

CREDENTIALS POLICY

**HSHS HOLY FAMILY HOSPITAL
GREENVILLE, ILLINOIS**

**an Affiliate of
Hospital Sisters Health System**

TABLE OF CONTENTS

	<u>PAGE</u>
1. GENERAL	1
1.A. PREAMBLE	1
1.B. TIME LIMITS	1
1.C. DELEGATION OF FUNCTIONS	1
1.D. CONFIDENTIALITY AND PEER REVIEW PROTECTION.....	1
1.D.1. Confidentiality	1
1.D.2. Peer Review Protection.....	2
1.E. INDEMNIFICATION.....	2
1.F. EMPLOYMENT.....	2
1.G. DEFINITIONS.....	2
2. QUALIFICATIONS, CONDITIONS, AND RESPONSIBILITIES	7
2.A. QUALIFICATIONS	7
2.A.1. Threshold Eligibility Criteria.....	7
2.A.2. Waiver of Threshold Eligibility Criteria.....	9
2.A.3. Factors for Evaluation.....	10
2.A.4. No Entitlement to Appointment.....	10
2.A.5. Nondiscrimination.....	11
2.A.6. Ethical and Religious Directives.....	11
2.B. GENERAL CONDITIONS OF APPOINTMENT, REAPPOINTMENT, AND CLINICAL PRIVILEGES	11
2.B.1. Basic Responsibilities and Requirements	11
2.B.2. Burden of Providing Information.....	13

	<u>PAGE</u>
2.C. APPLICATION	14
2.C.1. Information	14
2.C.2. Misstatements and Omissions	14
2.C.3. Grant of Immunity and Authorization to Obtain/Release Information	15
3. PROCEDURE FOR INITIAL APPOINTMENT AND PRIVILEGES.....	18
3.A. PROCEDURE FOR INITIAL APPOINTMENT AND PRIVILEGES.....	18
3.A.1. Application.....	18
3.A.2. Initial Review of Application.....	18
3.A.3. Department Chair and/or Chief Nursing Executive Procedure.....	19
3.A.4. Credentials Committee Procedure	19
3.A.5. Medical Staff Executive Committee Recommendation.....	20
3.A.6. Board Action.....	20
3.A.7. Time Periods for Processing	21
4. CLINICAL PRIVILEGES.....	22
4.A. CLINICAL PRIVILEGES	22
4.A.1. General	22
4.A.2. Privilege Waivers	23
4.A.3. Relinquishment of Individual Clinical Privileges	24
4.A.4. Resignation of Appointment and Clinical Privileges	24
4.A.5. Clinical Privileges for New Procedures	24
4.A.6. Clinical Privileges That Cross Specialty Lines	26
4.A.7. Clinical Privileges for Dentists and Oral and Maxillofacial Surgeons.....	27
4.A.8. Clinical Privileges for Podiatrists.....	27
4.A.9. Physicians in Training.....	28
4.A.10. Telemedicine Privileges	28
4.A.11. Focused Professional Practice Evaluation for Initial Privileges	29
4.B. TEMPORARY CLINICAL PRIVILEGES	30
4.B.1. Temporary Clinical Privileges	30
4.C. EMERGENCY SITUATIONS	31

	<u>PAGE</u>
4.D. DISASTER PRIVILEGES	31
4.E. CONTRACTS FOR SERVICES	32
5. PROCEDURE FOR REAPPOINTMENT	36
5.A. PROCEDURE FOR REAPPOINTMENT	36
5.B. REAPPOINTMENT CRITERIA.....	36
5.B.1. Eligibility for Reappointment	36
5.B.2. Factors for Evaluation.....	36
5.C. REAPPOINTMENT PROCESS.....	37
5.C.1. Reappointment Application Form.....	37
5.C.2. Conditional Reappointments.....	38
5.C.3. Potential Adverse Recommendation.....	38
6. ISSUES INVOLVING MEDICAL STAFF OR ALLIED HEALTH STAFF MEMBERS.....	39
6.A. OVERVIEW AND GENERAL PRINCIPLES	39
6.A.1. Options Available to Medical Staff Leaders and Hospital Administration	39
6.A.2. Documentation.....	39
6.A.3. No Recordings of Meetings	40
6.A.4. No Right to Counsel.....	40
6.A.5. No Right to the Presence of Others.....	40
6.A.6. Involvement of Supervising Physician in Matters Pertaining to Allied Health Staff Members.....	40
6.B. COLLEGIAL INTERVENTION AND PROGRESSIVE STEPS	40
6.C. ONGOING AND FOCUSED PROFESSIONAL PRACTICE EVALUATION ..	41
6.D. MANDATORY MEETING.....	42
6.E. FITNESS FOR PRACTICE EVALUATION.....	42

	<u>PAGE</u>
6.F. AUTOMATIC RELINQUISHMENT	42
6.F.1. Failure to Complete Medical Records	43
6.F.2. Failure to Satisfy Threshold Eligibility Criteria	43
6.F.3. Criminal Activity	43
6.F.4. Failure to Provide Information.....	43
6.F.5. Failure to Attend a Mandatory Meeting.....	43
6.F.6. Failure to Complete or Comply with Training or Educational Requirements	44
6.F.7. Failure to Comply with Request for Fitness for Practice Evaluation.....	44
6.F.8. Reinstatement from Automatic Relinquishment and Automatic Resignation.....	44
6.F.9. Hearings Regarding Automatic Relinquishments.....	45
6.G. LEAVES OF ABSENCE	45
6.G.1. Initiation.....	45
6.G.2. Duties of Member on Leave	46
6.G.3. Reinstatement.....	46
6.H. PRECAUTIONARY SUSPENSION OR RESTRICTION OF CLINICAL PRIVILEGES.....	47
6.H.1. Grounds for Precautionary Suspension or Restriction.....	47
6.H.2. Request for Hearing and Medical Staff Executive Committee Action.....	48
6.H.3. Care of Patients	49
6.I. INVESTIGATIONS	49
6.I.1. Initial Review.....	49
6.I.2. Initiation of Investigation.....	50
6.I.3. Investigative Procedure.....	50
6.I.4. Recommendation	52
7. HEARING AND APPEAL PROCEDURES	53
7.A. INITIATION OF HEARING.....	53
7.A.1. Grounds for Hearing	53
7.A.2. Actions Not Grounds for Hearing.....	53
7.A.3. Notice of Recommendation	54
7.A.4. Request for Hearing	54

	<u>PAGE</u>
7.A.5. Notice of Hearing and Statement of Reasons	55
7.A.6. Witness List	55
7.A.7. Hearing Panel, Presiding Officer, and Hearing Officer	55
7.A.8. Counsel	58
7.B. PRE-HEARING PROCEDURES	58
7.B.1. General Procedures	58
7.B.2. Time Frames	58
7.B.3. Provision of Relevant Information.....	58
7.B.4. Pre-Hearing Conference.....	59
7.B.5. Stipulations	60
7.B.6. Provision of Information to the Hearing Panel	60
7.C. THE HEARING.....	60
7.C.1. Time Allotted for Hearing	60
7.C.2. Record of Hearing.....	60
7.C.3. Rights of Both Sides and the Hearing Panel at the Hearing	61
7.C.4. Order of Presentation	61
7.C.5. Admissibility of Evidence.....	61
7.C.6. Persons to Be Present.....	61
7.C.7. Presence of Hearing Panel Members	62
7.C.8. Failure to Appear	62
7.C.9. Postponements and Extensions.....	62
7.D. HEARING CONCLUSION, DELIBERATIONS, AND RECOMMENDATIONS	62
7.D.1. Basis of Hearing Panel Recommendation.....	62
7.D.2. Deliberations and Recommendation of the Hearing Panel	62
7.D.3. Disposition of Hearing Panel Report	62
7.E. APPEAL PROCEDURE.....	63
7.E.1. Time for Appeal.....	63
7.E.2. Grounds for Appeal.....	63
7.E.3. Time, Place and Notice	63
7.E.4. Nature of Appellate Review.....	63
7.F. BOARD ACTION	64
7.F.1. Final Decision of the Board	64

	<u>PAGE</u>
7.F.2. Adverse Decisions/Economic Factors	64
7.F.3. Right to One Hearing and One Appeal Only	64
8. ALLIED HEALTH PROFESSIONALS.....	66
8.A. CONDITIONS OF PRACTICE.....	66
8.A.1. Standards of Practice for Advanced Practice Providers and Dependent Providers in the Inpatient Setting.....	66
8.A.2. Oversight by Supervising Physician	67
8.A.3. Questions Regarding the Authority of an Advanced Practice Provider or Dependent Provider	68
8.A.4. Responsibilities of Supervising Physicians	68
8.B. PROCEDURAL RIGHTS FOR LICENSED INDEPENDENT PROVIDERS AND ADVANCED PRACTICE PROVIDERS.....	69
8.B.1. Notice of Recommendation and Hearing Rights	69
8.B.2. Hearing Committee	69
8.B.3. Hearing Process	70
8.B.4. Hearing Committee Report.....	71
8.B.5. Appellate Review.....	72
9. CONFLICTS OF INTEREST	73
10. HOSPITAL EMPLOYEES.....	74
11. AMENDMENTS AND ADOPTION.....	75

ARTICLE 1

GENERAL

1.A. PREAMBLE

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

1.B. 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.

1.C. DELEGATION OF FUNCTIONS

- (1) When a function is to be carried out by a member of Hospital Administration, by a Medical Staff Leader or by a Medical Staff committee, the individual, or the committee through its chair, may delegate performance of the function to one or more designees.
- (2) When a Medical Staff or Allied Health Staff member is unavailable or unable to perform an assigned function, one or more of the Medical Staff Leaders may perform the function personally or delegate it to another appropriate individual.

1.D. CONFIDENTIALITY AND PEER REVIEW PROTECTION

1.D.1. Confidentiality:

All professional review activity and recommendations will be strictly confidential. No disclosures of any such information (discussions or documentation) may be made outside of the meetings of the committees charged with such functions, 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 by the Chief Executive Officer or by legal counsel to the Hospital.

Any breach of confidentiality may result in appropriate sanctions, including but not limited to a professional review action or appropriate legal action. Breaches of confidentiality shall not constitute a waiver of any privilege. Any member of the Medical Staff or the

Allied Health Staff who becomes aware of a breach of confidentiality is encouraged to inform the Chief Executive Officer or the President of the Medical Staff (or the Vice-President of the Medical Staff if the President of the Medical Staff is the person committing the claimed breach).

1.D.2. Peer Review Protection:

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

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

All oral and written communications, reports, recommendations, actions, and minutes made or taken by peer review committees are confidential and covered by the provisions of applicable law and are deemed to be “professional review bodies” as that term is defined in the Health Care Quality Improvement Act of 1986 (“HCQIA”), 42 U.S.C. §11101 et seq.

1.E. INDEMNIFICATION

The Hospital will provide a legal defense for, and will indemnify, all Medical Staff Leaders, peer review committees, members, and authorized representatives when engaged in those capacities, in accordance with applicable laws and the Hospital’s Bylaws.

1.F. EMPLOYMENT

Appointment and clinical privileges, and the process for considering an individual’s request for the same, are not part of the employment process and it is understood that the Hospital’s employment policies and processes, are not applicable.

1.G. DEFINITIONS

The following definitions apply to terms used in this Policy:

- 1) “ALLIED HEALTH PROFESSIONALS” (“AHPs”) means individuals other than members of the Medical Staff who are authorized by law and by the Hospital to

provide patient care services within the hospital. Allied health professionals are described as Licensed Independent Providers, Advanced Practice Providers or Surgical Providers in the Medical Staff Bylaws documents:

- “LICENSED INDEPENDENT PROVIDER” (LIP) means an Allied Health Professional who is permitted by law and by the Hospital to provide patient care services independently, without direction or collaboration/supervision, within the scope of their license and consistent with the clinical privileges granted. Licensed Independent provider also includes those physicians not appointed to the Medical Staff who seek to exercise certain limited clinical privileges at the Hospital under the conditions set forth in this Policy (i.e. moonlighting residents). See Appendix A to the Policy on Allied Health Professionals.
 - “ADVANCED PRACTICE PROVIDER” (APP) means a type of Allied Health Professional who provides a medical level of care or performs surgical tasks consistent with granted clinical privileges, but who is required by law and/or the Hospital to exercise some or all of those clinical privileges under the direction of, or in collaboration with, a Supervising/collaborating Physician pursuant to a written supervision/collaborative agreement. See Appendix B to the policy on Allied Health Professionals.
 - “SURGICAL PROVIDER” means a type of Allied Health Professional who provides a medical level of care in performing surgical tasks consistent with granted privileges. Who is required by law and Hospital to exercise all of those clinical privileges under the direction of a supervising provider pursuant to a written supervision agreement. See Appendix B to the Policy on Allied Health Professionals.
- 2) “APPLICANT” means any physician, dentist, oral surgeon, podiatrist, Advanced Practice Provider, Surgical Provider and Licensed Independent Provider who has submitted an application for initial appointment or reappointment to the Medical Staff or the Allied Health Staff or for clinical privileges.
 - 3) “BOARD” means the Board of Directors of the Hospital, which has the overall responsibility for the Hospital, or its designated committee.
 - 4) “BOARD CERTIFICATION” is the designation conferred by one of the affiliated specialties of the American Board of Medical Specialties, the American Osteopathic Association, the American Board of Oral and Maxillofacial Surgery, or the American Board of Podiatric Surgery, upon an individual, as applicable.
 - 5) “CHIEF EXECUTIVE OFFICER” means the individual appointed by the Board to act on its behalf in the overall management of the Hospital.

