

**MEDICAL STAFF BYLAWS, POLICIES, AND
RULES AND REGULATIONS
OF
INDIANA UNIVERSITY HEALTH
Metro Region**



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

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

1.C. TIME LIMITS

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

1.D. DELEGATION OF FUNCTIONS

- (1) When a function under this Policy is to be carried out by a member of Hospital administration, by a Medical Staff member, or by a Medical Staff committee, the individual, or the committee through its chair, may delegate performance of the function to a qualified designee who is a practitioner or Hospital employee (or a committee of such individuals). Any such designee must treat and maintain all credentialing, privileging, and peer review information in a strictly confidential manner and is bound by all other terms, conditions, and requirements of the Medical Staff Bylaws and related policies. The delegating individual or

committee is responsible for ensuring that the designee appropriately performs the function in question. Any documentation created by the designee is a record of the committee that is ultimately responsible for the review in a particular matter.

- (2) When a Medical Staff Leader is unavailable or unable to perform a necessary function, one or more of the Medical Staff Leaders may perform the function personally or delegate it to another appropriate individual.

1.E. HOSPITAL EMPLOYEES

- (1) Any member of the Medical Staff or Allied Health Staff who is employed by IU Health or an IU Health-affiliated group is bound by all of the same conditions and requirements in this Policy that apply to members who are not employed by IU Health or an IU Health-affiliated group.
- (2) If a concern about an employed member's clinical competence, conduct or behavior arises, the concern may be reviewed and addressed in accordance with this or another Medical Staff policy, in which event a report will be provided to IU Health. This provision does not preclude IU Health or IU Health-affiliated group from addressing an issue in accordance with its employment policies/manuals or in accordance with the terms of any applicable employment contract.

1.F. CONFIDENTIALITY AND PEER REVIEW PROTECTION

1.F.1. Confidentiality:

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

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

Any breach of confidentiality may result in a professional review action and/or appropriate legal action. Such breaches are unauthorized and do not waive the peer review privilege. Any member of the Medical Staff who becomes aware of a breach of confidentiality must immediately inform the CEO, the CMO, or the President of the Medical Staff.

1.F.2. Peer Review Protection:

- (a) All credentialing and professional practice evaluation activities pursuant to this Policy and related Medical Staff documents shall be performed by ~~the~~ “peer review committees in accordance with the relevant state law. These committees include, but are not limited to:
- (1) all standing and ad hoc Medical Staff and Hospital committees;
 - (2) all sections;
 - (3) hearing and appellate review panels;
 - (4) the Board and its committees; and
 - (5) any individual acting for or on behalf of any such entity, including but not limited to the Medical Staff Leaders, the CMO, all Hospital personnel, and experts or consultants retained to assist in peer review activities.

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

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

ARTICLE 2

QUALIFICATIONS, CONDITIONS, AND RESPONSIBILITIES

2.A. QUALIFICATIONS

2.A.1. Threshold Eligibility Criteria:

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

- (a) have a current, unrestricted license to practice in Indiana that is not subject to probation and have never had a license to practice revoked, restricted or suspended by any state licensing agency;
- (b) where applicable to their practice, have a current, unrestricted DEA registration and state controlled substance license;
- (c) be located (office and residence) within the geographic service area of the Hospital, as defined by the Board, close enough to fulfill their Medical Staff responsibilities and to provide timely and continuous care for their patients in the Hospital;
- (d) have current, valid professional liability insurance coverage in a form and in amounts satisfactory to the Hospital and the state of Indiana;
- (e) have never been convicted of, or entered a plea of guilty or no contest to, Medicare, Medicaid, or other federal or state governmental or private third-party payer fraud or program abuse, nor have been required to pay civil monetary penalties for the same;
- (f) have never been, and not currently be, excluded, precluded, or debarred from participation in Medicare, Medicaid, or other federal or state governmental health care program;
- (g) have never had Medical Staff appointment, permission to practice, or clinical privileges, or status as a participating provider denied, revoked, suspended, or terminated by any health care facility or health plan for reasons related to clinical competence or professional conduct, or termination of employment with “do not rehire” status from IU Health;
- (h) have never resigned Medical Staff appointment or permission to practice or relinquished privileges during a Medical Staff investigation or in exchange for not conducting such an investigation;

- (i) have never been convicted of, or entered a plea of guilty or no contest, to any felony; or to any misdemeanor relating to controlled substances, illegal drugs, insurance or health care fraud or abuse, child abuse, elder abuse, or violence;
- (j) agree to personally fulfill all responsibilities regarding emergency service call coverage for their specialty or to obtain appropriate coverage (as determined by the Credentials Committee) by another member of the Medical Staff;
- (k) have or agree to make appropriate coverage arrangements (as determined by the Credentials Committee) with other members of the Medical Staff for those times when the individual will be unavailable;
- (l) demonstrate recent clinical activity in their primary area of practice during at least two of the last four years;
- (m) if applying for privileges in an area that is covered by an exclusive contract, meet the specific requirements set forth in that contract;
- (n) document compliance with all applicable training and educational protocols as well as orientation requirements that may be adopted by the MSEC or required by the Board, including, but not limited to, those involving electronic medical records, the privacy and security of protected health information, infection control, and patient safety;
- (o) provide documentation showing evidence of any immunizations, vaccinations, and/or screening tests required by Medical Staff or Hospital Policy;
- (p) if seeking to practice as an Advanced Practice Provider, have a written agreement with a Supervising/Collaborating Physician, which agreement must meet all applicable requirements of state law and Hospital policy;
- (q) 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;
- (r) be board certified in their primary area of practice at the Hospital. Applicants who are not board certified at the time of application but who have completed their residency or fellowship training within the last five years shall be eligible for Medical Staff appointment. However, in order to remain eligible, applicants must achieve board certification in their primary area of practice within five years from the date of completion of their residency or fellowship training; and

- (s) maintain board certification and, to the extent required by the applicable specialty/subspecialty board, satisfy recertification requirements. Recertification shall be assessed at reappointment.

The requirements in (q), (r) and (s) shall be applicable only to those individuals who apply for initial staff appointment after February 24, 2011. Existing members shall be governed by the residency training and board certification requirements in effect at the time of their initial appointment.

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

- (a) Any applicant who does not satisfy one or more of the threshold eligibility criteria outlined above may request that it be waived. The applicant requesting the waiver bears the burden of demonstrating (i) that he or she is otherwise qualified, and (ii) exceptional circumstances exist (e.g., when there is a demonstrated Hospital or Medical Staff need for the services in question). Exceptional circumstances generally do not include situations where a waiver is sought for the convenience of an applicant (e.g., applicants who wish to defer taking Board examinations).
- (b) A request for a waiver shall be submitted to the Credentials Committee for consideration. In reviewing the request for a waiver, the Credentials Committee may consider the specific qualifications of the applicant in question, input from the relevant Section chief or co-chiefs, and the best interests of the Hospital and the communities it serves. Additionally, the Credentials Committee may, in its discretion, consider the application form and other information supplied by the applicant. The Credentials Committee's recommendation will be forwarded to the MSEC. Any recommendation to grant a waiver must include the specific basis for the recommendation.
- (c) The MSEC shall review the recommendation of the Credentials Committee and make a recommendation to the Board regarding whether to grant or deny the request for a waiver. Any recommendation to grant a waiver must include the specific basis for the recommendation.
- (d) No applicant is entitled to a waiver or to a hearing if the Board determines not to grant a waiver. A determination that an applicant is not entitled to a waiver is not a "denial" of appointment or clinical privileges. Rather, that individual is ineligible to request appointment or clinical privileges. A determination of ineligibility is not a matter that is reportable to either the state board or the National Practitioner Data Bank.
- (e) The granting of a waiver in a particular case does not set a precedent for any other applicant or group of applicants.

- (f) If a waiver is granted that does not specifically include a time limitation, the waiver is considered to be permanent and the individual does not have to request a waiver at subsequent reappointment cycles.
- (g) An application for appointment that does not satisfy an eligibility criterion will not be processed until the Board has determined that a waiver should be granted.

2.A.3. Factors for Evaluation:

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

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

2.A.4. No Entitlement to Appointment:

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

- (a) is employed by IU Health 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 appointment or privileges 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 on the basis of gender, race, creed, sexual orientation, 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 quality care to all patients for whom the individual has responsibility;
 - (2) to abide by the Bylaws, policies, and Rules and Regulations of the Hospital and Medical Staff and any revisions or amendments thereto;
 - (3) to participate in Medical Staff affairs through committee service and participation in performance improvement and professional practice evaluation/peer review activities, and to perform such other reasonable duties and responsibilities as may be assigned;
 - (4) within the scope of his or her privileges, to provide emergency service call coverage, consultations, and care for unassigned patients (a member must complete all scheduled emergency service call obligations or arrange appropriate coverage) Response time to the facility for emergency consultation is within 60 minutes;
 - (5) to comply with clinical practice or evidence-based medicine protocols pertinent to his or her medical specialty, as may be adopted by the Medical Staff or the Medical Staff leadership, including those related to national patient safety initiatives and core measures, or to clearly document the clinical reasons for variance;

- (6) to comply with all applicable training and educational protocols as well as orientation requirements that may be adopted by the MSEC or required by the Board, including, but not limited to, those involving electronic medical records, the privacy and security of protected health information, infection control, and patient safety;
- (7) to inform the CMO or President of the Medical Staff, in writing or via e-mail, as soon as possible but in all cases within 10 days, of any change in the individual's status or any change in the information provided on the individual's application form. This information shall be provided, with or without request, and shall include, but not be limited to:
- any and all complaints regarding, or changes in, licensure status or DEA certificate,
 - adverse changes in professional liability insurance coverage,
 - the filing of a professional liability lawsuit against the practitioner,
 - changes in the practitioner's status (appointment, privileges, and/or scope of practice) at any other hospital or health care entity as a result of peer review activities or in order to avoid initiation of peer review activities,
 - changes in the practitioner's employment status at any medical group or hospital as a result of issues related to clinical competence or professional conduct,
 - any arrest, charge, indictment, conviction, or a plea of guilty or no contest related to a felony or to any misdemeanor relating to controlled substances, illegal drugs, insurance or health care fraud or abuse, child abuse, elder abuse, or violence,
 - exclusion or preclusion from participation in Medicare/Medicaid or any sanctions imposed,
 - any changes in the individual's ability to safely and competently exercise clinical privileges or perform the duties and responsibilities of appointment or permission to practice because of health status issues, including, but not limited to, a physical, mental, or emotional condition that could adversely affect the individual's ability to practice safely and competently, or impairment due to addiction, alcohol use, or other similar issue (all of which shall be referred for review under the Medical Staff's health policy),

- any referral to a state board health-related program, and
 - any charge of, or arrest for, driving under the influence (“DUI”) (which shall be referred for review under the Medical Staff’s health policy);
- (8) to immediately submit to an appropriate evaluation, which may include diagnostic testing (including, but not limited to, a blood and/or urine test) and/or a complete physical, mental, and/or behavioral evaluation, if at least two Medical Staff Leaders (or one Medical Staff Leader and one member of the Administrative team) are concerned with the individual’s ability to safely and competently care for patients. The health care professional(s) to perform the testing and/or evaluations shall be determined by the Medical Staff Leaders (or the Medical Staff Leader and member of the Administrative team) and the Medical Staff member must execute all appropriate releases to permit the sharing of information with the Medical Staff Leaders;
 - (9) to meet with Medical Staff Leaders and/or Hospital administration upon request, to provide information regarding professional qualifications upon written request, and to participate in collegial efforts as may be requested;
 - (10) to participate in personal or phone interviews in regard to an application for initial appointment or reappointment, if requested;
 - (11) to maintain and monitor a current professional e-mail address which is HIPAA compliant with the Medical Staff Office, which will be the primary mechanism used to communicate all Medical Staff information to the member;
 - (12) to provide valid contact information in order to facilitate practitioner-to-practitioner communication (e.g., mobile phone number or valid answering service information);
 - (13) if exercising clinical privileges, to use the Hospital sufficiently to allow continuing assessment of current competence;
 - (14) to seek consultation whenever necessary;
 - (15) to complete in a timely manner all medical and other required records and to utilize the electronic medical record as required with respect to health care delivered in the Hospital;
 - (16) to perform all services and to act in a cooperative and professional manner;

- (17) to promptly pay any applicable dues, assessments, or fines; and
- (18) to satisfy continuing medical education requirements.
- (b) In addition to the above, every individual seeking to practice as an Advanced Practice Provider and his or her respective Supervising/Collaborating Physician specifically agree that:
 - (1) any privileges granted by the Board to any Allied Health Practitioner who is an Advanced Practice Provider will be performed in the Hospital only under the supervision of a Supervising/Collaborating Physician;
 - (2) the number of Advanced Practice Providers 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 Practice Provider will give notice, within three days, to the CEO of any revisions or modifications that are made to the supervision agreement.
- (c) Additional supervision requirements are set forth in Appendix A.

2.B.2. Burden of Providing Information:

- (a) 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, 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 and reappointment have the burden of providing evidence that all the statements made and information given on the application are accurate and complete.
- (c) An application shall be complete when all questions on the application form have been answered, all supporting documentation has been supplied, all information has been verified from primary sources, and all application fees have been paid. An application shall become incomplete if the need arises for new, additional, or clarifying information at any time during the credentialing process. Whenever there is a need for new, additional, or clarifying information – outside of the

normal, routine credentialing process – the application will not be processed until the information is provided. If the application continues to be incomplete 30 days after the individual has been notified of the need for new, additional, or clarifying information, the application shall be deemed to be withdrawn.

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

2.C. APPLICATION

2.C.1. Information:

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

2.C.2. Misstatements and Omissions:

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

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

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

- (a) Immunity:

The applicant releases from any and all liability, extends immunity to, and agrees not to sue the Hospital or the Board, any member of the Medical Staff or Board, their authorized representatives, and third parties who provide information for any

matter relating to appointment, reappointment, clinical privileges, or the applicant's qualifications for the same. This immunity covers any actions, recommendations, communications, and/or disclosures involving the individual that are made, or taken by the Medical Staff, the Hospital, its authorized representatives, or third parties in the course of credentialing and peer review activities. The participant agrees not to sue any individuals for acts that are covered under the immunities set forth above. This immunity also extends to any reports that are made to government regulatory and licensure boards or agencies pursuant to federal or state law.

(b) Authorization to Obtain Information from Third Parties:

The applicant specifically authorizes the Hospital, Medical Staff Leaders, and their authorized representatives (1) to consult with any third party who may have information bearing on the applicant's professional qualifications, credentials, clinical competence, character, ability to perform safely and competently, ethics, behavior, or any other matter reasonably having a bearing on his or her qualifications for initial and continued appointment to the Medical Staff or the Allied Health Staff, and (2) to obtain any and all communications, reports, records, statements, documents, recommendations or disclosures of third parties that may be relevant to such questions. The applicant also specifically authorizes third parties to release this information to the Hospital and its authorized representatives upon request. Further, the applicant ~~also~~ agrees to sign necessary consent forms to permit a consumer reporting agency to conduct a criminal background check on the applicant and report the results to the Hospital.

