St. Francis Hospital

Medical Staff Bylaws

Adopted by the Medical Staff April 21, 2012

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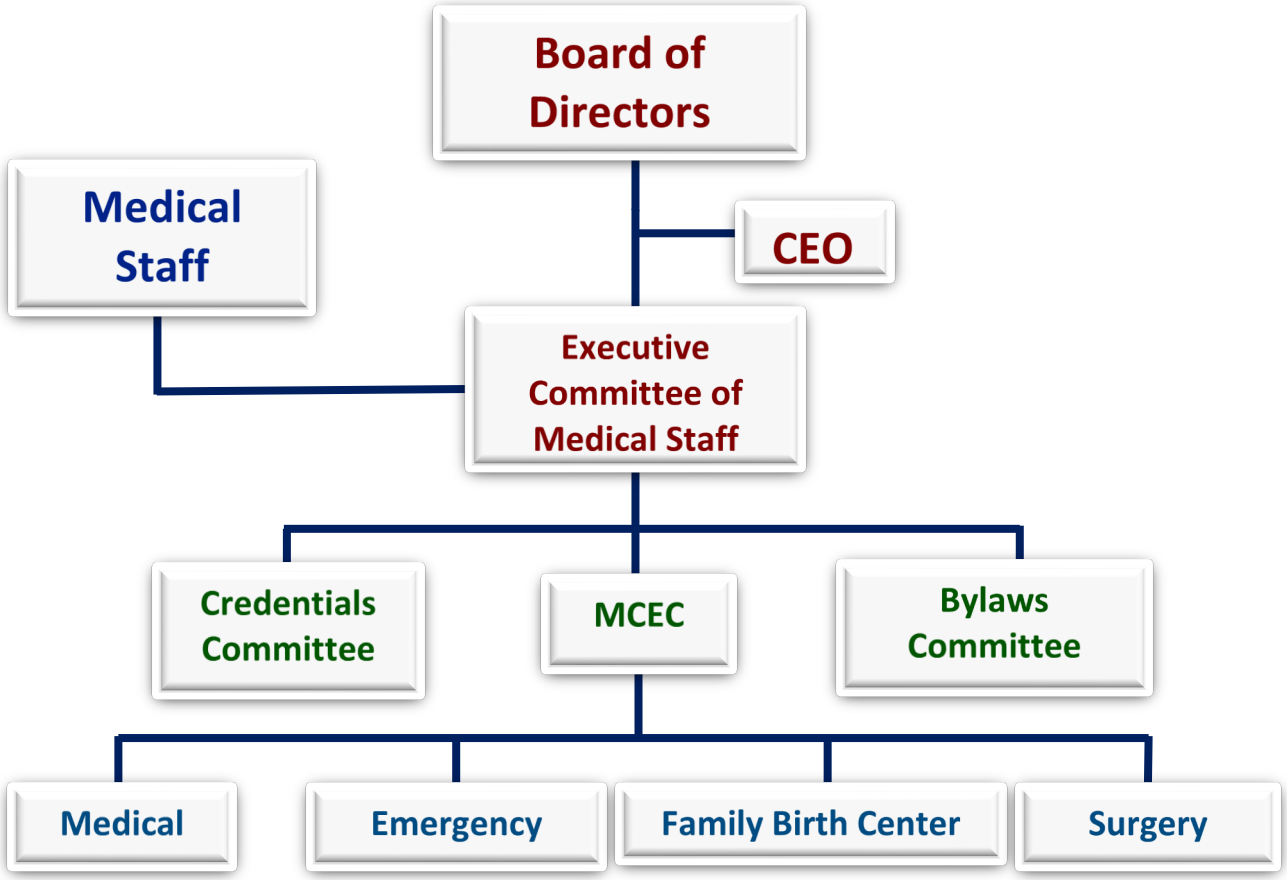
Foreword to the Medical Staff Bylaws

St. Francis Hospital, Litchfield Illinois

The Bylaws of the Medical Staff of St. Francis Hospital are comprised of three manuals, The Organization and Structure of the Medical Staff, The Credentialing Manual, and The Fair Hearing Plan. Medical Staff Policies, though not strictly part of the Bylaws, carry the same weight and effect as the bylaws.

The Medical Staff Policies can be amended, edited, added to or changed by a majority vote of the Executive Committee of the medical staff. Medical staff members who disagree with changes by the Executive Committee of the Medical Staff Policies are entitled to have a general medical staff ruling by activating the Conflict Resolution process discussed in Article 7 of the Organization Manual.



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While Bylaws and Credentials Policies are in process of revisions the table of contents will not be updated until final revisions are completed.

Organization and Structure of the Medical Staff

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Organization and Structure of the Medical Staff

Article 1: Definitions

The following definitions shall apply to terms used in these bylaws:

- **Governing Body**

  Governing Body means the Board of Directors of St. Francis.

- **Chief Executive Officer**

  Chief Executive Officer (CEO) refers to the duly appointed representative of the Governing Body who shall function in the capacity of hospital administrator, president, or other title denoting the responsibilities of the position. The Chief Executive Officer acts on behalf of the Governing Body in the overall management of the hospital and is an ex-officio member of all Medical Staff Committees.

- **Executive Committee**

  Executive Committee means the Executive Committee of the Medical Staff unless specifically written "Executive Committee of the Governing Body".

- **Medical Staff**

  Medical Staff means an organization of licensed practitioners consisting of physicians, dentists, and podiatrists who treat patients or provide other diagnostic and/or therapeutic services in the hospital and who are granted privileges to do so by the hospital Board of Directors.

- **Medical Staff Year**

  Medical Staff Year means the time period from July 1 through June 30.

- **Medical Staff Office**

  The office of the Medical Staff Specialist.

- **Service**

  Service or Clinical Service means an organizational unit of the medical staff denoting clinical areas of practice in the hospital including but not limited to the general areas of medicine, surgery, maternity, and emergency.

- **Physician**

  A physician means an individual who has completed graduate school training and has earned an MD (Medical Doctor) or DO (Doctor of Osteopathy) degree and who has completed additional postgraduate training and who maintains a valid license.

- **Telemedicine Physician**

  A Telemedicine Physician is a licensed professional who meets the criteria for the definition of "Physician" above but who renders consultative services to patients utilizing electronic media for interaction rather than physical presence during the encounter. A Telemedicine Physician

must meet the same requirements as consulting physicians and as such, are considered as consultants and credentialed through the same process. If approved for staff membership, they are members of the consulting staff category.

- **Dentist**

  A dentist means an individual who has completed graduate school training and has earned a DMD (Doctor of Dental Medicine) or DDS. (Doctor of Dental Surgery) degree and who maintains a valid license as a "Dentist."

- **Podiatrist**

  A podiatrist means an individual who has completed graduate school training and has earned a DPM (Doctor of Podiatric Medicine) degree and who maintains a valid license as a "Podiatric Physician."

- **Allied Health Professional**

  Allied Health Professionals (AHP's) 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"** 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 providers also include 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**" 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. See Appendix B to the policy on Allied Health Professionals.
  - **"Surgical Providers"** means a type of Allied Health Professional who provides a medical level 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 this policy on Allied Health Professionals.

- **Administration**

  The office of the hospital President/CEO or his designee.

- **Locum Tenens**

  A locum tenens provider is defined as a physician, podiatrist or dentist who is substituting for another like provider who is absent due to illness, vacation or leave of absence for a period not to exceed six consecutive months.

- **Special Definitions**
  - A singular term shall include the plural, and the masculine gender shall include the feminine and the feminine gender shall include the masculine except when a particular context clearly requires a different meaning.
  - Shall or Must: Terms used to indicate a mandatory statement; the only acceptable method under the present standard.
  - Should: Terms used in the interpretation of a statement to reflect the commonly accepted method, yet allowing for the use of effective alternates.
  - May: Term used in the interpretation of a statement to reflect an acceptable method that is recognized but not necessarily preferred.

- **PATIENT CONTACTS –** are defined as any admission, consultation, procedure, discharge, response to emergency call, evaluations, 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.

Article 2: Categories of the Medical Staff

Only those individuals who satisfy the qualifications and conditions for appointment to the Medical Staff and Allied Health Staff set forth in the Bylaws or Bylaws- related documents are eligible to apply for appointment to one of the categories listed below.

2.A. ACTIVE STAFF

2.A.1. Qualifications:

The Active Staff will consist of members of the Medical Staff who:

a) are involved in at least 100 unique patient contacts over a 24- month period; and

b) are willing to participate in Medical Staff functions and/or demonstrate a commitment to the Medical Staff and Hospital through service on hospital or Medical Staff committees and/or active participation in performance improvement or professional practice evaluation functions.

Guidelines:

Unless an Active Staff member can definitively demonstrate to the satisfaction of the Credentials Committee at the time of reappointment that their practice patterns have changed and that they will satisfy the activity requirements of this category:

- Any member who has fewer than 100 patient contacts per 24-month appointment term will not be eligible to request Active Staff status at the time of their reappointment.

- The member must select and be transferred to another staff category that best reflects their relationship to the Medical Staff and the Hospital (options – Courtesy, Consulting, Coverage or Affiliate).

2.A.2. Prerogatives and Responsibilities:

Active Staff Members:

a) may admit patients in accordance with the member's admitting privileges, except as otherwise provided in the Bylaws or Bylaws-related documents, or as limited by the Board;

b) may vote in all general and special meetings of the Medical Staff and applicable department and committee meetings, by any method (e.g., email, mail, ballot, facsimile) designated in a notice presenting a question for vote

c) may hold office, serve on Medical Staff committees, and serve as department chairperson and chairperson of committees; and

d) may exercise clinical privileges granted.

Active Staff members must assume all the responsibilities of the Active Staff, including:

a) serving on committees, as requested;*

b) providing specialty coverage for the Emergency Department and accepting referrals from the Emergency Department for follow-up care of patients treated in the Emergency Department;

c) providing care for unassigned patients;

d) participating in the professional practice evaluation and performance improvement processes (including constructive participation in the development of clinical practice protocols and guidelines pertinent to their specialties);

e) accepting inpatient consultations, when requested;

f) must pay any applicable application fees, dues, and assessments; and

g) shall perform assigned duties.

Members of the Active Staff who are 65 years of age or older may request to be excused from rotational obligations, including providing specialty coverage for the Emergency

Department and accepting referrals from the Emergency Department. The request will be reviewed by the Medical Staff Department, and a recommendation made to the Medical Staff Executive Committee and final action by the Board. In reviewing a request, consideration should be given to need and the effect on others who serve on the Emergency Department call roster. A member who is relieved of the obligation of providing coverage may be required to resume on-call duties if the Medical Staff Department determines later, that call coverage in the member's specialty area is not adequate.

2.B. COURTESY STAFF

2.B.1. Qualifications:

The Courtesy Staff will consist of members of the Medical Staff who:

a) are involved in fewer than 100 unique patient contacts over a 24-month period;

b) at each reappointment time, provide quality data and other information as may be requested to assist in an appropriate assessment of current clinical competence and overall qualifications for appointment and clinical privileges (including, but not limited to, information from another hospital, information from the individual's office practice, information from insurers or managed care organizations in which the individual participates, and/or receipt of confidential evaluation forms completed by referring/referred to physicians).

Guidelines:

Unless a Courtesy Staff member can definitively demonstrate to the satisfaction of the Credentials Committee at the time of reappointment that their practice patterns have changed and that they will satisfy the activity requirements of this category:

a) Any member who has more than 100 patient contacts per 24-month period will be transferred to Active Staff status.

2.B.2. Prerogatives and Responsibilities:

Courtesy Staff Members:

a) may admit patients in accordance with clinical privileges granted;

b) may attend and participate in Medical Staff and department meetings (without vote);

c) may not hold office or serve as department chairperson or committee chairperson, unless waived by the Medical Staff Executive Committee and the Board;

d) may exercise clinical privileges granted;

e) may be invited to serve on committees (with vote);

f) are generally excused from providing specialty coverage for the Emergency Department for unassigned patients, but will be required to provide specialty coverage if the Medical Staff Executive Committee finds that there are insufficient Active Staff members in a particular specialty area to perform these responsibilities;

g) must assume the care of any of their patients who present to the Emergency Department when requested to do so by an Emergency Department physician;

h) must accept referrals from the Emergency Department for follow-up care of their patients treated in the Emergency Department;

i) must cooperate in the professional practice evaluation and performance improvement processes;

j) must pay any applicable application fees, dues, and assessments; and

k) shall perform assigned duties.

2.C. CONSULTING STAFF

2.C.1. Qualifications:

The Consulting Staff will consist of members of the Medical Staff who:

a) demonstrate professional ability and expertise and provide a service not otherwise available (or is in very limited supply) on the Active or Courtesy Staff;

b) provide services at the Hospital only at the request of other members of the Medical Staff;

c) at each reappointment time, provide quality data and other information as may be requested to assist in an appropriate assessment of current clinical

competence and overall qualifications for appointment and clinical privileges (including, but not limited to, information from another hospital, information from the individual's office practice, information from insurers or managed care organizations in which the individual participates, and/or receipt of confidential evaluation forms completed by referring/referred to physicians).

2.C.2. Prerogatives and Responsibilities:

Consulting Staff Members:

a) may evaluate and treat, but not admit or provide overall patient management for, patients in conjunction with other members of the Medical Staff;

b) may attend meetings of the Medical Staff and applicable department meetings (without vote) and applicable committee meetings (with vote);

c) may not hold office, serve as a department chairperson, or committee chairperson, unless waived by the Medical Staff Executive Committee and the Board;

d) may exercise clinical privileges granted;

e) are generally excused from providing specialty coverage for the Emergency Department for unassigned patients, but will be required to provide specialty coverage if the Medical Staff Executive Committee finds that there are insufficient Active Staff members in a particular specialty area to perform these responsibilities;

f) must assume the care of any of their patients who present to the Emergency Department when requested to do so by an Emergency Department physician;

g) must accept referrals from the Emergency Department for follow-up care of their patients treated in the Emergency Department;

h) must cooperate in the professional practice evaluation and performance improvement processes;

i) must pay any applicable application fees, dues, and assessments; and

j) shall perform assigned duties.

2.D. COVERAGE STAFF

2.D.1. Qualifications:

The Coverage Staff will consist of members of the Medical Staff who:

a) desire appointment to the Medical Staff solely for the purpose of being able to provide coverage assistance to Medical Staff members who are members of their group practice or their coverage group;

b) at each reappointment time, provide quality data and other information to assist in an appropriate assessment of current clinical competence and overall qualifications for appointment and clinical privileges (including, but not limited to, information from another hospital, information from the individual's office practice, information from insurers or managed care organizations in which the individual participates, and/or receipt of confidential evaluation forms completed by referring/referred to physicians); and

c) agree that their Medical Staff appointment and clinical privileges will be automatically relinquished, with no right to a hearing or appeal, if their coverage arrangement with the Medical Staff member(s) terminates for any reason.