- 6) "CLINICAL DEPARTMENT" means an organization unit of the Medical Staff denoting clinical areas of practice in the Hospital, including but not limited to, general areas of medicine, surgery, maternity, and emergency services.
- 7) "CLINICAL PRIVILEGES" or "PRIVILEGES" means the authorization granted by the Board to render specific clinical procedures and patient care services, subject to the provisions of this Policy.
- 8) "CORE PRIVILEGES" or "CORE" means a defined grouping of clinical privileges for a specialty or subspecialty that includes the fundamental patient care services that are routinely taught in residency or fellowship training for that specialty or subspecialty and that have been determined by the Medical Staff Leaders and Board to require closely related skills and experience.
- 9) "DAYS" means calendar days.
- 10) "DENTIST" means a Doctor of Dental Surgery ("D.D.S.") or Doctor of Dental Medicine ("D.M.D.").
- 11) "HOSPITAL" means Holy Family Hospital of the Hospital Sisters of the Third Order of St. Francis.
- 12) "HOSPITAL MANAGEMENT" means the Chief Executive Officer or his designee, including the administrator on call.
- 13) "MEDICAL STAFF EXECUTIVE COMMITTEE" means the Medical Staff Executive Committee of the Medical Staff.
- 14) "MEDICAL STAFF" means all physicians, dentists, oral surgeons, and podiatrists who have been appointed to the Medical Staff by the Board.
- 15) "MEDICAL STAFF LEADER" means any Medical Staff officer, Clinical Department Chair, or committee chairperson.
- 16) "MEMBER" means any physician, dentist, oral surgeon, podiatrist, Licensed Independent Provider, Advanced Practice Provider, and Surgical Provider who has been granted Medical Staff or Allied Health Staff appointment by the Board to practice at the Hospital.
- 17) "NOTICE" means written communication by regular U.S. mail, e-mail, facsimile, or Hospital mail.
- 18) "PATIENT CONTACTS" are defined as any admission, consultation, procedure, discharge, response to emergency call, evaluation, treatment, or service performed in any facility operated by the Hospital or affiliate, including outpatient facilities. It shall not include referrals for diagnostic tests or imaging.

- 19) “PHYSICIAN” includes both Doctors of Medicine (“M.D.s”) and Doctors of Osteopathic Medicine (“D.O.s”).
- 20) “PODIATRIST” means a Doctor of Podiatric Medicine (“D.P.M.”).
- 21) “PROFESSIONAL REVIEW ACTION” has the meaning defined in the HCQIA.
- 22) “PROFESSIONAL REVIEW ACTIVITY” has the meaning defined in the HCQIA.
- 23) “RESTRICTION” means a mandatory concurring consultation, where the consultant must approve the proposed procedure or treatment before privileges may be exercised. It does not include conditions for performance improvement placed upon the exercise of privileges, such as general consultation, second opinions, proctoring, monitoring, education, training, mentoring or specification of a maximum number of patients, nor does it include a limitation on the exercise of clinical privileges resulting from an exclusive arrangement with another physician or group of physicians or other action by the Board.
- 24) “SELF-GOVERNMENT” means the duty of the officers and committees and services of the Medical Staff to initiate and carry out the functions delegated by the Board and to fulfill the obligations provided for in the Medical Staff Bylaws, this Policy and other applicable policies.
- 25) “SPECIAL NOTICE” means hand delivery, certified mail (return receipt requested), or overnight delivery service providing receipt.
- 26) “SPECIAL PRIVILEGES” means clinical privileges that fall outside of the core privileges for a given specialty, which require additional education, training, or experience beyond that required for core privileges in order to demonstrate competence.
- 27) “SUPERVISING/COLLABORATING PROVIDER” means a member of the Medical Staff or a Licensed Independent Provider with clinical privileges, who has agreed in writing to supervise or collaborate with an Advanced Practice Provider or Surgical Provider and to accept full responsibility for the actions of the Advanced Practice Provider or Surgical Provider while they are practicing in the Hospital.
- 28) “SUPERVISION/COLLABORATION” means the supervision of (or collaboration with) an Advanced Practice Provider or Surgical Provider by a supervising/collaborating provider, that may or may not require the actual presence of the supervising/collaborating provider, but that does require, at a minimum, that the supervising/collaborating provider be readily available for consultation. The requisite level of supervision (general, direct, or personal) will be determined at the time each Advanced Practice Provider or Surgical Provider is credentialed and will be consistent with any applicable written supervision or collaboration agreement

that may exist. (“General” supervision means that the physician is immediately available by phone, “direct” supervision means that the physician is on the Hospital’s campus, and “personal “supervision means that the physician is in the same room).

- 29) “TELEMEDICINE” means the provision of clinical services to patients by practitioners from a distance via electronic communications.
- 30) “UNASSIGNED PATIENT” means any individual who comes to the Hospital for care and treatment who does not have a prior relationship with a physician on the Medical Staff, or whose attending physician or designated alternate is unavailable to attend the patient, or who does not want the prior attending physician to provide him/her care while a patient at the Hospital.

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, an applicant must, as applicable:

- (a) have a current, unrestricted license to practice in this state that is not subject to any restrictions, probationary terms, or conditions not generally applicable to all licensees, and have never had a license to practice revoked, restricted or suspended by any state licensing agency;
- (b) have a current, unrestricted DEA registration and state controlled substance license, if required to practice within the applicant's area of medical specialty;
- (c) be able to fulfill Medical Staff responsibilities and to provide timely and continuous care for his or her patients in the Hospital;
- (d) have current, valid professional liability insurance coverage in a form and in amounts satisfactory to the Hospital;
- (e) have never been, and not currently be, excluded or precluded from participation in Medicare, Medicaid, or other federal or state governmental health care program;
- (f) have never had Medical Staff or Allied Health Staff appointment, clinical privileges, or status as a participating provider denied, revoked, or terminated by any health care facility, including this Hospital, or health plan for reasons related to clinical competence or professional conduct;
- (g) have never resigned Medical Staff or Allied Health Staff appointment or relinquished privileges during an investigation or in exchange for not conducting such an investigation at any health care facility, including this Hospital;
- (h) have not, within the last ten years, been convicted of, or entered a plea of guilty or no contest to, any felony or misdemeanor involving (i) controlled substances; (ii) illegal drugs; (iii) insurance or health care fraud (including Medicare, Medicaid or other federal or state governmental or private third party payer fraud or program abuse); (iv) violent acts, sexual misconduct, moral turpitude, child or elder abuse; or been required to pay a civil money penalty for governmental fraud or program abuse;

- (i) document current flu vaccination [or other exception approved by the medical staff];
- (j) agree to fulfill all responsibilities regarding emergency call for their specialty;
- (k) have an appropriate coverage arrangement, as determined by the Credentials Committee, with other members of the Medical Staff for those times when the individual will be unavailable;
- (l) document compliance with all applicable training and educational protocols that may be adopted by the Medical Staff Executive Committee and required by the Board, including, but not limited to, those involving electronic medical records or patient safety;
- (m) meet any current or future eligibility requirements that are applicable to the clinical privileges being sought or granted;
- (n) if applying for privileges in an area that is covered by an exclusive contract or arrangement, meet the specific requirements set forth in that contract;
- (o) demonstrate recent clinical activity in their primary area of practice during the last two years;
- (p) have successfully completed*:
 - (1) a residency and, if applicable, fellowship training program approved by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association in the specialty in which the applicant seeks clinical privileges;
 - (2) a dental or an oral and maxillofacial surgery training program accredited by the Commission on Dental Accreditation of the American Dental Association;
 - (3) a podiatric surgical residency program accredited by the Council on Podiatric Medical Education of the American Podiatric Medical Association; or
 - (4) for allied health professionals, have satisfied the applicable training requirements as established by the Hospital;

* These requirements will be applicable only to those individuals who apply for initial staff appointment after the date of adoption of this Policy. Existing members will be governed by the residency training and board certification requirements in effect at the time of their initial appointment, unless those requirements would be more burdensome than the current requirements and/or would result in an existing member no longer retaining eligibility under Section 2.A.1(p).

- (q) be Board certified in their primary area of practice at the Hospital by the appropriate specialty/subspecialty board of the American Board of Medical Specialties, the American Osteopathic Association, the American Board of Oral and Maxillofacial Surgery, the American Dental Association, or the American Board of Podiatric Surgery, as applicable. Applicants who are not board certified at the time of application but who have completed their residency or fellowship training within the last seven years will be eligible for Medical Staff appointment. However, in order to remain eligible, those applicants must achieve board certification in their primary area of practice within seven years from the date of completion of their residency or fellowship training;*
- (r) maintain board certification in their primary area of practice at the Hospital and, to the extent required by the applicable specialty/subspecialty board, satisfy recertification requirements. Recertification will be assessed at reappointment;* and
- (s) if seeking to practice as an Advanced Practice Provider or Dependent Provider, must have a written agreement with a Supervising/Collaborating Physician, if a written agreement is required by law or Hospital policy, which agreement must meet all applicable requirements of state law and Hospital policy.

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

- (a) Any applicant who does not satisfy one or more of the threshold eligibility criteria may request that it be waived. Waivers of threshold eligibility criteria will not be granted routinely. The applicant 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.
- (b) A request for a waiver must 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 Department Chair, and the best interests of the Hospital and the communities it serves. Additionally, the Credentials Committee may, in its discretion, consider the application form and other information supplied by the applicant. The Credentials Committee will forward its recommendation, including the basis for such, to the Medical Staff Executive Committee. Any recommendation to grant a waiver must include the specific basis for the recommendation.
- (c) The Medical Staff Executive Committee will review the recommendation of the Credentials Committee and make a recommendation to the Board regarding whether to grant or deny the request for a waiver. Any recommendation to grant a waiver must include the specific basis for the recommendation.

- (d) The Board's determination regarding whether to grant a waiver is final. A determination not to grant a waiver is not a "denial" of appointment or clinical privileges and the applicant who requested the waiver is not entitled to a hearing. A determination to grant a waiver in a particular case is not intended to set a precedent. A determination to grant a waiver does not mean that appointment will be granted, only that processing of the application can begin.

2.A.3. Factors for Evaluation:

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

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

2.A.4. No Entitlement to Appointment:

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

- (a) is employed by this Hospital or its subsidiaries and/or affiliates, or has a contract with this Hospital;
- (b) is or is not a member or employee of any particular physician group;

- (c) is licensed to practice a profession in this or any other state;
- (d) is a member of any particular professional organization;
- (e) has had in the past, or currently has, Medical Staff or Allied Health Staff appointment 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 will be denied appointment or clinical privileges on the basis of gender, race, creed, religion, sexual orientation, or national origin.

2.A.6. Ethical and Religious Directives:

All members will abide by the terms of the Ethical and Religious Directives for Catholic Health Care Services promulgated by the National Conference of Catholic Bishops with respect to their practice at the Hospital. No member will engage in activity prohibited by the Directives at the Hospital.

2.B. GENERAL CONDITIONS OF APPOINTMENT, REAPPOINTMENT,
AND CLINICAL PRIVILEGES

2.B.1. Basic Responsibilities and Requirements:

As a condition of being granted appointment, reappointment or clinical privileges and as a condition of ongoing appointment and maintenance of clinical privileges, every individual specifically agrees to the following:

- (a) to provide continuous and timely care to all patients for whom the individual has responsibility;
- (b) to abide by the bylaws, policies, and rules and regulations of the Hospital and Medical Staff and any revisions or amendments thereto;
- (c) to participate in Medical Staff affairs through committee service and participation in performance improvement and peer review activities, and to perform such other reasonable duties and responsibilities as may be assigned;
- (d) to provide emergency call coverage, consultations, and care for unassigned patients;

- (e) to comply with clinical practice or evidence-based protocols pertinent to his or her medical specialty, as may be adopted by the Medical Staff Executive Committee or document the clinical reasons for variance;
- (f) to obtain, when requested, an appropriate fitness for practice evaluation, which may include diagnostic testing (such as blood and/or urine test) or a complete physical, mental, and/or behavioral evaluation, as set forth in this Policy;
- (g) to participate in personal or phone interviews in regard to an application for initial appointment or reappointment, if requested;
- (h) to use the Hospital sufficiently to allow continuing assessment of current competence;
- (i) to seek consultation whenever necessary;
- (j) to complete in a timely manner all medical and other required records;
- (k) to perform all services and to act in a cooperative and professional manner;
- (l) to promptly pay any applicable dues, assessments, or fines;
- (m) to utilize the Hospital's electronic medical record system when providing care in the Hospital setting;
- (n) to satisfy continuing medical education requirements;
- (o) to attend and participate in any applicable orientation programs at the Hospital before participating in direct patient care;
- (p) to comply with all applicable training and educational protocols that may be adopted by the Medical Staff Executive Committee, including, but not limited to, those involving electronic medical records, patient safety, and infection control;
- (q) to maintain and monitor a current e-mail address with the Hospital and Central Verification Office, which will be the primary mechanism used to communicate all Medical Staff or Allied Health Staff information to the member;
- (r) to disclose conflicts of interest regarding relationships with pharmaceutical companies, device manufacturers, other vendors or other persons or entities as may be required by Hospital or Medical Staff policies, including, but not limited to, disclosure of financial interests in any product, service, or medical device not already in use at the Hospital that a Medical Staff member may request the Hospital to purchase;

- (s) that, if the individual is a member of the Medical Staff who serves or plans to serve as a Supervising Physician to an Advanced Practice Provider or Dependent Provider, that the member of the Medical Staff will abide by the supervision requirements and conditions of practice set forth in Article 8; and
- (t) that, if the individual is an Advanced Practice Provider or Dependent Provider, he or she will abide by the conditions of practice set forth in Article 8.

