding principle shall be that the record contains information sufficient to allow the Board to decide whether the individual is qualified for appointment and clinical privileges.

7.C.6. Persons to Be Present

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

7.C.7. Postponements and Extensions

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

7.C.8. Presence of Hearing Panel Members

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

7.D. HEARING CONCLUSION, DELIBERATIONS, AND RECOMMENDATIONS

7.D.1. Basis of Hearing Panel Recommendation

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

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

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

7.D.3. Disposition of Hearing Panel Report

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

7.E. APPEAL PROCEDURE

7.E.1. Time for Appeal

(a) Within ten days after notice of the Hearing Panel's recommendation, either party may request an appeal. The request shall be in writing, delivered to the 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 days, an appeal is deemed to be waived and the Hearing Panel's report and recommendation shall be forwarded to the Board for final action.

#### 7.E.2. Grounds for Appeal

The grounds for appeal shall be limited to the following:

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

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

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

#### 7.E.4. Nature of Appellate Review

- (a) The Board may serve as the Review Panel or the chair of the Board may appoint a Review Panel, composed of members of the Board.
- (b) The Review Panel may consider the record upon which the recommendation was made, including the hearing transcripts and exhibits, post-hearing statements, the findings and recommendations of the Executive Committee and Hearing Panel and any other information that it deems relevant, and recommend final action to the Board.
- (c) The hearing before the Review Panel shall be an appellate and not an evidentiary hearing. Each party shall have the right to present a written statement in support of its position on appeal. The party requesting the appeal shall submit a statement first and the other party shall then have ten days to respond. In its sole discretion, the Review Panel may allow each party or its representative to appear personally and make an oral presentation. The Review Panel may limit the amount of time for any such presentation.
- (d) The Review Panel may (i) affirm the recommendation of the Hearing Panel, (ii) reverse the recommendation of the Hearing Panel, or (iii) refer the recommendation back to the Hearing Panel for further consideration with reasons for doing so. If the decision is to refer the matter back, the Hearing Panel shall give the matter further consideration and respond to the directions of the Review Panel and may, in its discretion, hold a further hearing or act on the record and make a further recommendation to the Review Panel, which shall thereupon, without further notice to the individual or a hearing, take final action.

### 7.F. BOARD ACTION

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

- (a) The decision of the Board, acting, in its discretion, as a whole or through the appointed Review Panel, shall be final after it either (i) considers the appeal as a Review Panel, or (ii) receives the Hearing Panel's report when no appeal has been requested.

- (b) The Board or Review Panel shall render its final decision in writing, including the basis for its decision, and shall send special notice to the individual. A copy shall also be provided to the Chairman of the Medical Staff.
- (c) The final decision of the Board or Review Panel shall be effective immediately and shall not be subject to further review.

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

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

## ARTICLE 8

### **PROCEDURAL RIGHTS FOR ALLIED HEALTH PRACTITIONERS**

#### **8.A. PROCEDURAL RIGHTS FOR LICENSED INDEPENDENT PRACTITIONERS & ADVANCED DEPENDENT PRACTITIONERS**

- (1) In the event that the Executive Committee recommends that a Licensed Independent Practitioner or Advanced Dependent Practitioner (hereinafter, for the purpose of this Section only, “Allied Health Practitioner”) not be granted privileges or that the privileges granted be terminated or not renewed, the Chairman of the Medical Staff or CMO shall give notice of the recommendation to the affected Allied Health Practitioner. The notice shall state that the Allied Health Practitioner has a right to request a hearing.
- (2) If the Allied Health Practitioner wants to request a hearing, the request must be made in writing, directed to the Chairman of the Medical Staff and CMO, within 30 days after receipt of the notice of the adverse recommendation. The hearing will be convened as soon as practical, but no sooner than 30 days after the CMO receives the Allied Health Practitioner’s request for a hearing, unless an earlier hearing date has been specifically agreed to by the parties. The Allied Health Practitioner will be informed of the nature of the information supporting the adverse recommendation at least 30 days prior to the hearing.
- (3) The hearing to review the adverse recommendation will be held before the Executive Committee or a subcommittee of the Executive Committee (“Hearing Committee”). The Hearing Committee will not include any individual who is in direct economic competition with the affected Allied Health Practitioner or his/her Supervising Physician(s). Employment by, or a contractual arrangement with, the Hospital or an affiliate shall not preclude an individual from serving on the Hearing Committee.
- (4) The Allied Health Practitioner and his/her Supervising Physician shall both appear personally before the Hearing Committee.
- (5) The record of the hearing will be maintained by a stenographic reporter or by a recording of the proceedings. Copies of the transcript will be available at the Allied Health Practitioner’s individual expense.
- (6) The hearing will last no longer than three hours. The Allied Health Practitioner may present affidavits, but no more than four, as evidence in support of his/her case.
- (7) Both the Allied Health Practitioner and the Executive 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.
- (8) At the hearing, the Allied Health Practitioner and his/her Supervising Physician shall be provided with an opportunity to refute the recommendation and the reasons supporting it. The Allied Health Practitioner will have the burden of demonstrating that the recommendation was arbitrary, capricious, or not supported by substantial evidence. The quality of care provided to patients and the smooth operation of the Hospital will be the paramount considerations.