2.D.2. Prerogatives and Responsibilities:

Coverage Staff Members:

a) when providing coverage assistance to a Medical Staff member, will be entitled to admit and/or treat patients who are the responsibility of the Medical Staff member who is being covered (i.e., the Active, Courtesy or Consulting Staff member's own patients or unassigned patients who present through the Emergency Department when the Medical Staff member is on call), if applicable;

b) will assume all Medical Staff functions and responsibilities as may be assigned, including, where appropriate, emergency service care, consultation, and teaching assignments when covering for members of their group practice or coverage group;

c) may attend Medical Staff and department meetings (without vote); and

applicable committee meetings (with vote);

d) must cooperate in the professional practice evaluation and performance improvement processes;

e) may not hold office or serve as department chairperson or committee chairperson;

f) may exercise clinical privileges granted;

g) must pay any applicable application fees, dues, and assessments; and

h) shall perform assigned duties.

2.E. AFFILIATE STAFF

2.E.1.Qualifications:

The Affiliate Staff will consist of members of the Medical Staff who:

a) desire to be associated with, but who do not intend to establish a practice at, this Hospital and wish to be membership-only category, with no clinical privileges being granted;

b) are interested in pursuing professional and educational opportunities, including continuing medical education, available at the Hospital;

c) are permitted to access hospital services for patients by referral of patients to Active Staff members for admission and care; and

d) must submit an application as prescribed by the Bylaws or Bylaws-related documents excluding privileges, satisfy the qualifications for appointment set forth in the Bylaws or Bylaws-related documents, but are exempt from the qualifications pertaining to response times, location within the geographic service area, emergency call, and coverage arrangements.

2.E.2. Prerogatives and Responsibilities:

Affiliate Staff Members:

a) may attend meetings of the Medical Staff and applicable department meetings (without vote);

b) may not hold office or serve as department chairperson or committee chairperson;

c) shall generally have no staff committee responsibilities, but may be assigned to serve on committees (with vote)~~;~~

d) may attend educational activities sponsored by the Medical Staff and the Hospital;

e) may refer patients to members of the Medical Staff for admission and/or care;

f) are encouraged to communicate directly with members of the Medical Staff about the care of any patients referred, as well as to visit any such patients who are hospitalized;

g) may review the medical records and test results (via paper or electronic access) for any patients who are referred;

h) may perform preoperative history and physical examinations in the office and have those reports entered into the Hospital's medical records;

i) are not granted inpatient or outpatient clinical privileges and, therefore, may not admit patients, attend patients, write orders or progress notes, perform consultations, assist in surgery, or otherwise participate in the provision or management of clinical care to patients at the Hospital;

j) may refer patients to the Hospital's diagnostic facilities subject to the rules and policies of the hospital and the clinical departments;

k) are encouraged to accept referrals from the Emergency Department for follow-up care of patients treated in the Emergency Department; and

l) must pay any applicable application fees, dues, and assessments.

The grant of appointment to the Affiliate Staff is a courtesy only, which may be terminated by the Board upon recommendation of the Medical Staff Executive Committee, with no right to a hearing or appeal.

2.F. TELEMEDICINE (Non-Staff)

2.F.1. Qualifications:

The Telemedicine (Non-Staff) providers will consist of providers who provide care, evaluation and treatment of patients only remotely via electronic communication, or sorely for the interpretation of diagnostic services.

a) at each reappointment time, provide quality data and other information as may be requested to assist in an appropriate assessment of current clinical competence and overall qualifications for appointment and clinical privileges (including, but not limited to, information from another hospital, information from the individual's office practice, information from insurers or managed care organizations in which the individual participates, and/or receipt of confidential evaluation forms completed by referring/referred to physicians).

2.F.2. Prerogatives and Responsibilities:

Telemedicine (Non-Staff) Members:

a) may evaluate and treat (but not admit or provide overall patient management for) patients in conjunction with other members of the Medical Staff.

b) may not hold office or serve as department chairperson or committee chairperson, unless waived by the Medical Staff Executive Committee and the Board;

c) may attend meetings of the Medical Staff and applicable department meetings (without vote);

d) may be invited to serve on committees (with vote);

e) must participate in providing emergency department on-call and other coverage arrangements as defined by policy and/or contractual agreements;

f) must cooperate in the professional practice evaluation and performance improvement processes;

g) may exercise clinical privileges granted;

h) must pay any applicable application fees, dues, and assessments; and

i) shall perform assigned duties.

2.G. HONORARY STAFF

2.G.1. Qualifications:

The Honorary Staff will consist of members of the Medical Staff and Allied Health Staff who~~:~~

a) have a record of previous long-standing service to the Hospital, have retired from the active practice of medicine; and, in the discretion of the Medical Staff Executive Committee, are in good standing at the time of initial application for membership on the Honorary Staff; and/or

b) are recognized for outstanding or noteworthy contributions to the medical sciences.

Once an individual is appointed to the Honorary Staff, that status is ongoing, at the continuing discretion of the Medical Staff Executive Committee. As such, there is no need for the individual to submit a reappointment application.

2.G.2. Prerogatives and Responsibilities:

Honorary Staff Members:

a) may not consult, admit, or attend to patients;

b) may attend Medical Staff and department meetings when invited to do so (without vote);

c) may not hold office or serve as department chairperson or committee chairperson;

d) may be appointed to committees (without vote);

e) are entitled to attend educational programs of the Medical Staff and the Hospital; and

f) are not required to pay application fees, dues, or assessments.

2.H. ALLIED HEALTH STAFF

2.H.1. Qualifications:

The Allied Health Staff consists of Allied Health Professionals who are granted clinical privileges and are appointed to the Allied Health Staff. The Allied Health Staff is not a category of the Medical Staff but is included in this Article for convenient reference.

2.H.2. Prerogatives and Responsibilities:

Allied Health Staff Members:

a) may attend and participate in Medical Staff department meetings (without vote);

b) may not hold office or serve as department chairperson or committee chairperson;

c) may be invited to serve on committees (with vote);

d) must cooperate in the professional practice evaluation and performance improvement processes;

e) may exercise clinical privileges or scope of practice as granted; and

f) must pay any applicable application fees, dues, and assessments.

Article 3: Executive Committee, Officers, Medical Staff Meetings

Section 3.1: Executive Committee

- **Composition:**

The voting members of the Executive Committee shall consist of the officers of the medical staff as defined in Section 3.2. The President of the Medical Staff shall be Chairperson of the Executive Committee. The non-voting members are the CEO and, at the discretion of the CEO, other members of the Administrative Team. Members of the hospital Board of Directors may attend meetings of the Executive Committee and participate in its discussions, but without vote.

- **Duties:**

The duties of the Executive Committee shall be to:

1) represent and to act on behalf of the medical staff in all matters, without requirement of subsequent approval by the staff between meetings of the medical staff, subject only to any limitations imposed by these bylaws (including approval of bylaws amendments which must be voted on by the entire medical staff);
2) coordinate the activities and general policies of the various services;
3) receive and act upon those committee reports as specified in these bylaws, and to make recommendations concerning them to the Chief Executive Officer and the Governing Body;
4) implement policies of the medical staff that are not the responsibility of the clinical services;
5) provide liaison among medical staff, the CEO, and the Governing Body;

6) keep the medical staff abreast of applicable accreditation and regulatory requirements affecting the hospital;

7) enforce hospital and medical staff rules in the best interest of patient care and of the hospital on the part of all persons who exercise privileges granted by the Governing Body including medical staff members and Allied Health ProfessionalsAHP);

8) evaluate and investigate questions of the clinical competence, patient care and treatment, case management or inappropriate behavior of any medical staff member or AHP in accordance with these bylaws;

9) be responsible for the enforcement of the medical staff bylaws, policies, rules and regulations, for implementation of sanctions where these are indicated, and for the medical staff's compliance with procedural safeguards in all instances where corrective action has been requested involving a medical staff member;

10) enforce educational or remedial training requirements and stipulate any supervisory requirements as developed by the Executive Committee after evaluation and consultation as necessary.

11) be responsible to the Governing Body for the implementation of the hospital's performance improvement plan as it affects the medical staff;

12) review the Bylaws, and Policies of the Medical Staff and associated documents as needed and recommend such changes thereto as may be necessary or desirable;

13) make recommendations to the Governing Body concerning medical staff appointments, reappointments and clinical privileges in accordance with the medical staff procedural policy; and

14) function as an ad hoc Impaired Physician Committee to assist and address the physical and mental health problems of medical staff members and related education needs.

- **Meetings, Reports and Recommendations**

The Executive Committee shall meet at least ten times per year or more often if necessary. The Secretary/Treasurer shall maintain reports of all meetings, which shall include the minutes of the various medical staff committees. Important actions of the Executive Committee shall be reported to the medical staff as a part of the Executive Committee's report at each medical staff meeting. Recommendations of the Executive Committee shall be transmitted to the Governing Body with a copy to the CEO. The Chairperson of the Executive Committee, his representative and such members of the committee as may be necessary, shall be available to meet with the Governing Body (or its applicable committee) on all recommendations that the Executive Committee may make.

Section 3.2: Duties of Officers

The officers of the medical staff shall be the President, President-Elect, Secretary/Treasurer and Past President. Officers must be a MD or DO and members of the Active Staff at the time of

nomination and election and must continue so during their term of office. Failure to maintain such status shall immediately create a vacancy in the office involved.

- **The President shall:**

1) serve as the chief administrative officer of the medical staff;
2) act in coordination and cooperation with the CEO in all matters of mutual concern within the hospital;
3) call, preside at, and be responsible for the agenda of all regular meetings of the Medical Staff and Executive Committee;
4) serve as ex-officio member of all other medical staff committees without vote;
5) appoint committee members, after consultation with the hospital Chief Executive Officer, to all standing, special, and multidisciplinary medical staff committees except the Executive Committee;
6) represent the views, policies, needs, and grievances of the medical staff to the Governing Body and to the CEO;
7) receive, communicate, apply, and interpret the policies of the Governing Body to the medical staff and report to the Governing Body on the performance and maintenance of quality and safety with respect to the medical staff's delegated responsibility to provide medical care; and
8) be the representative for the medical staff in its professional and public relations.

- **The President-Elect shall:**

1) serve as chairperson of the Medical Care Evaluation Committee (MCEC) and
2) serve as ex-officio member of all other medical staff committees without vote.

In the absence of the President, the President-Elect shall:

1) assume all the duties and have the authority of the President;
2) automatically succeed the President when the latter fails to serve for any reason.

- **The Secretary/Treasurer shall:**

1) keep accurate and complete minutes of all medical staff meetings;
2) call medical staff meetings on order of the President;
3) attend to all correspondence;
4) act as medical staff treasurer and perform such other duties as ordinarily pertain to his office; and
5) in the absence of the President and President-Elect, shall temporarily assume the duties of the President.

- **The Immediate Past President shall:**

1) shall serve on the Executive Committee;

2) in the absence of the President, President-Elect, and Secretary-Treasurer, temporarily assume the duties of the President.

Section 3.3: Election of Officers

1) Officers shall be elected at an Annual Meeting by Active Staff members of the medical staff.
2) At least one month before the scheduled date of the next medical staff election, the President shall appoint a Nominating Committee consisting of three Active Staff members. The Nominating Committee shall prepare a slate of one or more nominees for each office to be filled at that election and shall report the slate at the last official meeting of the medical staff year.
3) After the announcement of nominations by the Nominating Committee, other nominations shall be in order from the floor.
4) The officers of the medical staff shall be elected by a majority vote of all members of the Active Staff.

Section 3.4: Term of Office

All officers shall serve a two year term from the date they assume office or until a successor is elected. Officers shall take office on the first day of the medical staff year (July 1).

Section 3.5: Removal of Officers

1) The Executive Committee, by a three-fourths majority vote of the entire committee, may remove any medical staff officer for conduct detrimental to the interests of the hospital, medical staff, or who is suffering from a physical or mental infirmity that renders him incapable of fulfilling the duties of the office. Notice of the meeting at which an action is to take place shall be given in writing to the officer at least ten days prior to the date of the meeting. The officer shall be afforded the opportunity to speak in his own behalf prior to the taking of any vote on his removal.
2) A medical staff member with voting privileges has the right to initiate a recall election of a medical staff officer by engaging the Conflict Resolution process defined in Article 7.
3) If the officer being recalled is the President, the President-Elect shall officiate at this special meeting and shall assume the responsibilities of the President as defined in the following section.

Section 3.6: Vacancies in Office

If there is a vacancy in the office of the President prior to the expiration of the President's term, the President-Elect shall assume the duties and authority of the President for the remainder of the unexpired term. If there is a vacancy in any other office, the Executive Committee shall appoint another Active Staff member to serve out the remainder of the unexpired term. Such appointment shall be effective when approved by the Governing Body.

Section 3.7: Meetings of the Medical Staff

1) The medical staff shall hold at least four meetings per year.
2) Special Staff Meetings:

a. Special meetings of the medical staff may be called at any time by the President of the Medical Staff, a majority of the Executive Committee, or a petition signed by not less than one-third of the voting medical staff.

b. In the event that it is necessary for the medical staff to act on a question without being able to meet, the voting membership may be presented with the question by mail or other electronic means of communication and their votes returned to the President by same.

c. Such a vote shall be valid if affirmed by a majority of the medical staff eligible to vote.

3) Quorum:
   a. A quorum for the Executive Committee of the Medical Staff shall consist of one-half the members of the Executive Committee.

   b. The presence of one-fourth of the persons eligible to vote shall constitute a quorum for any regular or special meeting of the medical staff or its designated committees.

   c. Once a quorum is assembled, the business of the meeting may continue and all actions taken shall be binding even though less than a quorum exists at a later time in the meeting.

4) Voting:
   a. Any individual who, by virtue of position, attends a meeting in more than one capacity shall be entitled to only one vote.

Article 4: Medical Staff Committees

Section 4.1: Committees of the Medical Staff

Committees of the Medical Staff are:

a. Medical Care Evaluation Committee (MCEC)
b. Credentials Committee
c. Bylaws Committee
d. Nominating Committee (Ad Hoc)

Section 4.2: Common Characteristics of Committee Meetings

1) Meeting Times: All committees shall meet at least four times per year at a time set by the chairperson of the committee. The agenda for the meeting and its general conduct shall be set by the chairperson.