2.B.2. Burden of Providing Information:

- (a) All applicants and members have the burden of producing information deemed adequate by the Hospital for a proper evaluation of current competence, character, ethics, and other qualifications and for resolving any doubts.
- (b) Applicants have the burden of providing evidence that all the statements made and all information provided by the applicant in support of the application are accurate and complete.
- (c) An application will be complete when all questions on the application form have been answered, all supporting documentation has been supplied, and all information has been verified from primary sources. An application will become incomplete if the need arises for new, additional, or clarifying information. Any application that continues to be incomplete 30 days after the applicant has been notified of the additional information required will be deemed to be withdrawn.
- (d) Applicants are responsible for providing a complete application, including adequate responses from references. An incomplete application will not be processed.
- (e) Applicants and members are responsible for notifying the President of the Medical Staff or the Chief Executive Officer of any change in status or any change in the information provided on the application form. This information is required to be provided with or without request, at the time the change occurs, and includes, but not be limited to:
 - (1) any information on the application form;
 - (2) any threshold eligibility criteria for appointment or clinical privileges;
 - (3) any and all complaints, documents or other information known to the practitioner regarding, or changes in, licensure status or DEA controlled substance authorization,
 - (4) changes in professional liability insurance coverage;
 - (5) the filing of a professional liability lawsuit against the practitioner;

- (6) arrest, charge, indictment, conviction, or a plea of guilty or no contest in any criminal matter;
- (7) exclusion or preclusion from participation in Medicare, Medicaid or any other federal or state healthcare program or any sanctions imposed with respect to the same; and
- (8) any changes in the practitioner's ability to safely and competently exercise clinical privileges or perform the duties and responsibilities of appointment because of health status issues, including, but not limited to, impairment due to addiction (all of which will be referred for review under the policy on practitioner health). It is the responsibility of each Medical Staff member or other credentialed healthcare professional to submit any changes in information, corrections, updates, or modifications to the individual's credentials data on file with the Hospital within five business days, as required by the Health Care Professional Credentials Data Collection Act (410 ILCS 517). All reports will be made to the Hospital on the State of Illinois mandated Health Care Professional Update Data Gathering Form.

2.C. APPLICATION

2.C.1. Information:

- (a) Application forms for appointment, reappointment, and clinical privileges will be approved by the Board, upon recommendation by the Credentials Committee and the Medical Staff Executive Committee.
- (b) The applications for initial appointment, reappointment, and clinical privileges existing now and as may be revised are incorporated by reference and made a part of this Policy.
- (c) The application will contain a request for specific clinical privileges and will require detailed information concerning the applicant's professional qualifications. The applicant will 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 will be informed in writing of the nature of the misstatement or omission and permitted to provide a written response within 15 days. The Chair of the Credentials Committee and Chief Executive Officer will review the response and determine whether the application should be processed further.

- (b) If appointment has been granted prior to the discovery of a misstatement or omission, appointment and privileges may be deemed to be automatically relinquished pursuant to this Policy.
- (c) No action taken pursuant to this section will entitle the applicant or member to a hearing or appeal.

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

(a) Conditions Prerequisite to Application and Consideration:

As a condition of having a request for application considered or applying for appointment, reappointment, or clinical privileges, every individual accepts the terms set forth in this Section.

(b) Scope of Conditions:

The terms set forth in this Section:

- (1) commence with the individual's initial contact with the Credentials Verification Office ("CVO") or the Hospital, whether an application is furnished or appointment, clinical privileges, or scope of practice are granted;
- (2) apply throughout the credentialing process and the term of any appointment, reappointment, clinical privileges, or scope of practice; and
- (3) survive for all time, even if appointment, reappointment, or clinical privileges is denied, revoked, reduced, restricted, suspended, or otherwise affected as part of the Hospital's professional review activities and even if the individual no longer maintains appointment, or clinical privileges at the Hospital.

(c) Use and Disclosure of Information about Individuals:

(1) Information Defined:

For purposes of this Section, "information" means information about the individual, regardless of the form (which shall include verbal, electronic, and paper), which pertains to the individual's appointment, reappointment, clinical privileges, or scope of practice, or the individual's qualifications for the same, including, but not limited to:

- (i) information pertaining to the individual's clinical competence, professional conduct, character, reputation, ethics, and ability to practice safely with or without accommodation, and any other

matter reasonably having a bearing on the individual's satisfaction of the criteria for initial and continued appointment to the Medical Staff or Allied Health Staff and for clinical privileges;

- (ii) any matter addressed on the application form or in the Medical Staff Bylaws, Credentials Policy, and other Hospital or Medical Staff policies and rules and regulations;
- (iii) any reports about the individual which are made by the Hospital, its Medical Staff Leaders, or their representatives to the National Practitioner Data Bank or relevant state licensing boards/agencies; and
- (iv) any references received or given about the individual.

(2) Authorization for Criminal Background Check:

The individual agrees to sign consent forms to permit a consumer reporting agency to conduct a criminal background check and report the results to the Hospital.

(3) Authorization to Share Information within the System:

The individual authorizes the Hospital and its affiliates to share information with one another.

(4) Authorization to Obtain Information from Third Parties:

The individual authorizes the CVO, Hospital, Medical Staff Leaders, and their representatives to request or obtain information from third parties and specifically authorizes third parties to release information to the Hospital.

(5) Authorization to Disclose Information to Third Parties:

The individual authorizes the Hospital, Medical Staff Leaders, and their representatives to disclose information to other hospitals, health care facilities, managed care organizations, government regulatory and licensure boards or agencies, and their representatives to assist them in evaluating the individual's qualifications.

(d) Hearing and Appeal Procedures:

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

(e) Immunity:

To the fullest extent permitted by law, the individual releases from any and all liability, extends immunity to, and agrees not to sue the CVO, the Hospital, the Board, and the Medical Staff, their authorized representatives, any members of the Medical Staff, Allied Health Staff, or Board, and any third party who provides information.

This immunity covers any actions, recommendations, reports, statements, communications, or disclosures that are made, taken, or received by the Hospital, its representatives, or third parties in the course of credentialing and peer review activities or when using or disclosing information as described in this Section. Nothing herein shall be deemed to waive any other immunity or privilege provided by federal or state law.

(f) Legal Actions:

If, despite this Section, an individual institutes legal action challenging any credentialing, privileging, peer review, or other professional review action or activity and does not prevail, he or she will reimburse the Hospital and any member of the Medical Staff, or Allied Health Staff, or Board involved in the action for all costs incurred in defending such legal action, including costs and attorney's fees, and expert witness fees.

ARTICLE 3

PROCEDURE FOR INITIAL APPOINTMENT AND PRIVILEGES

3.A. PROCEDURE FOR INITIAL APPOINTMENT AND PRIVILEGES

3.A.1. Application:

- (a) Applications for appointment to the Medical Staff shall be in writing, and shall be submitted on forms approved by the Board and the State of Illinois under the Healthcare Professional Credentials Data Collection Act (410 ILCS 517) and the Healthcare Professional Credentials Data Collection Code (77 Ill. Administrative Code 965.11). These forms shall be obtained from the Hospital. The application shall contain a request for specific clinical privileges desired by the applicant and shall require detailed information and verification concerning the applicant's professional qualifications.
- (b) Prospective applicants will be sent the application form and a letter that outlines the threshold eligibility criteria for appointment and the applicable criteria for clinical privileges.
- (c) A completed application form with copies of all required documents must be returned to the CVO within 90 days after receipt. The application must be accompanied by the application fee.
- (d) Applications may be provided to residents and fellows who are in the final six months of their training. Final action will not be taken until all applicable threshold eligibility criteria are satisfied.
- (e) In the discretion of the Credentials Committee and Medical Staff Executive Committee, applications may be conditionally approved pending receipt of documentation to demonstrate satisfaction of threshold eligibility criteria. Final action will not be taken, and no privileges shall be granted or clinical services provided, until all applicable threshold eligibility criteria are satisfied.

3.A.2. Initial Review of Application:

- (a) As a preliminary step, the application will be reviewed by the CVO to determine that all questions have been answered and that the applicant satisfies all threshold eligibility criteria. Applicants who fail to return completed applications or fail to meet the threshold eligibility criteria will be notified that their applications will not be processed. A determination of ineligibility does not entitle the individual to a hearing and appeal.

- (b) The CVO will oversee the process of gathering and verifying relevant information, and confirming that all references and other information deemed pertinent have been received.
- (c) Evidence of the applicant's character, professional competence, qualifications, behavior, and ethical standing will 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 chairperson 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. The National Practitioner Data Bank and the Office of Inspector General, Medicare/Medicaid Exclusions will be queried, as required, and a criminal background check will be obtained.
- (d) An interview(s) with the applicant may be conducted. The purpose of the interview is to discuss and review any aspect of the applicant's application, qualifications, and requested clinical privileges. This interview will be conducted by one or any combination of any of the following: the department chairperson, the Credentials Committee, a Credentials Committee representative, the Medical Staff Executive Committee, the President of the Medical Staff, or the Chief Executive Officer.

3.A.3. Department Chair and/or Chief Nursing Officer Procedure:

The Medical Staff Office will transmit the complete application and all supporting materials to the director of each Clinical Department in which the applicant seeks clinical privileges. The Clinical Department Chair will prepare a written report regarding whether the applicant has satisfied all of the qualifications for appointment and the clinical privileges requested. The report will be on a form provided by Medical Staff Office. The Chief Nursing Officer will also review and report on the applications for all advanced practice registered nurses.

3.A.4. Credentials Committee Procedure:

- (a) The Credentials Committee will consider the report prepared by the Clinical Department Chair and Chief Nursing Officer, if applicable, and will make a recommendation.
- (b) The Credentials Committee may use the expertise of the Clinical Department Chair, Chief Nursing Officer, if applicable, or any member of the Clinical Service, 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, if there is any question about the applicant's ability to perform the privileges requested and the responsibilities of appointment, the Credentials Committee may require a fitness for practice evaluation by a physician(s)

satisfactory to the Credentials Committee. The results of this evaluation will be made available to the Committee.

- (d) The Credentials Committee may recommend the imposition of specific conditions related to behavior, health or clinical issues. The Credentials Committee may also recommend that appointment be granted for a period of less than two years in order to permit closer monitoring of the applicant's compliance with any conditions.
- (e) If the recommendation of the Credentials Committee is delayed longer than 60 days, the chairperson of the Credentials Committee will send a letter to the applicant, with a copy to the Chief Executive Officer, explaining the reasons for the delay.

3.A.5. Medical Staff Executive Committee Recommendation:

- (a) At its next regular meeting after receipt of the written report and recommendation of the Credentials Committee, the Medical Staff Executive Committee will:
 - (1) adopt the report and recommendation of the Credentials Committee as its own; or
 - (2) refer the matter back to the Credentials Committee for further consideration of specific questions; or
 - (3) state its reasons for disagreement with the report and recommendation of the Credentials Committee.
- (b) If the recommendation of the Medical Staff Executive Committee is to appoint, the recommendation will be forwarded to the Board.
- (c) If the recommendation of the Medical Staff Executive Committee would entitle the applicant to request a hearing, the Medical Staff Executive Committee will forward its recommendation to the Chief Executive Officer, who will promptly send special notice to the applicant. The Chief Executive Officer will then hold the application until after the applicant has completed or waived a hearing and appeal.

3.A.6. Board Action:

- (a) The Board may delegate to a committee, consisting of at least two Board members, action on appointment, reappointment, and clinical privileges if there has been a favorable recommendation from the Credentials Committee and the Medical Staff Executive Committee and there is no evidence of any of the following:
 - (1) a current or previously successful challenge to any license or registration;

- (2) an involuntary termination, limitation, reduction, denial, or loss of appointment 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 will be effective immediately and will be forwarded to the Board for consideration at its next meeting.

- (b) When there has been no delegation to the Board Committee, upon receipt of a recommendation that the applicant be granted appointment and clinical privileges, the Board may:
 - (1) grant appointment and clinical privileges as recommended; or
 - (2) refer the matter back to the Credentials Committee or Medical Staff Executive Committee or to another source for additional research or information; or
 - (3) modify the recommendation.
- (c) If the Board disagrees with a favorable recommendation, it should first discuss the matter with the chairperson of the Credentials Committee and the chairperson of the Medical Staff Executive Committee. If the Board's determination remains unfavorable, the Chief Executive Officer will promptly send special notice that the applicant is entitled to request a hearing
- (d) Any final decision by the Board to grant, deny, modify, 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 will not create any right for the applicant to have the application processed within this precise time period.

ARTICLE 4

CLINICAL PRIVILEGES

4.A. CLINICAL PRIVILEGES

4.A.1. General:

- (a) Appointment or reappointment will not confer any clinical privileges or right to practice at the Hospital. Only those clinical privileges granted by the Board may be exercised, subject to the terms of this Policy.
- (b) A request for privileges will be processed only when an applicant satisfies threshold eligibility criteria for the delineated privileges. An individual who does not satisfy the eligibility criteria for clinical privileges may request that the criteria be waived.
- (c) Requests for clinical privileges that are subject to an exclusive contract or arrangement will not be processed except as consistent with the applicable contract.
- (d) Recommendations for clinical privileges will be based on consideration of the following:
 - (1) education, relevant training, experience, and demonstrated current competence, including medical/clinical knowledge, technical and clinical skills, judgment, interpersonal and communication skills, and professionalism with patients, families, and other members of the health care team and peer evaluations relating to these criteria;
 - (2) appropriateness of utilization patterns;
 - (3) ability to perform the privileges requested competently and safely;
 - (4) information resulting from ongoing and focused professional practice evaluation and other performance improvement activities, as applicable;
 - (5) availability of coverage in case of the applicant's illness or unavailability;
 - (6) adequate professional liability insurance coverage for the clinical privileges requested;
 - (7) the Hospital's available resources and personnel;
 - (8) any previously successful or currently pending challenges to any licensure or registration, or the voluntary or involuntary relinquishment of such licensure or registration;

- (9) any information concerning professional review actions or voluntary or involuntary termination, limitation, reduction, or loss of appointment or clinical privileges at another hospital;
 - (10) practitioner-specific data as compared to aggregate data, when available;
 - (11) morbidity and mortality data, when available; and
 - (12) professional liability actions, especially any such actions that reflect an unusual pattern or number of actions.
- (e) Requests for additional clinical privileges must state the additional clinical privileges requested and provide information sufficient to establish eligibility. If the member is eligible and the request is complete, it will be processed in the same manner as an application for initial clinical privileges.