(c) Authorization to Release Information to Third Parties:

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

(d) Authorization to Share Information Among IU Health Entities:

The individual specifically authorizes IU Health Entities (as defined below) to share with one another credentialing, peer review, and other information and documentation pertaining to the individual's clinical competence, professional conduct, and health. This information and documentation may be shared at any time, including, but not limited to, any initial evaluation of an individual's qualifications, any periodic reassessment of those qualifications, or when a

question is raised about the individual. The sharing of any information or documentation pursuant to this Section does not waive any privilege, and all such disclosures shall be made with the understanding that the receiving entity will only use such information and documentation for peer review purposes.

For purposes of this Section, an IU Health Entity means any entity which, directly or indirectly, through one or more intermediaries, is controlled by IU Health. This includes, but is not limited to, IU Health hospitals, ambulatory surgery centers, and IU Health affiliated physician groups.

(e) Hearing and Appeal Procedures:

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

(f) Legal Actions:

If notwithstanding the provisions in this Section, an individual institutes legal action challenging any credentialing, privileging, peer review, or other action affecting appointment or privileges, or any report that may be made to government regulatory and licensure boards or agencies, and does not prevail, he or she shall reimburse the Hospital and any member of the Medical Staff or Board involved in the action for all costs incurred in defending such legal action, including reasonable attorney's fees, expert witness fees, and lost revenues.

(g) Scope of Section:

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

- (1) whether or not appointment or clinical privileges are granted;
- (2) throughout the term of any appointment or reappointment period and thereafter;
- (3) should appointment, reappointment, or clinical privileges be revoked, reduced, restricted, suspended, and/or otherwise affected as part of the Hospital's professional review activities;
- (4) as applicable, to any third-party inquiries received after the individual leaves the Medical Staff or Allied Health Staff about his/her tenure at the Hospital; and
- (5) as applicable, to any reports that may be made to government regulatory and licensing boards or agencies pursuant to federal or state law.

ARTICLE 3

PROCEDURE FOR INITIAL APPOINTMENT AND PRIVILEGES

3.A. PROCEDURE FOR INITIAL APPOINTMENT AND PRIVILEGES

3.A.1. Application:

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

3.A.2. Initial Review of Application:

- (a) A completed application form with copies of all required documents must be returned to the Medical Staff Office within 30 days after receipt. The application must be accompanied by the application fee.
- (b) As a preliminary step, the application shall be reviewed by the Medical Staff Office to determine that all questions have been answered and that the applicant satisfies all threshold eligibility criteria. Incomplete applications will not be processed. Applicants who fail to return completed applications or fail to meet the threshold eligibility criteria shall be notified that their applications shall not be processed. A determination of ineligibility does not entitle the individual to the hearing and appeal rights outlined in this Policy, and is not reportable to any state agency or to the National Practitioner Data Bank.
- (c) The Medical Staff Office shall oversee the process of gathering and verifying relevant information, and confirming that all references and other information deemed pertinent have been received.

- (d) Evidence of the applicant's character, professional competence, qualifications, behavior, and ethical standing shall be examined. This information may be contained in the application, and obtained from references and other available sources, including the applicant's past or current department chair at other health care entities, residency training director, and others who may have knowledge about the applicant's education, training, experience, and ability to work with others.
- (e) An interview(s) with the applicant may be conducted by one of or a combination of any of the following: the Section chief or co-chiefs, the Credentials Committee, a Credentials Committee representative, the MSEC, the President of the Medical Staff, CMO, or the CEO.

3.A.3. Section Chief or Co-Chiefs Procedure:

- (a) The chief(s) or co-chiefs in each Section in which the applicant has requested clinical privileges shall review the application and all supporting materials and prepare a report regarding whether the applicant has satisfied all of the qualifications for appointment and the clinical privileges requested.
- (b) The applicable Section chief(s) or co-chiefs shall be available to the Credentials Committee, the MSEC, and the Board to answer any questions that may be raised with respect to that chief's report and findings.

3.A.4. Credentials Committee Procedure:

- (a) The Credentials Committee shall consider the report prepared by the Section chief(s) or co-chiefs and shall make a recommendation.
- (b) The Credentials Committee may use the expertise of the Section chief(s) or co-chiefs(s), or any member of the Section, or an outside consultant, if additional information is required regarding the applicant's qualifications.
- (c) After determining that an applicant is otherwise qualified for appointment and privileges, the Credentials Committee shall review the health status information to determine if there is any question about the applicant's ability to perform the privileges requested and the responsibilities of appointment. If so, the Credentials Committee may require that the applicant undergo a physical and/or mental examination by a physician(s) satisfactory to the Credentials Committee. The results of this examination shall be made available to the Committee for its consideration. Failure of an applicant to undergo an examination within a reasonable time after a written request from the Credentials Committee shall be considered a voluntary withdrawal of the application and all processing of the application shall cease.

- (d) The Credentials Committee may recommend the imposition of specific conditions related to behavior, health or clinical issues. The Credentials Committee may also recommend that appointment be granted for a period of less than two years in order to permit closer monitoring of the applicant's compliance with any conditions. Unless these matters involve the specific recommendations set forth in Section 7.A.1(a) or 8.A.1(a) of this Policy, such conditions do not entitle an individual to request the procedural rights set forth in Article 7 or Article 8 of this Policy.
- (e) If the recommendation of the Credentials Committee is delayed longer than 60 days, the chair of the Credentials Committee shall send a letter to the applicant, with a copy to the CEO, explaining the reasons for the delay.

3.A.5. MSEC Recommendation:

- (a) At its next regular meeting after receipt of the written report and recommendation of the Credentials Committee, the MSEC 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 MSEC is to appoint, the recommendation shall be forwarded to the Board.
- (c) If the recommendation of the MSEC would entitle the applicant to request a hearing, the MSEC shall forward its recommendation to the CEO, who shall promptly send Special Notice to the applicant. The CEO shall then hold the application until after the applicant has completed or waived a hearing and appeal.

3.A.6. Board Action:

- (a) Expedited Review. The Board may delegate to a committee, consisting of at least two Board members, action on appointment, reappointment, and clinical privileges if there has been a favorable recommendation from the Credentials Committee and the MSEC 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 or privileges 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) Full Board Review. When there has been no delegation to the Board Committee, upon receipt of a recommendation for appointment and clinical privileges, the Board may:
 - (1) appoint the applicant and grant clinical privileges as recommended; or
 - (2) refer the matter back to the Credentials Committee or MSEC 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 determines to reject a favorable recommendation, it should first discuss the matter with the chair of the Credentials Committee and the chair of the MSEC. If the Board's determination remains unfavorable to the applicant, the CEO shall promptly send Special Notice to the applicant that the applicant is entitled to request a hearing.
- (d) Any final decision by the Board to grant, deny, revise, or revoke appointment or clinical privileges 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.

3.B. FPPE TO CONFIRM COMPETENCE AND PROFESSIONALISM

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

3.C. DEVELOPMENT OF A RE-ENTRY PLAN

- (1) **Review.** If an individual who fails to demonstrate recent clinical activity in his or her primary area of practice during the last two years requests a waiver, the relevant Department Chair, Chief Medical Officer (“CMO”) and Medical Director (if applicable and if requested by the Department Chair) will review the application. The individual will be offered the opportunity to provide written input and to discuss his or her application with this group. This group will then consider the factors in the next section and recommend to the Credentials Committee Chair whether a re-entry plan is appropriate. If so, the group will recommend the proposed terms of the re-entry plan (including, but not limited to, the options described in subsection (4) below).
- (2) **Factors for Consideration.** In addition to the application and any supporting documentation, the following factors shall be considered in determining whether the development of a re-entry plan is appropriate and, if so, the terms of any such re-entry plan:
 - (a) length of time that the individual was out of practice;
 - (b) whether the individual obtained CME, attended professional conferences, conducted research, or engaged in other activities to stay up to speed with changes in his or her specialty during that time;
 - (c) if the individual previously practiced at the Hospital, the scope of privileges, levels of performance, and any long-standing commitment to the Hospital prior to leaving practice and whether the leave was planned or unplanned;
 - (d) an assessment of the individual’s practice status at the time of departure from practice (either at this Hospital or at another facility if not previously practicing at the Hospital), including quality data, malpractice history, and references;
 - (e) any clinical activities the individual engaged in outside of an acute care hospital setting during the time he/she was out of practice; and
 - (f) any state licensing body requirements with regard to re-entry to practice.
- (3) **No Requirement to Develop Re-Entry Plan.** Based on all of the information available, the Credentials Committee shall determine whether a re-entry plan is appropriate for the individual. Nothing in this Policy requires the Hospital to develop a re-entry plan for an individual who fails

to satisfy the eligibility criterion related to clinical activity. The Hospital may determine that the individual is simply ineligible for membership and/or privileges and the factors at hand do not weigh in favor of making an exception to the rule in the case of this individual. Such determinations do not entitle the individual to a Medical Staff hearing or appeal, nor do they require the Hospital to report to the National Practitioner Data Bank or to the state licensing board.

- (4) ***Re-Entry Plan Options.*** If the Credentials Committee determines to offer an individual the opportunity for a waiver through a re-entry plan, that plan may include, but is not limited to, the following (used individually or in combination):
- (a) ***Participation in a Formal Evaluation/Assessment Program*** which means that the individual must enroll in a program approved by the Credentials Committee that is designed to identify specific deficiencies in the individual's clinical practice. The individual must complete the assessment program within a specified time period. The individual must execute a release to allow the Credentials Committee to communicate information to, and receive information from, the selected assessment program. The cost of such program will be borne by the individual.
 - (b) ***Additional Education/CME*** which means that the individual must arrange for education or CME of a duration and type approved by the Credentials Committee. The educational activity/program may be chosen by the Credentials Committee or by the individual. If the activity/program is chosen by the individual, it must be approved by the Credentials Committee. The cost of such program will be borne by the individual.
 - (c) ***Additional Training*** which means that the individual must complete additional training in a program approved by the Credentials Committee. Such training could take the form of a clinical refresher course, a specialty board refresher course, or a formal fellowship or residency program, as determined by the Credentials Committee. The individual must execute a release to allow the Credentials Committee to communicate information to, and receive information from, the selected program. The individual must successfully complete the training within the period of time specified by the Credentials Committee. The director of the training program or appropriate supervisor must provide an assessment and evaluation of the individual's current competence, skill, judgment and technique to the Credentials Committee. The cost of such program will be borne by the individual.

- (d) ***Second Opinions/Consultations*** which means that before the practitioner proceeds with a particular treatment plan or procedure, the practitioner must obtain a second opinion or consultation from a Medical Staff member approved by the Credentials Committee. If there is any disagreement about the proper course of treatment, the practitioner must discuss the matter further with practitioners identified by the Credentials Committee before proceeding further. The practitioner providing the second opinion/consultation must complete a second opinion/consultation report form for each case, which shall be reviewed by the Credentials Committee. Any costs associated with a requirement for a second opinion or consultation under this section will be borne by the practitioner.
- (e) ***Concurrent Proctoring*** which means that a certain number of the practitioner's future cases of a particular type (e.g., the practitioner's first five vascular cases or first five cases managing a particular medical condition) must be personally proctored or reviewed concurrently (i.e., as care is provided) by a Medical Staff member approved by the Credentials Committee, or by an appropriately credentialed individual from outside of the Medical Staff approved by the Credentials Committee. For proceduralists, the proctor must be present during the relevant portions of the operative procedure. For other practitioners, the proctor must personally assess the practitioner's evaluation of the patient and be available throughout the course of treatment. Proctors are intended to be observers who neither supervise the practitioner nor direct the care of the patient, but they are authorized to intervene in a patient's care whenever that may be in a patient's best interests. Proctors must complete the appropriate review form, which shall be reviewed by the Credentials Committee. Any costs associated with a requirement for concurrent proctoring under this section will be borne by the practitioner.
- (f) ***Focused Prospective Monitoring*** which means that a certain number of the practitioner's future cases of a particular type will be subject to a focused review (e.g., review of the next 10 similar cases performed or managed by the practitioner).
- (g) ***Additional Conditions*** which means the Credentials Committee has wide latitude to tailor the re-entry plan and make additional recommendations on the imposition of conditions of membership or clinical privileges (e.g., simulation, modification of privileges, requiring that the individual provide evidence of his or her compliance with any applicable state licensing board or agency

re-entry requirements, etc.). The costs of any of the conditions imposed under this section will be borne by the individual.

The Credentials Committee shall indicate whether the individual must complete any or all of the elements of the re-entry plan prior to his or her membership and clinical privileges becoming effective. If any part of the re-entry plan will be completed after membership and privileges are granted, the Credentials Committee may delegate oversight of the plan to the Physician Performance Committee (“PPC”). Additional guidance regarding the re-entry plan is found in **Appendix E**.

- (5) ***Re-Entry Following a Health Issue.*** The process set forth in this Policy will be used if an individual has been absent from clinical practice for an extended period of time, regardless of the cause of that absence. If the Hospital determines that a re-entry plan would address the individual’s lack of recent clinical activity and that the individual’s application will thus be processed, the health issue will then be evaluated pursuant to the process set forth in the Credentialing Policy (i.e., after determining that the individual is otherwise qualified for appointment and privileges, the Credentials Committee may require the individual to submit documentation or undergo a fitness for practice evaluation to confirm the individual’s ability to practice safely).

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. Each individual who has been appointed to the Medical Staff or Allied Health Staff is entitled to exercise only those clinical privileges specifically granted by the Board.
- (b) For privilege requests to be processed, the applicant must satisfy any applicable threshold eligibility criteria.
- (c) Requests for clinical privileges that are subject to an exclusive contract shall not be processed except as consistent with the applicable contract.
- (d) Core privileges, special privileges, privilege delineations, and/or the criteria for the same shall be developed by the relevant Sections and shall be forwarded to the Credentials Committee for review and recommendation. The Credentials Committee will forward its recommendations to the MSEC, which will review the matter and forward its recommendations to the Board for final action. The clinical privileges recommended to the Board shall be based on consideration of the following factors:
 - (1) education, relevant training, experience, and demonstrated current competence, including medical/clinical knowledge, technical and clinical skills, judgment, interpersonal and communication skills, and professionalism with patients, families, and other members of the health care team and peer evaluations relating to these criteria;
 - (2) appropriateness of utilization patterns;
 - (3) ability to perform the privileges requested competently and safely;
 - (4) information resulting from ongoing and focused professional practice evaluation and other performance improvement activities, as applicable;
 - (5) availability of other qualified staff members with appropriate privileges (as determined by the Credentials Committee) to provide coverage in case of the applicant's illness or unavailability;

- (6) adequate professional liability insurance coverage for the clinical privileges requested;
 - (7) the Hospital's available resources and personnel;
 - (8) any previously successful or currently pending challenges to any licensure or registration, or the voluntary or involuntary relinquishment of such licensure or registration;
 - (9) any information concerning professional review actions or voluntary or involuntary termination, limitation, reduction, or loss of appointment or clinical privileges at another hospital;
 - (10) practitioner-specific data as compared to aggregate data, when available;
 - (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) Requests for increased privileges must state the additional clinical privileges requested and provide information sufficient to establish eligibility. If the member is eligible and the application is complete, it shall be processed in the same manner as an application for initial clinical privileges.
 - (f) 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).