2) Appointment of Committee Members: All committee chairpersons and members, unless otherwise provided for in these bylaws, shall be appointed by the President of the Medical Staff. All chairpersons shall be selected from among persons appointed to the Active Staff. Such appointments shall be made by the President for a term of 2 years. These appointments will remain in effect until new appointments are made by the incoming President. The President shall appoint another Active Staff member to complete the unexpired term of a chairperson whose position is vacated. All appointed

members may be removed and vacancies filled by the President of the Medical Staff at his discretion.

3) Urgent Issues: Each committee may report directly to the Executive Committee, for its consideration and appropriate action, any situation involving questions of the clinical competency, patient care and treatment, case management, professional ethics, infraction of hospital or medical staff bylaws, policies or rules, or unacceptable conduct on the part of any individual member to the medical staff.

4) Conflict of Interest: In any instance where a member of a committee has a conflict of interest in any matter involving another medical staff member that comes before that committee, or in any instance where a member of a committee brought the complaint against a member that committee member shall not participate in the discussion or voting on the matter and shall excuse himself from the meeting during that time. The member may be asked and may answer any questions concerning the matter before leaving.

5) Minutes: Minutes of the meetings of each committee shall be prepared and shall include a record of the attendance of members and the recommendations made. The minutes shall be signed by the chairperson and copies thereof shall be forwarded to the Executive Committee and at the same time to the CEO and certain committees as specified elsewhere in these bylaws. Each committee shall maintain a permanent file of the minutes of its meetings in the Administrative Office.

6) Special Meetings: A special meeting of any committee may be called by or at the request of the committee's chairperson, by the president, or by a petition signed by not less than one-fourth of the members of the committee (but in no event less than two (2) members).

7) Voting: In the event that it is necessary for a committee or clinical service committee to act on a question without being able to meet, the voting members may be presented with the question, in person, by mail, or electronic media and their vote returned to the chairperson of the committee. Such a vote shall be binding so long as the question is voted on by a majority of the committee eligible to vote.

8) Ex-Officio Members: The President of the Medical Staff, the CEO or their respective designees shall be members, ex-officio, on all committees.

Section 4.3: Medical Care Evaluation Committee (MCEC)

1) Composition:
The Medical Care Evaluation Committee shall consist of the directors of the clinical services. Their term shall coincide with the term of the parent committee appointment. The committee shall meet at least six times per year. The President-Elect shall be the chairperson of the committee. Other invited members of hospital committees may attend but are not members of this committee.

2) Executive Session:
Members of the MCEC Executive session are the physician chairperson and the service directors. The CEO or his designee is an ex-officio member of the MCEC Executive session and may be present at an executive session meeting. When issues arise concerning performance, competence or behavior of a medical staff member, the MCEC

will meet in executive session. All other hospital personnel will be excused for this peer review process.

3) Duties:
The MCEC shall:

   a. review, analyze and evaluate on a continuing basis the clinical performance of the medical staff and the individual members through reports received from the four Clinical Services of the medical staff and hospital committees as appropriate including, but not limited to, Infection Control Committee, Performance Improvement, Pharmacy and Therapeutics Committee, Laboratory/Blood Utilization Committee, Health Information Services Committee, Safety Committee and Utilization Review Committee and take any necessary actions based thereon.

   b. make recommendations to the Executive Committee on matters pertaining to:

      i. the establishment and enforcement of professional standards of care;
      ii. continual improvement of the quality of care; and
      iii. educational objectives for the medical staff.

   c. report after each meeting to the Executive Committee the status of medical care within the hospital.

Section 4.4: Credentials Committee

1) Composition:
The Credentials Committee shall consist of five members of the medical staff appointed for a two-year term, a chairperson appointed by the President of the Medical Staff and the directors of the four medical staff clinical services. The Credentials Committee shall meet at least four times per year or more often as necessary to fulfill its duties.

2) Executive Session:
Members of the Credentials Executive session are the physician chairperson and the service directors. The CEO or his designee is an ex-officio member of the Credentials Executive session and may be present at an executive session meeting. When issues arise concerning performance, competence or behavior of a medical staff member, the Credentials Committee will meet in executive session. All other hospital personnel will be excused for this peer review process.

3) Duties:
The Credentials Committee shall:

   a. review the credentials of all applicants for medical staff appointment and reappointment;

   b. review the credentials of all applicants who request appointment and/or privileges at the hospital as Allied Health Professionals ;

   c. make evaluation of and interview such applicants as may be necessary;

   d. review and make recommendations for approval of clinical privileges for medical staff and AHP applicants; and

e. report its findings and recommendations in accordance with the Medical Staff Procedural Policy to the Medical Staff Executive Committee.

Section 4.5: Bylaws Committee

1) Composition:
The Bylaws Committee shall consist of two (2) persons appointed from the Active Medical Staff. A representative from hospital administration shall serve on the Committee, ex-officio, without vote. The Bylaws Committee shall meet at least annually or more often as necessary to fulfill its duties.

2) Duties:
The Bylaws Committee shall:

   a. review the Bylaws of the Medical Staff, the Medical Staff Policies, and other associated documents and recommend amendments as appropriate to the Executive Committee to ensure that current medical staff practices are stated; and

   b. receive and consider all recommendations for changes in these bylaws made by the Governing Body, the Medical Staff, any committee of the medical staff, any individual appointed to the medical staff, and/or the CEO.

3) Approval Process:

   a. All recommendations for amendments, changes, rewrites, alteration or correction of the Medical Staff Bylaws shall be submitted to the Medical Staff who shall vote on the modifications.

   b. All proposed amendments of these bylaws initiated by a signed petition of 20% of the medical staff shall, as a matter of procedure, be referred to the Bylaws Committee. The Bylaws Committee shall make a recommendation on the proposed amendments and report on that recommendation at the next regular meeting of the medical staff, or at a special meeting called for such purpose.

   c. Amendments, changes, corrections, alterations or rewrites shall be voted upon at that meeting provided that copies of proposed deletions, changes or additions are given to each active staff member at least 14 days prior to the meeting.

   d. To be adopted, an amendment must receive the approval of a majority of the active medical staff, either voting at the meeting or by absentee ballot.

   e. The Medical Staff may propose, with two-thirds majority of all voting members, an amendment to the bylaws directly to the Governing Body without Executive Staff or Bylaws Committee approval.

   f. Amendments, changes, corrections, alterations or rewrites so adopted shall be effective when approved by the Governing Body.

4) Executive Committee Amendments

    a. The Executive Committee shall have the power to adopt such amendments to the bylaws as are, in the Committee's judgment, technical or legal modifications or clarifications, reorganization or renumbering, or amendments made necessary because of punctuation, spelling or other errors of grammar or expression.

    b. Such amendments shall be effective immediately after notification is given to the medical staff as provided below, and shall be permanent if not disapproved by the medical staff or the Governing Body within 60 days of adoption by the Executive Committee.

    c. The action to amend may be taken by a motion acted upon in the same manner as any other motion before the Executive Committee.

    d. Immediately upon adoption, such amendments shall be sent to the CEO and distributed to the entire medical staff.

    e. If any recommendation made by the Executive Committee is disputed by any member of the medical staff, then the conflict resolution process will be followed as described in Article 7: Conflict Resolution.

Section 4.6: Creation of Standing Medical Staff Committees

The Executive Committee of the Medical Staff may, by resolution and upon approval of the Governing Body, without amendment of these bylaws, establish additional committees to perform one or more staff functions. Committees established in these bylaws may not be altered without a two-thirds vote of the voting medical staff members followed by Governing Body approval. Any function required to be performed by these bylaws which are not assigned to a standing or special committee shall be performed by the Executive Committee.

Section 4.7: Membership on Hospital Committees

In order to further carry out the function of the medical staff and to provide medical staff input where appropriate, the President of the Medical Staff may appoint members to hospital committees which may include, but are not limited to: Infection Control, Pharmacy and Therapeutics, Lab/Blood Utilization, Health Information Services (Medical Records), Utilization Review, or other ad hoc committees of the hospital as appropriate and after consultation with the CEO.

Section 4.8: Special Committees

Special committees shall be formed and their members and chairpersons appointed by the President of the Medical Staff as required. Such committees shall confine their activities to the purpose for which they were appointed, and shall report to the Executive Committee.

Article 5: Clinical Services of the Medical Staff

Section 5.1: The Clinical Service

1) The Clinical Services are:

a. **Medical Service**
b. **Surgical Service**
c. **Family Birth Center Service**
d. **Emergency Service**

2) Sub-specialties may be organized as a section of a Clinical Service and must be directly responsible to the Clinical Service within which it functions.
3) The Medical Staff and the Governing Body by their joint action, at such time as deemed appropriate, may divide, combine, and/or delete clinical service(s) and/or sections.

Section 5.2: Common Characteristics of Clinical Service Meetings

Clinical Service meeting times, appointment of committee members, urgent issues, conflict of interest, minutes, special meetings, voting, and ex-officio members shall follow the guidelines of Common Characteristics of Committee meetings referenced in Section 4.2. The only exception is that findings of the Clinical Service meetings shall be forwarded to the MCEC for routine matters and directly to the Medical Staff Executive Committee only for matters of urgency.

Since Clinical Service responsibilities are a daily and ongoing process, the physician in charge of each service is designated as a "director" of that service and also serves as the chairperson of any meetings of the service.

Section 5.3: Functions of Clinical Services

1) Guidelines for Delineation of Clinical Privileges:
    a. Each clinical service director shall recommend to the Credentials Committee guidelines for the assignment of clinical privileges within the clinical service.
    b. Such guidelines shall be consistent with, and subject to, the bylaws, policies of the medical staff and the hospital as well as any applicable state, federal and local law.
    c. These guidelines shall become effective when approved by the Governing Body upon recommendation by the Executive Committee. Clinical privileges shall be approved based upon training, experience and demonstrated capability and competence within the specialty covered by the service.
2) Quality Review Functions:
    a. Each service shall monitor and evaluate medical care in all major clinical activities of the service. This monitoring and evaluation shall include:
        i. the routine collection of information about important aspects of patient care provided in the service and about the clinical performance of its members; and
        ii. the periodic assessment of this information to identify opportunities to improve care and to identify important problems in patient care.
    b. Each clinical service shall recommend, subject to approval and adoption by the Executive Committee and Governing Body, objective criteria that shall be used by each service or by the hospital's performance improvement program in the

monitoring and evaluation of patient care. When problems in patient care, clinical performance or opportunities to improve patient care are identified, each service shall document the actions taken and evaluate the effectiveness of such actions.

3) Reports:
    a. In discharging these functions, each Clinical Service shall report to the Medical Care Evaluation Committee its analysis of patient care and recommendations for improvement as well as any evaluation or recommended action involving any individual member of the service.
    b. Copies of these reports shall be filed with the Chief Executive Officer and shall be considered at the time of reappointment.

Section 5.4: Service Director Appointment and Terms

1) The director of each service shall be a member of the Active Staff who is qualified by training, experience, demonstrated capability and administrative ability for the position.
2) The director of each service shall be appointed by the President after consultation with the CEO and approval by the majority vote of the Executive Committee. Appointment of a chairperson shall be made for a period of two (2) years.
3) Removal of a chairperson during his term of office will be by a majority vote of the Executive Committee. Another chairperson will be appointed from the members of the Active Staff by the President of the Medical Staff to serve the remainder of the term.
4) Removal of a director can be contested by any member of the Active Staff in accordance with procedures found in the Article 7: Conflict Resolution.

Section 5.5: Service Director Responsibilities

The Clinical Service Director shall:

1) be responsible for administrative activities within the service and its integration into the hospital's primary function;
2) maintain continuing surveillance of the professional performance of all individuals who have delineated clinical privileges in the service, and report to the Credentials Committee as part of the reappointment process his or her recommendations regarding the assignment of clinical privileges in that service;
3) recommend to the Credentials Committee, criteria for clinical privileges in the service and report on members who fulfill the criteria for privileges;
4) be responsible for development, implementation, and enforcement, within the service, of the hospital policies, directives and the medical staff bylaws, and policies;
5) be responsible for implementation, within the service, of actions taken by the Governing Body and the Executive Committee;
6) recommend to the Credentials Committee the appointment, reappointment, and delineation of clinical privileges for all applicants seeking privileges in the service;
7) coordinate teaching, education and research programs in the service;

8) report and recommend to hospital management, when necessary, with respect to matters affecting patient care in the service, including personnel, staffing, supplies, space requirements, special regulations, standing orders, and other needed resources;
9) assume responsibility for the corresponding service leadership, meeting agenda, and accomplishment of the service duties as defined in the bylaws;
10) assist the hospital management in the preparation of annual reports and such budget planning pertaining to the service; and
11) establish policies under which consultation by a qualified specialist is required;

Section 5.6: Clinical Service Meetings

1) Clinical Services meetings shall occur at least four times per year at a time set by the service director to review and evaluate the clinical work of the service, to consider the findings of ongoing quality management and safety activities, and to discuss any other matters concerning the service. The agenda for the meeting and its general conduct shall be set by the service director who shall also serve as the meeting chairperson.
2) When issues of individual physician performance are concerned, the Clinical Service Director shall call an executive session and shall excuse all but the medical staff members so that peer review can be conducted. The CEO or his designee may attend this meeting.
3) If an issue of concern is identified at this executive session, as a sitting member of the Medical Care Evaluation Committee, the service director shall bring the issue to that committee for its consideration and recommendation.
4) The minutes of the full service committee will reflect that a case, identified by number, was discussed by the medical staff members in attendance. Hospital staff with the exception of the CEO, or his designate, shall not be in attendance at this specific subcommittee meeting of medical staff members held for the express purpose of peer review. The case will be reviewed by the multispecialty members of the Medical Care Evaluation Committee at their next scheduled meeting.

Article 6: Policies, Rules and Regulations of the Medical Staff

Section 6.1: Rules and Regulations

1) Medical staff policies, rules, and regulations as may be necessary to implement more specifically the general principles of conduct found in these bylaws shall be adopted in accordance with this Article. Medical Staff Policies shall have the same force and effect as these bylaws but are considered separate and distinct from these bylaws.
2) Rules and regulations may also be adopted, amended, repealed or added by a majority of the Medical Staff Executive Committee at a regular meeting (or special meeting called for that purpose) where a quorum exists following 14 days notice. All such changes shall become effective when approved by the Governing Body.