- (9) The Allied Health Practitioner will have the right to submit a memorandum, for consideration by the Hearing Committee, at the close of the hearing.
- (10) The Hearing Committee shall forward its recommendation, along with all supporting information, to the CMO. The CMO shall give notice of the recommendation to the affected Allied Health Practitioner.
- (11) The Allied Health Practitioner shall have 30 days from the receipt of the notice of the Hearing Committee's recommendation to request an appeal, and such a request must be in writing to the CMO and the Chairman of the Medical Staff. If a written request for appeal is not submitted by the Allied Health Practitioner to the CMO within the 30-day time frame specified herein, the Hearing Committee's recommendation shall be forwarded by the CMO or to the Board for final action. If a timely request for appeal is submitted by the Allied Health Practitioner, 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 economic competition with the affected Allied Health Practitioner or his/her Supervising Physician(s). Employment by, or a contractual arrangement with, the Hospital or an affiliate shall not preclude an individual from serving on the Appeal Panel. However, the Appeal Panel shall include at least one member who is not employed by the Hospital.
- (12) The appeal shall be performed by the Appeal Panel, and the Appeal Panel will consider the record upon which the adverse recommendation was made and may accept additional written information, provided the information is new and relevant and was not made available to the Hearing Committee during its consideration of the matter. The Allied Health Practitioner and the Executive Committee will each have the right to submit a written statement to the Appeal Panel. At the sole discretion of the Appeal Panel, the Allied Health Practitioner and a representative of the Executive Committee may also appear personally to discuss their position.
- (13) Upon completion of the review, the Appeal Panel may recommend that the Board affirm, modify or reverse the recommendation of the Hearing Committee. Alternatively, the Appeal Panel may recommend that the matter be referred back to the Hearing Panel for further clarification, with a written explanation of the need for the clarification. Thereafter, the Hearing Panel will report to the Appeal Panel in 30 days.
- (14) The final recommendation of the Appeal Panel shall be forwarded by the CMO to the Board for final action.

#### **8.B. PROCEDURAL RIGHTS FOR DEPENDENT PRACTITIONERS**

- (1) In the event that a recommendation is made by the Credentials Committee, the Executive Committee or the Board that a Dependent Practitioner not be granted a scope of practice or that a scope of practice previously granted be restricted for a period of more than 30 days, terminated, or not renewed, the individual shall receive special notice of the recommendation. 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 Credentials Committee, the

Executive Committee, or the Board, depending on who made the recommendation.

- (2) If a meeting is requested, the meeting shall be scheduled to take place within a reasonable time frame. The meeting shall be informal and shall not be considered a hearing. The Supervising Physician and the Dependent Practitioner shall both be permitted to attend this meeting. However, no counsel shall be present.
- (3) Following this meeting, the Credentials Committee shall make its final recommendation to the Executive Committee. Upon receipt of a recommendation from the Executive Committee, the Board shall take final action.