4.A.2. Privilege Waivers:

- (a) When clinical privileges have been delineated by core or specialty, a request for privileges will only be processed if the individual applies for the full core or specialty delineation. (This only applies to requests for privileges within the individual's primary specialty.)
- (b) In limited circumstances, the Hospital may consider a waiver of the requirement that clinical privileges be granted by core or specialty. If an individual wants to request such a waiver, the request must be submitted in writing to the Medical Staff Office. The request must indicate the specific clinical privileges within the core or specialty that the individual does not wish to provide, state a good cause basis for the request, and include evidence that he or she does not provide the relevant patient care services in any health care facility.
- (c) Requests for waivers will be processed in the same manner as requests for waivers of appointment criteria.
- (d) The following factors, among others, may be considered in deciding whether to grant a waiver:
 - (1) the Hospital's mission and ability to serve the health care needs of the community by providing timely, appropriate care;
 - (2) the effect of the request on the Hospital's ability to comply with applicable regulatory requirements, including the Emergency Medical Treatment and Active Labor Act;
 - (3) the expectations of members who rely on the specialty;

- (4) fairness to the individual requesting the waiver;
 - (5) fairness to other Medical Staff members who serve on the call roster in the relevant specialty, including the effect that the modification would have on them; and
 - (6) the potential removal for gaps in call coverage that might result from an individual's from the call roster and the feasibility of safely transferring patients to other facilities.
- (e) If the Board grants a waiver related to privileges, it will specify the effective date.
 - (f) No one is entitled to a waiver or to a hearing or appeal if a waiver is not granted.

4.A.3. Relinquishment of Individual Clinical Privileges:

A request to relinquish any individual clinical privilege, whether or not part of the core, must provide a good cause basis for the modification of clinical privileges. All such requests will be processed in the same manner as a request for waiver, as described above.

4.A.4. Resignation of Appointment and Clinical Privileges:

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

4.A.5. Clinical Privileges for New Procedures:

- (a) Requests for clinical privileges to perform either a procedure not currently being performed at the Hospital or a new technique to perform an existing procedure ("new procedure") will not be processed until a determination has been made that the procedure will be offered by the Hospital and criteria for the clinical privilege(s) have been adopted.
- (b) As an initial step in the process, the individual seeking to perform the new procedure will prepare and submit a report to the Department Chair and the Credentials Committee addressing the following:
 - (1) minimum education, training, and experience necessary to perform the new procedure safely and competently;
 - (2) clinical indications for when the new procedure is appropriate;

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

The Department Chair and the Credentials Committee will review this report, conduct additional research as necessary, and make a preliminary recommendation as to whether the new procedure should be offered at the Hospital.

- (c) If the preliminary recommendation is favorable, 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 minimum education, training, and experience necessary to perform the procedure or service;
 - (2) the clinical indications for when the procedure or service is appropriate;
 - (3) the extent (time frame and mechanism) of focused monitoring and supervision that should occur if the privileges are granted; and
 - (4) the manner in which the procedure would be reviewed as part of the Hospital's ongoing and focused professional practice evaluation activities.
- (d) The Credentials Committee will forward its recommendations to the Medical Staff Executive Committee, which will review the matter and forward its recommendations to the Board for final action.

4.A.6. Clinical Privileges That Cross Specialty Lines:

- (a) Requests for clinical privileges that previously have been exercised only by members in another specialty will 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 will 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 clinical privilege at other similar hospitals, and the experiences of those other hospitals.
- (c) The Credentials Committee will then conduct additional research and consult with experts, as necessary, including those on the Medical Staff (e.g., Department Chairs, individuals on the Medical Staff with special interest and/or expertise) and those outside the Hospital (e.g., other hospitals, residency training programs, specialty societies).
- (d) The Credentials Committee may or may not recommend that individuals from different specialties be permitted to request the clinical privileges at issue. If it does, the Committee may develop recommendations regarding:
 - (1) the minimum education, training, and experience necessary to perform the clinical privileges in question;
 - (2) the clinical indications for when the procedure is appropriate;
 - (3) the manner of addressing the most common complications that arise, which may be outside of the scope of the clinical privileges that have been granted to the requesting individual;
 - (4) the extent (time frame and mechanism) of focused monitoring and supervision that should occur if the privileges are granted 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 will forward its recommendations to the Medical Staff Executive Committee, which will review the matter and forward its recommendations to the Board for final action. The Board will make reasonable efforts to render a final decision within sixty (60) days of receipt of the Medical Staff Executive Committee's recommendation.

4.A.7. Clinical Privileges for Dentists and Oral and Maxillofacial Surgeons:

- (a) For any patient who meets the classifications of ASA 1 (normal, healthy patients) or ASA 2 (patients with mild systemic disease with no functional limitations),

dentists and oral and maxillofacial surgeons may admit the patient and 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 Medical Staff Executive Committee. They must, nevertheless, have an agreement with a physician on the Medical Staff (established and declared in advance) who is available to respond should any medical issue arise with the patient.

- (b) For any patient who meets ASA 3 or ASA 4 classifications, a medical history and physical examination of the patient will be made and recorded by a physician who is a member of the Medical Staff before dental or oral surgery may be performed. In addition, a designated physician will be responsible for the medical care of the patient throughout the period of hospitalization.
- (c) The dentist or oral and maxillofacial surgeon will be responsible for the oral surgery care of the patient, including the appropriate history and physical examination, as well as all other appropriate elements of the patient's record. Dentists and oral and maxillofacial surgeons may write orders within the scope of their licenses and consistent with relevant Hospital policies and rules and regulations.

4.A.8. Clinical Privileges for Podiatrists:

- (a) Podiatrists will be responsible for the podiatric care of the patient, including the podiatric history and the podiatric physical examination, as well as all appropriate elements of the patient's record. Podiatrists may write orders which are within the scope of their license and consistent with relevant Hospital policies and rules and regulations.
- (b) A medical history and physical examination of the patient will be made and recorded by a physician who is a member of the Medical Staff before podiatric surgery will be performed. In addition, a designated physician will be responsible for the medical care of the patient throughout the period of hospitalization.

4.A.9. Physicians in Training:

- (a) Physicians in training will not be granted appointment to the Medical Staff or clinical privileges. The program director, clinical faculty, or attending staff member will be responsible for the direction and supervision of the on-site or day-to-day patient care activities of each trainee, who will be permitted to perform only those clinical functions set out in curriculum requirements, affiliation agreements, or training protocols approved by the Medical Staff Executive Committee or its designee. The applicable program director will be responsible for verifying and evaluating the qualifications of each physician in training.
- (b) Individuals who are in training who wish to moonlight (outside of the training program) will be granted specific privileges as set forth in this Policy. A resident

who is moonlighting must comply with the institutional and program training requirements. Loss of employment by the Hospital in the training program will result in the automatic relinquishment of clinical privileges, without a right to the hearing and appeal procedures.

4.A.10. Telemedicine Privileges:

- (a) Telemedicine is the provision of clinical services to patients by practitioners from a distance via electronic communications.
- (b) A qualified individual may be granted telemedicine privileges, but need not be appointed to the Medical Staff or Allied Health Staff.
- (c) Requests for initial or renewed telemedicine privileges will be processed through one of the following options, as determined by the Chief Executive Officer 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 and Allied Health 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), and the hospital or telemedicine entity is accredited by the Hospital's accrediting body, a request for telemedicine privileges may be processed using an alternative 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 complies with all applicable Medicare regulations and accreditation standards. The distant hospital or telemedicine entity must provide:
 - (i) confirmation that the practitioner is licensed in the state where the Hospital is located;
 - (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 received about the individual requesting telemedicine privileges will be provided to the Medical Staff Executive Committee for review and recommendation and to the Board for final action. Notwithstanding the process set forth in this subsection, the Hospital may determine that an applicant for telemedicine privileges is ineligible for appointment or clinical privileges if the applicant fails to satisfy the threshold eligibility criteria set forth in this Policy.

- (d) Telemedicine privileges, if granted, will be for a period of not more than two years.
- (e) Individuals granted telemedicine privileges will be subject to the Hospital's peer review activities. The results of the peer review activities, including any adverse events and complaints filed about the practitioner providing telemedicine services from patients, other practitioners or staff, will be shared with the hospital or entity providing telemedicine services.
- (f) Telemedicine privileges granted in conjunction with a contractual agreement will be incident to and coterminous with the agreement.

4.A.11. Focused Professional Practice Evaluation for Initial Privileges:

- (a) All initial grants of clinical privileges, whether at the time of appointment, reappointment, or during the term of an appointment, will be subject to focused professional practice evaluation by the Clinical Department Chair or by a physician(s) designated by the Credentials Committee.
- (b) This focused professional practice evaluation may include chart review, monitoring, proctoring, external review, and other information. The clinical activity requirements, including numbers and types of cases to be reviewed, will be determined by the Credentials Committee.
- (c) A newly appointed member's appointment and privileges will expire if he or she fails to fulfill the clinical activity requirements within the time frame recommended by the Credentials Committee. In such case, the individual may not reapply for initial appointment or privileges for two years.
- (d) If a member who has been granted additional clinical privileges fails to fulfill the clinical activity requirements within the time frame recommended by the

Credentials Committee, the additional clinical privileges will expire and the member may not reapply for the privileges in question for two years.

- (e) When, based upon information obtained through the focused professional practice evaluation process, a recommendation is made to terminate, revoke, or restrict clinical privileges for reasons related to clinical competence or professional conduct, the member will be entitled to a hearing and appeal.

4.B. TEMPORARY CLINICAL PRIVILEGES

4.B.1. Temporary Clinical Privileges:

- (a) Temporary privileges may be granted by the Chief Executive Officer, upon recommendation of the President of the Medical Staff, to:
 - (1) applicants for initial appointment whose complete application is pending review by the Board, following a favorable recommendation of the Credentials Committee. In order to be eligible for temporary clinical privileges, an applicant must have demonstrated ability to perform the clinical privileges requested and have had no (i) current or previously successful challenges to licensure or registration or (ii) involuntary restriction, reduction, denial or termination of membership or clinical privileges at another health care facility.
 - (2) non-applicants, when there is an important patient care, treatment, or service need, including the following:
 - (i) the care of a specific patient;
 - (ii) when necessary to prevent a lack of services in a needed specialty area;
 - (iii) proctoring; or
 - (iv) when serving as a locum tenens for a member of the Medical Staff or Allied Health Staff.
- (b) The following verified information will be considered prior to the granting of any temporary clinical privileges: current licensure, relevant training, experience, current competence, current professional liability coverage acceptable to the Hospital, and results of a query to the National Practitioner Data Bank.
- (c) The grant of temporary clinical privileges will not exceed 120 days.
- (d) For non-applicants, who are granted temporary locum tenens privileges, the individual may exercise locum tenens privileges for a maximum of 120 days,

consecutive or not, anytime during the 24-month period following the grant of privileges, subject to the following conditions:

- (1) the individual must notify the Hospital at least 15 days prior to exercising these privileges (exceptions for shorter notice periods may be considered in situations involving health issues); and
 - (2) the individual must inform the Hospital of any change that has occurred to the information provided on the application form for locum tenens privileges.
- (e) Prior to any temporary clinical privileges being granted, the individual must agree in writing to be bound by the bylaws, rules and regulations, policies, procedures and protocols of the Medical Staff and the Hospital.
 - (f) The granting of temporary clinical privileges is a courtesy that may be withdrawn by the Chief Executive Officer at any time, after consulting with the President of the Medical Staff, the chairperson of the Credentials Committee or the Department Chair.
 - (g) The Clinical Department Chair or the President of the Medical Staff will assign to another member of the Medical Staff responsibility for the care of patients until they are discharged. Whenever possible, consideration will 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 department status or specific grant of clinical privileges.
- (3) When the emergency situation no longer exists, the patient will be assigned by the department chair 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 Chief Executive Officer 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 or Allied Health 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 will 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 will oversee the care provided by volunteer licensed independent practitioners. This oversight will 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 and/or groups of practitioners for the performance of clinical and administrative services at the Hospital. All individuals providing Clinical Services pursuant to such contracts shall obtain and maintain clinical privileges at the Hospital, in accordance with the terms of this Policy.

- (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 by resolution limits the practitioners who may exercise privileges in any clinical specialty to employees of the Hospital or its affiliates,

no other practitioner except those authorized by or pursuant to the contract or resolution may exercise clinical privileges to perform the specified services while the contract or resolution is in effect. This means that only authorized practitioners 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 will be processed.