Section 6.2: Policies

1) Medical staff policies may be adopted as needed for implementation of the procedures contained within these bylaws. These policies shall set the medical appropriateness guidelines that are to be required of each individual exercising clinical privileges in the hospital and shall act as an aid to evaluating performance under, and compliance with these standards.
2) Policies may be adopted, amended or repealed by majority vote of the members of the Executive Committee present and voting at any meeting of that committee where a quorum exists.
3) Medical Staff disputes with the decision of the Executive Committee regarding a rule and/or regulation shall be resolved in accordance with procedures found in Article 7: Conflict Resolution.

Article 7: Conflict Resolution Process

Section 7.1: Purpose

The purpose of this section is to define the process whereby a disagreement between the organized Medical Staff and a medical staff committee can be resolved by the voting members of the medical staff. The Executive Committee, MCEC, Credentials Committee, and Bylaws Committee, while acting on behalf of the Medical Staff, cannot propose bylaws, rules, regulations, etc. that are in conflict with the wishes of the Medical Staff as a whole.

Section 7.2: Process

1) The committees of the Medical Staff shall represent the will of the Medical Staff as a whole and shall consider any rule, regulation, bylaw or bylaw change, submitted by any member of the Medical Staff. If that decision to accept or reject the proposal is in dispute, then a special meeting of the Medical Staff as a whole shall be called by the President of the Medical Staff providing 20% of the voting members have signed a petition asking for such a meeting.
2) Notification of this meeting shall be communicated to the voting members of the Medical Staff by correspondence or electronic media at least 14 days prior to the meeting.
3) Only the matter in dispute shall be discussed at this meeting and no other business transacted or decisions made.
4) After appropriate discussion, a vote will be taken of all voting members of the medical staff whether present or absent. Voting shall be by attendance at the meeting, correspondence, or electronic media. Two-thirds of the voting members shall decide whether the matter at hand shall be passed and sent to the Governing Body if appropriate. The decision of the Medical Staff shall take priority over any committee decision regarding these bylaws, changes, amendments or approval and enforcement of Medical Staff Policies.

5) Approval or disapproval of the matter at hand will be directly conveyed to the CEO and the hospital Governing Body by the President without the need for further Executive Staff, MCEC, Bylaws Committee, or Credentials Committee approval.

Credentialing Manual

Article 1: Definitions

The definitions listed in the Organization and Structure of the Medical Staff manual are the same for the Credentials and Fair Hearing Manuals. See Article 1 of that manual. Definitions unique to the Credentialing Manual are:

- **State Designated Application Forms**

  The State designated application form refers to the State of Illinois Health Care Professional Credentialing (Recredentialing) and Business Data Gathering Form, as authorized by the Healthcare Professional Credentials Data Collection Act (410 ILCS517) and the Healthcare Professional Credentials Data Collection Code (77 Illinois Administrative Code 965.110) and incorporated herein by reference.

- **Hospital and its Authorized Representatives**

  The hospital corporation and any of the following individuals who have any responsibility for obtaining or evaluating the individual's credentials, or acting upon the individual's application or conduct in the hospital: members of its Governing Body and their appointed representatives; the Chief Executive Officer or his designees; the President of the Medical Staff; other hospital employees; consultants to the hospital; the hospital's attorney and his or her partners, associates or designees; and all members of the medical staff who have any responsibility for obtaining or evaluating the individual's credentials, or acting upon his application or conduct in the hospital.

- **Third Parties**

  All individuals, including members of the hospital's medical staff, and members of the medical staffs of other hospitals or other physicians or health practitioners, nurses or other organizations, associations, partnerships and corporations or government agencies, whether hospitals, health care facilities or not, from whom information has been requested by the hospital or its authorized representatives.

The Credentialing Manual is part of the Bylaws of the Medical Staff of St. Francis Hospital.

Article 2: Appointment to the Medical Staff

Section 2.1: General

Appointment to the medical staff is a privilege which shall be extended only to professionally competent individuals who continuously meet the qualifications, standards and requirements set forth in this manual and in such policies as are adopted from time to time by the Governing Body. All individuals practicing medicine, dentistry, and podiatry, in this hospital, unless exempted by specific provisions of the bylaws and this manual, must first have been appointed to the medical staff.

Section 2.2: Clinical Privileges

Medical staff appointment or reappointment shall not confer any clinical privileges or right to practice in the hospital. Each individual who has been given an appointment to the medical staff of the hospital shall be entitled to exercise only those clinical privileges specifically granted by the Governing Body, except as stated in policies adopted by the Governing Body. The clinical privileges recommended to the Governing Body shall be based upon the applicant's:

a. Education;
b. residency training relative to the requested privileges;
c. ongoing training and education;
d. experience;
e. demonstrated current competence and judgment;
f. references;
g. utilization patterns;
h. peer review findings;
i. health status;
j. availability of qualified medical coverage;
k. adequate levels of professional liability insurance coverage;
l. the hospital's available resources and personnel;
m. the requested privileges being within the recognized scope of the individual's specialty and training; and
n. other relevant information, including findings by the service director of each clinical service in which such privileges are sought.

The applicant shall have the burden of establishing his qualifications for and competence to exercise the clinical privileges he requested. The reports of the clinical service in which privileges are sought shall be forwarded to the Credentials Committee and thereafter processed as a part of the initial application for staff appointment.

Section 2.3: Specific Qualifications

Only physicians, dentists, and podiatrists, who satisfy the following conditions, shall be qualified for appointment to the medical staff:

1) current license to practice in this state;
2) current, valid professional liability insurance coverage in such form and in amounts satisfactory to the Governing Body; and
3) documentation of:
    a. completion of residency training (for physicians);
    b. adherence to the ethics of their profession;
    c. good reputation and character, including the applicant's mental and emotional stability;

d. current health status;

e. ability to work harmoniously with others sufficiently to convince the hospital that all patients treated by them in the hospital shall receive quality care and that the hospital and its medical staff shall be able to operate in an orderly manner; and

f. background, experience, training and demonstrated capability and competence.

Section 2.4: No Entitlement to Appointment

No individual shall be entitled to appointment to the medical staff or exercise clinical privileges in the hospital by virtue of the fact that such individual:

1) is licensed to practice his profession in this or any other state;
2) is a member of any particular professional organization; or
3) has had in the past, or currently has, medical staff appointment or privileges in this or another hospital.

Section 2.5: Non-Discrimination Policy

No individual shall be denied appointment on the basis of sex, religion, race, creed, national origin, or physical handicap that does not conflict with requested privileges.

Section 2.6: Ethical and Religious Directives

All medical staff appointees and others exercising clinical privileges in the hospital shall abide by the terms of the most current edition of the Ethical and Religious Directives for Catholic Health Facilities promulgated by the National Conference of Catholic Bishops. No activity prohibited by said Directives shall be engaged in by any medical staff member or any other person when exercising clinical privileges at this hospital.

Section 2.8: Focused Professional Practice Evaluation (FPPE)

The FPPE is completed for new medical staff applicants, current medical staff members requesting additional privileges or when patterns, trends, outliers or issues have been identified during department/committee reviews.

Section 2.9: Rights and Responsibilities of Appointees

Appointment to the medical staff shall require that each appointee assume such reasonable duties and responsibilities as the Governing Body or the medical staff shall require.

Article 3: Application for Initial Appointment

Section 3.1: Application

Applications for appointment to the medical staff shall be in writing, and shall be submitted on forms designated by the State of Illinois and on supplemental forms approved by the Governing Body upon recommendation of the Executive Committee. These forms shall be obtained from the Medical Staff Office and after completion, submitted to the Medical Staff Office for processing. The signed application and supplemental forms 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 including:

1) the names and complete addresses of at least two physicians (for physician applicants), or two dentists (for dentist applicants), or two podiatrists (for podiatrist applicants), or other practitioners as appropriate, who have had recent extensive experience in observing and working with the applicant and who can provide information pertaining to the applicant's medical/clinical knowledge, technical and clinical skills, clinical judgment, interpersonal/communication skills and present professional competence and character. At least one reference shall be from the same specialty area as the applicant;
2) Post-graduate training, including
    a. the name and address of each institution, degrees granted, programs completed, dates attended;
    b. the names and address of practitioners responsible for the applicant's performance evaluations;
    c. Names and address of residency chairpersons and at least one other contact person of each residency or department of any and all hospitals or other institutions at which the applicant has worked or trained;
    d. Any specialty or subspecialty board certifications, recertification and/or eligibility; and
    e. Information requested will be the same as that referenced in Section 3.1 1) above. (If the number of hospitals the applicant has worked in is great or if a number of years have passed since the applicant worked at a particular hospital, the Credentials and Executive Committees and the Governing Body may take into consideration the applicant's good faith effort to produce this information)
3) information as to whether the applicant's medical staff appointment or clinical privileges have ever been revoked, suspended, reduced, voluntarily withdrawn, sanctioned, probated, reprimanded or monitored in any way or not renewed at any other hospital or health care facility;
4) information as to whether the applicant has ever withdrawn his application for appointment, reappointment or clinical privileges, or resigned from the medical staff before final decision is reached regarding an adverse action by a hospital's or health care facility's governing board;
5) all current medical, dental or other professional licensures or certifications and drug enforcement administration licenses including the dates and numbers of each as well as:
    a. information as to whether the applicant's membership in local, state or national professional societies or his license to practice any profession in any state, or his Drug Enforcement Administration license has ever been suspended, modified or terminated;
    b. if applicable, a copy of the Illinois Controlled Substance Registration;
    c. all the applicant's current licenses to practice;
    d. a copy of Drug Enforcement Administration license;
    e. medical, dental or podiatric school diploma; and

f. certificates from all post graduate training programs completed.

6) a procedural log listing all procedures that have been performed during training or in the past two years of practice that support the requirement for training and experience for those procedures requested in the application process. Each procedure shall identify whether the applicant was the primary provider of the procedure or was the assistant during the procedure.

7) information as to whether the applicant has currently in force professional liability insurance coverage, the name of the insurance company and the amount and classification of such coverage;

8) information concerning applicant's malpractice litigation experience including past or pending cases and including any information of all settled cases without litigation;

9) the nature and specifics of any pending or completed actions involving the denial, revocation, suspension, reduction, limitation, probation, withdrawal, non-renewal or voluntary relinquishment (by resignation or expiration) of:

   a. licenses or certificates to practice any profession in any state or country,

   b. drug enforcement administration or other controlled substances registrations;

   c. memberships or fellowships in local, state or national professional organizations;

   d. specialty or subspecialty board certifications,

   e. faculty memberships at any medical or other professional schools;

   f. staff membership status, or clinical privileges at any other hospital, clinic or health care institution.

10) all reports to the National Practitioners Data Bank;

11) information on the applicant's current physical and mental health status;

12) information as to whether the applicant has ever been named as a defendant in a criminal action, details about any such instance and any disposition thereof as well as any criminal charges pending against the applicant;

13) A copy of a valid government-issued photo identification issued by a state or federal agency (e.g., driver’s license or passport).

14) information on the citizenship and visa status of the applicant;

15) payment of the nonrefundable application processing fee; and

16) such other information as the Executive Committee or the Governing Body may require.

In addition to providing the above information, the applicant shall additionally sign forms allowing representatives of the Medical Staff Office or Credentials Committee permission:

1) to inspect records and documents pertinent to his/her licensure, specific training, experience, current competence, and/or health status;

2) to allow the release of information from the applicant's present and past professional liability insurance carriers;

3) to allow any and all references identified above to speak freely and without reservation or threat of retribution regarding the training, experience, competency and demonstrated capability of procedures performed as well as issues of moral, professional, and ethical natures.

The applicant must sign attestation statements:

1) that the applicant has received and had an opportunity to read a copy of the Medical Staff Bylaws, policies, rules and regulations of the medical staff in force at the time of his application and that the applicant has agreed to be bound by the terms thereof in all matters relating to consideration of his application without regard to whether or not he is granted appointment to the medical staff or clinical privileges;

2) of his willingness to appear for personal interviews in regard to his application;

3) that any misrepresentation or misstatement in, or omission from the application whether intentional or not, may constitute cause for automatic and immediate rejection of the application resulting in denial of appointment and clinical privileges. In the event that an appointment has been granted prior to the discovery of such misrepresentation, misstatement or omission, such discovery may result in summary dismissal from the medical staff;

4) that the applicant shall:

   a. refrain from fee-splitting or other inducements relating to patient referral;

   b. abide by generally recognized ethical principles applicable to his profession;

   c. provide continuous care for his patients in the hospital and refrain from delegating responsibility for diagnosis or care of hospitalized patients to any individual who is not qualified to undertake this responsibility or who is not adequately supervised;

   d. abide by the terms of the Ethical and Religious Directives for Catholic Health Facilities promulgated by the National Conference of Catholic Bishops and perform no activity prohibited by said Directives, and agrees that no activity prohibited by said Directives shall be engaged in when exercising clinical privileges at this hospital.

   e. abide by all bylaws, policies, and procedures of the hospital, including all bylaws, policies, rules and regulations of the medical staff as shall be in force during the time the applicant is appointed to the medical staff;

   f. accept committee assignments and such other reasonable duties and responsibilities as shall be assigned by the President of the Medical Staff to the applicant after appointment by the Governing Body;

   g. submit any reasonable evidence of current health status that may be requested by the Executive Committee of the medical staff;

h. refrain from deceiving patients as to the identity of an operating surgeon or any other individual providing treatment or services; and

i. agree to admit and care for patients during their hospital stay who have been admitted from the Emergency Department who do not have a physician on staff. Such patients shall be admitted with consideration of the physician's area of specialty and expertise.

5) agree to abide by all privacy, security and confidentiality guidelines including Health Insurance Portability and Accountability Act (HIPAA) standards.

6) submit to the Chief Executive Officer any change in information, corrections, updates, or modifications to the physician's or healthcare professional's credentials data on file with the Hospital within five (5) business days. Such reports shall be made on the State of Illinois mandated Healthcare Professional Update Data Gathering Form.

Section 3.2: Burden of Providing Information

1) The applicant has the ongoing responsibility of producing timely, accurate and complete information for a proper and thorough evaluation of the information requested in the application or satisfying any requests for clarification or additional information concerning same and resolving any doubts concerning same.

2) The applicant shall have the burden of producing adequate information for a proper evaluation of his or her competence, character, ethics and other qualifications, and of resolving any doubts about such qualifications.

3) The applicant shall have the burden of providing evidence that all the statements made and information given on the application are true and correct.

Until the applicant has provided all information requested by the hospital, the application shall be deemed incomplete and shall not be processed.