4.A.2. Privilege Modifications, Waivers, and Resignations:

- (a) Scope. This Section applies to all requests for modification of clinical privileges during the term of appointment (increases and relinquishments), waivers related to eligibility criteria for privileges or the scope of those privileges, and resignations of all clinical privileges and appointment to the Medical Staff or Allied Health Staff. Any such requests should be submitted in writing or via e-mail to the Medical Staff Office.
- (b) Increased Privileges.
 - (1) Requests for increased privileges must state the specific additional clinical privileges requested and provide information sufficient to establish

eligibility, as specified in applicable criteria, and current clinical competence.

- (2) If the individual is eligible and the application is complete, it will be processed in the same manner as an application for initial clinical privileges.

(c) Relinquishment of Privileges.

A request to relinquish any individual clinical privilege, whether or not part of the core, will be processed in accordance with the following:

- (1) **Formal Request:** The individual must forward a written or electronic request to the Medical Staff Office, which must indicate the specific patient care services 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.
- (2) **On-Call Obligations:** By limiting the scope of privileges, the individual nevertheless agrees to participate in the general on-call schedule for the relevant specialty and to maintain sufficient competency to assist other physicians on the Medical Staff in assessing and stabilizing patients who require services within that specialty, if this call responsibility is required by the Medical Staff leadership after review of the specific circumstances involved. If, upon assessment, a patient needs a service that is no longer provided by the individual due to this request, the individual shall work cooperatively with the other practitioners in arranging for another individual with appropriate clinical privileges to care for the patient or, if such an individual is not available, in arranging for the patient's transfer.
- (3) **Review Process:** A request for a relinquishment shall be submitted to the Credentials Committee for consideration. In reviewing the request, the Credentials Committee may obtain input from the relevant Section chiefs or co-chiefs and shall consider the following factors:
 - (i) the Hospital's mission and ability to serve the health care needs of the community by providing timely, appropriate care within its facilities;
 - (ii) whether sufficient notice has been given to provide a smooth transition of patient care services;
 - (iii) fairness to the individual requesting the relinquishment, including past service and the other demands placed on the individual;

- (iv) fairness to other Medical Staff members who serve on the call roster in the relevant specialty, including the effect that the relinquishment would have on them and any inequalities that may be created;
- (v) 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;
- (vi) 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
- (vii) how the request may affect the Hospital's ability to comply with applicable regulatory requirements, including the Emergency Medical Treatment and Active Labor Act.

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

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

(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. All such requests will be processed in accordance with the process described in Section 2.A.2.
- (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 process set forth in paragraph (c) above shall be followed.

(e) Resignation of Appointment and Privileges.

- (1) Any individual who wishes to resign all of his or her clinical privileges and appointment to the Medical Staff or Allied Health Staff shall provide notification of such decision to the Medical Staff Office. This notification should indicate the individual's specific resignation date.
- (2) On the effective date of the individual's resignation, completion of the following obligations will be confirmed, recorded in the individual's confidential file, and divulged in response to any future credentialing inquiries concerning the individual:
 - (i) completion of all medical records;
 - (ii) appropriate management of any hospitalized patients who were under the individual's care at the time of resignation (i.e., patients were discharged or transferred to another member with appropriate clinical privileges); and
 - (iii) completion of any scheduled emergency service call (or arrangement for appropriate coverage) prior to resigning.

- (f) 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 significant new technique to perform an existing procedure ("new procedure") shall not be processed until (1) a determination has been made that the procedure shall be offered by the Hospital; and (2) criteria for 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 will prepare and submit a report to the CMO addressing the following:
 - (1) appropriate education, training, and experience necessary to perform the new procedure safely and competently;
 - (2) clinical indications for when the new procedure is appropriate;
 - (3) whether there is empirical evidence of improved patient outcomes with the new procedure or other clinical benefits to patients;

- (4) whether proficiency for the new procedure is volume-sensitive and if the requisite volume would be available;
- (5) whether the new procedure is being performed at other similar hospitals and the experiences of those institutions; and
- (6) whether the Hospital currently has the resources, including space, equipment, personnel, and other support services, to safely and effectively perform the new procedure.

Hospital administration shall review this report, and consult with the President of the Medical Staff, the applicable Section chief or co-chiefs, and the Credentials Committee (any of which may conduct additional research as may be necessary;) and shall make a preliminary determination as to whether the new procedure should be offered to the community.

- (c) If the preliminary determination of the Hospital is favorable, the Credentials Committee will determine whether the request constitutes a “new procedure” as defined by this Section or if it is an extension of an existing privilege. If it is determined that it does constitute a “new procedure,” the Credentials Committee will then develop threshold credentialing criteria to determine those individuals who are eligible to request the clinical privileges. In developing the criteria, the Credentials Committee may conduct additional research and consult with experts, as necessary, and develop recommendations regarding:
 - (1) the appropriate 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 in order to confirm competence; 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 MSEC, 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 MSEC’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) At any point in the process, the individual requesting the new procedure or technique may be asked to meet with the Credentials Committee, the MSEC, and/or the Board before any determination is made. The individual may also be asked to provide written responses to specific questions related to his or her request and/or to provide additional information in support of his or her request.
- (g) 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 members in another specialty shall not be processed until the steps outlined in this section have been completed and a determination has been made regarding the member's eligibility to request the clinical privilege(s) in question.
- (b) As an initial step in the process, the individual seeking the privilege shall submit a report to the Credentials Committee that specifies the minimum qualifications needed to perform the procedure safely and competently, whether the individual's specialty is performing the privilege at other similar hospitals, and the experiences of those other hospitals in terms of patient care outcomes and quality of care.
- (c) The Credentials Committee shall then conduct additional research and consult with experts, as necessary, including those on the Medical Staff (e.g., Section chiefs or co-chiefs, 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 appropriate education, training, and experience necessary to perform the clinical privileges in question;
 - (2) the clinical indications for when the procedure is appropriate;
 - (3) the manner of addressing the most common complications that arise which may be outside of the scope of the clinical privileges that have been granted to the requesting individual;
 - (4) the extent (time frame and mechanism) of focused monitoring and supervision that should occur if the privileges are granted in order to confirm competence;

- (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 MSEC, 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 MSEC'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) The scope and extent of surgical procedures that a dentist or an oral and maxillofacial surgeon may perform in the Hospital shall be delineated and recommended in the same manner as other clinical privileges.
- (b) A medical history and physical examination of the patient shall be made and recorded by a physician who is a member of the Medical Staff before dental surgery shall be performed (with the exception of (c) below), and a designated physician shall be responsible for the medical care of the patient throughout the period of hospitalization.
- (c) Oral and maxillofacial surgeons who admit patients without underlying health problems may perform a complete admission history and physical examination and assess the medical risks of the procedure on the patient if they are deemed qualified to do so by the Credentials Committee and.
- (d) The dentist or oral and maxillofacial surgeon shall be responsible for the dental care of the patient, including the dental history and dental physical examination, as well as all appropriate elements of the patient's record. Dentists and oral and maxillofacial surgeons may write orders within the scope of their license and consistent with the Medical Staff Rules and Regulations and in compliance with the Hospital and Medical Staff Bylaws and this Policy.

4.A.6. Physicians in Training:

- (a) Physicians in training shall not be granted appointment to the Medical Staff or clinical privileges. The program director, clinical faculty, or attending staff member shall be responsible for the direction and supervision of the on-site or day-to-day patient care activities of each trainee, who shall be permitted to perform only those clinical functions set out in curriculum requirements,

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

4.A.7. Telemedicine Privileges:

- (a) A qualified individual may be granted telemedicine privileges regardless of whether the individual is appointed to the Medical Staff.
- (b) Requests for initial or renewed telemedicine privileges shall be processed through one of the following options, as determined by the CEO in consultation with the President 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) a signed attestation that the applicant satisfies all of the distant hospital or telemedicine entity's qualifications for the clinical privileges granted;
- (v) a signed attestation that all information provided by the distant hospital or telemedicine entity is complete, accurate, and up-to-date; and
- (vi) any other attestations or information required by the agreement or requested by the Hospital.

This information shall be provided to the MSEC 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. LIMITED CLINICAL PRIVILEGES SITUATIONS

4.B.1. New Applicants:

- (a) An applicant for initial appointment may be granted clinical privileges for a limited period of time by the CEO under the following conditions:
 - (1) the applicant has submitted a complete application, along with any 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; and consideration of information from the National Practitioner Data Bank 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 permission to practice or the involuntary limitation, reduction, denial, or loss of clinical privileges, at another health care facility; and
 - (4) the application is pending review by the MSEC and the Board, following a favorable recommendation by the President of the Medical Staff and the Credentials Committee or its Chair, and after considering the evaluation of the applicable Section Chief or co-chiefs.
- (b) In this situation, privileges will be granted for a maximum period of 60 consecutive days.

4.B.2. Locum Tenens:

- (a) The CEO may grant privileges to an individual serving as a locum tenens for a member of the Medical Staff or Allied Health 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 any application fee;
 - (2) the verification process is complete, including verification of current licensure, current competence (verification of good standing in all hospitals where the individual practiced), 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 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 permission to practice or the involuntary limitation, reduction, denial, or loss of clinical privileges, at another health care facility;

- (4) the applicant has received a favorable recommendation from the President of the Medical Staff and/or CMO, after considering the evaluation of the applicable Section chief or co-chiefs; and
 - (5) the applicant will be subject to any focused professional practice requirements established by the Hospital.
- (b) In this situation, the individual may exercise locum tenens privileges for a maximum of 180 days. At the end of the 180 days, the group utilizing the individual will be contacted as to the need to extend the privileges for another period of time. If there is no further need for the individual, the privileges expire. Should there be a need for the individual to continue, the request will be referred to the Credentials Committee, MSEC and the Board for approval of the extension.

4.B.3. Visiting:

- (a) Privileges may be granted for a limited period of time by the CEO when there is an important patient care, treatment, or service need. For example, where privileges are needed:
 - (1) for 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.
- (b) The following factors will be considered and/or verified prior to the granting of privileges in these situations:
 - (1) the applicant has received a favorable recommendation of the relevant Section chief or co-chiefs and the President of the Medical Staff and/or CMO; and
 - (2) verification of current licensure, relevant training or experience, current competence (i.e., verification of good standing in the individual's most recent hospital affiliation), current professional liability coverage acceptable to the Hospital, and results of a query to the National Practitioner Data Bank and from OIG queries.
- (c) The grant of clinical privileges in these situations will not exceed 60 days. The verifications for such grants of privileges shall generally be accomplished in advance; however, in an emergency situation, where life-threatening circumstances exist, the verifications listed above may be completed immediately

after the grant of privileges. In exceptional situations, this period of time may be extended in the discretion of the CEO and the President of the Medical Staff.

4.B.4. General Terms for Limited Clinical Privilege Situations:

- (a) Automatic Expiration. All grants of limited clinical privileges shall automatically expire on the date specified at the time of initial granting unless further affirmative action is taken by the relevant Section chief or co-chiefs, the Chair of the Credentials Committee, the President of the Medical Staff, and the CEO with approval of the Board to renew such privileges.
- (b) Compliance with Bylaws and Policies. Prior to any privileges being granted in these situations, 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.
- (c) FPPE. Individuals who are granted privileges in these situations will be subject to the Hospital policy regarding focused professional practice evaluation.
- (d) Supervision Requirements. Special requirements of supervision and reporting may be imposed on any individual granted clinical privileges in these situations.
- (e) Withdrawal of Clinical Privileges. The CEO may withdraw admitting privileges granted pursuant to this Section at any time, after consulting with the President of the Medical Staff, the relevant Section chief or co-chiefs, or the CMO. Clinical privileges shall then expire as soon as patients have been discharged or alternate care has been arranged.

If the care or safety of patients might be endangered by continued treatment by the individual granted privileges in these situations, the CEO, the relevant Section chief or co-chiefs, the President of the Medical Staff, or the CMO may immediately withdraw all such privileges. The Section chief or co-chiefs or the President 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 Section chief or co-chiefs or the President 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 CEO or the President 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; or (5) identification by a current Hospital employee or Medical Staff member who possesses personal knowledge regarding the individual’s ability to act as a volunteer during a disaster.
- (3) Primary source verification of a volunteer’s license shall begin as soon as the immediate situation is under control and must be completed within 72 hours from the time the volunteer begins to provide service at the Hospital.
- (4) In extraordinary circumstances when primary source verification cannot be completed within 72 hours, it should be completed as soon as possible. In these situations, there must be documentation of the following: (a) the reason primary source verification could not be performed in the required time frame; (b) evidence of the volunteer’s demonstrated ability to continue to provide adequate care; and (c) an attempt to obtain primary source verification as soon as possible. If a volunteer has not provided care, then primary source verification is not required.
- (5) The Medical Staff shall oversee the care provided by 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.

4.E. CONTRACTS FOR SERVICES

(1) From time to time, the Hospital may enter into contracts with practitioners or groups of practitioners for the performance of clinical and administrative services. All individuals functioning pursuant to such contracts shall obtain and maintain clinical privileges, in accordance with the terms of this Policy. In addition, if any such individual is the subject of an adverse credentialing or peer review recommendation by the MSEC based upon the individual's clinical competence or professional conduct, the individual shall be entitled to the procedural rights set forth in this Policy before the Board takes final action on the matter.

(2) To the extent that:

(a) any such contract confers the exclusive right to perform specified services to one or more practitioners or groups of practitioners, OR

(b) the Board adopts a resolution that limits the practitioners who may exercise privileges in any clinical specialty to employees of Indiana University Health or its affiliates,

no other practitioner except those authorized by the exclusive contract or Board resolution may exercise clinical privileges to perform the specified services while the contract or resolution is in effect. This means that only practitioners authorized by the exclusive contract or Board resolution are eligible to apply for the clinical privileges in question at the time of initial appointment, during the term of an appointment, or at reappointment. No other applications shall be processed.

(3) If any such exclusive contract or Board resolution would have the effect of preventing an existing Medical Staff member from exercising clinical privileges that had previously been granted, the following notice and review procedures apply:

(a) The affected Medical Staff member shall be given at least 90 days advance notice of the exclusive contract or Board resolution and have the right to meet with the Board or a committee designated by the Board to discuss the matter prior to the contract in question being signed by the Hospital or the Board resolution becoming effective.