- (3) Prior to the Hospital pursuing any exclusive contract and/or Board resolution described in paragraph (2) in a specialty area that has not previously been subject to such a contract or resolution, the Board will request the Medical Staff Executive Committee's review of the matter. The Medical Staff Executive Committee (or a subcommittee of its members appointed by the President of the Medical Staff) will review the quality of care and service implications of the proposed exclusive contract or Board resolution, and provide a report of its findings and recommendations to the Board within 30 days of the Board's request. As part of its review, the Medical Staff Executive Committee (or subcommittee) may obtain relevant information concerning quality of care and service matters from (i) members of the applicable specialty involved, (ii) members of other specialties who directly utilize or rely on the specialty in question, and (iii) Hospital Administration. However, the actual terms of any such exclusive arrangement or employment contract, and any financial information related to them, including but not limited to the remuneration to be paid to Medical Staff members who may be a party to the arrangement, are not relevant and shall neither be disclosed to the Medical Staff Executive Committee nor discussed as part of the Medical Staff Executive Committee's review.
- (4) After receiving the Medical Staff Executive Committee's report, the Board shall make a preliminary determination as to whether or not to proceed with an exclusive contract or Board Resolution. If the Board makes a preliminary determination to do so, and if the determination would have the effect of preventing an existing member from exercising clinical privileges that had previously been granted, the affected member is entitled to the following notice and hearing procedures:
- (a) The affected member shall be given at least 60 days' advance notice of the exclusive contract or Board resolution. The notice shall inform the member of the right to request a hearing as set forth in this Section prior to the

contract in question being signed by the Hospital or the Board resolution becoming effective.

- (b) The affected member must request the hearing within 14 days of receiving the notice, and the hearing must then be commenced and concluded within 30 days of the member's request (unless the individual and the Board agree upon a different time frame/schedule). A report and recommendation must be prepared by the hearing committee within this 30-day period and copies sent to the affected member, the Board, and the Medical Staff Executive Committee.
 - (c) The hearing shall be held before a committee appointed by the Board, which shall include representatives from the Medical Staff Executive Committee. At the hearing, the affected member shall be entitled to present any information and documentation that he or she deems relevant to the Board's preliminary decision to enter into the exclusive contract or enact the resolution, as well as to present witnesses in support of his or her position. Neither the affected member nor the Board's representative shall be accompanied by counsel at this hearing, but the hearing committee may select an attorney to assist it in conducting an orderly and fair hearing and in the preparation of the committee's report and recommendation.
 - (d) Following receipt of the hearing committee's report and recommendation, the Board shall make a final decision in the matter. If the Board confirms its preliminary determination to enter into the exclusive contract or enact the Board resolution, the affected member shall be notified that he or she is ineligible to continue to exercise the clinical privileges covered by the exclusive contract or Board resolution. 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 Board resolution is in effect.
 - (e) The affected member shall not be entitled to any 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 of this Policy.
 - (f) The inability of a physician to exercise clinical privileges because of an exclusive contract or resolution is not a matter that requires a report to the Illinois licensure board or to the National Practitioner Data Bank.
- (5) Except as provided in paragraph (1), in the event of any conflict between these Medical Staff Bylaws and the terms of any contract, the terms of the contract shall control. In particular, nothing in this Section shall preclude or limit a Medical Staff member's right to waive, in writing, his or her right to request a hearing upon being granted the exclusive right to provide particular services at the Hospital, either

individually or as a member of a group. If any exclusive contract is signed by a representative of a group of physicians, any waiver that is contained in the contract shall apply to all members of the group unless stated otherwise in the contract.

ARTICLE 5

PROCEDURE FOR REAPPOINTMENT

5.A. PROCEDURE FOR REAPPOINTMENT

All terms, conditions, requirements, and procedures relating to initial appointment will apply to continued appointment and clinical privileges and to reappointment.

5.B. REAPPOINTMENT CRITERIA

5.B.1. Eligibility for Reappointment:

To be eligible to apply for reappointment and renewal of clinical privileges, an individual must have, during the previous appointment term:

- (a) completed all medical records in a timely manner in compliance with Hospital policy;
- (b) completed all continuing medical education requirements;
- (c) satisfied all Medical Staff and Allied Health Staff responsibilities, including payment of any dues, fines, and assessments;
- (d) continued to meet all qualifications and criteria for appointment and the clinical privileges requested;
- (e) paid any applicable reappointment processing fee; and
- (f) 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 will be considered complete and processed further.

5.B.2. Factors for Evaluation:

In considering an application for reappointment, the factors listed in Section 2.A.3 of this Policy will be considered. Additionally, the following factors will be evaluated as part of the reappointment process:

- (a) compliance with the bylaws, rules and regulations, and policies of the Medical Staff and the Hospital;

- (b) participation in Medical Staff duties, including committee assignments and emergency call;
- (c) 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 will not be identified);
- (d) any focused professional practice evaluations;
- (e) the results of ongoing professional practice evaluations;
- (f) verified complaints received from patients or staff;
- (g) compliance with core measures and patient safety and utilization measures; and
- (h) other reasonable indicators of continuing qualifications.

5.C. REAPPOINTMENT PROCESS

5.C.1. Reappointment Application Form:

- (a) Appointment terms will not extend beyond two years.
- (b) An application for reappointment will be furnished to members at least four months prior to the expiration of their current appointment term. A completed reappointment application must be returned to the CVO within 30 days.
- (c) Failure to return a complete application within 60 days of receipt may result in the automatic expiration of appointment and clinical privileges at the end of the then current term of appointment unless the application can still be processed in the normal course, without extraordinary effort on the part of the CVO and Hospital and Medical Staff Leaders.
- (d) The application will be reviewed by the CVO to determine that all questions have been answered and that the member satisfies all threshold eligibility criteria for reappointment and for the clinical privileges requested.
- (e) The CVO will oversee the process of gathering and verifying relevant information. The CVO will also be responsible for confirming that all relevant information has been received.

5.C.2. Conditional Reappointments:

- (a) Recommendations for reappointment may be subject to an applicant's compliance with specific conditions. These conditions may relate to behavior (e.g., professional code of conduct) or to clinical issues (e.g., general consultation requirements, proctoring, completion of CME requirements).
- (b) Unless the conditions involve the matters set forth in Section 7.A.1(a) of this Policy, the imposition of such conditions does not entitle an individual to request the procedural rights set forth in Article 7. Reappointments may also be recommended for periods of less than two years in order to permit closer monitoring of a member's compliance with any conditions that may be imposed. A recommendation of a conditional reappointment or for reappointment for a period of less than two years does not, in and of itself, entitle a member to request a hearing or appeal as set forth in Article 7.
- (c) In the event the applicant for reappointment is the subject of an unresolved concern that is being addressed through the peer review process, an investigation or a hearing at the time reappointment is being considered, a conditional reappointment for a period of less than two years may be granted pending the completion of that process.

5.C.3. Potential Adverse Recommendation:

- (a) If the Credentials Committee or the Medical Staff Executive Committee is considering a recommendation to deny reappointment or to reduce clinical privileges, the committee chairperson will notify the member of the possible recommendation and invite the member to meet prior to any final recommendation being made.
- (b) Prior to this meeting, the member will be notified of the general nature of the information supporting the recommendation contemplated.
- (c) 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 committee's recommendation.
- (d) 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 represented by legal counsel at this meeting.

ARTICLE 6

ISSUES INVOLVING MEDICAL STAFF OR ALLIED HEALTH STAFF MEMBERS

6.A. OVERVIEW AND GENERAL PRINCIPLES

6.A.1. Options Available to Medical Staff Leaders and Hospital Administration:

- (a) This Policy empowers Medical Staff Leaders and Hospital Administration to use various options to address and resolve issues that may be raised about members of the Medical Staff and the Allied Health Staff. The various options available to Medical Staff Leaders and Hospital Administration and the mechanisms they may use when questions pertaining to competence, health or behavior are raised are outlined below and include, but are not limited to, the following:
 - (1) collegial intervention and progressive steps;
 - (2) ongoing and focused professional practice evaluations;
 - (3) mandatory meeting;
 - (4) fitness for practice evaluation (including blood and/or urine test);
 - (5) automatic relinquishment of appointment and clinical privileges;
 - (6) leaves of absence;
 - (7) precautionary suspension; and
 - (8) formal investigation.
- (b) In addition to these options, Medical Staff Leaders and Hospital Administration also have the discretion to determine whether a matter should be handled in accordance with another policy (e.g., HSHS code of conduct policy, practitioner health policy, peer review policy) or should be referred to the Medical Staff Executive Committee for further action.

6.A.2. Documentation:

- (a) Except as otherwise expressly provided, Medical Staff Leaders and Hospital Administration may use their discretion to decide whether to document any meeting with an individual that may take place pursuant to the processes and procedures outlined in this Article.

- (b) Any documentation that is prepared will be shared with the individual. The individual will have an opportunity to review the documentation and respond to it. The initial documentation, along with any response, will be maintained in the individual's confidential file.

6.A.3. No Recordings of Meetings:

It is the policy of the Hospital to maintain the confidentiality of all Medical Staff meetings, including, but not limited to, discussions relating to credentialing, quality assessment, performance improvement, and peer review activities. The discussions that take place at such meetings are private conversations that occur in a private place. In addition to existing bylaws and policies governing confidentiality, individuals in attendance at such meetings are prohibited from making audio or video recordings at such meetings.

6.A.4. No Right to Counsel:

- (a) The processes and procedures outlined in this Article are designed to be carried out in an informal manner. Therefore, lawyers **will not** be present for any meeting that takes place pursuant to this Article. By agreement of the President of the Medical Staff and Chief Executive Officer, an exception may be made to this general rule.
- (b) If the individual refuses to meet without his or her lawyer present, the meeting will be canceled and it will be reported to the Medical Staff Executive Committee that the individual failed to attend the meeting.

6.A.5. No Right to the Presence of Others:

Peer review activities are confidential and privileged to the fullest extent permitted by law. Accordingly, the individual may not be accompanied by friends, relatives or colleagues when attending a meeting that takes place pursuant to this Article, unless agreed upon by the President of the Medical Staff.

6.A.6. Involvement of Supervising Physician in Matters Pertaining to Allied Health Staff Members:

If any peer review activity pertains to the clinical competence or professional conduct of a member of the Allied Health Staff, the Supervising Physician (if any) will be notified and may be invited to participate.

6.B. COLLEGIAL INTERVENTION AND PROGRESSIVE STEPS

- (1) The use of collegial intervention efforts and progressive steps by Medical Staff Leaders and Hospital Administration is encouraged.
- (2) The goal of those efforts is to arrive at voluntary, responsive actions by the individual to resolve an issue that has been raised. Collegial efforts and progressive

steps may be carried out, within the discretion of Medical Staff Leaders and Hospital Administration, but are not mandatory. No hearing rights will be triggered by any efforts taken pursuant to this Section.

- (3) Collegial intervention efforts and progressive steps are part of the Hospital's ongoing and focused professional practice evaluation activities and may include, but are not limited to, the following:
 - (a) sharing and discussing applicable policies, such as policies regarding appropriate behavior, emergency call obligations, and the timely and adequate completion of medical records;
 - (b) counseling, mentoring, monitoring, proctoring, consultation, and education;
 - (c) sharing comparative quality, utilization, and other relevant information, including any variations from clinical protocols or guidelines, in order to assist an individual to conform his or her practice to appropriate norms;
 - (d) communicating expectations for professionalism and behaviors that promote a culture of safety;
 - (e) informational letters of guidance, education, or counseling; and
 - (f) Performance Improvement Plans.

6.C. ONGOING AND FOCUSED PROFESSIONAL PRACTICE EVALUATION

- (1) Individuals who are 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 to confirm their competence.
- (2) All individuals who provide patient care services at the Hospital will have their care evaluated on an ongoing basis. This ongoing professional practice evaluation process may include an analysis of data to provide feedback and to identify issues in an individual's professional performance, if any.
- (3) When concerns are raised about an individual's practice through the ongoing practice evaluation process or through a specialty-specific trigger, a reported concern, or other triggers (i.e., clinical trend or specific case that requires further review, patient complaint, corporate compliance issue, or sentinel event), a focused professional practice evaluation will be undertaken to evaluate the concern.

6.D. MANDATORY MEETING

- (1) Whenever there is a concern regarding an individual's clinical practice or professional conduct, Medical Staff Leaders may require the individual to attend a mandatory meeting.
- (2) Special notice will be given at least three days prior to the meeting and will inform the individual that attendance at the meeting is mandatory.
- (3) Failure of an individual to attend a mandatory meeting may result in an automatic relinquishment of appointment and privileges as set forth below.

6.E. FITNESS FOR PRACTICE EVALUATION

- (1) An individual may be requested to submit to an appropriate evaluation (such as blood and/or urine test), or a complete fitness for practice evaluation to determine his or her ability to safely practice.
- (2) A request for an evaluation may be made of an applicant by the Credentials Committee in accordance with Section 3.A.4(c) during the initial appointment process or of a member during an investigation. A request for an evaluation may also be made when at least two Medical Staff Leaders (or one Medical Staff Leader and one member of the Hospital Administration) are concerned with the individual's ability to safely and competently care for patients.
- (3) The Medical Staff Leaders or committee that requests the evaluation will:
(i) identify the health care professional(s) to perform the evaluation; (ii) inform the individual of the time period within which the evaluation must occur; and
(iii) provide the individual with all appropriate releases and/or authorizations to allow the Medical Staff Leaders, or relevant committee, to discuss with the health care professional(s) the reasons for the evaluation and to allow the health care professional to discuss and report the results to the Medical Staff Leaders or relevant committee.
- (4) Failure to obtain the requested evaluation may result in an application being withdrawn or an automatic relinquishment of appointment and privileges as set forth below.

6.F. AUTOMATIC RELINQUISHMENT

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 and, as such, it does not trigger an obligation on the part of the Hospital to file a report with the National Practitioner Data Bank.