Section 3.3: Authorizations

By applying for appointment, reappointment or clinical privileges, the applicant expressly accepts these conditions during the processing and consideration of his application, whether or not he is granted appointment or clinical privileges. The following statements, which shall be included on the Medical Staff Credentialing Application, Attestation, Agreement and Release application form, are expressed conditions applicable to any medical staff applicant, any appointee to the medical staff and to all others having or seeking clinical privileges in the hospital.

- **Immunity:**

  To the fullest extent permitted by law, the individual releases from any and all liability, and extends absolute immunity to the hospital, its authorized representatives and any third parties as defined below, with respect to any acts, communications or documents, recommendations or disclosures involving the individual, concerning the following:

  a. applications for appointment or clinical privileges, including temporary privileges;

  b. evaluations concerning reappointment or changes in clinical privileges;

c. proceedings for suspension or reduction of clinical privileges or for revocation of medical staff appointment, or any other disciplinary sanction;

d. summary suspension;

e. hearings and appellate reviews;

f. medical care evaluations;

g. utilization reviews;

h. other activities relating to the quality of patient care or professional conduct;

i. matters or inquiries concerning the individual's professional qualifications, credentials, clinical competence, character, mental or emotional stability, physical condition, ethics, or behavior;

j. any other matter that might directly or indirectly affect on the individual's competence, on patient care, or on the orderly operation of this or any other hospital or health care facility; and

k. information obtained from an inquiry of the National Practitioner's Data Bank.

The foregoing shall be privileged to the fullest extent permitted by laws. Such privilege shall extend to the hospital and its authorized representatives, and to any third parties.

- **Authorization to Obtain Information:**

  The individual specifically authorizes the hospital and its authorized representatives to consult with any third party who may have information bearing on the individual's professional qualifications, credentials, clinical competence, character, mental or emotional stability, physical condition, ethics, behavior or any other matter reasonably having a bearing on the individual's satisfaction of the criteria for initial and continued appointment to the medical staff. This authorization also covers the right to inspect or obtain any and all communications, reports, records, statements, documents, recommendations or disclosures of said third parties that may be relevant to such questions. The individual also specifically authorizes said third parties to release said information to the hospital and its authorized representatives upon request.

- **Authorization to Release Information:**

  Similarly, the individual specifically authorizes the hospital and its authorized representatives to release such information to other hospitals, health care facilities and their agents, who solicit such information for the purpose of evaluating the applicant's professional qualifications pursuant to the applicant's request for appointment or clinical privileges.

Article 4: Application Process

Section 4.1: Application Process

The completed and signed application form shall be submitted to the Medical Staff Office, who shall be responsible for verifying the information contained in the application. Upon verifying the application information, the Medical Staff Office in conjunction with the Medical Staff President, shall make a determination as to whether or not the information contained in the application meets the criteria for eligibility to apply for medical staff membership or advanced practice professional privileges as contained herein. If a determination is made that the application fails to satisfy the criteria, the Medical Staff Office shall provide the applicant with written notice of same, which shall include an explanation of the reasons for the determination. The determination should be made and the applicant notified within 60 days of receipt of the completed application form. The right to a fair hearing as outlined in the Credentialing Manual and Fair Hearing Plan shall apply to the applicant.

Section 4.2: Criteria for Evaluating a Applicant's Qualifications

The criteria considered in evaluating an applicant's qualifications for medical staff membership or privileges shall include but is not limited to:

1) need in the Hospital service area for additional practitioners in the specialty of the applicant, and ability to accommodate additional practitioners.
2) the existence of an exclusive contract for services in the specialty of the pre-applicant.
3) failure to provide current state or DEA licensure information or professional liability insurance with limits required by the Hospital or any information requested in the application process.
4) health issues that affect the pre-applicant's ability to practice his or her profession.
5) conviction of a felony.
6) prior or current actions involving denial, revocations, suspension, limitation, probation, withdrawal, non-renewal or voluntary relinquishment of any license or medical staff membership privilege, or other relevant information.
7) ethical, moral or other activities or behavior inconsistent with the mission of the Hospital.
8) adequacy of alternate/coverage arrangements.
9) the hospital's ability to provide bed, equipment and support facilities for the applicant's specialty or for the additional pre-applicant.
10) the hospital's long term goals and objectives.

Section 4.3: Submission of Application

After the hospital application and state designated application forms are accepted, determined complete and the application fee paid, the Medical Staff Office shall establish and maintain a separate credentialing file for each applicant and process the application in accordance with the following (An incomplete application shall not be processed):

1) The Medical Staff Office shall direct an inquiry:

a. to the National Practitioner's Data Bank requesting information regarding the applicant for appointment;

b. to the Director of the Department of Professional Regulation and the Illinois Controlled Substance Registration concerning the licensure/registration status and any disciplinary action taken against the applicant;

c. confirming liability insurance in amounts and form acceptable to the Governing Body;

d. Drug Enforcement Administration license if appropriate;

e. the Centers for Medicare and Medicaid Services (CMS) list of providers excluded from Medicare (Office of the Inspector General [OIG] List of Excluded Individuals and Excluded Entities). The above listed inquiries are obtained through the Catholic Healthcare Audit Network (CHAN)

f. criminal background check; and

g. letters of verification, references, and other information or materials deemed pertinent.

2) Applicants with privileges at another Joint Commission accredited institution may enter into an agreement with the Hospital if a Credential Verification Organization (CVO) Agreement exists that would allow the institution to provide its documentation verifying the applicant's credentials. This requires that the applicant complete an original application for appointment to the Hospital's medical staff, complete the appropriate Hospital Request for Privileges form, and pay the application fee. The applicant's submission of these documents and the Hospital's receipt of documentation verifying the applicant's credentials from another accredited institution will not necessarily constitute a complete application nor does it guarantee approval of the privileges at this Hospital. The Medical Staff Office and the Credentials Committee may require additional information.

3) After the Medical Staff Office determines the application to be complete, the application and all supporting materials will be transmitted to the Credentials Committee for evaluation at its next regularly scheduled meeting.

Section 4.4: Initial Credentials Committee Procedure

Upon receipt of the completed state designated application form and supplemental forms for appointment, the Credentials Committee shall inform the service director of each clinical service in which the applicant seeks clinical privileges of the pending application, request review of said application and a report of his findings. When appropriate, the chairperson of the Credentials Committee shall consult with a member of the medical staff in the same subspecialty as the applicant about the privileges requested in that subspecialty.

Section 4.5: Service Director Procedure

The service director of each clinical service in which the applicant seeks clinical privileges shall provide the Credentials Committee with specific written approval or disapproval of the requested privileges. This assessment shall be made a part of the Credentials Committee's report. As part

of the process of making this report, the service director has the right to meet with the applicant to discuss any aspect of his application, his qualifications and his requested clinical privileges.

Section 4.6: Subsequent Credentials Committee Procedure

1) The Credentials Committee shall examine all evidence of the applicant's character, professional competence, qualifications, prior behavior and ethical standing and shall determine, through information contained in references given by the applicant and from other sources available to the committee, including an appraisal from the service director of each clinical service in which privileges are sought, whether the applicant has established and satisfied all of the necessary qualifications for the requested clinical privileges.
2) As part of this process, the Credentials Committee may:
    a. require a physical and mental examination of the applicant, relating to the applicant's requested scope of practice, by a physician or physicians satisfactory to the Committee and shall require that the results be made available for the Committee's consideration;
    b. require the applicant to meet with the Committee to discuss any aspect of the applicant's application or qualifications, or to discuss the clinical privileges requested by the applicant; and
    c. request additional information from the applicant to clarify issues that may arise from the Committee's review of the application.
3) At the next regularly scheduled meeting of the Credentials Committee following receipt of the completed application, the Committee shall make a written report of its findings to the Executive Committee with respect to whether:
    a. the applicant be appointed to the medical staff;
    b. the application deferred for further consideration;
    c. the application be rejected.
4) If, after considering the report of each service director concerned, the Credentials Committee recommends appointment to the medical staff, the Committee may suggest temporary clinical privileges for important or urgent patient care needs. The CEO, acting on behalf of the Governing Body and after consultation with the President of the Medical Staff, may authorize temporary privileges until the next regularly scheduled meeting of the Medical Staff Executive Committee. The Executive Committee may recommend continuing temporary privileges until considered by the next regularly scheduled meeting of the Governing Body, at which time a final determination is made.
5) The chairperson of the Credentials Committee or his designee shall be available to the Executive Committee to answer any questions that may be raised with respect to the recommendation.
6) If the report of the Credentials Committee is delayed longer than 90 days, the chairperson of the Credentials Committee shall send a letter to the applicant, with a copy to the

Executive Committee and the Chief Executive Officer, explaining the delay. In no case will the report of the Credentials Committee be delayed beyond 120 days.

Section 4.7: Executive Committee Procedure

At the next regularly scheduled meeting of the Executive Committee after its receipt of the Credentials Committee's report, the Executive Committee shall consider the report and make a written recommendation to the Governing Body stating:

a. that the applicant be appointed to the medical staff;

b. that the application be deferred for further consideration;

c. that the application for appointment and/or for some or all of the clinical privileges requested be rejected; or

d. that the application be referred back to the Credentials Committee for further consideration.

Section 4.8: Subsequent Action on the Application

1) When favorable to the applicant, the recommendation of the Executive Committee shall be promptly forwarded, together with all supporting documentation, to the Governing Body. All recommendations to appoint will specifically recommend the clinical privileges to be granted, which may be qualified by any probationary conditions relating to such clinical privileges. The Governing Body, at its next regularly scheduled meeting, will review and act on the Executive Committee's report.

2) When the recommendation of the Executive Committee is to defer the application for further consideration or when the Executive Committee refers the application back to the Credentials Committee, it must be followed up within 90 days by a subsequent recommendation to the Governing Body for either appointment to the medical staff with specified clinical privileges and conditions if any, or for rejection of the application for staff appointment.

3) When the recommendation of the Executive Committee would entitle the applicant to a hearing pursuant to these Bylaws, it shall be forwarded to the Chief Executive Officer who shall promptly notify the applicant in writing with return receipt requested. The application will be held by the Medical Staff Office until after the applicant has exercised or has been deemed to have waived his right to a hearing, after which the application and supporting documentation shall be forwarded by the Executive Committee, together with the application and all supporting documentation, to the Governing Body.

Article 5: Clinical Privileges for Podiatrists and Dentists

1) The scope and extent of surgical procedures that a podiatrist/dentist may perform in the hospital shall be delineated and reported in the same manner as other clinical privileges. Surgical procedures performed by podiatrists/dentists shall be under the overall supervision of the service director of surgery.

2) A medical history and physical examination of the patient shall be made and recorded by a physician member of the medical staff or qualified advanced practice provider credentialed as such before podiatric/dental surgery shall be scheduled.
3) A designated medical staff physician shall be responsible for the medical care of the patient throughout the period of hospitalization.
4) The podiatrist/dentist shall be responsible for the podiatry/dental care of the patient, including the podiatry/dental history and physical examination as well as all appropriate elements of the patient's record. Podiatrists/dentists may write orders within the scope of their license.

Article 6: Procedure for Temporary Clinical Privileges

Section 6.1: Temporary Privileges

The CEO, or designee, acting on behalf of the Board and based on the recommendation of the President of the Medical Staff or designee, may grant temporary privileges. Temporary privileges may be granted in circumstances discussed below.

- **Important Patient Care, Treatment or Service Need:**

  Temporary privileges may be granted on a case by case basis when an important patient care treatment or service need exists that mandates an immediate authorization to practice, for a limited period of time, not to exceed 120 calendar days. When granting such privileges the Medical Staff Office verifies current licensure and current liability insurance coverage.

- **Complete Application Awaiting Approval:**

  When an initial complete application raises no concerns, temporary privileges may be granted for up to 120 calendar days when the new applicant for medical staff membership and/or privileges is waiting for review and recommendation by the Executive Committee and approval by the Board. Criteria for granting temporary privileges in these circumstances include the applicant providing evidence of the following which has been verified by the Medical Staff Office:

  a. current licensure;
  b. education training and experience;
  c. current competence;
  d. current DEA (if applicable);
  e. current professional liability insurance in the amount required;
  f. malpractice history;
  g. one positive reference specific to the applicant’s competence from an appropriate medical peer;
  h. ability to perform the privileges requested;

i. a query to the Catholic Healthcare Audit Network (CHAN)

j. results from a query to the National Practitioner Data Bank.

Additionally, the application must not have any concerns as defined by the Medical Staff.

Section 6.2: Special Requirements

Special requirements of supervision and monitoring may be imposed by the service director concerning any individual granted temporary clinical privileges. Temporary privileges shall be immediately terminated by the Chief Executive Officer or his designee upon notice of any failure by the individual to comply with such special conditions.

Section 6.3: Termination of Temporary Clinical Privileges

1) The Chief Executive Officer, or, in his absence, his designee, may at any time, after receiving a recommendation from the President of the Medical Staff or a service director responsible for the individual's supervision, terminate an individual's supervision, and/or terminate an individual's temporary admitting privileges. Clinical privileges shall then be terminated when the physician's inpatients are discharged from the hospital. However, where it is determined that the care or safety of such patients would be endangered by continued treatment by the individual, a summary termination of temporary clinical privileges may be imposed by the Chief Executive Officer, or President of the Medical Staff, and such termination shall be immediately effective.

2) The President of the Medical Staff, shall assign to a medical staff member responsibility for the care of such terminated individual's patients until they are discharged from the hospital, giving consideration whenever possible to the wishes of the patient in the selection of the substitute.

3) Temporary privileges shall be automatically terminated at such time as the Executive Committee has an unfavorable recommendation with respect to the applicant's appointment to the staff. At the Executive Committee's discretion, temporary clinical privileges shall be modified to conform to the recommendation of the Executive Committee that the applicant be granted different permanent privileges from the temporary privileges.

4) Appeal to the decision to terminate or modify temporary privileges may be invoked by the applicant according the Fair Hearing Plan section of these bylaws. The summary termination of any privileges whether temporary or otherwise shall be deemed a reportable event and reported to the NPDB. The medical staff member may then request a fair hearing appeal to contend the decision. If the decision is modified, then a "Revision to Action" report will be filed with the NPDB as necessary at a later date. Failure to request appeal to the decision within 30 days shall constitute acknowledgement by the applicant of the decision and his waiving the appeals process.