## ARTICLE 9

### **CONFLICTS OF INTEREST**

- (a) When performing a function outlined in this Policy, the Bylaws, the Organization Manual, or the Rules and Regulations, if any member has or reasonably could be perceived as having a conflict of interest or a bias, that member shall not participate in the final discussion or voting on the matter, and shall be excused from any meeting during that time. However, the member may provide relevant information and may answer any questions concerning the matter before leaving.
- (b) Any member with knowledge of the existence of a potential conflict of interest or bias on the part of any other member may call the conflict of interest to the attention of the Chairman of the Medical Staff (or the Chairman of the Medical Staff-Elect if the Chairman of the Medical Staff is the person with the potential conflict) or the applicable department chair or committee chairman. The Chairman of the Medical Staff or the applicable department chair or committee chairman shall make a final determination as to whether the provisions in this Article should be triggered.
- (c) The fact that a department 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 department 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

### HOSPITAL EMPLOYEES

- (a) Except as provided below, the employment of an individual by the Hospital shall be governed by the Hospital's employment policies and manuals and the terms of the individual's employment relationship or written contract. To the extent that the Hospital's employment policies or manuals, or the terms of any applicable employment contract, conflict with this Policy, the employment policies, manuals and descriptions and terms of the individual's employment relationship or written contract shall apply.
- (b) A request for appointment, reappointment, clinical privileges, or a scope of practice submitted by an applicant or Member who is employed by the Hospital shall be processed in accordance with the terms of this Policy. A report regarding each practitioner's qualifications shall be made to Administration or Human Resources (as appropriate) to assist the Hospital in making employment decisions.
- (c) If a concern about an employed member's clinical conduct or competence originates with the Medical Staff, the concern shall be reviewed and addressed in accordance with this Policy, after which a report shall be provided to Human Resources.



**ARTICLE 11**

**AMENDMENTS**

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

**ARTICLE 12**

**ADOPTION**

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

## GLOSSARY

The following definitions apply to terms used in this Policy:

- (1) “ADVANCED DEPENDENT PRACTITIONERS” means all those Allied Health Practitioners who are licensed or certified under state law, are granted clinical privileges, and function in the Hospital under the supervision of a practitioner(s) appointed to the Medical Staff. The Supervising Physician(s) is responsible for the actions of the Advanced Dependent Practitioner in the Hospital.
- (2) “ALLIED HEALTH PRACTITIONERS” (“AHPs”) means individuals other than Medical Staff members who are authorized by law and by the Hospital to provide patient care services.
- (3) “BOARD” means the Board of Directors of the Hospital, which has the overall responsibility for the Hospital, or its designated committee.
- (4) “BOARD CERTIFICATION” is the designation conferred by one of the affiliated specialties of the American Board of Medical Specialties (“ABMS”), the American Osteopathic Association (“AOA”), the American Board of Oral and Maxillofacial Surgery, or the American Board of Podiatric Surgery, upon an individual, as applicable, who has successfully completed an approved educational training program and an evaluation process, including passing an examination, in the individual’s area of clinical practice. The approved boards for certification for members of the Allied Health Staff are included in Appendix D.
- (5) “CHIEF MEDICAL OFFICER” (“CMO”) means the individual appointed by the Board to act as the CMO of the Hospital, in cooperation with the Chairman of the Medical Staff.
- (6) “CLINICAL PRIVILEGES” or “PRIVILEGES” means the authorization granted by the Board to render specific patient care services, for which the Medical Staff leaders and Board have developed eligibility and other credentialing criteria and focused and ongoing professional practice evaluation standards.
- (7) “COMPLETED APPLICATION” means that all questions on the application form have been answered, all supporting documentation has been supplied, and all information has been verified from primary sources. An application shall become incomplete if the need arises for new, additional, or clarifying information at any time. Any application that continues to be incomplete 30 days after the applicant has been notified of the additional information required shall be deemed to be withdrawn.
- (8) “CREDENTIALS POLICY” means the Hospital’s Medical Staff Credentials Policy.