Except as otherwise provided below, an automatic relinquishment of appointment and privileges will be effective immediately upon actual or special notice to the individual.

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

Failure of an individual to complete medical records, after notification by the medical records department of delinquency in accordance with applicable policies and rules and regulations, may result in automatic relinquishment of all clinical privileges.

6.F.2. Failure to Satisfy Threshold Eligibility Criteria:

Failure of an individual to satisfy any of the threshold eligibility criteria set forth in this Policy will result in automatic relinquishment of appointment and clinical privileges.

6.F.3. Criminal Activity:

The occurrence of specific criminal actions will result in the automatic relinquishment of appointment and clinical privileges. Specifically, an arrest, charge, indictment, conviction, plea of guilty or plea of no contest pertaining to any felony or misdemeanor, including, but not limited to, the following will result in an automatic relinquishment: (a) Medicare, Medicaid, or other federal or state governmental or private third-party payer fraud or program abuse; (b) controlled substances; (c) illegal drugs; (d) violent act; (e) sexual misconduct; (f) moral turpitude; (g) theft; (h) weapons; or (i) child or elder abuse.

6.F.4. Failure to Provide Information:

- (a) Failure of an individual to notify the President of the Medical Staff or Chief Executive Officer of any change in any information provided on an application for initial appointment or reappointment may, as determined by the Medical Staff Executive Committee, result in the automatic relinquishment of appointment and clinical privileges.
- (b) Failure of an individual to provide information pertaining to an individual's qualifications for appointment or clinical privileges in response to a written request from the Credentials Committee, the Medical Staff Executive Committee, or any other authorized committee may, as determined by the Medical Staff Executive Committee, result in the automatic relinquishment of appointment and clinical privileges until the information is provided to the satisfaction of the requesting party.

6.F.5. Failure to Attend a Mandatory Meeting:

Failure to attend a mandatory meeting requested by the Medical Staff Leaders or Hospital Administration, after appropriate notice has been given, may, as determined by the Medical Staff Executive Committee, result in the automatic relinquishment of appointment and

clinical privileges. The relinquishment will remain in effect until the individual attends the mandatory meeting and reinstatement is granted as set forth below.

6.F.6. Failure to Complete or Comply with Training or Educational Requirements:

Failure of an individual to complete or comply with training and educational requirements that are adopted by the Medical Staff Executive Committee and/or required by the Board, including, but not limited to, those pertinent to electronic medical records or patient safety, will result in the automatic relinquishment of clinical privileges.

6.F.7. Failure to Comply with Request for Fitness for Practice Evaluation:

- (a) Failure of an **applicant** to undergo a requested fitness for practice evaluation or to execute any of the required releases (i.e., to allow the Medical Staff Leaders, or the relevant committee, to discuss with the health care professional(s) the reasons for the evaluation and to allow the health care professional to report the results to the Medical Staff Leaders or relevant committee) will be considered a voluntary withdrawal of the application.
- (b) Failure of a **member** to undergo a requested fitness for practice evaluation or to execute any of the required releases (i.e., to allow the Medical Staff Leaders, or the relevant committee, to discuss with the health care professional(s) the reasons for the evaluation and to allow the health care professional to report the results to the Medical Staff Leaders or relevant committee) will result in the automatic relinquishment of appointment and privileges.

6.F.8. Reinstatement from Automatic Relinquishment and Automatic Resignation:

- (a) If the matter leading to the automatic relinquishment of appointment and privileges has been resolved within 90 days of the relinquishment, the individual may request to be reinstated.
- (b) A request for reinstatement from an automatic relinquishment following completion of all delinquent records will be processed in accordance with applicable policies and rules and regulations. Failure to complete the medical records that caused relinquishment within the time required will result in automatic resignation from the Medical Staff or Allied Health Staff.
- (c) Requests for reinstatement from an automatic relinquishment following the expiration or lapse of a license, controlled substance authorization, or insurance coverage will be processed by the Hospital. If any questions or concerns are noted, the matter will be referred for further review in accordance with (d) below.
- (d) All other requests for reinstatement from an automatic relinquishment will be reviewed by the relevant Department Chair, the chairperson of the Credentials Committee, the President of the Medical Staff, and the Chief Executive Officer. If

all these individuals make a favorable recommendation on reinstatement, the individual may immediately resume clinical practice at the Hospital. This determination will then be forwarded to the Credentials Committee, the Medical Staff Executive Committee, and the Board for ratification. If, however, any of the individuals reviewing the request have any questions or concerns, those questions will be noted and the reinstatement request will be forwarded to the full Credentials Committee, Medical Staff Executive Committee and Board for review and recommendation.

- (e) Failure to resolve a matter leading to an automatic relinquishment within 90 days of the relinquishment, and to be reinstated as set forth above, will result in an automatic resignation from the Medical Staff or Allied Health Staff.

6.F.9. Hearings Regarding Automatic Relinquishments:

- (a) Any individual who is the subject of an automatic relinquishment of appointment and/or clinical privileges may request a hearing with the Medical Staff Executive Committee. Any such request must be made within three days of the notice of the automatic relinquishment provided to the individual. The hearing must then be held within 15 days of the date of the automatic relinquishment (unless the individual and the Medical Staff Executive Committee agree upon a different time frame/schedule).
- (b) The hearing shall be governed exclusively by this Section 6.F.9. The provisions of Article 7 of this Policy shall not apply to hearings related to automatic relinquishments of Medical Staff appointment and/or clinical privileges.
- (c) The scope of the hearing shall be limited to demonstrating that the event that led to the automatic relinquishment did not occur or that there was an extraordinary and unique circumstance that justified the event. At the hearing, the individual will be given an opportunity to personally discuss the matter with the Medical Staff Executive Committee, provide additional information and documentation, and present witnesses to support his or her position. Neither the individual nor the Medical Staff Executive Committee shall be represented by counsel at this hearing. The decision of the Medical Staff Executive Committee following the hearing shall be final, with no right of further appeal.

6.G. LEAVES OF ABSENCE

6.G.1. Initiation:

- (a) A leave of absence of up to one year must be requested in writing and submitted to the Chief Executive Officer. The request should, when possible, state the beginning and ending dates and the reasons for the leave. Except in extraordinary circumstances, the request will be submitted at least 30 days prior to the anticipated start of the leave.

- (b) The Chief Executive Officer will determine whether a request for a leave of absence will be granted, after consulting with the President of the Medical Staff and the relevant Department Chair. 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 Chief Executive Officer any time they are away from Medical Staff, Allied Health 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. Upon becoming aware of such circumstances, the Chief Executive Officer, in consultation with the President of the Medical Staff, may trigger an automatic medical leave of absence at any point after becoming aware of the Medical Staff member's absence from patient care.
- (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, the determination will be final, with no recourse to a hearing and appeal.

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

During a leave of absence, the individual will not exercise any clinical privileges and will be excused from Medical Staff and Allied Health Staff responsibilities (e.g., meeting attendance, committee service, emergency service call obligations). The obligation to pay dues will continue during a leave of absence except that a member granted a leave of absence for U.S. military service will be exempt from this obligation.

6.G.3. Reinstatement:

- (a) The individual on leave will be notified at least 45 days in advance of the expiration of the leave of absence. If possible, at least 30 days prior to the expiration of the leave, the individual must request, in writing, reinstatement of his or her privileges. Individuals requesting reinstatement will 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 will then be reviewed by the relevant Department Chair, the chairperson of the Credentials Committee, the President of the Medical Staff, and the Chief Executive Officer.
- (b) If a favorable recommendation on reinstatement is made, the individual may immediately resume clinical practice. However, if any of the individuals reviewing the request have any questions, those questions will be noted and the reinstatement request will be forwarded to the full Credentials Committee, Medical Staff Executive Committee, and Board.

- (c) 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 capable of resuming a hospital practice and safely exercising the clinical privileges requested.
- (d) Absence for longer than one year will result in resignation of Medical Staff or Allied Health Staff appointment and clinical privileges unless an extension is granted by the Chief Executive Officer. Extensions will be considered only in extraordinary cases where the extension of a leave is in the best interest of the Hospital.
- (e) If an individual's current appointment is due to expire during the leave, the individual's appointment and clinical privileges will expire at the end of the appointment period, and the individual will be required to apply for reappointment.

6.H. PRECAUTIONARY SUSPENSION OR RESTRICTION OF CLINICAL PRIVILEGES

6.H.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 Chief Executive Officer, the President of the Medical Staff, the chief of the relevant clinical department, the Medical Staff Executive Committee, or the Board Chairperson is authorized to immediately suspend or restrict all or any portion of an individual's clinical privileges. If the individual voluntarily refrains from exercising clinical privileges for longer than 30 days while the matter is being reviewed, it must be reported to the National Practitioner Data Bank.
- (b) A precautionary suspension can be imposed at any time, including after a specific event, a pattern of events, or a recommendation by the Medical Staff Executive Committee that would entitle the individual to request a hearing. When possible, prior to the imposition of a precautionary suspension, the person(s) considering the suspension will meet with the individual and review the concerns that support the suspension and afford the individual an opportunity to respond.
- (c) Precautionary suspension is an interim step in the professional review activity and does not imply any final finding regarding the concerns supporting the suspension.
- (d) A precautionary suspension is effective immediately and will be promptly reported to the Chief Executive Officer and the President of the Medical Staff. A precautionary suspension will remain in effect unless it is modified by the Chief Executive Officer or the Medical Staff Executive Committee.

6.H.2. Request for Hearing and Medical Staff Executive Committee Action:

- (a) Request for Hearing. Any individual who is the subject of a precautionary suspension or restriction may request a hearing with the Medical Staff Executive Committee. Any such request must be made within three days of the imposition of the suspension or restriction. The hearing must then be held within 15 days of the imposition of the suspension or restriction (unless the individual and the Medical Staff Executive Committee agree upon a different time frame/schedule). Prior to the hearing, the individual shall be provided a brief written description of the reason(s) for the precautionary suspension or restriction, including the names and medical record numbers of the patient(s) involved (if any).
- (b) Scope of Hearing. The scope of any such hearing shall be limited to the appropriateness of imposing, and the need to continue, the precautionary suspension under the circumstances. At the hearing, the individual will be given an opportunity to personally discuss the matter with the Medical Staff Executive Committee, provide additional information and documentation, and present witnesses to support his or her position. The individual may also propose ways other than a precautionary suspension or restriction to protect patients and other individuals. Neither the suspended individual nor the Medical Staff Executive Committee shall be accompanied by counsel at this hearing.
- (c) Medical Staff Executive Committee Action. Whether or not a hearing is requested by the individual, the Medical Staff Executive Committee shall review the information and circumstances resulting in the precautionary suspension or restriction and determine whether the action should be affirmed, lifted, expunged, or modified. The decision of the Medical Staff Executive Committee should be made as soon as practical following the suspension or restriction, but not later than 10 days following the date of the hearing (if one is requested).
 - (1) Affirmed. The Medical Staff Executive Committee may affirm the precautionary suspension or restriction pending completion of a formal investigation pursuant to Section 6.I of this Policy. If, following the formal investigation, the Medical Staff Executive Committee makes another recommendation that would entitle the practitioner to a hearing under Section 7.A.1(a) of this Policy, the practitioner may request such a hearing and it will be conducted in accordance with the provisions of Article 7.
 - (2) Lifted or Modified. If the Medical Staff Executive Committee determines that the precautionary suspension or restriction should be lifted or modified, this decision shall take effect immediately. The Medical Staff Executive Committee shall then take whatever next steps are appropriate under the circumstances, which could include still proceeding with a formal investigation pursuant to Section 6.C of this Policy. The Board (or a committee of the Board) shall review the Medical Staff Executive Committee's determination to lift or modify the suspension or restriction on

an expedited basis. If the Board (or committee) disagrees with the determination of the Medical Staff Executive Committee, representatives of the Board and the Medical Staff Executive Committee shall meet to discuss the matter and determine appropriate next steps.

6.H.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 physician.
- (b) All members of the Medical Staff have a duty to cooperate with the President of the Medical Staff, the Department Chair, the Medical Staff Executive Committee, and the Chief Executive Officer in enforcing precautionary suspensions or restrictions.

6.I. INVESTIGATIONS

6.I.1. Initial Review:

- (a) Whenever a concern has been raised, or where collegial efforts have not resolved an issue regarding the following, the matter may be referred to the President of the Medical Staff, the Department Chair, the chairperson of a standing committee, the Chief Executive Officer, or the chairperson of the Board:
 - (1) clinical competence or clinical practice, including patient care, treatment or management;
 - (2) the safety or proper care being provided to patients;
 - (3) the known or suspected violation of applicable ethical standards, code of conduct, or the bylaws, policies, rules and regulations of the Hospital or the Medical Staff; or
 - (4) conduct that is considered lower than the standards of the Hospital or disruptive to the orderly operation of the Hospital, its Medical Staff or its Allied Health Staff, including the inability of the member to work harmoniously with others.
- (b) In addition, if the Board becomes aware of information that raises concerns about the qualifications of any Medical Staff or Allied Health Staff member, the matter will be referred to the President of the Medical Staff, or the Chief Executive Officer.

- (c) The person to whom the question is referred will make a sufficient inquiry to determine whether the question is credible and, if so, may forward it to the Medical Staff Executive Committee. If the question pertains to a member of the Allied Health Staff, the Supervising Physician will also be notified.
- (d) To preserve impartiality, the person to whom the matter is directed shall not be a member of the same practice as, or a relative of, the person that is being reviewed, unless such restriction is deemed not practicable, appropriate, or relevant by the President of the Medical Staff.
- (e) No action taken pursuant to this section will constitute an investigation.