Section 6.4: Emergency Clinical Privileges

- **Disaster Privileges:**

1) If the institution's Disaster Plan has been activated and the organization is unable to meet immediate patient needs, the CEO and other individuals as identified in the institution's Disaster Plan with similar authority, may, on a case by case basis consistent with medical licensing and other relevant state statutes, grant disaster privileges to selected physicians, dentists, podiatrists, and advanced practice providers. These practitioners must present a valid government-issued photo identification issued by a state or federal agency (e.g., driver's license or passport) and at least one of the following:
    a. current picture hospital ID card that clearly identifies professional designation;
    b. current license to practice;
    c. primary source verification of the license;
    d. identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT), or Medical Reserve Corps (MRC), Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP), or other recognized state or federal organizations or groups;
    e. identification indicating that the individual has been granted authority to render patient care, treatment, and services in disaster circumstances (such authority having been granted by a federal, state, or municipal entity); or
    f. identification by a current hospital or medical staff member who possesses personal knowledge regarding the volunteer's ability to act as a licensed independent practitioner during a disaster.
2) The medical staff will use a mechanism (i.e. ID badge) to readily identify volunteer practitioners who have been granted disaster privileges.
3) The medical staff will oversee the professional performance of volunteer practitioners who have been granted disaster privileges by direct observation, mentoring, or clinical record review. The President of the Medical Staff will make a decision (based on information obtained regarding the professional practice of the volunteer) within 72 hours whether disaster recovery privileges should be continued.
4) Primary source verification of licensure begins as soon as the immediate situation is under control, and is completed within 72 hours from the time the volunteer practitioner presents to the organization. If primary source verification cannot be completed in 72 hours, there will be documentation of the following:
    a. why primary source verification could not be performed in 72 hours;
    b. evidence of a demonstrated ability to continue to provide adequate care, treatment, and services; and
    c. an attempt to rectify the situation as soon as possible.

5) Once the immediate situation has passed and such determination has been made consistent with the institution's Disaster Plan, the practitioner's disaster privileges will terminate immediately.

6) Any individual identified in the institution's Disaster Plan with the authority to grant disaster privileges shall also have the authority to terminate disaster privileges. Such authority may be exercised in the sole discretion of the CEO (or his designate) and will not give rise to a right to a fair hearing or an appeal.

- **Emergency Privileges**

1) In an emergency involving a particular patient, a physician currently appointed to the medical staff may be permitted by the hospital to act in such emergency by exercising clinical privileges not specifically assigned to him.

2) When the emergency situation no longer exists, such physician must request the temporary privileges necessary to continue to treat the patient. In the event such temporary privileges are denied or the physician does not request such privileges, the patient shall be assigned by the President of the Medical Staff or his designee to an appropriate physician currently appointed to the medical staff. The wishes of the patient shall be considered in the selection of a substitute physician.

3) For the purpose of this section, an "emergency" is defined as a condition which could result in serious or permanent harm to a patient or in which the life of a patient is in immediate danger and any delay in administering treatment would add to that harm or danger.

Article 7: Privileges for Allied Health Professionals (AHP)

Section 7.1: Advanced Practice Providers and Surgical Providers

- **Selection Procedure**

1) To the extent the Governing Body determines to permit such AHP's to act in the hospital, the Credentials Committee shall present to the Executive Committee findings concerning the scope of each such individual's activities within the hospital. The Executive Committee shall in turn present to the Governing Body recommendations concerning the same.

2) Each AHP shall have a supervising member of the medical staff who shall be responsible for the activity, exercise of privileges and supervision of those privileges when applying for clinical privileges. The privileges of an AHP shall fall within the privilege list of the supervising medical staff member and are subject to the same requirements for documentation of training, experience, competence and demonstrated ability as those medical staff members with clinical privileges.

3) No such individual shall provide services in the hospital as an AHP unless and until the Credentials Committee has received on a form approved by the Governing Body, sufficient information about the qualifications of that individual to permit the

Credentials Committee to make findings concerning the scope of activities the individual shall be permitted to undertake in the hospital. The form shall be prepared in consultation with the individual's supervising medical staff member and signed by both. The applicant remains solely responsible for any omissions or errors in the application and must respond accordingly to those.

4) The Executive Committee, based on the findings of the Credentials Committee, shall recommend to the Governing Body a written delineation of the scope of activities each AHP is permitted to undertake in the hospital. The supervising medical staff member shall have the opportunity to appear before the Credentials Committee and discuss the proposed delineation before any final action is taken on it by the Governing Body. The AHP may act in the hospital pursuant to the approved delineation only so long as the supervising medical staff member maintains appointment in good standing to the medical staff.

- **Conditions of Practice**

1) AHP's shall be subject to the provisions of this Plan governing initial appointment, reappointment, and investigations and shall only engage in acts within the scope of practice specifically granted by the Governing Body. An AHP and his/her supervising medical staff member have a right to a hearing and appeal as described in the Fair Hearing Plan portion of these bylaws.

2) AHP's shall not be entitled to any other rights, privileges, and responsibilities of appointment to the medical staff.

3) Any activities permitted by the Governing Body to be done in the hospital by AHP's shall be done only under the supervision of his supervising medical staff member. However, "supervision" shall not require the actual physical presence of the supervisor. Should any hospital employee who is licensed or certified by the state have any question regarding the clinical competence or authority of the AHP either to act or to issue instructions outside the physical presence of the supervising medical staff member shall require the AHP's supervisor validate, either at the time or later, the instructions of the AHP. Any act or instruction of the AHP shall be delayed until such time as the hospital employee can be certain that the act is clearly within the scope of the AHP's activities as permitted by the Governing Body.

4) The number of AHP's supervised by a medical staff member, as well as the acts they may undertake, shall be consistent with applicable state statutes and regulations, the Medical Staff Policies and the policies of the Governing Body.

5) It shall be the responsibility of AHP's to provide evidence of professional liability insurance covering him in amounts required by the Governing Body. An AHP shall act in the hospital only while such coverage is in effect.

Article 8: Reappointment and Actions Affecting Medical Staff Members and APP's

Section 8.1: Procedure for Reappointment

- **Application for Medical Staff Reappointment**

1) Each current medical staff member who wishes to be reappointed to the medical staff shall be responsible for completing the state designated reappointment application form, supplemental application forms, and submitting the nonrefundable application processing fee. The reappointment application shall be submitted to the Chief Executive Officer or his designee at least three months prior to the expiration of the appointee's then current appointment. Failure to submit an application by that time may result in automatic expiration of the appointee's appointment and clinical privileges at the end of the appointee's then current appointment period. A separate credentialing file shall be maintained for each applicant for reappointment in the Medical Staff Office.
2) The Chief Executive Officer shall direct an inquiry to the National Practitioner's Data Bank requesting information regarding the applicant for reappointment; additionally, a request shall be made of the Office of the Inspector General (OIG) list of Excluded Individual/Entities, Director of the Department of Professional Regulation, information concerning the licensure status and any disciplinary action taken against the applicant. A professional reference questionnaire shall be forwarded to relevant hospitals, medical clinics, and other healthcare organizations where the applicant has or had clinical privileges to verify medical staff status and performance. After receiving the above information, confirmation of liability insurance, Drug Enforcement Administration license if appropriate, and other information or materials deemed pertinent, the Chief Executive Officer or his designee shall determine the application to be complete and transmit the application and all supporting materials to the Credentials Committee for evaluation at its next regularly scheduled meeting.
3) Reappointment, if granted, shall be for a period of not longer than two years. If an application for reappointment is filed and complete but the Governing Body has not acted on it prior to the expiration of the appointee's current appointment, the appointee's may be granted temporary privileges for important patient care until such time as the Governing Body acts on the reappointment application but in no case longer than 90 days.
4) Applicants with privileges at another Joint Commission accredited institution may enter into an agreement with the Hospital if a Credential Verification Organization (CVO) Agreement exists that would allow the institution to provide its documentation verifying the applicant's credentials. This requires that the applicant complete an original application for appointment to the hospital's medical staff, complete the appropriate Hospital Request for Privileges form, and pay the application fee. The applicant's submission of these documents and the hospital's receipt of documentation verifying the applicant's credentials from another accredited institution will not necessarily constitute a complete application nor does it guarantee

approval of the privileges at this hospital. The Medical Staff Office and the Credentials Committee may require additional information.

- **Factors to be Considered**

Each recommendation concerning reappointment of a person currently appointed to the medical staff or a change in staff category, where applicable, shall be based upon such appointee's:

a. ethical behavior, clinical competence and clinical judgment in the treatment of patients;

b. compliance with the hospital bylaws and policies and with the medical staff bylaws, policies, and rules and regulations;

c. behavior in the hospital, including cooperation with medical and hospital personnel as it related to patient care or the orderly operation of this hospital, and general attitude toward patients, the hospital and its personnel;

d. use of the hospital's facilities for his patients, taking into consideration the individual's comparative utilization patterns;

e. physical and mental health;

f. capacity to satisfactorily treat patients as indicated by the results of the hospital's performance improvement activities or other reasonable indicators of continuing qualifications;

g. satisfactory completion of such continuing education requirements as may be imposed by law, this hospital or applicable accreditation agencies; and

h. other relevant findings from the hospital's performance improvement or medical staff monitoring activities.

- **Clinical Service Approval Procedure**

1) Following receipt of the completed reapplication, The Medical Staff Office shall transmit to the service director of each service in which the appointee seeks clinical privileges, copies of the requested clinical privileges, those presently held by the applicant and a copy of their application.

2) Not later than 30 days after he receives the application, the service director of each service shall submit specific written approval or disapproval of the requested privileges for each individual seeking reappointment in the same medical staff category with the same clinical privileges the applicant then holds. In addition, the service director shall submit specific written approval or disapproval to the Credentials Committee, and the reasons therefore, for any changes in clinical privileges or for non-reappointment both for those who applied for changes and those who did not.

3) Criteria for evaluating requests for increase or decrease of clinical privileges shall be based upon the factors set forth previously in this Article.

- **Credentials Committee Procedure**

1) The Credentials Committee, at its next regularly scheduled meeting after receiving the complete reappointment application and after receiving the reports from the service director of each service, shall review all pertinent information available including all information provided from other committees of the medical staff and from hospital management for the purpose of making its findings concerning staff reappointment, for change in staff category, and for the granting of clinical privileges for the ensuing appointment period.
2) The Credentials Committee may require that a person currently seeking reappointment procure a physical and/or mental examination, related to the applicant's scope of practice, by a physician or physicians satisfactory to the Credentials Committee and make the results of such examination available for the committee's consideration. The Credentials Committee may require such examination either as part of the reapplication process or during the appointment period to aid in determining whether clinical privileges should be granted or continued. Failure of an individual seeking reappointment to procure such an examination within a reasonable time after being requested to do so in writing by the Credentials Committee shall constitute a voluntary relinquishment of all medical staff and clinical privileges until such time as the Credentials Committee has received the examination results and has had a reasonable opportunity to evaluate them and make a report thereon.
3) The Credentials Committee shall transmit its report and findings to the Executive Committee within 60 days. Where the Credentials Committee's findings indicate non-reappointment, non-promotion of an eligible current appointee, or a further limitation in clinical privileges, the reason for the same shall be stated, documented and included in the Credentials Committee's report. The Chairperson of the Credentials Committee or his designee shall be available to the Executive Committee to answer any questions that may be raised with respect to the recommendation.

- **Executive Committee Procedure**

The Executive Committee may additionally require the applicant for reappointment to submit any reasonable evidence of current health status related to the applicant for reappointment's scope of practice. At the next regularly scheduled meeting, the Executive Committee shall consider that report and make a written report to the Governing Body that the applicant be:

a. reappointed to the medical staff;
b. deferred for further consideration;
c. rejected for some or all of the clinical privileges requested; or
d. refer the application back to the Credentials Committee for further consideration at the next regularly scheduled meeting.

The Governing Body will then have 60 days to review and act on the Executive Committee's report.

- **Meeting with Affected Individual**

If, during the processing of a particular individual's reappointment, it becomes apparent to the Executive Committee or its chairperson that the committee is considering a recommendation that would deny reappointment, deny a requested clinical privilege, or reduce clinical privileges, the Chairperson of the Executive Committee shall notify the individual of the general tenor of the pending recommendation and ask him if he desires to meet with the committee prior to any final recommendation by the Committee. At such meeting, the affected individual shall be informed of the general nature of the evidence supporting the action contemplated and shall be invited to discuss, explain or refute it. This interview shall not constitute a hearing and none of the procedural rules provided in Fair Hearing Plan shall apply nor shall minutes of the discussion in the meeting be kept as this is a peer review discussion. However, the Committee shall indicate as part of its report to the Governing Body whether such a meeting occurred.

- **Procedure Thereafter**

If a recommendation is made by the Executive Committee concerning reappointment that would entitle the applicant to a hearing pursuant to the Fair Hearing Plan, the CEO shall promptly notify the individual of the recommendation in accordance with the Fair Hearing Plan. The recommendation shall not be forwarded to the Governing body until the individual has exercised or has been deemed to have waived his right to a hearing as provided in the Fair Hearing Plan, after which the Governing Body shall be given the committee's final recommendation and shall act on the application. If for any reason the application for reappointment has not been finally acted on by the Governing Body prior to the end of the appointment year, the then current appointment shall expire and/or clinical privileges in question shall be suspended until final action on the application is taken by the Governing Body.

Section 8.2: Procedures for Requesting Increase in Clinical Privileges

1) Whenever, during the term of his appointment to the medical staff, an individual desires to increase his clinical privileges, he shall apply in writing to the Chief Executive Officer. The application shall state in detail the specific additional clinical privileges desired and the applicant's relevant recent training and experience which justify increased privileges. A state licensure and NPDB query shall be done prior to review by the Credentials Committee. This application shall be transmitted by the Chief Executive Officer to the Credentials Committee and by it to the appropriate service directors. Thereafter, it shall be processed in the same manner as an application for initial clinical privileges if the request is made during the term of appointment, or as a part of the reappointment application. Focused Professional Practice Evaluation (FPPE) shall be completed by the service director within 6 months of granting additional privileges and results forwarded to the Credentials Committee.
2) Recommendations for an increase in clinical privileges made to the Governing Body shall be based upon the factors set forth previously in this Article.
3) The recommendation for such increased privileges may carry with it such requirements for supervision or consultation for such period of time or other conditions as are thought necessary or desirable by the Executive Committee as recommended by the Credentials Committee.

Section 8.3: Issues Regarding Clinical Competence, Ethics and Conduct

- **Section 8.3.1: Grounds for Action**

The Executive Committee shall investigate whenever, on the basis of information and belief, the president of the Medical Staff, the service director of a clinical service, the chairperson of the Governing Body or the Chief Executive Officer has cause to question:

1) the clinical competence of any medical staff appointee;
2) the care or treatment of a patient or patients or management of a case by any medical staff appointee;
3) the known or suspected violation by any medical staff appointee of applicable ethical standards or the bylaws, policies, rules or regulations of the hospital or its Governing Body or its medical staff, including, but not limited to the hospital's performance improvement, risk management, and utilization review programs; or
4) behavior or conduct on the part of any medical staff appointee that is considered lower than the standards of the hospital or disruptive of the orderly operation of the hospital or its medical staff, including the inability of the appointee to work harmoniously with others.