- (9) “DAYS” means calendar days.
- (10) “DENTIST” means a doctor of dental surgery (“D.D.S.”) or doctor of dental medicine (“D.M.D.”).
- (11) “DEPENDENT PRACTITIONERS” means all those Allied Health Practitioners who are permitted to practice in the Hospital only under the supervision of a practitioner(s) appointed to the Medical Staff and who function pursuant to a defined scope of practice. The Supervising Physician(s) is responsible for the actions of the Dependent Practitioner in the Hospital.
- (12) “EXECUTIVE COMMITTEE” means the Medical Executive Committee of the Medical Staff.
- (13) “HOSPITAL” means Indiana University Health Ball Memorial Hospital.
- (14) “HOUSE STAFF” means all physicians who are assigned for graduate medical education and will ordinarily carry the title of resident or fellow.
- (15) “LICENSED INDEPENDENT PRACTITIONERS” means all those Allied Health Practitioners who are licensed or certified under state law, authorized to function independently in the Hospital, and granted clinical privileges. These individuals require no formal or direct supervision by a physician.
- (16) “MEDICAL STAFF” means all physician, dentist, and podiatrist who have been appointed to the Medical Staff by the Board.
- (17) “MEDICAL STAFF LEADER” means any Medical Staff Officer, member of the Executive Committee, Department Chair, and Vice Chair.
- (18) “MEMBER” means 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.
- (19) “NOTICE” means written communication by regular U.S. mail, e-mail, facsimile, or Hospital mail.
- (20) “PEER REVIEW COMMITTEES” includes professional review bodies, as defined in the HCQIA, that is, a health care entity and the governing body or any committee of a health care entity which conducts professional review activity, and includes any committee of the Medical Staff of such an entity when assisting the governing body in a professional review activity.

- (21) “PERMISSION TO PRACTICE” means the authorization granted to Allied Health Practitioners by the Board to exercise a scope of practice or clinical privileges. For ease of use, when applicable to an Allied Health Practitioner, any reference in this Policy to “appointment” or “reappointment” shall be interpreted as a reference to initial or continued permission to practice.
- (22) “PHYSICIAN” includes both doctors of medicine (“M.D.s”) and doctors of osteopathy (“D.O.s”).
- (23) “PODIATRIST” means a doctor of podiatric medicine (“D.P.M.”).
- (24) “PRESIDENT” means the individual appointed by the Board to act on its behalf in the overall management of Hospital.
- (25) “PROFESSIONAL REVIEW ACTION” has the meaning defined in the HCQIA, that is, an action by the Board or recommendation of the Executive Committee 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.
- (26) “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.
- (27) “SCOPE OF PRACTICE” means the authorization granted by the Board to perform certain clinical activities and functions under the supervision of, or in collaboration with, a Supervising Physician.
- (28) “SPECIAL NOTICE” means hand delivery, certified mail (return receipt requested), or overnight delivery service providing receipt.
- (29) “SUPERVISING PHYSICIAN” means a member of the Medical Staff with clinical privileges, who has agreed in writing to supervise a Dependent Practitioner or an Advanced Dependent Practitioner and to accept full responsibility for the actions of the Dependent Practitioner or Advanced Dependent Practitioner while he or she is practicing in the Hospital.

- (30) “SUPERVISION” means the supervision of, or collaboration with, an Advanced Dependent Practitioner or a Dependent Practitioner and a Supervising Physician that generally does not require the actual presence of the Supervising Physician, but that does require that the Supervising Physician be readily available for consultation, unless otherwise required by law or Hospital policy.

## APPENDIX A

### **CONDITIONS OF PRACTICE APPLICABLE TO ALLIED HEALTH PRACTITIONERS**

#### A.1. Oversight by Supervising Physician

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

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

- (a) Should any member of the Medical Staff, or any employee of the Hospital who is licensed or certified by the state, have a reasonable question regarding the clinical competence or authority of an Advanced Dependent Practitioner or Dependent Practitioner to act or issue instructions outside the presence of the Supervising Physician, such individual will have the right to request that the Supervising Physician validate, either at the time or later, the instructions of the Advanced Dependent Practitioner or Dependent Practitioner. Any act or instruction of the Advanced Dependent Practitioner or Dependent Practitioner will be delayed until such time as the individual with the question has ascertained that the act is clearly within the clinical privileges or scope of practice granted to the individual.
- (b) Any question regarding the conduct of an Advanced Dependent Practitioner will be reported to the Chairman of the Medical Staff, the chair of the Credentials Committee, the relevant department chair, or the CMO for appropriate action. Any question raised about the conduct of a Dependent Practitioner will be reported to Human Resources for appropriate action. The individual(s) to whom the concern has been reported will also discuss the matter with the Supervising Physician.