6.I.2. Initiation of Investigation:

- (a) The Medical Staff Executive Committee will review the matter in question, may discuss the matter with the individual, and will determine whether to conduct an investigation or direct that the matter be handled pursuant to another policy. An investigation will commence only after a determination by the Medical Staff Executive Committee.
- (b) The Medical Staff Executive Committee will inform the individual in writing that an investigation has begun. Notification may be delayed if, in the judgment of the Medical Staff Executive Committee, informing the individual immediately might compromise the investigation or disrupt the operation of the Hospital, Medical Staff, or Allied Health Staff.
- (c) The Board may also determine to commence an investigation and may delegate the investigation to the Medical Staff Executive Committee, a subcommittee of the Board, or an ad hoc committee.

6.I.3. Investigative Procedure:

- (a) Once a determination has been made to begin an investigation, the Medical Staff Executive Committee will investigate the matter itself or appoint an individual or committee ("Investigating Committee") to do so. The Investigating Committee may include individuals not on the Medical Staff or Allied Health Staff. The Investigating Committee will **not** include any individual who:
 - (1) is in direct competition with the individual being investigated;
 - (2) is a relative of the individual being investigated;
 - (3) has an actual bias, prejudice, or conflict of interest that would prevent the individual from fairly and impartially considering the matter; or
 - (4) actively participated in the matter at any previous level.

- (b) Whenever the questions raised concern the clinical competence of the individual under review, the ad hoc committee will include a peer of the individual (e.g., physician, dentist, oral surgeon, or podiatrist).
- (c) The individual will be notified of the composition of the Investigating Committee. Within five days of receipt of this notice, the individual must submit any reasonable objections to the service of any Investigating Committee member to the Chief Executive Officer. The objections must be in writing. The Chief Executive Officer will review the objection and determine whether another member should be selected to serve on the Investigating Committee.
- (d) The Investigating Committee may:
 - (1) review relevant documents, which may include patient records, incident reports and relevant literature or guidelines;
 - (2) conduct interviews;
 - (3) use outside consultants, as needed, for timeliness, expertise, thoroughness and objectivity; or
 - (4) require an examination or assessment by a health care professional(s) acceptable to it. The individual being investigated will execute a release allowing the Investigating Committee to discuss with the health care professional(s) the reasons for the examination or assessment and allowing the health care professional to discuss and report the results to the Investigating Committee. Failure to execute such a release will result in automatic relinquishment of privileges.
- (e) As part of the investigation, the individual will have an opportunity to meet with the Investigating Committee. Prior to this meeting, the individual will be informed of the questions being investigated and will be invited to discuss, explain, or refute the questions. A summary of the interview will be made and included with the Investigating Committee's report. This meeting is not a hearing, and none of the procedural rules for hearings will apply. Lawyers will not be present at this meeting.
- (f) The Investigating Committee will make a reasonable effort to complete the investigation and issue its report within 30 days, provided that an outside review is not necessary. When an outside review is used, the Investigating Committee will make a reasonable effort to complete the investigation and issue its report within 30 days of receiving the results of the outside review. These time frames are intended to serve as guidelines and, as such, will not be deemed to create any right for an individual to have an investigation completed within such time periods.

- (g) At the conclusion of the investigation, the Investigating Committee will prepare a report to the Medical Staff Executive Committee with its findings, conclusions, and recommendations.

6.I.4. Recommendation:

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

ARTICLE 7

HEARING AND APPEAL PROCEDURES²

7.A. INITIATION OF HEARING

7.A.1. Grounds for Hearing:

- (a) A Medical Staff member is entitled to request a hearing whenever the Medical Staff Executive Committee makes one of the following recommendations:
 - (1) denial of initial appointment, reappointment or requested clinical privileges;
 - (2) revocation of appointment or clinical privileges;
 - (3) suspension of clinical privileges for more than 30 days (other than precautionary suspension);
 - (4) restriction of clinical privileges, as defined by the National Practitioner Data Bank, meaning clinical privileges action that is the result of a professional review action based on clinical competence or professional conduct that leads to the inability of a practitioner to exercise his or her own independent judgment in a professional setting; or
 - (5) denial of reinstatement from a leave of absence if the reasons relate to professional competence or conduct.
- (b) No other recommendation or action will entitle the individual to a hearing.
- (c) If the Board determines to take any of these actions without an adverse recommendation by the Medical Staff Executive Committee, an individual is entitled to request a hearing. For ease of use, this Article refers to adverse recommendations of the Medical Staff Executive Committee. When a hearing is triggered by an adverse proposed action of the Board, any reference in this Article to the “Medical Staff Executive Committee” will be interpreted as a reference to the “Board.”

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

None of the following actions constitute grounds for a hearing. These actions take effect without hearing or appeal. The individual is entitled to submit a written statement regarding these actions for inclusion in his or her file:

² This Article only applies to Medical Staff members. The hearing and appeal procedures for Licensed Independent Providers and Advanced Practice Providers are contained in Article 8.

- (a) a letter of guidance, counsel, warning, or reprimand;
- (b) conditions, monitoring, proctoring, or a general consultation requirement;
- (c) a lapse, withdrawal of or decision not to grant or not to renew temporary privileges;
- (d) automatic relinquishment of appointment or privileges (entitles the individual to the hearing rights set forth in Section 6.F.9);
- (e) a requirement for additional training or continuing education;
- (f) precautionary suspension (entitles the individual to request the hearing rights set forth in Section 6.H.2);
- (g) denial of a request for leave of absence or for an extension of a leave;
- (h) removal from the on-call roster or any reading or rotational panel;
- (i) the voluntary acceptance of a performance improvement plan option;
- (j) determination that an application is incomplete;
- (k) determination that an application will not be processed due to a misstatement or omission; or
- (l) determination of ineligibility based on a failure to meet threshold eligibility criteria, a lack of need or resources, or because of an exclusive contract.

7.A.3. Notice of Recommendation:

The Chief Executive Officer will promptly give special notice of a recommendation which entitles an individual to request a hearing. This notice will contain:

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

7.A.4. Request for Hearing:

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

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

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

7.A.6. Witness List:

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

7.A.7. Hearing Panel, Presiding Officer, and Hearing Officer:

- (a) Hearing Panel:

The Chief Executive Officer, after consulting with the President of the Medical Staff, will appoint a Hearing Panel in accordance with the following guidelines:

- (1) The Hearing Panel will consist of at least three members, one of whom will be designated as chairperson.
 - (2) The Hearing Panel may include any combination of:
 - (i) any member of the Medical Staff or Allied Health Staff, or
 - (ii) physicians or laypersons not connected with the Hospital (i.e., physicians not on the Medical Staff or Allied Health Staff or laypersons not affiliated with the Hospital).
 - (3) Knowledge of the underlying peer review matter, in and of itself, will not preclude the individual from serving on the Hearing Panel.
 - (4) Employment by, or other contractual arrangement with, the Hospital or an affiliate will not preclude an individual from serving on the Panel.
 - (5) The Hearing Panel will not include any individual who:
 - (i) is in direct economic competition with the individual requesting the hearing;
 - (ii) is professionally associated with, a relative of, or involved in a referral relationship with, the individual requesting the hearing;
 - (iii) has an actual bias, prejudice, or conflict of interest that would prevent the individual from fairly and impartially considering the matter; or
 - (iv) actively participated in the matter at any previous level.
- (b) Presiding Officer:
- (1) The Chief Executive Officer, after consultation with the President of the Medical Staff, will appoint an attorney to serve as Presiding Officer. The Presiding Officer will not act as an advocate for either side at the hearing.
 - (2) The Presiding Officer will:
 - (i) schedule and conduct a pre-hearing conference;
 - (ii) allow the participants in the hearing to have a reasonable opportunity to be heard and to present evidence, subject to reasonable limits on the number of witnesses and duration of direct and cross-examination;

- (iii) prohibit conduct or presentation of evidence that is cumulative, excessive, irrelevant or abusive or that causes undue delay;
 - (iv) maintain decorum throughout the hearing;
 - (v) determine the order of procedure;
 - (vi) rule on matters of procedure and the admissibility of evidence; and
 - (vii) conduct argument by counsel on procedural points outside the presence of the Hearing Panel unless the Panel wishes to be present.
- (3) The Presiding Officer may 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, may be a legal advisor to it, and may draft the report of the Hearing Panel's decision based upon the findings and discussions of the Panel, but will not vote on its recommendations.

(c) Hearing Officer:

- (1) As an alternative to a Hearing Panel, in matters in which the underlying recommendation is based upon concerns involving behavior, sexual harassment, or failure to comply with rules, regulations or policies and not issues of clinical competence, knowledge, or technical skill, the Chief Executive Officer, after consulting with and obtaining the agreement of the President of the Medical Staff, may appoint a Hearing Officer. The Hearing Officer, who should preferably be an attorney, will perform the functions of a Hearing Panel. The Hearing Officer may not be, or represent clients, in direct economic competition with the individual requesting the hearing.
- (2) If a Hearing Officer is appointed instead of a Hearing Panel, all references in this Article to the "Hearing Panel" or "Presiding Officer" will be deemed to refer to the Hearing Officer.

(d) Compensation:

Members of the Hearing Panel, the Presiding Officer, or the Hearing Officer may be compensated for their service by the Hospital. The individual requesting the hearing may participate in that compensation. Compensation shall not constitute grounds for challenging the impartiality of the Hearing Panel members.

(e) Objections:

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

7.A.8. Counsel:

The Presiding Officer, Hearing Officer, and counsel for either party may be attorneys at law licensed to practice, in good standing, in this state.

7.B. PRE-HEARING PROCEDURES

7.B.1. General Procedures:

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

7.B.2. Time Frames:

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

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

7.B.3. Provision of Relevant Information:

- (a) Prior to receiving any confidential documents, the individual requesting the hearing must agree that all documents and information will be maintained as confidential and will not be disclosed or used for any purpose outside of the hearing. The individual must also provide a written representation that his or 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 will 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 Medical Staff Executive Committee;
 - (3) copies of relevant minutes (with portions regarding other physicians and unrelated matters deleted); and
 - (4) copies of any other documents relied upon by the Medical Staff Executive Committee.

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

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

7.B.4. Pre-Hearing Conference:

- (a) The Presiding Officer will require the individual and the Medical Staff Executive Committee (or a representative of each, who may be counsel) to participate in a pre-hearing conference.
- (b) All objections to exhibits or witnesses will be submitted, in writing, five days in advance of the pre-hearing conference. The Presiding Officer will not entertain subsequent objections unless the party offering the objection demonstrates good cause.

- (c) At the pre-hearing conference, the Presiding Officer will resolve all procedural questions, including any objections to exhibits or witnesses.
- (d) Evidence unrelated to the reasons for the recommendation or to the individual's qualifications for appointment or the relevant clinical privileges will be excluded.
- (e) The Presiding Officer will establish the time to be allotted to each witness's testimony and cross-examination.

7.B.5. Stipulations:

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

7.B.6. Provision of Information to the Hearing Panel:

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

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

7.C. THE HEARING

7.C.1. Time Allotted for Hearing:

It is expected that the hearing will 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 will 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.2. Record of Hearing:

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

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

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

7.C.4. Order of Presentation:

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

7.C.5. Admissibility of Evidence:

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

7.C.6. Persons to Be Present:

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

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

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

7.C.8. Failure to Appear:

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

7.C.9. Postponements and Extensions:

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

7.D. HEARING CONCLUSION, DELIBERATIONS, AND RECOMMENDATIONS

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

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

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

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

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

The Hearing Panel will deliver its report to the Chief Executive Officer. The Chief Executive Officer will send by special notice a copy of the report to the individual who requested the hearing. The Chief Executive Officer will also provide a copy of the report to the President of the Medical Staff.

7.E. APPEAL PROCEDURE

7.E.1. Time for Appeal:

- (a) Within ten days after notice of the Hearing Panel's recommendation, either party may request an appeal. The request will be in writing, delivered to the Chief Executive Officer in person or by certified mail, return receipt requested, and will 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 will be forwarded to the Board for final action.

7.E.2. Grounds for Appeal:

The grounds for appeal will be limited to the following:

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

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

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

7.E.4. Nature of Appellate Review:

- (a) The Board may serve as the Review Panel or the chairperson of the Board may appoint a Review Panel, composed of members of the Board or others, including but not limited to reputable persons outside the Hospital.
- (b) The Review Panel may consider the record upon which the recommendation was made, including the hearing transcripts and exhibits, post-hearing statements, the findings and recommendations of the Medical Staff Executive Committee and Hearing Panel and any other information that it deems relevant, and recommend final action to the Board.
- (c) Each party will have the right to present a written statement in support of its position on appeal. The party requesting the appeal will submit a statement first and the other party will 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 oral argument not to exceed 30 minutes.

- (d) 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 provided at the Hearing Panel proceedings. Additional evidence will be accepted only if the Review Panel determines that the party seeking to admit it can demonstrate that it is new, relevant evidence or that any opportunity to admit it at the hearing was improperly denied.

7.F. BOARD ACTION

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

- (a) The Board will take final action within 30 days after it (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 when no appeal has been requested.
- (b) The Board may review any information that it deems relevant, including, but not limited to, the findings and recommendations of the Medical Staff Executive Committee, Hearing Panel, and Review Panel (if applicable).
- (c) Consistent with its ultimate legal authority for the operation of the Hospital and the quality of care provided, the Board may adopt, modify, or reverse any recommendation that it receives or refer the matter for further review.
- (d) The Board will render its final decision in writing, including the basis for its decision, and will send special notice to the individual. A copy will also be provided to the President of the Medical Staff.
- (e) Except where the matter is referred by the Board for further review, the final decision of the Board will be effective immediately and will not be subject to further review.