A written request for an investigation of the matter shall be addressed to the Executive Committee making specific reference to the activity or conduct which gave rise to the request. The investigation shall be deemed to begin at this point.

- **Section 8.3.2: Investigative Procedure**

The Executive Committee shall meet as soon after receiving the request as practical and if, in the opinion of the Executive Committee:

1) the request for investigation contains information sufficient to warrant an investigation, the Executive Committee, at its discretion, shall make such a recommendation, with or without a personal interview with the medical staff member; or
2) the request for investigation does not, at that point, contain information sufficient to warrant an investigation, the Executive Committee shall immediately evaluate the matter, appoint a subcommittee to do so, or, if it is deemed necessary, appoint an Investigative Committee.
    a) This Investigative Committee shall consist of up to three (3) persons, any of whom may or may not hold appointments to the medical staff. This committee shall not include partners, associates or relatives of the affected individual.
    b) The Executive Committee, its subcommittee, or the Investigating Committee, if used, shall have available to them the full resources of the medical staff and the hospital to aid in their work, as well as the authority to use outside consultants as required. The committee may also require a physical and mental examination of the member by a physician or physicians satisfactory to the committee and shall require that the results of such examination be made available for the committee's consideration.

3) The individual with respect to whom an investigation has been requested shall have an opportunity to meet with the Investigating Committee before it makes its report. At this meeting (but not, as a matter of right, in advance of it) the individual shall be informed of the general nature of the evidence supporting the investigation requested and shall be invited to discuss, explain or refute it. This interview shall not constitute a hearing, and none of the procedural rules provided in the Fair Hearing Plan with respect to hearings shall apply. A summary of such interview shall be made by the Investigating Committee and included with its report to the Executive Committee.
4) If a subcommittee or Investigating Committee is used, the Executive Committee may accept, modify or reject the recommendation it receives from that committee.

- **Section 8.3.3: Suspension of Privileges**

At any time during the investigation, the Executive Committee, with the approval of the Chief Executive Officer, may suspend all or any part of the clinical privileges of the person being investigated. This suspension shall be deemed to be administrative in nature, for the protection of hospital patients. It shall remain in effect without appeal during the investigation and subsequent hearing if commenced, and shall not indicate the validity of the charges. If such a suspension is placed into effect, the investigation shall proceed expeditiously so that, if findings warrant it, a hearing will be commenced within 15 days after the suspension and completed without delay.

- **Section 8.3.4: Procedure Thereafter**

1) In acting after the investigation, the Executive Committee may:
    a. recommend that no action is justified;
    b. issue a written warning;
    c. issue a letter of reprimand;
    d. impose terms of probation;
    e. impose a requirement for consultation;
    f. recommend reduction of clinical privileges;
    g. recommend suspension of clinical privileges for a term;
    h. recommend revocation of staff appointment; or
    i. make such other recommendations as it deems necessary or appropriate.
2) Any recommendation by the Executive Committee that would entitle the affected individual to the procedural rights provided in The Fair Hearing Plan shall be forwarded to the Chief Executive Officer who shall promptly notify the affected individual by certified mail with return receipt requested. The Medical Staff Office shall then hold the recommendation until after the individual has exercised or has been deemed to have waived his right to a hearing as provided in The Fair Hearing Plan. At that time, the Chief Executive Officer shall forward the recommendation of the Executive Committee, together with all supporting documentation, to the Governing Body. The chairperson of the Executive Committee or his designee shall

be available to the Governing Body or its appropriate committee to answer any questions that may be raised with respect to the recommendation.

3) If the action of the Executive Committee does not entitle the individual to a hearing in accordance with The Fair Hearing Plan, the action shall take effect immediately without action of the Governing Body and without right of appeal to the Governing Body. A report of the action taken and reasons therefore shall be made by the Executive Committee to the Governing Body and the action shall stand unless modified by the Governing Body. In the event the Governing Body determines to consider modification of the action of the Executive Committee and such modification would entitle the individual to a hearing in accordance with The Fair Hearing Plan, it shall so notify the affected individual, through the Chief Executive Officer, and shall take no final action thereon until the individual has exercised or has been deemed to have waived the procedural rights provided in The Fair Hearing Plan.

Section 8.4: Summary Suspension of Clinical Privileges

- **Grounds for Summary Suspension**

The following shall each have the authority to summarily suspend all or any portion of the clinical privileges of a medical staff member or other individual whenever the failure to take such action may result in an imminent danger to the health of an individual.

a. the President of the Medical Staff,

b. a Service Director,

c. the Chairperson of the Credentials Committee,

d. the Chief Executive Officer (or in his absence, his designee), or

e. the Chairperson of the Governing Body, on the advice and approval of the Medical Staff Executive Committee, Clinical Service or other regularly constituted committee or ad hoc committee.

Such summary suspension shall become effective immediately upon imposition, shall immediately be reported in writing to the Chief Executive Officer, the President of the Medical Staff, and the Chairperson of the Credentials Committee and shall remain in effect unless or until modified by the Chief Executive Officer or the Governing Body. Such suspension shall not imply any final finding of responsibility for the situation that caused the suspension.

- **Executive Committee Procedure**

1) Any person who exercises his authority under Section 8.4.1 to summarily suspend clinical privileges shall immediately report his action to the Executive Committee to take further action in the matter.

2) A hearing shall be commenced within 15 days after the suspension and completed without delay. At that point the Executive Committee shall take such further action as is required in the manner specified under Section 3 of this Article.

3) The summary suspension shall remain in force after the appropriate committee takes responsibility unless and until modified by that committee or the Chief

Executive Officer or until the matter that required the suspension is finally resolved.

- **Care of Suspended Individual's Patients**

1) Immediately upon the imposition of a summary suspension, the appropriate Service Director or in his absence the President of the Medical Staff, shall assign to another individual with appropriate clinical privileges, responsibility for care of the suspended individual's patients, still in the hospital at the time of such suspension, until such time as they are discharged. The wishes of the patient shall be considered in the selection of a substitute.
2) It shall be the duty of the President of the Medical Staff and the Service Director to cooperate with the Chief Executive Officer in enforcing all suspensions.

Section 8.5: Procedure for Dealing with Impaired Physicians

- **Definition: Impairment**

The inability to practice medicine with reasonable skill and safety due to physical or mental disabilities, impairments or impediments which may include, but is not limited to, mental disorder, physical or mental deterioration through the aging process, loss of motor skill, or substance abuse.

- **Impairment Referral**

1) Self referral: Upon any medical staff member voluntarily presenting with impairment to a member of the Credentials Committee, an officer of the Medical Staff, a service director or to hospital management, the information shall be immediately disclosed to the Medical Staff Executive Committee.
2) Third-Party Referral: Any hospital staff or member of the Medical Staff who has a reasonable suspicion that a member of the Medical Staff has an impairment shall act as follows:
    a) The individual who reasonably suspects a medical staff member of having an impairment shall provide a written report to the Medical Staff Executive Committee. The report shall include a detailed description of the specific conduct that constitutes the basis for the alleged impairment.
    b) If the individual's report contains sufficient information to support that the medical staff member may have an impairment, the Medical Staff Executive Committee shall conduct an evaluation into the allegations contained in the report.
    c) If the Medical Staff Executive Committee finds no merit to the allegations, the evaluation ceases.
    d) If, after the evaluation, the Medical Staff Executive Committee deems there is sufficient evidence that the medical staff member has an impairment, then the Impaired Physician Committee (IPC) is convened to investigate the allegation. The medical staff member shall be told that the Committee has concluded

based upon its evaluation that the physician suffers from an impairment that affects his/her practice. The medical staff member shall not be told who filed the report.

3) Any action of the IPC is considered peer review.
4) If the IPC determines that the report of alleged impairment has merit, but is currently insufficient to warrant immediate action, the IPC shall monitor the medical staff member until a determination can be made concerning whether or not the medical staff member has an impairment.
5) If the IPC determines that a medical staff member has an impairment, the Committee may, in addition to other advocacy measures to aid the medical staff member's retention or recovery of optimal professional performance:
    a) Obtain a written agreement from the medical staff member that he will:
        i. Undertake a rehabilitation program;
        ii. Undergo random blood, urinalysis, breathalyzer testing and/or psychological testing administered and monitored by the IPC, or its designee;
        iii. Restrict, suspend, or discontinue his/her medical practice; as appropriate.
    b) Take the necessary actions as the Medical Staff Executive Committee consistent with the Bylaws if an agreement is not obtained from the medical staff member.
6) The IPC shall act as advocate to the medical staff member and his family by recommending referral treatment facilities, personal or professional advisors, and practical support.
7) The IPC shall assist medical staff members in locating a suitable rehabilitation program and obtain appropriate reports when treatment was rendered.
8) The IPC shall monitor the medical staff member's exercise of clinical privileges in the hospital as deemed necessary in light of the circumstances and impairment involved.
9) The IPC will respect a medical staff member's privacy and maintain confidentiality to the extent possible. Names of referral services shall also be held in confidence. All parties involved shall be informed of the required confidentiality.
10) All actions and activities of the IPC are preliminary in nature, and none of the procedural rules provided in the Fair Hearing Plan are available to the medical staff member.

Section 8.6: Adverse Actions Affecting Medical Staff Members and AHP's

1) Exclusion from Medicare will result in the individual's voluntary relinquishment of hospital medical staff membership or privileges to the extent that the scope or nature of

the individual's practice at the hospital requires them to treat or be involved in the treatment of Medicare patients.

2) A conviction or plea that materially affects the medical staff member's or appointee's professional standing and ability to practice such as a felony related to violence, physical or sexual abuse, drug offense, or health care fraud and abuse, will result in voluntary relinquishment of all hospital privileges as of that date.

3) Action by the appropriate state licensing board or agency revoking or suspending an individual's professional license, or loss or lapse of state license to practice for any reason, shall result in voluntary relinquishment of all hospital medical staff membership clinical privileges as of that date, until the matter is resolved and the license restored. In the event the individual's license is only partially restricted, the clinical privileges that would be affected by the license restriction shall be similarly voluntarily restricted.

4) If at any time a medical staff member's professional liability insurance lapses, falls below the required minimum (as determined by the Governing Body), is terminated or otherwise ceases to be in effect (in whole or in part), the member's clinical privileges that would be affected shall be voluntarily relinquished or restricted as applicable as of that date until the matter is resolved and adequate professional liability insurance coverage is restored. If liability coverage is restored, the medical staff member must assure to the satisfaction of the Governing Body that any acts, omissions, or commissions during the period of time when there was no coverage have been covered by the reinstated liability insurance carrier.

5) The admitting and/or consultation privileges as well as scheduling of elective procedures by any individual shall be voluntarily relinquished for failure to complete medical records after notification by the Health Information Services of such delinquency in accordance with applicable regulations or policies governing the same. Privileges will be reinstated upon completion of delinquent medical records.

Section 8.7: Procedure for Leave of Absence

1) Persons appointed to the medical staff, for good cause, may be granted leaves of absence by the Governing Body for a stated period of time not to exceed one year. Absence for longer than one year shall constitute voluntary resignation of medical staff appointment and clinical privileges unless an exception is made by the Governing Body.

2) Requests for leaves of absence shall be made to the service directors of the service in which the individual applying for leave has his or her primary clinical privileges, and shall state the beginning and ending dates of the requested leave. The service director shall transmit the request together with his or her recommendation to the Executive Committee which shall make a recommendation report and transmit it to the Governing Body and CEO.

3) At the conclusion of the leave of absence, the individual may be reinstated, upon filing a written statement with the CEO summarizing his professional activities during the leave of absence. The individual shall also provide such other information as may be requested by the service director at the time.

4) In acting upon the request for reinstatement, the Governing Body may approve reinstatement either to the same or a different staff category, and may recommend limitation or modification of the clinical privileges upon reinstatement.

Section 8.8: Confidentiality and Reporting

Actions taken and recommendations made pursuant to this Article shall be treated as confidential in accordance with such policies regarding confidentiality as may be adopted by the Governing Body. In addition, reports of actions taken pursuant to this Plan shall be made by the Chief Executive Officer to such governmental agencies as may be required by law.

Section 8.9: Peer Review

All information, minutes, reports, meeting notes, communications, memoranda, recommendations and actions made or taken pursuant to this Plan are deemed to be inadmissible as evidence or available as discovery in any kind of legal proceeding as covered by the provisions of the Medical Studies Act (Illinois Compiled Statutes 734 ILCS 5/8-2101, Illinois Statutes for Peer Review 210 ILCS 85/10.2, Medical Practice Act 225 ILCS 60/5), or the corresponding provisions of any subsequent federal or state statute providing protection to peer review or related activities. Peer review begins when a Medical Staff Officer, Service Director, Chairman of the Credentials Committee, or hospital Chief Executive Officer begin to evaluate, on behalf of the medical staff, a complaint, unusual occurrence, or report of an incident involving a member of the medical staff.

Fair Hearing Plan

Article 1: Initiation of Hearing

An applicant or an individual holding a medical staff appointment and/or assigned privileges shall be entitled to a hearing whenever a recommendation or an action unfavorable to him (see Section 2.2 below) has been made by the Executive Committee. The applicant is also entitled to a hearing whenever an unfavorable action is made by the Governing Body and the Fair Hearing Plan has not previously been invoked on the matter.

The purpose of the hearing shall be to recommend a course of action to those acting for the Hospital Corporation, whether Medical Staff or Governing Body, and to make findings concerning the nature of each basis for any adverse decision recommended to the Governing Body; the duties of the Hearing Panel shall be so defined and carried out.

Article 2: The Hearing

Section 2.1: Notice of Recommendation

1) When a recommendation is made which, according to this Plan, entitles an individual to a hearing prior to a final decision of the Governing Body on that recommendation, the affected individual shall be given notice within 15 days by the Chief Executive Officer, in writing with return receipt requested. This notice shall contain:
    a. a statement of the recommendation made and the general reasons for it;
    b. notice that the individual has the right to request a hearing on the recommendation within 30 days of receipt of the notice;
    c. a summary of the rights in the hearing as provided for in this Plan.
2) Such individual shall have 30 days following the date of the receipt of such notice within which to request a hearing by a panel hereinafter referred to as the Hearing Panel. Said request shall be made by written notice to the Chief Executive Officer. In the event the affected individual does not request a hearing within the timeframe and in the manner set forth above, he shall be deemed to have waived his right to such hearing and to have accepted the action involved and such action shall thereupon become effective immediately upon final Governing Body action.