(b) At the meeting, the affected Medical Staff member shall be entitled to present any information relevant to the Hospital's decision to enter into the exclusive contract or enact the Board resolution. If, following this meeting, the Board decides to enter into the exclusive contract or enact the

Board resolution, the affected Medical Staff member shall be ineligible to continue to exercise the clinical privileges covered by the exclusive contract or resolution unless a waiver has been granted. In that circumstance, the ineligibility begins as of the effective date of the exclusive contract or Board resolution and continues for as long as the contract or resolution is in effect.

- (c) The affected Medical Staff member shall not be entitled to any other procedural rights beyond those outlined above with respect to the Board's decision or the effect of the decision on his or her clinical privileges, notwithstanding the provisions in Article 7 or any other provision of this Credentialing Policy or the Medical Staff Bylaws.
 - (d) The inability of a physician to exercise clinical privileges because of an exclusive contract or Board resolution is not a matter that requires a report to the Indiana licensure board or to the National Practitioner Data Bank.
- (4) In the event of any conflict between this Policy or the Medical Staff Bylaws and the terms of any contract, the terms of the contract shall control.

ARTICLE 5

PROCEDURE FOR REAPPOINTMENT

5.A. ELIGIBILITY FOR REAPPOINTMENT

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

- (1) completed all medical records;
- (2) completed all continuing medical education requirements (50 Level I CME for Medical Staff and for Allied Health Staff, per applicable licensing and certification requirements);
- (3) satisfied all Medical Staff or Allied Health Staff responsibilities, including payment of any dues, fines, and assessments;
- (4) continued to meet all qualifications and criteria for appointment and the clinical privileges requested;
- (5) paid any applicable reappointment processing fee; and
- (6) had sufficient patient contacts to enable the assessment of current clinical judgment and competence for the privileges requested. Any member seeking reappointment who has minimal activity at the Hospital must submit such information as may be requested (such as a copy of his or her confidential quality profile from his or her primary hospital, clinical information from his or her private office practice, or a quality profile from a managed care organization or insurer), before the application shall be considered complete and processed further.

5.B. FACTORS FOR EVALUATION

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

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

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

5.C. REAPPOINTMENT APPLICATION

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

5.D. PROCESSING APPLICATIONS FOR REAPPOINTMENT

- (1) The Medical Staff Office shall forward the application to the relevant Section chief and/or co-chiefs 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.

5.E. CONDITIONAL REAPPOINTMENTS

- (1) Recommendations for reappointment and renewed privileges may be contingent upon an individual's compliance with certain specific conditions that have been recommended. These conditions may relate to behavior (e.g., personal code of conduct) or to clinical issues (e.g., general consultation requirements, appropriate documentation requirements, including timely completion of medical records, proctoring, completion of CME requirements). Unless the conditions involve the matters set forth in Section 7.A.1(a) or 8.A.1(a) of this Policy (as applicable), the imposition of such conditions does not entitle an individual to request the procedural rights set forth in Article 7 or Article 8 of this Policy.
- (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 have been recommended. 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 or Article 8.
- (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.

5.F. POTENTIAL ADVERSE RECOMMENDATION

- (1) If the Credentials Committee or MSEC is considering a recommendation to deny reappointment or to reduce clinical privileges, the committee chair will notify the member of the possible recommendation and invite the member to meet prior to any final recommendation being made.
- (2) Prior to this meeting, the member will be notified of the general nature of the information supporting the recommendation contemplated.
- (3) At the meeting, the member will be invited to discuss, explain, or refute this information. A summary of the interview will be made and included with the Credentials Committee's and/or MSEC's recommendation.

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

5.G. FPPE TO CONFIRM COMPETENCE AND PROFESSIONALISM

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

ARTICLE 6

PEER REVIEW PROCEDURES FOR QUESTIONS INVOLVING MEDICAL STAFF MEMBERS

6.A. COLLEGIAL EFFORTS AND PROGRESSIVE STEPS

- (1) This Policy encourages the use of collegial efforts and progressive steps by Medical Staff Leaders and Hospital administration to address questions relating to an individual's clinical practice and/or professional conduct. The goal of these efforts is to arrive at voluntary, responsive actions by the individual to resolve questions that have been raised.
- (2) Collegial efforts and progressive steps include, but are not limited to:
 - (a) informal mentoring, coaching, or counseling by a Medical Staff Leader (e.g., advising an individual of policies regarding appropriate behavior, communication issues, emergency call obligations, or the timely and adequate completion of medical records);
 - (b) sharing comparative data, including any variations from clinical practice or evidence-based protocols or guidelines, in order to assist the individual with conforming his or her practice to appropriate norms;
 - (c) addressing minor performance issues through an Informational Letter;
 - (d) sending an Educational Letter that describes opportunities for improvement and provides guidance and suggestions;
 - (e) facilitating a formal Collegial Counseling session (i.e., a planned, face-to-face meeting between an individual and one or more Medical Staff Leaders) in order to directly discuss a matter and the steps needed to be taken to resolve it; and
 - (f) developing a Voluntary Enhancement Plan or a Performance Improvement Plan, which may include a wide variety of tools and techniques that can result in a constructive and successful resolution of the concern.
- (3) All collegial efforts and progressive steps are fundamental and integral components of the Hospital's professional practice evaluation activities and are confidential and privileged in accordance with Indiana law.
- (4) Copies of any formal documentation that is prepared by a Medical Staff Leader regarding such collegial efforts and progressive steps, including letters that follow a formal Collegial Counseling session, will be included in an individual's

confidential file and maintained in a confidential manner consistent with its privileged status. Any written responses to collegial efforts and progressive steps that may be received from an individual shall also be included in the individual's confidential file.

- (5) Collegial efforts and progressive steps are encouraged, but are not mandatory, and shall be within the discretion of the appropriate Medical Staff Leaders. When a question arises, the Medical Staff and/or Hospital Leaders may:
 - (a) address it pursuant to the collegial efforts and progressive steps provisions of this Section;
 - (b) refer the matter for review in accordance with the Professional Practice Evaluation Policy and/or other relevant policy; or
 - (c) refer it to the MSEC for its review and consideration in accordance with Section 6.C of this Article.
- (6) Should any recommendation be made or an action taken that entitles an individual to a hearing in accordance with this Policy, the individual is entitled to be accompanied by legal counsel at the hearing. However, individuals do not have the right to be accompanied by counsel when the Medical Staff Leaders and Hospital management are engaged in collegial efforts or other progressive steps. These efforts are intended to resolve issues in a constructive manner and do not involve the formal hearing process. In addition, there shall be no recording (audio or video) or transcript made of any meetings that involve collegial efforts or progressive steps activities.

6.B. PROFESSIONAL PRACTICE EVALUATION ACTIVITIES

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

6.C. INVESTIGATIONS

6.C.1. Initial Review:

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

- (1) the clinical competence or clinical practice of any member, including the care, treatment, or management of a patient or patients;
- (2) the safety or proper care being provided to patients;
- (3) the known or suspected violation by any member of applicable ethical standards or the Bylaws, policies, Rules and Regulations of the Hospital or the Medical Staff; and/or
- (4) conduct by any member that is considered lower than the standards of the Hospital or disruptive to the orderly operation of the Hospital or its Medical Staff, including the inability of the member to work harmoniously with others,

the matter may be referred to the President of the Medical Staff, the Section chief or co-chiefs, the chair of a standing committee, the CMO, the CEO or the chair of the Board.

- (b) In addition, if the Board becomes aware of information that raises concerns about the qualifications of any member, the matter shall be referred to the President of the Medical Staff, the CMO, or the CEO 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 has sufficient credibility to warrant further review and, if so, shall forward it in writing to the MSEC.
- (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 MSEC, that committee shall review the matter and determine whether to conduct an investigation or to direct the matter to be handled pursuant to another relevant Medical Staff Policy (e.g., health, professionalism, etc.). In making this determination, the MSEC may discuss the matter with the individual. An investigation shall begin only after a formal determination by the MSEC to do so. The MSEC's determination shall be recorded in the minutes of the meeting where the determination is made.
- (b) The MSEC shall inform the individual that an investigation has begun. The notification shall include:
 - (1) the date on which the investigation was commenced;

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

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

6.C.3. Investigative Procedure:

(a) Selection of Investigating Committee.

Once a determination has been made to begin an investigation, the MSEC shall either investigate the matter itself or appoint an ad hoc committee to conduct the investigation, keeping in mind the conflict of interest guidelines outlined in Article 9. Any ad hoc committee may include individuals not on the Medical Staff. Whenever the questions raised concern the clinical competence of the individual under review, the ad hoc committee shall include a peer of the individual (e.g., physician, dentist, nurse practitioner, etc., as applicable).

(b) Investigating Committee's Review Process.

- (1) The committee conducting the investigation ("investigating committee") shall have the authority to review relevant documents and interview individuals. A summary of each interview will be prepared and the interviewee will be asked to review, revise, and sign his or her summary, which will then be included as an attachment to the investigating committee's report.
- (2) The investigating committee shall also have available to it the full resources of the Medical Staff and the Hospital, including the authority to arrange for an external review, if needed. An external review may be used whenever the Hospital and investigating committee determine that:
 - (i) there are ambiguous or conflicting findings by internal reviewers;
 - (ii) the clinical expertise needed to conduct the review is not available on the Medical Staff or the Allied Health Staff;

- (iii) an external review is advisable to prevent allegations of bias, even if unfounded; or
- (iv) the thoroughness and objectivity of the investigation would be aided by such an external review.

If such a decision is made to obtain an external review, the individual under investigation shall be notified of that decision and the nature of the external review. Upon completion of the external review, the individual shall be provided a copy of the reviewer's report.

- (3) The investigating committee may require a physical, mental, and/or behavioral examination of the individual by health care professionals 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. The cost of such health examination shall be borne by the individual.

(c) Meeting with the Investigating Committee.

- (1) The individual under investigation shall have an opportunity to meet with the investigating committee before it makes its report. Prior to this meeting, the individual shall be informed of the general questions being investigated. The investigating committee may also ask the individual to provide written response to specific questions related to the investigation and/or a written explanation of his or her perspective on events that led to the investigation for review by the investigating committee prior to the meeting.
- (2) This meeting is not a hearing, and none of the procedural rules for hearings shall apply. No recording (audio or video) or transcript of the meeting shall be permitted or made. Neither the individual being investigated nor the investigating committee will be accompanied by legal counsel at this meeting.
- (3) At the meeting, the individual shall be invited to discuss, explain, or refute the questions that gave rise to the investigation or that have been identified by the investigating committee during its review. A summary of the interview shall be prepared by the investigating committee and included with its report. The interview summary will be shared with the individual prior to the investigating committee finalizing its report, so that he or she may review it and recommend suggested changes. The investigating

committee retains the right to accept a suggested change if it believes the change more accurately reflects what occurred at the meeting. The committee may also consider additional comments on the interview summary so long as it is not disruptive to its work.

(d) Time Frames for Investigation.

The investigating committee shall make a reasonable effort to complete the investigation and issue its report within 30 days of the commencement of the investigation, provided that an external review is not necessary. When an external review is necessary, 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 external 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.

(e) Investigating Committee's Report.

- (1) At the conclusion of the investigation, the investigating committee shall prepare a report of the investigation. The report should include a summary of the review process (e.g., a list of documents that were reviewed, any individuals who were interviewed, etc.), specific findings and conclusions regarding each concern that was under review, and the investigating committee's recommendations.
- (2) In making its recommendations, the investigating committee shall strive to achieve a consensus as to what is in the best interests of patient care and the smooth operation of the Hospital, while balancing fairness to the individual, recognizing that fairness does not require that the individual agree with the recommendation. Specifically, the committee may consider:
 - (i) relevant literature and clinical practice guidelines, as appropriate;
 - (ii) all of the opinions and views that were expressed throughout the review, including reports from any external reviews;
 - (iii) any information or explanations provided by the individual under review; and
 - (iv) other information as deemed relevant, reasonable, and necessary by the investigating committee.

6.C.4. Recommendation:

- (a) The MSEC may accept, modify, or reject any recommendation it receives from an ad hoc investigating committee if one was appointed by the MSEC. In either case, at the conclusion of the investigation, the MSEC 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) impose a requirement for monitoring, proctoring, or consultation;
 - (5) impose a requirement for additional training or education;
 - (6) recommend reduction of clinical privileges;
 - (7) recommend suspension of clinical privileges for a term;
 - (8) recommend revocation of appointment and/or clinical privileges; or
 - (9) make any other recommendation that it deems necessary or appropriate.
- (b) A recommendation by the MSEC that would entitle the individual to request a hearing shall be forwarded to the CEO, who shall promptly inform the individual by special notice. The CEO shall hold the recommendation until after the individual has completed or waived a hearing and appeal.
- (c) If the determination of the MSEC does not entitle the individual to request a hearing, it shall take effect immediately and shall remain in effect unless modified by the Board.
- (d) In the event the Board considers a modification to the recommendation of the MSEC that would entitle the individual to request a hearing, the CEO shall inform the individual by special notice. No final action shall occur until the individual has completed or waived a hearing and appeal.
- (e) When applicable, any recommendations or actions that are the result of an investigation or hearing and appeal shall be monitored by Medical Staff Leaders on an ongoing basis through the Hospital's performance improvement activities or pursuant to the applicable policies regarding conduct, as appropriate.

6.D. PRECAUTIONARY SUSPENSION OR RESTRICTION OF CLINICAL PRIVILEGES

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, the CEO, the President of the Medical Staff, the CMO, the MSEC, or the Board chair is authorized to (1) afford the individual an opportunity to voluntarily refrain from exercising privileges pending an investigation; or (2) suspend or restrict all or any portion of an individual's clinical privileges pending an investigation.
- (b) The above actions can be taken at any time, including, but not limited to, immediately after the occurrence of an event that causes concern, following a pattern of occurrences that raises concern, or following a recommendation that would entitle the individual to request a hearing.
- (c) Precautionary suspension or restriction, or an agreement to refrain, is an interim step in the professional review activity, but it is not a complete professional review action in and of itself. It shall not imply any final finding of responsibility for the situation that caused the suspension or restriction.
- (d) A precautionary suspension or restriction shall become effective immediately upon imposition, shall immediately be reported to the CEO and the President of the Medical Staff, and shall remain in effect unless it is modified by the CEO or MSEC.
- (e) The individual in question shall be provided a letter via Special Notice that memorializes the individual's agreement to voluntarily refrain from practicing or imposition of a precautionary suspension and terms related to the same. The correspondence shall also contain a brief written description of the reason(s) for the action, including the names and medical record numbers of the patients involved (if any), within three days of the action.