7.F.2. Adverse Decisions/Economic Factors:

- (a) If an adverse final decision by the Board is based substantially on economic factors, the affected member shall be given 15 calendar days' notice prior to the implementation of the decision. Economic factor means any information or reasons for decisions unrelated to quality of care or professional competency.
- (b) Every such decision shall also be reported to the Hospital Licensing Board before the decision takes effect as required by Illinois law.

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

No individual will be entitled to more than one hearing and one appeal on any matter.

ARTICLE 8

ALLIED HEALTH PROFESSIONALS

8.A. CONDITIONS OF PRACTICE

8.A.1. Standards of Practice for Advanced Practice and Surgical Providers in the Inpatient Setting:

- (a) Advanced Practice and Surgical Providers are not permitted to function independently in the inpatient Hospital setting. As a condition of being granted permission to practice at the Hospital, all Advanced Practice and Surgical Providers specifically agree to abide by the standards of practice set forth in this Section. In addition, as a condition of being permitted to utilize the services of Advanced Practice and Surgical Providers in the Hospital, all Medical Staff members who serve as Supervising Physicians to such individuals also specifically agree to abide by the standards set forth in this Section.
- (b) The following standards of practice apply to the functioning of Advanced Practice and Surgical Providers in the inpatient Hospital setting:
 - (1) Admitting Privileges. Advanced Practice and Surgical Providers are not granted inpatient admitting privileges and therefore may not admit patients independent of the Supervising Physician.
 - (2) Specialty Privileges. In addition to core privileges granted to Advanced Practice and Surgical Providers, special procedures or subspecialty skills may be granted upon request and under the following circumstances:
 - (i) Demonstration of clinical competence for the procedure either by procedure log or clinical proctoring;
 - (ii) Collaborating agreement between Advanced Practice or Surgical Provider and Supervising Physician be signed that includes addendum for the specific procedure; and
 - (iii) Supervising Physician agrees to oversight, ongoing clinical case review and intervention as appropriate.
 - (2) Consultations. Advanced Practice Providers may not independently provide patient consultations in lieu of the provider's Supervising Physician. Advanced Practice Providers may gather data and order tests; however, the Supervising Physician must personally perform the requested consultation within 24 hours(as a general guideline) unless a longer time frame is specified by the individual requesting the consultation. For critical care consults, the consult must be personally completed by the physician

within 12 hours of the request, unless the patient's condition requires that the physician complete the consultation sooner.

- (3) Emergency On-Call Coverage. It will be within the discretion of the Emergency Department physician requesting assistance whether it is appropriate to contact an Advanced Practice Provider prior to the Supervising Physician. Advanced Practice Providers may not independently participate in the emergency on-call roster (formally, or informally by agreement with their Supervising Physicians), in lieu of the Supervising Physician. The Supervising Physician must personally respond to all calls, in accordance with requirements set forth in this Policy. Following discussion with the Emergency Department, the Supervising Physician may direct an Advanced Practice Provider to see the patient, gather data, and order tests for further review by the Supervising Physician. However, the Supervising Physician must still personally see the patient when requested by the Emergency Department physician.
- (4) Calls Regarding Supervising Physician's Hospitalized Inpatients. It will be within the discretion of the Hospital personnel requesting assistance to determine whether it is appropriate to contact an Advanced Practice or Surgical Provider prior to the Supervising Physician. However, the Supervising Physician must personally respond to all calls directed to him or her in a timely manner.
- (5) Daily Inpatient Rounds. An Advanced Practice Provider may assist the Supervising Physician in fulfilling his or her responsibility to round daily on all inpatients for whom the Supervising Physician is the designated attending physician, as appropriate.

8.A.2. Oversight by Supervising Physician:

- (a) Advanced Practice and Surgical Providers may function in the Hospital only so long as they have a Supervising Physician.
- (b) Any activities permitted to be performed at the Hospital by an Advanced Practice or Surgical Provider will be performed only under the oversight of the Supervising Physician.
- (c) If the appointment or clinical privileges of a Supervising Physician expire or are resigned, revoked or terminated, or the Advanced Practice or Surgical Provider fails, for any reason, to maintain an appropriate supervision relationship with a Supervising Physician, the clinical privileges or scope of practice of the Advanced Practice or Surgical Provider will be automatically relinquished, unless he or she has another Supervising Physician who has been approved as part of the credentialing process.

- (d) As a condition of clinical privileges or scope of practice, an Advanced Practice or Surgical Provider and the Supervising Physician must provide the Hospital with notice of any revisions or modifications that are made to the agreement between them. This notice must be provided to the Chief Executive Officer within three days of any such change.

8.A.3. Questions Regarding the Authority of an Advanced Practice or Surgical Provider:

- (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 or Surgical Provider to act or issue instructions outside the presence of the Supervising Physician, such individual will have the right to request that the Supervising Physician validate, either at the time or later, the instructions of the Advanced Practice or Surgical Provider. Any act or instruction of the Advanced Practice or Surgical Provider 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 or Surgical Provider will be reported to the President of the Medical Staff, the Chairperson of the Credentials Committee, the relevant Department Chair, or the Chief Executive Officer for appropriate action. The individual to whom the concern has been reported will also discuss the matter with the Supervising Physician.

8.A.4. Responsibilities of Supervising Physicians:

- (a) Physicians who wish to utilize the services of an Advanced Practice or Surgical Provider 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 before the Advanced Practice or Surgical Provider performs services or engages in any kind of activity in the Hospital.
- (b) Supervising Physicians who wish to utilize the services of Advanced Practice or Surgical Provider in the inpatient setting specifically agree to abide by the standards of practice set forth in Section 8.A.1 above.
- (c) The number of Advanced Practice or Surgical Providers acting under the supervision of one Medical Staff member, as well as the care they may provide, will be consistent with applicable state statutes and regulations and any other policies adopted by the Hospital. The Supervising Physician will make all appropriate filings with the State Board of Medicine regarding the supervision and responsibilities of the Advanced Practice or Surgical Provider, to the extent that such filings are required.

- (d) It will be the responsibility of the Supervising Physician to provide, or to arrange for, professional liability insurance coverage for the Advanced Practice or Surgical Provider in amounts required by the Board. The insurance must cover any and all activities of the Advanced Practice or Surgical Provider in the Hospital. The Supervising Physician will furnish evidence of such coverage to the Hospital. The Advanced Practice or Surgical Provider will act in the Hospital only while such coverage is in effect.

8.B. PROCEDURAL RIGHTS FOR LICENSED INDEPENDENT PROVIDERS AND ADVANCED PRACTICE PROVIDERS

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

- (a) In the event a recommendation is made by the Medical Staff Executive Committee that a Licensed Independent Provider 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. The special notice will include a general statement of the reasons for the recommendation and will advise the individual that they 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 Medical Staff Executive Committee, 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 Medical Staff Executive Committee will be interpreted as a reference to the Board.
- (c) If the Licensed Independent Provider or Advanced Practice Provider wants to request a hearing, the request must be in writing, directed to the Chief Executive Officer, 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.B.2. Hearing Committee:

- (a) If a request for a hearing is made timely, the Chief Executive Officer, in consultation with the President of the Medical Staff, 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 Licensed Independent Provider or Advanced Practice Provider, or any competitors of the affected individual.

- (b) The Chief Executive Officer, in consultation with the President of the Medical Staff, will appoint a Presiding Officer who 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.
- (c) As an alternative to a Hearing Committee in matters in which the underlying recommendation is based upon concerns involving behavior, sexual harassment, and/or compliance with Medical Staff rules, regulations and/or policies, and does not involve issues of clinical competence, the Chief Executive Officer, in consultation with the President of the Medical Staff, may appoint a Hearing Officer to perform the functions that would otherwise be carried out by the Hearing Committee. The Hearing Officer will preferably be an attorney at law. The Hearing Officer may not be in direct economic competition with the individual requesting the hearing and will not act as a prosecuting officer or as an advocate to either side at the hearing. In the event a Hearing Officer is appointed instead of a Hearing Committee, all references in this Article to the Hearing Committee or Presiding Officer will be deemed to refer instead to the Hearing Officer, unless the context would clearly otherwise require.

8.B.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 Medical Staff Executive Committee will first present the reasons for the recommendation. The practitioner 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 Licensed Independent Provider or Advanced Practice Provider and the Medical Staff Executive Committee may be represented at the hearing by legal counsel.

However, while counsel may be present at the hearing, counsel will not call, examine, or cross-examine witnesses or present the case.

- (f) The Licensed Independent Provider or Advanced Practice Provider will have the burden of demonstrating, by clear and convincing evidence, that the recommendation of the Medical Staff Executive Committee 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 Licensed Independent Provider or Advanced Practice Provider and the Medical Staff Executive Committee 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.B.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 Chief Executive Officer. The Chief Executive Officer will send a copy of the written report and recommendation by special notice to the Licensed Independent Provider or Advanced Practice Provider and to the Medical Staff Executive Committee.
- (b) Within ten days after notice of such recommendation, the Licensed Independent Provider or Advanced Practice Provider and/or the Medical Staff Executive Committee 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 Chief Executive Officer 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 Chief Executive Officer will forward the report and recommendation, the supporting information and the request for appeal to the Board. The Chairperson of the Board will arrange for an appeal.

8.B.5. Appellate Review:

- (a) An Appellate Review Committee appointed by the Chairperson 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 practitioner and the Medical Staff Executive Committee will each have the right to present a written statement on appeal.
- (c) At the sole discretion of the Appellate Review Committee, the Licensed Independent Provider or Advanced Practice Provider and a representative of the Medical Staff Executive Committee 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. 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 Licensed Independent Provider or Advanced Practice Provider will receive special notice of the Board's action. A copy of the Board's final action will also be sent to the Medical Staff Executive Committee for information.

ARTICLE 9

CONFLICTS OF INTEREST

- (a) When performing a function outlined in this Policy, the Bylaws, or the Medical Staff Rules and Regulations, if any member has or reasonably could be perceived as having a conflict of interest or a bias, that member will not participate in the final discussion or voting on the matter, and will be excused from any meeting during that time. However, the member may provide relevant information and may answer any questions concerning the matter before leaving.
- (b) Any member with knowledge of the existence of a potential conflict of interest or bias on the part of any other member may call the conflict of interest to the attention of the President of the Medical Staff (or the Vice President of the Medical Staff if the President of the Medical Staff is the person with the potential conflict) or the applicable Department Chair. The President of the Medical Staff or the applicable Department Chair will make a final determination as to whether the provisions in this Article should be triggered.
- (c) The fact that a Department Chair or a member is in the same specialty as a member whose performance is being reviewed does not automatically create a conflict. In addition, the assessment of whether a conflict of interest exists will be interpreted reasonably by the persons involved, taking into consideration common sense and objective principles of fairness. No member has a right to compel disqualification of another member based on an allegation of conflict of interest.
- (d) The fact that a Department Chair or a member or Medical Staff Leader chooses to refrain from participation, or is excused from participation, will not be interpreted as a finding of actual conflict.

ARTICLE 10

HOSPITAL EMPLOYEES

- (a) Except as provided below, the employment of an individual by the Hospital or one of its affiliates will be governed by applicable employment policies and manuals and the terms of the individual's employment relationship or written contract. To the extent that applicable employment policies or manuals, or the terms of any employment contract, conflict with this Policy, the employment policies, manuals and descriptions and terms of the individual's employment relationship or written contract will apply.
- (b) A request for appointment, reappointment or clinical privileges, submitted by an applicant or member who is employed by the Hospital or one of its affiliates, will be processed in accordance with the terms of this Policy. A report regarding each practitioner's qualifications will be made to appropriate management personnel to assist with employment decisions.
- (c) If a concern about an employed member's clinical competence, conduct or behavior arises, then the concern may be reviewed and addressed in accordance with this Policy, in which event a report will be provided to appropriate management personnel. However, nothing herein will require the individual's employer to follow this Policy.

ARTICLE 11

AMENDMENTS AND ADOPTION

- (a) The amendment process for this Policy is set forth in the Bylaws.
- (b) 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:	
Originally approved by the Board:	
Revisions adopted by the Medical Staff:	08/13/2025
Revisions approved by the Board:	08/28/2025

APPENDIX A

Those individuals currently or have the potential to practicing as Licensed Independent Providers at HSHS Holy Family Hospital are as follows:

Licensed Independent Provider

- Includes:
 - Audiologists
 - Psychologists

APPENDIX B

Those individuals currently or have the potential to practicing as Advanced Practice Provider at HSHS Holy Family Hospital are as follows:

Advanced Practice Provider

- Includes:
 - Advanced Practice Registered Nurses (all Nurse Practitioners)
 - Certified Physician Assistants
 - Certified Nurse Midwives
 - Clinical Nurse Specialists
 - Certified Registered Nurse Anesthetist

Those individuals currently or have the potential to practicing as Surgical Provider at HSHS Holy Family Hospital are as follows:

Surgical Provider

- Includes:
 - Certified Surgical First Assistant
 - Certified Surgical Assistant
 - Certified Surgical Technologist
 - Registered Nurse First Assist
 - Certified Anesthesiologist Assistant
 - Orthopaedic Technologist Certified

*Except as specifically indicated in article 8 and Appendix A and B outlining types of Allied Health Professionals, individuals who are not directly employed by the hospital system but are authorized to deliver patient care under oversight and guidance of a licensed provider are referred to as Healthcare Clinical Assistants (HCA's) or Depending Healthcare Providers (DHP's). Their clinical practice will be assessed and managed in accordance with Human Resource policies and procedures, and the provisions of this policy specially will not apply.