Section 2.2: Grounds for Hearing

No recommendation or action other than those hereinafter enumerated shall constitute grounds for a hearing:

a. denial of initial medical staff appointment;
b. denial of medical staff reappointment;
c. revocation of medical staff appointment;
d. denial of requested initial clinical privileges;

e. denial of requested increased clinical privileges;

f. decrease of clinical privileges;

g. suspension of total clinical privileges for a term of greater than 14 days for reasons of competence or conduct;

h. imposition of mandatory concurring consultation requirement.

Section 2.3: Unappealable Actions

The actions which shall take effect without hearing or appeal whether imposed by the Executive Committee or the Governing Body are:

1) voluntary or automatic relinquishment of clinical privileges, as provided for elsewhere in this Plan;

2) the imposition of any consultation requirement with the exception of a mandatory concurring consultation; and/or

3) the imposition of a requirement for retraining, additional training or continuing education.

Section 2.4: Notice of Hearing and Statement of Reasons

1) The Chief Executive Officer shall schedule the hearing and shall give notice of its time, place and date, in writing with return receipt requested, to the person who requested the hearing.

2) The notice shall also include a proposed list of witnesses who shall give testimony or evidence in support of the Executive Committee or the Governing Body at the hearing.

3) The hearing shall begin as soon as practicable, but no sooner than 30 days after the notice of the hearing and no later than 90 days unless an earlier hearing date has been specifically agreed to in writing by the parties.

4) This notice shall contain a statement of the specific reasons for the recommendation as well as the list of patient records and information supporting the recommendation. This statement, and the list of supporting patient record numbers and other information it contains, may be amended at any time, even during the hearing so long as the additional material is relevant to the continued appointment or clinical privileges of the individual requesting the hearing, and that individual and his counsel have had sufficient time to study this additional information.

Section 2.5: List of Witnesses

1) A written list of the names and addresses of the individuals, so far as is then reasonably known, who shall give testimony or evidence in support of the Executive Committee or the Governing Body at the hearing, shall be given with the notice of hearing.

2) The individual requesting the hearing shall provide a written list of the names and addresses of the individuals expected to offer testimony or evidence on his behalf within ten days after receiving notice of the hearing.

3) The witness list of either party may, in the discretion of the presiding officer, be supplemented or amended at any time during the course of the hearing; provided that notice of the change is given to the other party.

Section 2.6: Hearing Panel

1) When a hearing is requested, the Chief Executive Officer, acting for the Governing Body and after considering the recommendations of the President of the Medical Staff (and that of the Chairperson of the Governing Body, if the hearing is occasioned by a Governing Body determination) shall appoint a Hearing Panel which shall be composed of not less than three members who are mutually agreed upon by the majority of the active medical staff members.
2) The majority of the Panel shall be composed of medical staff members who shall not have actively participated in the consideration of the matter involved at any previous level or of physicians or of laypersons not connected with the hospital or a combination of such persons.
3) Such appointment shall include designation of the chairperson. Knowledge of the matter involved shall not preclude any individual from serving as a member of the Hearing Panel.

Section 2.7: Failure to Appear

Failure without good cause of the individual requesting the hearing to appear and proceed at such a hearing shall be deemed to constitute voluntary acceptance of the recommendations or actions pending, which shall then become final and effective immediately.

Section 2.8: Postponements and Extensions

Postponements and extensions of time beyond any time limit set forth in this Plan may be requested by anyone but shall be permitted only by the Hearing Panel or its chairperson on a demonstration of good cause.

Section 2.9: Deliberations and Recommendation of the Hearing Panel

Within 20 days after final adjournment of the hearing, the Hearing Panel shall conduct its deliberations outside the presence of any other person (except the Presiding Officer if one is appointed) and shall render a recommendation, accompanied by a report, which shall contain a concise statement of the reasons justifying the recommendation made and shall deliver such report to the Chief Executive Officer.

Section 2.10: Disposition of Hearing Panel Report

1) Upon its receipt, the Chief Executive Officer shall forward the Hearing Panel's report and recommendation, along with all supporting documentation, to the Governing Body for further action.
2) The CEO shall also send a copy of the report and recommendation, return receipt requested, to the individual who requested the hearing.
3) If the hearing has been conducted by reason of an adverse recommendation by the Executive Committee, a copy of the report of the Hearing Panel shall be delivered by the Chief Executive Officer to the Executive Committee for informational purposes.

Article 3: Hearing Procedure

Section 3.1: Representation

1) The individual requesting the hearing shall be entitled to be represented at the hearing by an attorney or other person of his choice to examine witnesses and present his case.
2) He shall inform the Chief Executive Officer in writing of the name of that person at least ten days prior to the date of the hearing.
3) The Chief Executive Officer shall appoint a person, who may be an attorney, to support the recommendations that give rise to the hearing and to examine and cross-examine witnesses at the hearing.
4) The Chief Executive Officer shall inform the individual requesting the hearing of who that person will be at least ten days prior to the hearing.

Section 3.2: Presiding Officer

1) The Chief Executive Officer may appoint an attorney as Presiding Officer. Such presiding officer may be legal counsel to the hospital. He must not act as a prosecuting officer, or as an advocate for either side at the hearing. He may participate in the private deliberations of the Hearing Panel and be a legal advisor to it, but shall not be entitled to vote on its recommendations. He or she may thereafter continue to advise the Governing Body on the matter.
2) If no Presiding Officer has been appointed, the chairperson of the Hearing Panel shall be the presiding officer, and shall be entitled to one vote. The Presiding Officer shall act to ensure that all participants in the hearing have a reasonable opportunity to be heard and to present all oral and documentary evidence, that decorum is maintained throughout the hearing and that no intimidation is permitted. He shall determine the order of procedure throughout the hearing, and shall have the authority and discretion, in accordance with this Plan, to make rulings on all questions which pertain to matters of procedure and to the admissibility of evidence, upon which he or she may be advised by legal counsel to the hospital.
3) In all instances he shall act in such a way that all information relevant to the continued appointment or clinical privileges of the person requesting the hearing is considered by the Hearing Panel in formulating its recommendations. It is understood that the Presiding Officer is acting at all times to see that all relevant information is made available to the Hearing Panel for its deliberations and recommendations to the Governing Body.

Section 3.3: Record of Hearings

The Hearing Panel shall maintain a record of the hearing by a reporter present to make a record of the hearing or a recording of the proceedings. The cost of such reporter shall be borne by the hospital, but copies of the transcript shall be provided to the individual requesting the hearing at that individual's expense. The Hearing Panel may, but shall not be required to, order that oral evidence shall be taken only on oath or affirmation administered by any person designated by such body and entitled to notarize documents in this state.

Section 3.4: Rights of Both Sides

If the person requesting the hearing does not testify in his own behalf, he may be called and examined as if under cross-examination. At a hearing, both sides shall have the right to:

a. call and examine witnesses to the extent available;

b. introduce exhibits; and

c. cross-examine any witness on any matter relevant to the issues and to rebut any evidence.

Section 3.5: Admissibility of Evidence

1) The hearing shall not be conducted according to rules of law relating to the examination of witnesses or presentation of evidence. Any relevant evidence shall be admitted by the Presiding Officer if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law.

2) Each party shall have the right to submit a memorandum of points and authorities, and the Hearing Panel may request such a memorandum to be filed, following the close of the hearing.

3) The Hearing Panel may question the witnesses, call additional witnesses or request documentary evidence if it deems it appropriate.

Section 3.6: Official Notice

1) The Presiding Officer shall have the discretion to take official notice of any matters, either technical or scientific, relating to the issues under consideration that could have been judicially noticed by the courts of this state.

2) Participants in the hearing shall be informed of the matters to be officially noticed and such matters shall be noted in the record of the hearing. Either party shall have the opportunity to request that a matter be officially noticed or to refute the notice matter by evidence or by written or oral presentation of authority.

3) Reasonable additional time shall be granted, if requested, to present written rebuttal of any evidence admitted on official notice.

Section 3.7: Basis of Decision

The decision of the Hearing Panel shall be based on the evidence produced at the hearing and shall include findings concerning the nature of each basis for any adverse decision recommended to or accepted by the governing board. This evidence may consist of the following:

a. oral testimony of witnesses;
b. memorandum of points and authorities presented in connection with the hearings;

c. any information regarding the person who requested the hearing (so long as that information has been admitted into evidence at the hearing and the person who requested the hearing had the opportunity to comment on and, by other evidence, refute it);

d. any and all applications, references, and accompanying documents; and

e. all officially noticed matters:

f. any other evidence that has been admitted.

Section 3.8: Burden of Proof

At any hearing conducted under this Article, the following rules governing the burden of proof shall apply:

1) The Governing Body or the Executive Committee, depending on whose recommendation prompted the hearing initially, shall first come forward with evidence in support of its recommendation. Thereafter, the burden shall shift to the person who requested the hearing to come forward with evidence in his support.
2) After all the evidence has been submitted by both sides, the Hearing Panel shall recommend in favor of the Executive committee or the Governing Body unless it finds that the individual who requested the hearing has proved that the recommendation that prompted the hearing was unreasonable, not sustained by the evidence, or otherwise unfounded.

Section 3.9: Adjournment and Conclusion

The presiding officer may adjourn the hearing and reconvene the same at the convenience of the participants without special notice. Upon conclusion of the presentation of oral and written evidence, the hearing shall be closed.

Article 4: Appeal

Section 4.1: Time for Appeal

1) Within ten days after the affected individual is notified of an adverse recommendation from the Hearing Panel, or Governing Body committee modifying a recommendation of a Hearing Panel which was not appealed in a manner adverse to the individual, he or she may request an appellate review.
2) The request shall be in writing, and shall be delivered to the Chief Executive Officer either in person or by certified mail, and shall include a brief statement of the reasons for appeal.
3) If such appellate review is not requested within ten days as provided herein, the affected individual shall be deemed to have accepted the recommendation involved and it shall thereupon become final and immediately effective.

Section 4.2: Grounds for Appeal

The grounds for appeal from an adverse recommendation shall be that:

1) there was substantial failure on the part of the Executive Committee, Hearing Panel or Governing Body committee, whichever's recommendation is the subject of the appellate review, to comply with this Plan and/or the hospital or medical staff bylaws in the conduct of hearings and recommendations based upon hearings so as to deny due process or a fair hearing; or
2) the above recommendations were made arbitrarily, capriciously or with prejudice; or
3) the above recommendations were not supported by the evidence.

Section 4.3: Time, Place and Notice

1) Whenever an appeal is requested as set forth in the preceding sections, the Chairperson of the Governing Body shall, within ten days after receipt of such request, schedule and arrange for an appellate review.

2) The Governing Body shall cause the affected individual to be given notice of the time, place and date of the appellate review. The date of appellate review shall be not less than 20 days, nor more than 40 days, from the date of receipt of the request for appellate review; provided, however, that when a request for appellate review is from an appointee who is under a suspension then in effect, the appellate review shall be held as soon as the arrangements may reasonably be made and not more than 14 days from the date of receipt of the request for appellate review. The time for appellate review may be extended by the Chairperson of the Governing Body for good cause with the consent of the affected individual.

Section 4.4: Nature of Appellate Review

1) The Chairperson of the Governing Body shall appoint a Review Panel composed of not less than three persons, either members of the Governing Body or others, including but not limited to reputable persons outside the hospital, or any combination of the same, to consider the record upon which the recommendation was made.

2) The Review Panel may accept additional oral or written evidence subject to the same rights of cross-examination or confrontation provided at the Hearing Panel proceedings. Such additional evidence shall be accepted only if the party seeking to admit it can demonstrate that he or she was deprived of the opportunity to admit it at the hearing and then only at the discretion of the Review Panel.

3) Each party shall have the right to present a written statement in support of its position on appeal, and in its sole discretion, the Review Panel may allow each party or its representative to appear personally and make oral argument. The Review Panel shall recommend final action to the Governing Body within 30 days.

4) The Governing Body may affirm, modify or reverse the recommendation of the Review Panel or, in its discretion, refer the matter for further review and recommendation. The Governing Body then has 30 days to make a decision.

Section 4.5: Final Decision of the Governing Body

Within 30 days after receipt of the Review Panel's recommendation, the Governing Body shall render a final decision in writing and shall deliver copies thereof to the affected individual, the CEO, and the President of the Medical Staff in person or by certified mail.

Section 4.6: Further Review

1) Except where the matter is referred for further action and recommendation in accordance with Section 4.4, the final decision of the Governing Body following the appeal shall be effective immediately and shall not be subject to further review. However, if the matter is referred for further action and recommendation, such recommendations shall be promptly made to the Governing Body in accordance with the instructions given by the Governing Body.

2) This further review process and the report back to the Governing Body shall in no event exceed 30 days in duration except as the parties may otherwise stipulate. Should a further decision then be required, the Governing Body will then have 60 days to review the matter and give its decision unless otherwise agreed to by the parties.

Section 4.7: Right to One Appeal Only

1) No applicant, medical staff appointee, LIP or APP shall be entitled as a matter of right to more than one appellate review on any single matter which may be the subject of an appeal, without regard to whether such subject is the result of action by the Executive Committee or Hearing Panel, or a combination of acts of such bodies.
2) In the event that the Governing Body ultimately determines to deny initial appointment or reappointment to the medical staff to an applicant or revoke or terminate the medical staff appointment of a current member of the medical staff, that individual may not again apply for medical staff appointment at this hospital unless the Governing Body provides otherwise.

Adoption

These Bylaws, (Organization and Structure of the Medical Staff, Credentialing Manual, and Fair Hearing Plan) shall be adopted if approved by at least 2/3^{rds} of the active medical staff at any regular or special meeting of the Active Medical Staff and shall replace any previous Bylaws. The Bylaws shall become effective when approved by the Governing Body of St. Francis Hospital.

Any other procedures, manuals, amendments or appendices are hereby incorporated by reference and become part of the medical staff bylaws.

Originally adopted by the Medical Staff:	April 21, 2012
Originally approved by the Board:	May 1, 2012
Revisions adopted by the Medical Staff:	July 8, 2017, 06/13/2025
Revisions approved by the Board:	05/07/2013, 11/03/2015, 09/05/2017, 03/06/2018, 06/26/2025

APPENDIX A

Those individuals currently or have the potential to practicing as Licensed Independent Providers at HSHS St. Francis 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 St. Francis 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 St. Francis 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.