6.D.2. MSEC Procedure:

- (a) The MSEC shall review the matter resulting in a precautionary suspension or restriction within a reasonable time under the circumstances, not to exceed four business days. Prior to, or as part of, this review, the individual shall be given an opportunity to meet with the MSEC. The individual may propose ways other than precautionary suspension or restriction to protect patients, employees, and/or the smooth operation of the Hospital, depending on the circumstances. Neither the MSEC nor the individual shall be accompanied by legal counsel at this meeting, and no recording (audio or video) or transcript of the meeting shall be permitted or made; however, minutes of the meeting shall be prepared.

- (b) After considering the matters resulting in the suspension or restriction and the individual's response, if any, the MSEC shall determine the appropriate next steps, which may include, but are not limited to, commencing a focused review or a formal investigation or recommending some other action that is deemed appropriate under the circumstances. The MSEC shall also determine whether the precautionary suspension or restriction should be continued, modified, or terminated pending the completion of the focused review or investigation (and hearing and appeal, if applicable).
- (c) There is no right to a hearing based on the imposition of a precautionary suspension or restriction.

6.D.3. Care of Patients:

- (a) Immediately upon the imposition of a precautionary suspension or restriction, the President of the Medical Staff shall assign to another individual with appropriate clinical privileges 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 practitioner.
- (b) All members of the Medical Staff and Allied Health Staff have a duty to cooperate with the President of the Medical Staff, the Section chief or co-chiefs, the MSEC, and the CEO in enforcing precautionary suspensions or restrictions.

6.E. AUTOMATIC RELINQUISHMENT

6.E.1. General:

- (a) Any of the occurrences described in this Section will constitute grounds for the automatic relinquishment of an individual's appointment and clinical privileges. An automatic relinquishment is considered an administrative action that happens by operation of this Policy and, as such, does not trigger an obligation on the part of the Hospital to file a report with the National Practitioner Data Bank and will take effect without hearing or appeal.
- (b) Except as otherwise provided below, an automatic relinquishment of appointment and clinical privileges will be effective immediately upon actual or Special Notice to the individual. Such notice will be provided after confirmation of the event(s) that led to the automatic relinquishment by the President of the Medical Staff and/or the CMO. Notice will also be given to the applicable Section chief or co-chiefs.

6.E.2. Triggers for Automatic Relinquishment:

(a) Failure to Complete Medical Records:

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

(b) Action by Government Agency or Insurer and Failure to Satisfy Threshold Eligibility Criteria:

- (1) Any action taken by any licensing board, professional liability insurance company, court or government agency regarding any of the matters set forth below, or any failure to satisfy any of the threshold eligibility criteria set forth in this Policy, must be promptly reported to the CMO or President of the Medical Staff by the affected individual.
- (2) An individual's appointment and clinical privileges shall be automatically relinquished, without the right to the procedural rights outlined in this Policy, if an individual fails to satisfy any of the threshold eligibility criteria set forth in Section 2.A.1 of this Policy on a continuous basis (except for board certification requirements, which shall be assessed at time of reappointment). This includes, but is not limited to, the following occurrences:
 - (i) Licensure: Revocation, expiration, suspension, or the placement of conditions or restrictions on an individual's license, or an individual's license being placed on probationary status (except where a health issue that has already been appropriately disclosed to the Medical Staff and Hospital for evaluation/monitoring led to the probation).
 - (ii) Controlled Substance Authorization: Revocation, expiration, suspension, or the placement of conditions or restrictions on an individual's DEA or state controlled substance authorization.
 - (iii) 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.
 - (iv) Medicare and Medicaid Participation: Debarment, proposed debarment, termination, exclusion, or preclusion by government

action from participation in the Medicare/Medicaid or other federal or state health care programs.

(v) Criminal Activity: Arrest, charge, 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; (iv) child abuse; (v) elder abuse; or (vi) violence. (DUIs will be reviewed in accordance with the Medical Staff's health policy.)

(3) Automatic relinquishment shall take effect immediately upon written notice to the individual provided via Special Notice, and shall continue until the matter is resolved and the individual is reinstated, if applicable.

(4) 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, as applicable.

(c) Failure to Provide Requested Information:

(1) Failure to provide information pertaining to an individual's qualifications for continued appointment or clinical privileges, in response to a written request from the President of the Medical Staff, the CMO, the CEO, the Credentials Committee, the MSEC, or any other committee authorized to request such information, shall result in automatic relinquishment of appointment and clinical privileges until the information is provided to the satisfaction of the requesting party.

(2) If the individual fails to provide the input requested within 30 days of the automatic relinquishment, the individual's Medical Staff or Allied Health Staff appointment and clinical privileges will be deemed to have been automatically resigned.

(d) Failure to Attend Special Conference:

(1) Whenever there is a concern regarding the clinical practice or professional conduct involving any individual, a Medical Staff Leader may require the individual to attend a special meeting with one or more of the Medical Staff Leaders and/or with a standing or ad hoc committee of the Medical Staff.

(2) No legal counsel shall be present at this meeting, and no recording (audio or video) or transcript shall be permitted or made.

- (3) The notice to the individual regarding this meeting shall be given by Special Notice at least three days prior to the meeting and shall inform the individual that attendance at the meeting is mandatory.
 - (4) Failure of the individual to attend the meeting shall result in the automatic relinquishment of the individual's appointment and clinical privileges until such time as the individual does attend the special meeting. If the individual does not attend the special meeting within 30 days of the date of relinquishment, the individual's Medical Staff or Allied Health Staff appointment and clinical privileges will be deemed to have been automatically resigned.
- (e) Failure to Complete or Comply with Training, Educational, or Orientation Requirements:
- (1) Failure to complete or comply with training, educational, or orientation requirements that are adopted by the MSEC or required by the Board, including, but not limited to, those pertinent to electronic medical records, the privacy and security of protected health information, infection control, or patient safety, shall result in the automatic relinquishment of the individual's appointment and clinical privileges until the individual completes or complies with the applicable training, educational, or orientation requirements.
 - (2) If the individual fails to complete or comply with the applicable training, educational, or orientation requirements within 30 days of the automatic relinquishment, the individual's Medical Staff or Allied Health Staff appointment and clinical privileges will be deemed to have been automatically resigned.
- (f) Failure to Meet Supervision Requirements:

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

6.E.3. Request for Reinstatement from an Automatic Relinquishment:

- (a) Requests for reinstatement following the expiration or lapse of a license, controlled substance authorization, and/or insurance coverage will be processed by the Medical Staff Office. If any questions or concerns are noted, the Medical Staff Office will refer the matter for further review in accordance with (b) below.

- (b) All other requests for reinstatement shall be reviewed by the relevant Section chief or co-chiefs, chair of the Credentials Committee, the President of the Medical Staff, the CMO and the CEO. If all these individuals make a favorable recommendation on reinstatement, the individual may immediately resume clinical practice at the Hospital. This determination shall then be forwarded to the Credentials Committee, the MSEC, 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, MSEC and Board for review and recommendation.

6.F. LEAVES OF ABSENCE

6.F.1. Initiation:

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

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

During the leave of absence, the individual shall not exercise any clinical privileges and shall be excused from all Medical Staff responsibilities (e.g., meeting attendance, committee service, emergency service call obligations). All medical records must be completed as soon as reasonably possible. The obligation to pay dues shall continue

during a leave of absence except that a member granted a leave of absence for U.S. military service shall be exempt from this obligation.

6.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 by the Hospital. Requests for reinstatement shall then be reviewed by the relevant Section chief or co-chiefs, the chair of the Credentials Committee, the President of the Medical Staff, the CMO and the CEO, and in accordance with the practitioner health policy, if applicable. If a favorable recommendation on reinstatement is made, the individual may immediately resume clinical practice. However, if any of the individuals reviewing the request have any questions or concerns, those questions shall be noted and the reinstatement request shall be forwarded to the full Credentials Committee, MSEC, and Board. If any request for reinstatement is not granted for reasons related to clinical competence or professional conduct, and if a report to the National Practitioner Data Bank is determined to be required, the individual shall be entitled to request a hearing and appeal.
- (b) If the leave of absence was for health reasons (except for maternity leave), 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 requested.
- (c) Absence for longer than one year shall result in automatic relinquishment of appointment and clinical privileges unless an extension is granted by the MSEC. Extensions shall only be considered in extraordinary cases.
- (d) If an individual's current appointment is due to expire during the leave, the individual's appointment and clinical privileges shall expire at the end of the appointment period, and the individual shall be required to apply for appointment.
- (e) Failure to request reinstatement in a timely manner shall be deemed a voluntary resignation of appointment and clinical privileges.

ARTICLE 7

HEARING AND APPEAL PROCEDURES

The hearing and appeal procedures in this Article are only applicable to members of the Medical Staff and are **not** applicable to members of the Allied Health Staff. The due process rights for Allied Health Staff members are set forth in Article 8 of this Policy.

7.A. INITIATION OF HEARING

7.A.1. Grounds for Hearing:

- (a) An individual is entitled to request a hearing whenever the MSEC makes one of the following recommendations based on the individual's professional competence or professional conduct which affects or could affect adversely the health or welfare of a patient or patients:
 - (1) denial of initial appointment to the Medical Staff;
 - (2) denial of reappointment to the Medical Staff;
 - (3) revocation of appointment to the Medical Staff;
 - (4) denial of requested clinical privileges;
 - (5) revocation of clinical privileges;
 - (6) suspension of clinical privileges for more than 30 days (other than precautionary suspension);
 - (7) mandatory concurring consultation requirement (i.e., the consultant must approve the course of treatment in advance); or
 - (8) denial of reinstatement from a leave of absence if the reasons relate to clinical competence or professional conduct.
- (b) No other recommendations shall entitle the individual to a hearing.
- (c) If the Board makes any of these determinations without an adverse recommendation by the MSEC, an individual would also be entitled to request a hearing. For ease of use, this Article refers to adverse recommendations of the MSEC. When a hearing is triggered by an adverse recommendation of the Board, any reference in this Article to the "MSEC" 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) determination that an applicant for membership fails to meet the threshold eligibility qualifications or criteria for membership;
- (b) ineligibility to request membership or privileges, or to continue privileges, because a relevant specialty is closed under a Medical Staff development plan or is covered under an exclusive provider agreement;
- (c) failure to process a request for a privilege when the individual does not meet the eligibility criteria to hold the privilege;
- (d) determination that an application is incomplete or untimely;
- (e) determination that an application shall not be processed due to a misstatement or omission;
- (f) change in assigned staff category or a determination that an individual is not eligible for a specific staff category;
- (g) expiration of membership and privileges as a result of failure to submit an application for reappointment within the allowable time period;
- (h) issuance of a letter of guidance, counsel, warning, or reprimand;
- (i) determination that conditions, monitoring, supervision, proctoring, or a general consultation requirement (i.e., the individual must obtain a consult but need not get prior approval for the treatment) is appropriate for an individual;
- (j) determination that a requirement for additional training or continuing education is appropriate for an individual;
- (k) the voluntary acceptance of a Performance Improvement Plan;
- (l) any requirement to complete a health assessment, diagnostic testing, a complete physical, mental or behavioral evaluation, or a clinical competency evaluation pursuant to any Bylaws-related document;
- (m) conducting an investigation into any matter or the appointment of an ad hoc investigating committee;

- (n) grant of conditional appointment or reappointment or of an appointment or reappointment period that is less than two years;
- (o) refusal of the Hospital to consider a request for appointment, reappointment, or privileges within five years of a final adverse decision regarding such request;
- (p) precautionary suspension;
- (q) automatic relinquishment of appointment or privileges or automatic resignation;
- (r) denial of a request for leave of absence, for an extension of a leave or for reinstatement from a leave if the reasons do not relate to clinical competence or professional conduct;
- (s) removal from the on-call roster or any other reading panel;
- (t) withdrawal of privileges granted under Section 4.B (limited clinical privilege situations);
- (u) requirement to appear for a special meeting; and
- (v) termination of any contract with or employment by the Hospital.

7.B. THE HEARING

7.B.1. Notice of Recommendation:

The CEO shall promptly give Special Notice of a recommendation which entitles an individual to request a hearing. This notice shall contain:

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

7.B.2. Request for Hearing:

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

7.B.3. Notice of Hearing and Statement of Reasons:

- (a) The CEO shall schedule the hearing and provide, by Special Notice, the following:
 - (1) the time, place, and date of the hearing;
 - (2) a proposed list of witnesses who shall give testimony at the hearing and a brief summary of the anticipated testimony;
 - (3) the names of the Hearing Panel members and Presiding Officer, if known; and
 - (4) a statement of the specific reasons for the recommendation, including a list of patient records (if applicable), and a general description of the information supporting the recommendation. This statement does not bar presentation of additional evidence or information at the hearing, so long as the additional material is relevant to the recommendation or the individual's qualifications and the individual has a sufficient opportunity to review and rebut the 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.B.4. Hearing Panel and Presiding Officer:

(a) Hearing Panel:

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

- (1) The Hearing Panel shall consist of at least three members, one of whom shall be designated as chair and may include any combination of:
 - (i) any member of the Medical Staff, provided the member has not actively participated in the matter at any previous level, or
 - (ii) physicians not connected with the Hospital (i.e., physicians not on the Medical Staff).
- (2) Knowledge of the underlying peer review matter, in and of itself, shall not preclude the individual from serving on the Panel.
- (3) Employment by, or other contractual arrangement with, the Hospital or an affiliate shall not preclude an individual from serving on the Panel.

- (4) The Panel shall not include any individual who is in direct economic competition with the individual requesting the hearing.
- (5) The Panel shall not include any individual who is demonstrated to have an actual bias, prejudice, or conflict of interest that would prevent the individual from fairly and impartially considering the matter.
- (6) In addition, the appointment of the Hearing Panel shall comply with the guidelines set forth in the conflict of interest provisions found in Article 9 of this Policy.

(b) Presiding Officer:

- (1) The CEO, after consulting with the President of the Medical Staff, shall appoint a Presiding Officer who shall be an attorney. The Presiding Officer may not be, or represent clients who are, in direct competition with the individual who requested the hearing and may not currently represent the Hospital in any legal matters. The Presiding Officer shall not act as an advocate for either side at the hearing.
- (2) The Presiding Officer shall:
 - (i) allow the participants in the hearing to have a reasonable opportunity to be heard and to present evidence, subject to reasonable limits on the number of witnesses and duration of direct and cross-examination;
 - (ii) prohibit conduct or presentation of evidence that is cumulative, excessive, irrelevant or abusive or that causes undue delay;
 - (iii) maintain decorum throughout the hearing;
 - (iv) determine the order of procedure;
 - (v) rule on all matters of procedure and the admissibility of evidence; and
 - (vi) conduct argument by counsel on procedural points within or outside the presence of the Hearing Panel at the Presiding Officer's discretion.
- (3) The Presiding Officer may be advised by legal counsel to the Hospital with regard to the hearing procedure.