#### A.3. Responsibilities of Supervising Physicians

- (a) Physicians who wish to use the services of an Advanced Dependent Practitioner or Dependent Practitioner in their clinical practice at the Hospital must notify

Physician Support Services of this fact in advance and must ensure that the individual has been appropriately credentialed in accordance with this Policy or the relevant Human Resources process before the Advanced Dependent Practitioner or Dependent Practitioner participates in any clinical or direct patient care of any kind in the Hospital.

- (b) The number of Advanced Dependent Practitioners or Dependent Practitioners acting under the supervision of one Medical Staff member, as well as the care they may provide, will be consistent with applicable state statutes and regulations and any other policies adopted by the Hospital. The Supervising Physician will make all appropriate filings with the state regarding the supervision and responsibilities of the Advanced Dependent Practitioner or Dependent Practitioner, to the extent that such filings are required.
- (c) It will be the responsibility of the Supervising Physician to provide, or to arrange for, professional liability insurance coverage for the Advanced Dependent Practitioner or Dependent Practitioner in amounts required by the Board. The insurance must cover any and all activities of the Advanced Dependent Practitioner or Dependent Practitioner in the Hospital. The Supervising Physician will furnish evidence of such coverage to the Hospital. The Advanced Dependent Practitioner or Dependent Practitioner will act in the Hospital only while such coverage is in effect.

## APPENDIX B

### **GUIDELINES FOR DETERMINING THE NEED FOR NEW CATEGORIES OF ALLIED HEALTH PRACTITIONERS**

#### **B.1. Review of Need**

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

#### **B.2. Additional Recommendations**

- (a) If the Joint Conference Committee makes a recommendation that there is a need for the particular category of Allied Health Practitioner at the Hospital, it shall also recommend:
  - (1) any specific qualifications and/or training that must be possessed beyond those set forth in this Policy;



- (2) a detailed description of a scope of practice or clinical privileges;
  - (3) any specific conditions that apply to practice within the Hospital; and
  - (4) any supervision requirements, if applicable.
- (b) In developing such recommendations, the Joint Conference Committee shall consult the appropriate department chair and consider relevant Indiana law and may contact professional societies or associations. The Joint Conference Committee may also recommend the number of Allied Health Practitioners that are needed.

## APPENDIX C

### **ALLIED HEALTH PRACTITIONERS**

1. **Licensed Independent Practitioners** means all those Allied Health Practitioners who are licensed or certified under state law, authorized to function independently in the Hospital, and granted clinical privileges. These individuals require no formal or direct supervision by a physician. The Allied Health Practitioners currently practicing at the Hospital as Licensed Independent Practitioners are as follows: M.D., D.O., D.P.M., D.D.S., Clinical Psychologist (Ed.D., Ph.D.).
2. **Advanced Dependent Practitioners** means all those Allied Health Practitioners who are licensed or certified under state law, are granted clinical privileges, and function in the Hospital under the supervision of a practitioner(s) appointed to the Medical Staff. The Allied Health Practitioners currently practicing at the Hospital as Advanced Dependent Practitioners are as follows: Nurse Practitioner, Certified Nurse Midwife, Physician Assistant.
3. **Dependent Practitioners** means all those Allied Health Practitioners who are permitted to practice in the Hospital only under the supervision of a practitioner(s) appointed to the Medical Staff and who function pursuant to a defined scope of practice. The Allied Health Practitioners currently practicing at the Hospital as Dependent Practitioners are as follows: Registered Nurse, Licensed Practice Nurse, Cardiovascular Perfusionist, Certified Surgical Technologist, Registered Radiologist Assistant, Clinical Social Worker, Mental Health Counselor, Dental Assistant, Medical Assistant.

## APPENDIX D

### **ALLIED HEALTH CERTIFICATION BODIES**

The following are boards that have been approved for certification of members of the Allied Health Staff:

- American Nurses Credentialing Center
- American Association of Nurse Practitioners
- National Commission on Certification of Physician Assistants
- American Association of Nurse Anesthetists
- American Registry of Radiologic Technologists
- American Midwifery Certification Board
- National Certification Corporation
- Oncology Nursing Certification Corporation