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

(c) Objections:

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

7.B.5. Counsel:

Any attorneys who participate in the hearing process, whether as the Presiding Officer or as counsel for either party, must be licensed to practice law in this or another state.

7.C. PRE-HEARING PROCEDURES

7.C.1. General Procedures:

- (a) The pre-hearing and hearing processes shall be conducted in an informal manner. Formal rules of evidence or procedure shall not apply.
- (b) Neither party has the right to issue subpoenas or interrogatories or to depose witnesses or other individuals prior to the hearing or to otherwise compel any individual to participate in the hearing or pre-hearing process.
- (c) Neither the individual who has requested the hearing, nor any other person acting on behalf of the individual, may contact Hospital employees or Medical Staff members whose names appear on the MSEC's witness list or in documents provided pursuant to this Article 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 will advise the individual who has 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. If an employee or Medical Staff member who is on the MSEC's witness list agrees to be interviewed pursuant to this provision, counsel for the MSEC may be present during the interview.

7.C.2. 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.3. Witness List:

- (a) At least 10 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.C.4. 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 MSEC;
 - (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 MSEC.

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.
- (d) At least ten days prior to the pre-hearing conference, (or as otherwise agreed upon by both sides), each party shall provide the other party with its proposed exhibits.

7.C.5. Pre-Hearing Conference:

The Presiding Officer shall require the individual and the MSEC or their representatives (who may be counsel) to participate in a pre-hearing conference, which shall be held no later than 14 days prior to the hearing. At the pre-hearing conference, the Presiding Officer shall resolve all procedural questions, including any objections to exhibits or witnesses. The Presiding Officer shall establish the time to be allotted to each witness's testimony and cross-examination. It is expected that the hearing shall last no more than 15 hours, with each side being afforded approximately seven and a half hours to present its case, in terms of both direct and cross-examination of witnesses. Both parties are required to prepare their case so that a hearing shall be concluded after a maximum of 15 hours. The Presiding Officer may, after considering any objections, grant limited extensions upon a demonstration of good cause and to the extent compelled by fundamental fairness.

7.C.6. Stipulations:

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

7.C.7. 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) any stipulations agreed to by the parties.

7.D. HEARING PROCEDURES

7.D.1. Rights of Both Sides and the Hearing Panel at the Hearing:

- (a) At a hearing, both sides shall have the following rights, subject to reasonable limits determined by the Presiding Officer:

- (1) to call and examine witnesses, to the extent they are available and willing to testify;
 - (2) to introduce exhibits;
 - (3) to cross-examine any witness on any matter relevant to the issues;
 - (4) to have representation by counsel who may call, examine, and cross-examine witnesses and present the case; and
 - (5) to submit proposed findings, conclusions and recommendations to the Hearing Panel as part of the Post-Hearing statement referenced in this Article, following the close of the hearing session(s).
- (b) If the individual who requested the hearing does not testify, he or she may be called and questioned.
- (c) The Hearing Panel may question witnesses, request the presence of additional witnesses, and/or request documentary evidence.

7.D.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.D.3. 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 transmitted to the Board for final action.

7.D.4. Presence of Hearing Panel Members:

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

7.D.5. Persons to Be Present:

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

7.D.6. Order of Presentation:

The MSEC 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.D.7. Admissibility of Evidence:

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

7.D.8. Post-Hearing Statement:

Each party shall have the right to submit a written statement, and the Hearing Panel may request that statements be filed, following the close of the hearing.

7.D.9. Postponements and Extensions:

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

7.E. HEARING CONCLUSION, DELIBERATIONS, AND RECOMMENDATIONS

7.E.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 MSEC 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.E.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 a recommendation, accompanied by a report, which shall contain a concise statement of the basis for its recommendation.

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

The Hearing Panel shall deliver its report to the CEO. The CEO shall send by Special Notice a copy of the report to the individual who requested the hearing. The CEO shall also provide a copy of the report to the MSEC.

7.F. APPEAL PROCEDURE

7.F.1. Time for Appeal:

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

7.F.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 or prior to the hearing, so as to deny a fair hearing; and/or
- (b) the recommendations of the Hearing Panel were made arbitrarily or capriciously or were not supported by credible evidence.

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

Whenever an appeal is requested as set forth in the preceding Sections, the Chair of the Board (or the CEO on behalf 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.F.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 not less than three persons, either members of the Board or others, including but not limited to reputable persons outside of the Hospital, to consider the record upon which the recommendation before it was made and recommend final action to the Board.

- (b) 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 argument not to exceed 30 minutes.
- (c) When requested by either party, the Review Panel may, in its discretion, accept additional oral or written evidence subject to the same rights of cross-examination or confrontation provided at the Hearing Panel proceedings. Such additional evidence shall be accepted only if the Review Panel determines that the party seeking to admit it has demonstrated that it is new, relevant evidence that could not have been presented at the hearing, or that any opportunity to admit it at the hearing was improperly denied.

7.G. BOARD ACTION

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

- (a) Within 30 days after the Board (i) considers the appeal as a Review Panel, (ii) receives a recommendation from a separate Review Panel, or (iii) receives the Hearing Panel's report and recommendation when no appeal has been requested, the Board shall consider the matter and take final action.
- (b) The Board may review any information that it deems relevant, including, but not limited to, the findings and recommendations of the MSEC, Hearing Panel, and Review Panel (if applicable). The Board may adopt, modify, or reverse any recommendation that it receives or, in its discretion, refer the matter to any individual or committee for further review and recommendation, or make its own decision based upon the Board's ultimate legal authority for the operation of the Hospital and the quality of care provided.
- (c) The Board shall render a final decision in writing, including specific reasons, and shall send Special Notice to the individual. A copy shall also be provided to the MSEC for its information.

7.G.2. Further Review:

Except where the matter is referred by the Board for further action and recommendation by any individual or committee, the final decision of the Board shall be effective immediately and shall not be subject to further review. If the matter is referred for further action and recommendation, such recommendation shall be promptly made to the Board in accordance with the instructions given by the Board.

7.G.3. Right to One Hearing and One Appeal Only:

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

ARTICLE 8

PROCEDURAL RIGHTS FOR LICENSED INDEPENDENT PRACTITIONERS AND ADVANCED PRACTICE PROVIDERS

8.A.1. Notice of Recommendation and Hearing Rights:

- (a) In the event a recommendation is made by the MSEC that a Licensed Independent Practitioner or Advanced Practice Provider not be granted clinical privileges or that the privileges previously granted be restricted for a period of more than 30 days, terminated, or not renewed, the individual will receive Special Notice of the recommendation from the CEO. The Special Notice will include a general statement of the reasons for the recommendation and will advise the individual that he or she may request a hearing.
- (b) The rights and procedures in this Section will also apply if the Board, without a prior adverse recommendation from the MSEC, makes a recommendation not to grant clinical privileges or that the privileges previously granted be restricted, terminated, or not renewed. In this instance, all references in this Article to the MSEC will be interpreted as a reference to the Board.
- (c) If the individual who is subject to the recommendation wants to request a hearing, the request must be in writing, directed to the CEO, within 30 days after receipt of written notice of the adverse recommendation.
- (d) The hearing will be convened as soon as is practical, but no sooner than 30 days after the notice of the hearing, unless an earlier hearing date has been specifically agreed to by the parties.

8.A.2. Hearing Committee:

- (a) If a request for a hearing is made timely, the CEO will appoint a Hearing Committee composed of up to three individuals (including, but not limited to, members of the Medical Staff, Hospital management, individuals not connected with the Hospital, or any combination of these individuals). The Hearing Committee will not include anyone who previously participated in the recommendation, any relatives or practice partners of the individual who requested the hearing, or any competitors of the affected individual.
- (b) The CEO will appoint a Presiding Officer, who will be an attorney and may be legal counsel to the Hospital. The role of the Presiding Officer will be to 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. The Presiding Officer will maintain decorum throughout the hearing.

8.A.3. Hearing Process:

- (a) A 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 individual's expense.
- (b) The hearing will last no more than six hours, with each side being afforded approximately three hours to present its case, in terms of both direct and cross-examination of witnesses.
- (c) At the hearing, a representative of the MSEC will first present the reasons for the recommendation. The affected individual will be invited to present information to refute the reasons for the recommendation.
- (d) Both parties will have the right to present witnesses. The Presiding Officer will permit reasonable questioning of such witnesses.
- (e) The affected individual and the MSEC may be represented at the hearing by legal counsel who may call, examine, and cross-examine witnesses and present the case.
- (f) The affected individual will have the burden of demonstrating, by clear and convincing evidence, that the recommendation of the MSEC 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.
- (g) The affected individual and the MSEC will have the right to prepare a post-hearing memorandum for consideration by the Hearing Committee. The Presiding Officer will establish a reasonable schedule for the submission of such memoranda.

8.A.4. Hearing Committee Report:

- (a) Within 20 days after the conclusion of the proceeding or submission of the post-hearing memoranda, whichever date is later, the Hearing Committee will prepare a written report and recommendation. The Hearing Committee will forward the report and recommendation, along with all supporting information, to the CEO. The CEO will send a copy of the written report and recommendation by Special Notice to the affected individual and to the MSEC.
- (b) Within ten days after notice of such recommendation, the affected individual and/or the MSEC may make a written request for an appeal. The request must

include a statement of the reasons, including specific facts, which justify an appeal.

- (c) The grounds for appeal will be limited to an assertion that there was substantial failure to comply with this Policy during the hearing, so as to deny a fair hearing, and/or that the recommendation of the Hearing Committee was arbitrary, capricious, or not supported by substantial evidence.
- (d) The request for an appeal will be delivered to the CEO by Special Notice.
- (e) If a written request for appeal is not submitted timely, the appeal is deemed to be waived and the recommendation and supporting information will be forwarded to the Board for final action. If a timely request for appeal is submitted, the CEO will forward the report and recommendation, the supporting information and the request for appeal to the Board. The Chair of the Board will arrange for an appeal.

8.A.5. Appellate Review:

- (a) An Appellate Review Committee appointed by the Chair of the Board will consider the record upon which the adverse recommendation was made. New or additional written information that is relevant and could not have been made available to the Hearing Committee may be considered at the discretion of the Appellate Review Committee. This review will be conducted within 30 days after receiving the request for appeal.
- (b) The affected individual and the MSEC will each have the right to present a written statement on appeal.
- (c) At the sole discretion of the Appellate Review Committee, the affected individual and a representative of the MSEC may also appear personally to discuss their position.
- (d) Upon completion of the review, the Appellate Review Committee will provide a report and recommendation to the full Board for action. Within 30 days of receiving the recommendation of the Appellate Review Committee, the Board will then make its final decision based upon the Board's ultimate legal responsibility to grant privileges and to authorize the performance of clinical activities at the Hospital.
- (e) The affected individual will receive Special Notice of the Board's action. A copy of the Board's final action will also be sent to the MSEC for information.

ARTICLE 9

CONFLICTS OF INTEREST

9.A.1. General Principles:

- (a) All those involved in credentialing, privileging, and professional practice evaluation activities (referred to collectively as “Medical Staff Functions” in this Article) must be sensitive to potential conflicts of interest (“COI”) in order to be fair to the individual whose qualifications are under review, to protect the individual with the potential conflict, and to protect the integrity of the review processes.
- (b) It is also essential that peers participate in Medical Staff Functions in order for these activities to be meaningful and effective. Therefore, whether and how an individual can participate must be evaluated reasonably, taking into consideration common sense and objective principles of fairness.
- (c) A potential conflict of interest depends on the situation and not on the character of the individual. To promote this understanding, any individual with a potential conflict of interest shall be referred to as an “Interested Member.”
- (d) No Medical Staff or Allied Health Staff member has the right to compel the disqualification of another member based on an allegation of conflict of interest. Rather, that determination is within the discretion of the Medical Staff Leaders or Board Chair, guided by this Article.
- (e) The fact that any individual chooses to refrain from participation, or is excused from participation, in any Medical Staff Function shall not be interpreted as a finding of an actual conflict that inappropriately influenced the review process.
- (f) **Appendix D** to this Policy is a chart that outlines the conflict of interest guidelines that are applicable to Medical Staff Functions at the Hospital. The remainder of this Article is intended to supplement **Appendix D** and expand on the guidelines that are summarized in the chart.

9.A.2. Process for Identifying Conflicts of Interest:

- (a) Self-Disclosure. Any individual involved in Medical Staff Functions must disclose all personal conflicts of interest relevant to those activities to the committee chair or CEO.
- (b) Identification by Others. Any individual who is concerned about a potential conflict of interest on the part of any other individual who is involved in Medical Staff Functions should inform the committee chair or CEO.

- (c) Identification by Individual Under Review. An individual who is the subject of review during any Medical Staff Functions is obligated to notify the committee chair or CEO of any known or suspected conflicts of interest by others who are involved in such activities. Any potential conflict of interest that is not raised timely by the individual under review shall be deemed waived.

9.A.3. Implementation of Conflict of Interest Guidelines in **Appendix D**:

This section describes how to implement the Conflict of Interest Guidelines found in **Appendix D** of this Policy:

- Paragraph (a) identifies the three COI situations that require special treatment and rules during the performance of Medical Staff Functions, irrespective of the Interested Member's level of participation in the process (e.g., individual reviewer or MSEC member);
- Paragraph (b) describes the other common situations that raise COI issues during the performance of Medical Staff Functions; and
- Paragraph (c) describes how to apply the guidelines in **Appendix D** to the common COI situations outlined in (b) at each level of the review processes.

(a) Three COI Situations that Require Special Treatment and Rules, Irrespective of an Interested Member's Level of Participation:

- (1) Employment or Contractual Arrangement with the Hospital. Because Medical Staff Functions are performed on behalf of the Hospital, the interests of those who are employed by, or under contract with, the Hospital are aligned with the Hospital's interest in seeing that those activities are performed effectively, efficiently, and lawfully. As such, employment by, or other contractual arrangement with, the Hospital or any of its affiliated entities does not, in and of itself, preclude an Interested Member from participating in Medical Staff Functions.
- (2) Self or Family Member. While Interested Members may provide information to other individuals involved in the review process, an Interested Member should not otherwise participate in the review of his or her own application or the professional practice evaluation of the care he or she provided in any such activities involving an immediate family member (spouse or domestic partner, parent, child, sibling, or in-law).
- (3) Relevant Treatment Relationship. As a general rule, an Interested Member who has provided professional health services to an individual whose application or provision of care is under review should not participate in the review process regarding the individual. However, if the

patient-physician relationship has terminated and the review process does not involve the health condition for which the individual sought professional health services, the Interested Member may participate fully in all Medical Staff Functions.

Furthermore, even if a current patient-physician relationship exists, the Interested Member may provide information to others involved in the review process if:

- (i) the information was not obtained through the treatment relationship, or
- (ii) the information was obtained through the treatment relationship, but the disclosure was authorized by the individual under review through the execution of a HIPAA-compliant authorization form.

(b) Other Common Situations that Raise COI Issues During Performance of Medical Staff Functions:

Participation by any Interested Member who is in one of the following situations – as it relates to the individual under review – will be evaluated under the guidelines outlined in Paragraph (c) and **Appendix D**.

- (1) Significant Financial Relationship (e.g., when the Interested Member and other practitioners: are members of a small, single specialty group; maintain a significant referral relationship; are partners in a business venture; or are individuals practicing in a specialty for which a policy matter – such as clinical privileging criteria – is being considered);
- (2) Direct Competitor (e.g., practitioners in the same specialty, but in different groups);
- (3) Close Friendships;
- (4) History of Personal Conflict (e.g., former partner, ex-spouse, or where there has been demonstrated animosity);
- (5) Personal Involvement in the Care That Is Subject to Review (e.g., where the Interested Member provided care in the case under review, but is not the subject of the review);
- (6) Active Involvement in Certain Prior Interventions with the Individual Under Review (e.g., where the Interested Member was involved in the development of a prior Performance Improvement Plan or in a disciplinary action involving the individual under review. This situation does not include participation in initial education or collegial intervention efforts

(e.g., sending an Educational Letter; meeting collegially with a colleague and sending a follow-up letter)); and/or

- (7) Formally Raised the Concern about Another Individual (e.g., where the Interested Member's concern triggered the review of another practitioner, as evidenced by the Interested Member's written report regarding the concern (i.e., sent a written concern to a Medical Staff Officer or CEO, or filed a report through the Hospital's electronic reporting system)).

(c) Application of the Guidelines in **Appendix D** to the Performance of Medical Staff Functions:

(1) Individual Reviewers in Credentialing and Professional Practice Evaluation Activities

An Interested Member may participate as an individual reviewer so long as a check and balance is provided by subsequent review by a Medical Staff committee. This includes, but is not limited to, the following:

- (i) participation in the review of applications for initial and renewed appointment and clinical privileges (which is subsequently reviewed by the Credentials Committee and/or MSEC); and
- (ii) participation as a case reviewer in professional practice evaluation activities (which is subsequently reviewed by an Investigating Committee and/or the MSEC).

(2) Credentials Committee, Leadership Council, and Committee for Professional Enhancement ("CPE") Members

As a general rule, an Interested Member may fully participate as a member of the Credentials Committee, Leadership Council, and CPE because these committees do not possess any disciplinary authority and do not make any final recommendation that could adversely affect the appointment or clinical privileges of a Practitioner, which is only within the authority of the MSEC and Board.

However, the chairs of these committees always have the discretion to recuse an Interested Member if they determine that the Interested Member's presence or participation would inhibit full and fair discussion of the issue, would skew the recommendation or determination of the committee, or would otherwise be unfair to the practitioner under review.

(3) Medical Staff Executive Committee

As a general rule, an Interested Member may fully participate as a member of the MSEC when it is approving routine and favorable recommendations regarding the granting of initial appointment, reappointments, and clinical privileges.

However, an Interested Member should be recused when that committee is considering a matter that could result in an adverse professional review action affecting the appointment or clinical privileges of an individual. The Interested Member's participation in MSEC meetings will be governed by the guidelines regarding recusal that are set forth in **Appendix D**.

(4) Investigating Committees

Once a formal investigation has been initiated by the MSEC, additional steps to manage conflicts of interest should be taken as a precaution. Therefore, an Interested Member should not be appointed as a member of an investigating committee and should not participate in the committee's deliberations or decision-making, but may be interviewed and provide information if necessary for the committee to conduct a full and thorough investigation.

(5) Hearing Panel

An Interested Member should not be appointed as a member of a Hearing Panel and should not participate in the Panel's deliberations or decision-making.

(6) Board

As a general rule, an Interested Member may fully participate as a member of the Board when it is approving routine and favorable recommendations regarding the granting of initial appointment, reappointments, and clinical privileges.

However, an Interested Member should be recused from the Board when the Board is considering action that will adversely affect the appointment or clinical privileges of an individual. The Interested Member's participation in Board meetings will be governed by the guidelines regarding recusal that are set forth in **Appendix D**.

ARTICLE 10
AMENDMENTS

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

ARTICLE 11

ADOPTION

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

Originally adopted by the Medical Staff on February 15, 2011 and approved by the Board on February 24, 2011.

Revisions by the Medical Staff Executive Committee on: September 18, 2018
Approved by the Board on: December 13, 2018

GLOSSARY

The following definitions apply to terms used in this Policy:

- (1) “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, including the following:
 - “ADVANCED PRACTICE PROVIDERS” 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, or in collaboration with, a practitioner(s) appointed to the Medical Staff. The Supervising/Collaborating Physician(s) is responsible for the actions of the Advanced Practice Provider in the Hospital.
 - “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/Collaborating Physician(s) is responsible for the actions of the Dependent Practitioner in the Hospital. Except as specifically indicated in Appendix A of this Policy, all aspects of the clinical practice of Dependent Practitioners in the Hospital shall be assessed and managed by Human Resources in accordance with Human Resources policies and procedures, and the provisions of this Policy shall specifically **not** apply (except for Appendix A of this Policy).
 - “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.
- (2) “BOARD” means the Board of Directors of the Hospital, which has the overall responsibility for the Hospital, or its designated committee.
- (3) “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 Foot and Ankle Surgery, upon an individual, as applicable, who has successfully completed an approved educational training program and an evaluation process, including passing an examination, in the individual’s area of clinical practice.

- (4) “CHIEF EXECUTIVE OFFICER” (“CEO”) means the individual appointed by the Board to act on its behalf in the overall management of the designated Hospital.
- (5) “CHIEF MEDICAL OFFICER” (“CMO”) means the individual appointed by the Board to act as the CMO of the designated Hospital, in cooperation with the President 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) “CORE PRIVILEGES” means a defined grouping of privileges for a specialty or subspecialty that includes the fundamental patient care services that are routinely taught in residency and/or fellowship training for that specialty or subspecialty and which have been determined by the Medical Staff Leaders and Board to require closely related skills and experience.
- (9) “CREDENTIALS POLICY” means the Hospital’s Medical Staff Credentials Policy.
- (10) “DAYS” means calendar days.
- (11) “DENTIST” means a doctor of dental surgery (“D.D.S.”) or doctor of dental medicine (“D.M.D.”).
- (12) “HOSPITAL” means an Indianapolis Metro Region Health Center that includes IU Health Methodist Hospital, IU Health University Hospital, Riley Hospital for Children at IU Health, IU Health Fishers Hospital, IU Health West Hospital, IU Health North Hospital, and IU Health Morgan or any related outpatient facilities for which Medical Staff privileges are required or appropriate.
- (13) “HOUSE STAFF” means all physicians who are assigned for graduate medical education and will ordinarily carry the title of resident or fellow.
- (14) “MEDICAL STAFF” means all physicians and dentists who have been appointed to the Medical Staff by the Board.

- (15) “MEDICAL STAFF EXECUTIVE COMMITTEE” or “MSEC” means the MSEC of the Medical Staff.
- (16) “MEDICAL STAFF LEADER” means any Medical Staff Officer, Section chief or co-chiefs, or committee chair.
- (17) “MEMBER” means any physician and dentist who has been granted Medical Staff appointment to the Medical Staff and/or any allied health practitioner who has been granted appointment to the Allied Health Staff, by the Board, to practice at the Hospital.
- (18) “NOTICE” means written communication by regular U.S. mail, Hospital mail, hand delivery, e-mail, facsimile, website, or other electronic method.
- (19) “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.
- (20) “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.
- (21) “PHYSICIAN” includes both doctors of medicine (“M.D.s”) and doctors of osteopathy (“D.O.s”).
- (22) “PROFESSIONAL REVIEW ACTION” has the meaning defined in the HCQIA, that is, an action by the Board or recommendation of the MSEC 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.
- (23) “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.

- (24) “SCOPE OF PRACTICE” means the authorization granted by the Board or CEO, as applicable, to perform certain clinical activities and functions under the supervision of, or in collaboration with, a Supervising/Collaborating Physician.
- (25) “SPECIAL NOTICE” means hand delivery, certified mail (return receipt requested), or overnight delivery service providing receipt.
- (26) “SPECIAL PRIVILEGES” means privileges that fall outside of the core privileges for a given specialty, which require additional education, training, and/or experience beyond that required for core privileges in order to demonstrate competence.
- (27) “SUPERVISING/COLLABORATING PHYSICIAN” means a member of the Medical Staff with clinical privileges, who has agreed in writing to supervise a Dependent Practitioner or an Advanced Practice Provider and to accept full responsibility for the actions of the Dependent Practitioner or Advanced Practice Provider while he or she is practicing in the Hospital.
- (28) “SUPERVISION” means the supervision of, or collaboration with, an Advanced Practice Provider or a Dependent Practitioner and a Supervising/Collaborating Physician that generally does not require the actual presence of the Supervising/Collaborating Physician, but that does require that the Supervising/Collaborating 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/Collaborating Physician:

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

A.2. Questions Regarding the Authority of an Advanced Practice Provider 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 Practice Provider or Dependent Practitioner to act or issue instructions outside the presence of the Supervising/Collaborating Physician, such individual will have the right to request that the Supervising/Collaborating Physician validate, either at the time or later, the instructions of the Advanced Practice Provider or Dependent Practitioner. Any act or instruction of the Advanced Practice Provider 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 Practice Provider will be reported to the President of the Medical Staff, the Chair of the Credentials Committee, the relevant Section chief or co-chief, or the CEO 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/Collaborating Physician.

A.3. Responsibilities of Supervising/Collaborating Physicians:

- (a) Physicians who wish to use the services of an Advanced Practice Provider or Dependent Practitioner in their clinical practice at the Hospital must notify the Medical Staff Office of this fact in advance and must ensure that the individual has been appropriately credentialed in accordance with this Policy or the relevant Human Resources process before the Advanced Practice Provider or Dependent Practitioner participates in any clinical or direct patient care of any kind in the Hospital.
- (b) The number of Advanced Practice Providers 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/Collaborating Physician will make all appropriate filings with the state regarding the supervision and responsibilities of the Advanced Practice Provider or Dependent Practitioner, to the extent that such filings are required.
- (c) It will be the responsibility of the Supervising/Collaborating Physician to provide, or to arrange for, professional liability insurance coverage for the Advanced Practice Provider or Dependent Practitioner in amounts required by the Board. The insurance must cover any and all activities of the Advanced Practice Provider or Dependent Practitioner in the Hospital. The Supervising/Collaborating Physician will furnish evidence of such coverage to the Hospital. The Advanced Practice Provider 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 individual in a category of Allied Health Practitioner that has not been approved by the Board requests permission to practice at the Hospital, the Board shall refer the matter to the Credentials Committee to evaluate the need for that particular category of Practitioner and to make a recommendation to the MSEC for its review and recommendation and then to the Board for final action.
- (b) As part of the process of determining need, the individual requesting permission to practice at the Hospital shall be invited to submit information about the nature of the proposed practice, why Hospital access is sought, and the potential benefits to the community by having such services available at the Hospital.
- (c) The Credentials Committee will review any information submitted by the individual and consider the following factors:
 - (1) the nature of the services that would be offered;
 - (2) any state license or regulation which outlines the scope of practice that the individual is authorized by law to perform;
 - (3) any state “non-discrimination” or “any willing provider” laws that would apply to the individual;
 - (4) the business and patient care objectives of the Hospital, including patient convenience;
 - (5) the community’s needs and whether those needs are currently being met or could be better met if the services offered by the individual were provided at the Hospital;
 - (6) the type of training that is necessary to perform the services that would be offered and whether there are individuals with more training currently providing those services;
 - (7) the availability of supplies, equipment, and other necessary Hospital resources;
 - (8) the need for, and availability of, trained staff to support the services that would be offered; and

- (9) the ability to appropriately supervise performance and monitor quality of care.
- (d) The Credentials Committee will then forward its recommendation on whether there is a need for the particular category of Allied Health Practitioner at the Hospital to the MSEC, which will review the matter and forward its recommendation to the Board for final action.

B.2. Additional Recommendations:

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

APPENDIX C

ALLIED HEALTH PRACTITIONERS

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

- Psychologist
- Podiatrist
- Optometrist

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

- Anesthesia Assistants
- Certified Nurse Midwife
- Certified Nurse Specialist
- Certified Registered Nurse Anesthetist
- Genetic Counselors
- Nurse Practitioner
- Physician Assistant – Certified
- Registered Radiology Assistants

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

- Certified Surgical Technologist
- Certified First Assist
- Certified Ophthalmology Technician/Assistant
- Dental Assistant
- Licensed Practical Nurse
- Medical Assistant
- Orthopedic Technologist/Assistant
- Registered Nurse

APPENDIX D

CONFLICT OF INTEREST GUIDELINES

Potential Conflicts	Levels of Participation								
	Provide Information	Individual Reviewer Application/ Case	Committee Member				Investigating Committee	Hearing Panel	Board
			Credentials	Leadership Council	CPE	MSEC			
Employment/contract relationship with Hospital	Y	Y	Y	Y	Y	Y	Y	Y	Y
Self or family member	Y	N	R	R	R	R	N	N	R
Relevant treatment relationship*	Y	N	R	R	R	R	N	N	R
Significant financial relationship	Y	Y	Y	Y	Y	R	N	N	R
Direct competitor	Y	Y	Y	Y	Y	R	N	N	R
Close friends	Y	Y	Y	Y	Y	R	N	N	R
History of conflict	Y	Y	Y	Y	Y	R	N	N	R
Provided care in case under review (but not subject of review)	Y	Y	Y	Y	Y	R	N	N	R
Involvement in prior PIP or disciplinary action	Y	Y	Y	Y	Y	R	N	N	R
Formally raised the concern	Y	Y	Y	Y	Y	R	N	N	R

Y (“Yes”) – means the Interested Member may serve in the indicated role; no extra precautions are necessary.

Y (“Yes, with infrequent but occasional limitations”) – means the Interested Member may generally serve in the indicated role. It is legally permissible for Interested Members to serve in these roles because of the check and balance provided by the multiple levels of review and the fact that the Credentials Committee, the Leadership Council, and the CPE have no disciplinary authority.

In addition, the Chair of each of these committees always has the authority and discretion to recuse a member in a particular situation if the Chair determines that the Interested Member’s presence would (i) inhibit the full and fair discussion of the issue before the committee, (ii) skew the recommendation or determination of the committee, or (iii) otherwise be unfair to the Practitioner under review.

N (“No”) – means the Interested Member should not serve in the indicated role.

R (“Recuse”) – means the Interested Member should be recused, in accordance with the guidelines on the next page.

* Special rules apply both to the provision of information and participation in the review process in this situation. See Section 9.A.3 of the Credentials Policy.

RULES FOR RECUSAL	
STEP 1 Confirm the conflict of interest	The Committee Chair or Board Chair should confirm the existence of a conflict of interest relevant to the matter under consideration.
STEP 2 Participation by the Interested Member at the meeting	The Interested Member may participate in any part of the meeting that does not involve the conflict of interest situation. When the matter implicating the conflict of interest is ready for consideration, the Committee Chair or Board Chair will note that the Interested Member will be excused from the meeting prior to the group's deliberation and decision-making. Prior to being excused, the Interested Member may provide information and answer any questions regarding the following: (i) any factual information for which the Interested Member is the original source; (ii) clinical expertise that is relevant to the matter under consideration; (iii) any policies or procedures that are applicable to the committee or Board or are relevant to the matter under consideration; (iv) the Interested Member's prior involvement in the review of the matter at hand (for example, an Investigating Committee member may describe the Investigating Committee's activities and present the Investigating Committee's written report and recommendations to the Medical Staff Executive Committee prior to being excused from the meeting); and (v) how the committee or Board has, in the past, managed issues similar or identical to the matter under consideration.
STEP 3 The Interested Member is excused from the meeting	The Interested Member will then be excused from the meeting (i.e., physically leave the meeting room and/or disconnect from any telephone or other electronic connection) prior to the committee's or Board's deliberation and decision-making.
STEP 4 Record the recusal in the minutes	The recusal should be documented in the minutes of the committee or Board. The minutes should reflect the fact that the Interested Member was excused from the meeting prior to deliberation and decision-making.

APPENDIX E

RE-ENTRY PLAN OPTIONS

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Note: Issues related to the development and monitoring of a re-entry plan are described in the Policy for Practitioner Re-Entry to Practice. The Implementation Issues Checklists in this Appendix may be used by the Credentials Committee to effectuate a re-entry plan. Checklists may be used individually or in combination with one another, depending on the nature of the re-entry plan.

A copy of a completed checklist may be provided to the individual who is participating in the re-entry plan, so that the Credentials Committee and the individual have a shared and clear understanding of the elements of the re-entry plan. While checklists may serve as helpful guidance to the Credentials Committee and the individual, there is no requirement that they be used. Failure to use a checklist or to answer one or more questions on a checklist will not affect the validity of a re-entry plan.

RE-ENTRY PLAN OPTION	IMPLEMENTATION ISSUES
<i>Formal Evaluation/ Assessment Program</i> <i>(Onsite multiple-day programs that may include formal testing, simulated patient encounters, chart review.)</i>	<i>Scope of Formal Evaluation/Assessment Program</i> ☐ Acceptable programs include: _____ _____ ☐ Credentials Committee approval required before practitioner enrolls ☐ Program approved: _____ ☐ Date of approval: _____ <i>Practitioner's Responsibilities</i> ☐ Sign release allowing Credentials Committee to provide information to program (if necessary) and program to provide report of assessment and evaluation to Credentials Committee. _____ _____ ☐ Enroll in program by: _____ ☐ Complete program by: _____ <i>Application Status</i> ☐ Will application remain on hold status pending the completion of evaluation/assessment program? ☐ Yes ☐ No _____ _____ <i>Follow-Up</i> ☐ Based on results of assessment, what additional precautions or interventions are necessary, if any? _____ _____ <i>Initial FPPE Requirements</i> ☐ Do the requirements for initial FPPE to confirm competence and professionalism need to be modified (focused case reviews, second opinions, proctoring, etc.) to ensure a successful re-entry? ☐ Yes ☐ No If yes, please describe recommendations for modification of initial FPPE: _____ _____

RE-ENTRY PLAN OPTION	IMPLEMENTATION ISSUES
<i>Additional Education/CME</i> <i>(Wide range of options)</i>	<i>Scope of Additional Education/CME</i> ☐ Be specific – what type? _____ _____ ☐ Acceptable programs include: _____ _____ ☐ Credentials Committee approval required before practitioner enrolls. ☐ Program approved: _____ ☐ Date of approval: _____ ☐ Time frames ☐ Practitioner must enroll by: _____ ☐ CME must be completed by: _____ ☐ Documentation of completion must be submitted to Credentials Committee _____ ☐ Date submitted: _____ <i>Application Status</i> ☐ Will application remain on hold status pending the completion of evaluation/assessment program? Yes ☐ No _____ _____ <i>Initial FPPE Requirements</i> ☐ Do the requirements for initial FPPE to confirm competence and professionalism need to be modified (focused case reviews, second opinions, proctoring, etc.) to ensure a successful re-entry? ☐ Yes ☐ No If yes, please describe recommendations for modification of initial FPPE: _____ _____

RE-ENTRY PLAN OPTION	IMPLEMENTATION ISSUES
<i>Additional Training</i> <i>(Wide range of options from hands-on CME to simulation to repeat of residency or fellowship.)</i>	<i>Scope of Additional Training</i> ☐ Be specific – what type? _____ _____ ☐ Acceptable programs include: _____ _____ ☐ Credentials Committee approval required before practitioner enrolls. ☐ Program approved: _____ ☐ Date of approval: _____ <i>Practitioner's Responsibilities</i> ☐ Sign release allowing Credentials Committee to provide information to training program (if necessary) and program to provide detailed evaluation/assessment to Credentials Committee <u>before</u> resuming practice. ☐ Enroll in program by: _____ ☐ Complete program by: _____ <i>Application Status</i> ☐ Will application remain on hold status pending the completion of evaluation/assessment program? ☐ Yes ☐ No _____ _____ <i>Initial FPPE Requirements</i> ☐ Do the requirements for initial FPPE to confirm competence and professionalism need to be modified (focused case reviews, second opinions, proctoring, etc.) to ensure a successful re-entry? ☐ Yes ☐ No If yes, please describe recommendations for modification of initial FPPE: _____ _____

RE-ENTRY PLAN OPTION	IMPLEMENTATION ISSUES
<i>Second Opinions/ Consultations</i> <i>(Before the practitioner proceeds with a particular treatment plan or procedure, he or she obtains a second opinion or consultation.)</i> <i>(This is not a “restriction” of privileges that triggers a hearing and reporting, if implemented correctly.)</i>	<i>Scope of Second Opinions/Consultations</i> ☐ What types of cases are subject to the second opinions/consultations? ☐ How many cases are subject to the second opinions/consultations? ☐ Based on practice patterns, estimated time to complete the second opinions/consultations? ☐ Must consultant evaluate patient in person prior to treatment/procedure? ☐ Yes ☐ No <i>Responsibilities of Practitioner</i> ☐ Notify consultant when applicable patient is admitted, or procedure is scheduled <u>and</u> ensure that all information necessary to provide consultation is available in the medical record (H&P, results of diagnostic tests, etc.). ☐ What time frame for notice to consultant is practical and reasonable (e.g., two days prior to scheduled, elective procedure)? ☐ If consultant must evaluate patient prior to treatment, inform patient that consultant will be reviewing medical record and will examine patient. ☐ If consultant must evaluate patient prior to treatment, include general progress note in medical record noting that consultant examined patient and discussed findings with practitioner. ☐ Discuss proposed treatment/procedure with consultant. <i>Qualifications of Consultant</i> ☐ Consultant must have clinical privileges in _____.

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<i>Second Opinions/Consultations</i> <i>(Before the practitioner proceeds with a particular treatment plan or procedure, he or she obtains a second opinion or consultation.)</i> <i>(This is not a “restriction” of privileges that triggers a hearing and reporting, if implemented correctly.)</i> <i>(cont’d.)</i>	☐ Possible candidates include: _____ _____ ☐ The following individuals agreed to act as consultants and were approved by the Credentials Committee (or designees) on: _____ (date) _____ _____ _____ _____ <i>Responsibilities of Consultant</i> <i>(Information provided by Credentials Committee; include discussion of legal protections for consultant.)</i> ☐ Review medical record prior to treatment or procedure. _____ _____ ☐ Evaluate patient prior to treatment or procedure, if applicable. _____ _____ ☐ Discuss proposed treatment/procedure with practitioner. _____ _____ ☐ Complete Second Opinion/Consultation Form and submit to Medical Staff Office <i>(not for inclusion in the medical record)</i>. _____ _____ <i>Disagreement Regarding Proposed Treatment/Procedure</i> If consultant and practitioner disagree regarding proposed treatment/procedure, consultant notifies one of the following so that an immediate meeting can be scheduled to resolve the disagreement: ☐ Vice President of Medical Affairs ☐ President of the Medical Staff ☐ Department Chair ☐ Other: _____ _____ _____

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<i>Second Opinions/Consultations</i> <i>(Before the practitioner proceeds with a particular treatment plan or procedure, he or she obtains a second opinion or consultation.)</i> <i>(This is not a “restriction” of privileges that triggers a hearing and reporting, if implemented correctly.)</i> <i>(cont’d.)</i>	<i>Results of Second Opinion/Consultations</i> ☐ Who will review results of second opinion/consultations with practitioner? ☐ After each case ☐ After total # of cases subject to review (unless sooner discussions are necessary based on case findings) ☐ Include consultants’ reports in practitioner’s quality file. <i>Additional Safeguards</i> ☐ Will practitioner be removed from some/all on-call responsibilities until the second opinions/consultations are completed? ☐ Yes ☐ No <i>Initial FPPE Requirements</i> ☐ Do the requirements for initial FPPE to confirm competence and professionalism need to be modified (focused case reviews, second opinions, proctoring, etc.) to ensure a successful re-entry? ☐ Yes ☐ No If yes, please describe recommendations for modification of initial FPPE:

RE-ENTRY PLAN OPTION	IMPLEMENTATION ISSUES
<i>Concurrent Proctoring</i> <i>(A certain number of the practitioner's future cases of a particular type (e.g., vascular cases, management of diabetic patients) must be directly observed.)</i> <i>(This is not a "restriction" of privileges that triggers a hearing and reporting, if implemented correctly.)</i>	<i>Scope of Proctoring</i> ☐ What types of cases are subject to proctoring? ☐ How many cases are subject to proctoring? <i>Time Frames</i> ☐ Based on practice patterns, estimated time to complete the proctoring? <i>Responsibilities of Practitioner</i> ☐ Notify proctor when applicable patient is admitted or procedure is scheduled <u>and</u> ensure that all information necessary for proctor to evaluate case is available in the medical record (H&P; results of diagnostic tests, etc.). ☐ What time frame for notice to proctor is practical and reasonable (e.g., two days prior to scheduled, elective procedure)? ☐ If proctor will personally assess patient <u>or</u> will participate in patient's care, discuss with patient prior to proctor's examination. ☐ Include general progress note in medical record noting that proctor examined patient and discussed findings with practitioner, <i>if applicable</i>. ☐ Agree that proctor has authority to intervene, if necessary. ☐ Discuss treatment/procedure with proctor.

RE-ENTRY PLAN OPTION	IMPLEMENTATION ISSUES
Concurrent Proctoring <i>(A certain number of the practitioner's future cases of a particular type (e.g., vascular cases, management of diabetic patients) must be directly observed.)</i> <i>(This is not a "restriction" of privileges that triggers a hearing and reporting, if implemented correctly.)</i> <i>(cont'd.)</i>	Qualifications of Proctor <i>(Credentials Committee must approve)</i> ☐ Proctor must have clinical privileges in _____ <i>(If proctor is not a member of the Medical Staff, credential and grant temporary privileges.)</i> ☐ Possible candidates include: _____ _____ ☐ The following individuals agreed to act as proctors and were approved by the Credentials Committee on _____: _____ _____ _____ Responsibilities of Proctor <i>(information provided by Credentials Committee; include discussion of legal protections for proctor)</i> ☐ Review medical record <u>and</u>: ☐ Procedure: Be present for the relevant portions of the procedure and be available post-op if complications arise. ☐ Medical: Be available during course of treatment to discuss treatment plan, orders, lab results, discharge planning, etc., and personally assess patient, if necessary. ☐ Intervene in care if necessary to protect patient and document such intervention appropriately in medical record. ☐ Discuss treatment plan/procedure with practitioner. ☐ Document review as indicated below and submit to Medical Staff Office. Documentation of Review <i>(not for inclusion in the medical record)</i> ☐ Case Review Worksheet ☐ Specific form developed for this re-entry plan ☐ General summary by reviewer ☐ Other:

RE-ENTRY PLAN OPTION	IMPLEMENTATION ISSUES
<i>Concurrent Proctoring</i> <i>(A certain number of the practitioner’s future cases of a particular type (e.g., vascular cases, management of diabetic patients) must be directly observed.)</i> <i>(This is not a “restriction” of privileges that triggers a hearing and reporting, if implemented correctly.)</i> <i>(cont’d.)</i>	<i>Results of Proctoring</i> ☐ Who will review results of proctoring with practitioner? ☐ After each case ☐ After total # of cases subject to review (unless sooner discussions are necessary based on case findings) ☐ Include proctor reports in practitioner’s quality file <i>Initial FPPE Requirements</i> ☐ Do the requirements for initial FPPE to confirm competence and professionalism need to be modified (focused case reviews, second opinions, proctoring, etc.) to ensure a successful re-entry? ☐ Yes ☐ No If yes, please describe recommendations for modification of initial FPPE:

RE-ENTRY PLAN OPTION	IMPLEMENTATION ISSUES
<i>Focused Prospective Monitoring</i> <i>(100% focused review of next X cases (e.g., obstetrical cases, laparoscopic surgery))</i>	<i>Scope of Monitoring</i> ☐ How many cases are subject to review? _____ ☐ What types of cases are subject to review? _____ ☐ Based on practitioner's anticipated practice patterns, estimated time for completion of monitoring? _____ ☐ Does monitoring include more than review of medical record? ☐ Yes ☐ No If yes, what else does it include? _____ ☐ Review to be done: ☐ Post-discharge ☐ During admission ☐ Review to be done by: ☐ Medical Staff Office ☐ Department Chair ☐ Vice President of Medical Affairs ☐ Other: _____ ☐ Must practitioner notify reviewer of cases subject to requirement? ☐ Yes ☐ No Other options? _____ <i>Documentation of Review</i> ☐ Case Review Worksheet ☐ Specific form developed for this review ☐ General summary by reviewer ☐ Other: _____ <i>Results of Monitoring</i> ☐ Who will review results of monitoring with practitioner? _____ ☐ After each case ☐ After total # of cases subject to review (unless sooner discussions are necessary based on case findings)

<i>RE-ENTRY PLAN OPTION</i>	<i>IMPLEMENTATION ISSUES</i>
<i>Focused Prospective Monitoring</i> <i>(100% focused review of next X cases (e.g., obstetrical cases, laparoscopic surgery))</i> <i>(cont'd.)</i>	<i>Initial FPPE Requirements</i> ☐ Do the requirements for initial FPPE to confirm competence and professionalism need to be modified (focused case reviews, second opinions, proctoring, etc.) to ensure a successful re-entry? ☐ Yes ☐ No If yes, please describe recommendations for modification of initial FPPE:

